Joint Reference Committee

May 31, 2014

Arlington, VA

PLEASE CLICK ON ITEM/ITEM NUMBER TO VIEW ITEM

Final Agenda

JRC Draft Summary of Actions

JRC Charge 2014

Report of the CEO and Medical Director

6. Report of the Assembly

    6.1 Multiple Co-payments Charged for Single Prescriptions
    6.2 Elimination of Tobacco Products Sold by National Retailers
    6.3 Maintaining Community Treatment Standards in Federal Correctional Facilities
    6.4 HIPAA and State Restrictions on Duty to Warn
    6.5 Psychiatric Education with Respect to Patients at Risk of Violent Behavior
    6.6 Psychiatrist Patient Relationship and Adverse External Influences in Resolving Danger
    6.7 Increasing Buprenorphine Prescribing Limits
    6.8 No Punishment for Choosing Not to Adopt Electronic Medical Records
    6.9 Patient Satisfaction Surveys and Physician Pay
    6.10 Remove Black Box Warning from Antidepressants
    6.11 American Psychiatric Association and Primary Care Organizations Collaboration in the Affordable Care Act Implementation
    6.12 Addressing the Shortage of Psychiatrists with Sources of Funding
    6.13 Area RFM Representative Modality and Opportunity for APA Updates and Education
    6.14 ABPN 2015 Exam Expectations
    6.15 APA Referendum Voting Procedure
    6.16 Creation of President's Awards for the District Branch and Area with the Highest Percentage of Voting

6.17 Reinstatement of the Committee on Persons with Mental Illness in the Criminal Justice System

6.18 Patient Safety and Veterans Affair Medical Center Participation in State Prescription Monitoring Programs

6.19 Position Statement on the Psychiatric Implication of HIV/HCV Co-infection

6.20 Draft II Summary of Actions

8. Reports from 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. G Healthcare Systems

8.H Council on Medical Education and Lifelong Learning

8.H.1 Request for New Component - Medical Education and Lifelong

8.H.2 Med Ed 2014 AM Meeting Minutes

8.I Council on Minority Mental Health and Health Disparities

8.J Council on Psychiatry and Law

8.J.2 Proposed APA Resource Document on Access to Firearms by People with Mental Disorders

8.J.3 PS Firearms and Mental Illness

8.J.4 RD Firearms and Mental Illness

8.K Council on Psychosomatic Medicine (Consultation-Liaison Psychiatry)

8.L Council on Quality Care

8.L.1 Revision to APA's Choosing Wisely® campaign

8.L.2 Review of APA's Conflict of Interest Policy

8.L.3 Clinical Practice Guidelines 2011

8.L.4 CMSS Principles for the Development of Specialty Society Guidelines

8.L.5 Referral Updates

Joint Reference Committee
January 12, 2014
New Orleans, LA

DRAFT SUMMARY OF ACTIONS
As of February 12, 2014

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

JRC Members Present:

Paul Summergrad, MD: JRC Chairperson; APA President-Elect (stipend); receives income from Tufts University School of Medicine through Tufts Medical Center Physicians Organization; President of the American Association of Chairs of Departments of Psychiatry; Forensic consulting; some non-promotional speaking

Jenny Boyer, MD: JRC Vice Chairperson, Speaker-Elect (stipend); receives income from the Veterans Administration; receives pension income from the State of Oklahoma (University retirement) and the Federal Government (Widow's pension).

I receive pensions from both state and federal govt. the state is from my retirement from the University and the federal is widow's pension

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

R Scott Benson, MD: Assembly Immediate Past Speaker; Private practice in Child and Adolescent and Forensic Psychiatry in Pensacola, Florida

Saul Levin, MD, MPA: CEO/Medical Director; receives income from the APA

Glenn A. Martin, MD: Private practice; City of New York; Medical Director for a Health Information Exchange in Queens; Icahn School of Medicine;

Dilip V. Jeste, MD: Excused

Staff:
Margaret Cawley Dewar – Director of Association Governance
Laurie McQueen – Associate Director, Association Governance

Other Attendees:
Annelle Primm, MD –Deputy Medical Director
Jon Fanning – Chief RFM and ECP Officer
Ian Hedges – Special Assistant to the CEO/Medical Director
Kristin Kroeger – Chief, Allied and External Partnerships
Shaun Snyder, JD – Chief Strategy Officer
Terri Swetnam, PhD – Chief Financial Officer

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
3	Review and Approval of the Summary of Actions from the October 2013 Joint Reference Committee Meeting Will the Joint Reference Committee approve the draft summary of actions from the October 2013 meeting?	The Joint Reference Committee approved the draft summary of actions from the October 2013 meeting.	Association Governance
4	CEO/Medical Director's Office Report Updates on Referrals		
4.A	Referral Update: ASMMAY1312.F; JRCOCT136.6 APA to Liaison with ABPN Regarding MOC Exam Timing The action paper asks that the APA liaison to the ABPN to advocate for members, specifically requesting that if a diplomate takes the re-certification exam prior to the expiration year of his/her certification, that the new 10-year certification period would begin at the expiration of the prior certification period, instead of beginning on the date the exam was taken. And, that the results of this discussion be communicated back to the Assembly at or before the May 2014 Assembly Meeting. The Joint Reference Committee referred this action paper to the Medical Director's Office for referral to the Division of Medical Education and Lifelong Learning. The Division of Education will communicate this issue to the ABPN. **Response**: The ABPN said that they would not allow more than 10 years to elapse between recertification exams, even if a diplomate takes the recertification exam 1 year earlier. This is in accordance with the ABMS policy for all diplomates in every ABMS specialty. This issue will be discussed at the APA/ABPN leadership meeting in January 2014.	The Joint Reference Committee thanked the CEO for the update on the action paper. It was noted that the January 2014 meeting with ABPN was canceled due to the weather and rescheduled for March 2014.	Office of the CEO APA will meet with ABPN at the AADPRT meeting in March 2014 Referral Update to JRC – May 2014 (deadline 5/16/2014) Staff responsible: Office of the CEO

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
4.B	Referral Update: ASMMAY1312.I; JRCOCT136.9 Revitalizing the Public Perception of the APA and the Psychiatric Profession The action paper asks that the APA Board of Trustees reorganize and increase funding to the Council on Communications such that it directs an energized communications and public relations campaign directed towards the public at large, through the lay and social media, utilizing such measures as broad-based advertising, public service announcements, press conferences and other effective public relations measures, seeking advice from public relations professionals; that this effort include messages about how parity violations have and do affect access to care and that the APA Board of Trustees direct the Medical Director to expand APA communications mission. Will the Joint Reference Committee refer the Assembly passed action paper 2013A1 12.I to the appropriate Component(s) for input or follow-up? The Joint Reference Committee referred the action paper to the American Psychiatric Foundation and the Council on Communication for review, comment and formation of a proposal for a public relations campaign against stigma and in support of parity. **Response**: This is being addressed by the ongoing APA wide communications audit carried out by Porter Novelli with preliminary recommendations to be presented to the APA Board of Trustees at its December 2013 meeting.	The Joint Reference Committee thanked the CEO for the update on the action paper and requested that the Assembly be apprised of the results of the communications audit and the overall communications plan for the APA. It was requested that the action paper be noted when responding to the Assembly.	Office of the CEO Report to the Assembly – May 2014 Staff responsible: Office of the CEO

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
4.C	Referral Update: ASMMAY1312.S; JRCOCT136.17 Use of New CPT Codes in Health Insurance Exchanges The action paper asks: 1. That the APA Division of Government Relations and the APA Division of Healthcare Systems and Financing shall jointly advocate that the Exchanges must cover all CPT® codes and coding conventions (including the new combination codes for psychotherapy services) and must use the Medicare RVU values as the basis for reimbursement for physician services in any fee-for-service plan; and 2. That the APA Division of Healthcare Systems and Financing shall prepare draft language and additional supporting material for use by district branches and state associations in advocating at the state level for both use of CPT® codes and coding conventions and for use of the Medicare RVUs in Exchanges established by states. The Joint Reference Committee referred this action paper to the Medical Director's Office to determine what elements of this action paper are already implemented by the Division of Healthcare Systems and Financing. **Response:** We will be monitoring what is happening in the exchange plans; all laws which address these issues have been compiled and based on a review of those laws, exchange plans have no special status. HIPAA already requires the use of CPT codes. APA regularly advocates access to all CPT codes using CPT coding conventions. We anticipate CMS finalizing the Medicare values for the CPT codes in the Final Rule on the 2014 Physician Fee Schedule, published in November 2013; APA will need to develop an action plan based on what CMS publishes in the Final Rule.	The Joint Reference Committee thanked the CEO for the update on this action paper and requested a date by which the action plan based on the CMS final rule will be available.	Office of the CEO Progress report to the JRC – May 2014 (deadline 5/16/2014) Staff responsible: Office of the CEO

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4.D	Referral Update: ASMNOV1212.A; JRCJUNE138.F.2 Adequacy of Health Insurance Provider Networks The Joint Reference Committee referred the action to the Medical Director's Office for the development of a cost estimate for the action plan of action outlined below to collect more detailed information on the adequacy of health insurance provider networks? The Council had a thorough discussion with Drs. Steve Daviss and Bob Roca about the issue of network adequacy. Together the Council and authors of an Assembly action paper on this issue developed a plan of action to better understand the issue. **Response**: A cost estimate is very difficult to gauge given the fact gathering necessary to move anything forward, and the fact that there is no federal standard as to what is considered "adequate," means this falls to each state. PRN is gathering some preliminary data as to network involvement and we are monitoring the roll-out of the exchange plans. Thus far we've had reports of inflated networks (names of individuals who were unaware they were in the network or who had resigned previously) as well as terminations of existing contracts by plans. A cost estimate would be $25,000 to $40,000 for what would be the engagement of an outside contractor to do a secret shopper survey of a provider network.	The Joint Reference Committee thanked the CEO for the update on this action paper. The JRC referred the action paper to the APA AMA delegation and requested that they craft a resolution on the adequacy of health insurance provider networks for the AMA House of Delegates in time for the next HOD meeting. The JRC requested that the resolution be reviewed by APA General Counsel, Colleen Coyle. In addition, a review by the Office of Research is requested.	APA AMA Delegation General Counsel Office of Research Referral Update to JRC – May 2014 (deadline 5/16/2014) Staff responsible: Becky Yowell

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4.E	<u>Referral Update: ASMNOV1212.N; JRCJAN136.10; JRCOCT138.G.1</u> <u>Surveying Recently Graduated Psychiatrists & their Residency Training Programs to Assess Preparedness in the Workforce, & Identify Potential Areas for Improvement in Training</u> The Action paper asks that the APA undertake a survey of recent psychiatry training program graduates, as well as a representative sample of general APA membership, to help to determine the work roles occupied by psychiatrists, the degree to which training programs prepared them for these roles and areas of strength and areas of potential improvement in current training curricula. The APA Assembly further requests ask the Council on Medical Education to oversee the survey work, review findings, compare findings with existing work and current ACGME standards, and present recommendations at the Fall Assembly. Recommendations should include areas identified as potentially being addressed by training programs, as well as areas that might be an APA membership benefit. The Joint Reference Committee referred the action to the Medical Director's Office and requested that this work be included in the work force survey being done within the Office of Research. **Response**: The Council on Medical Education and Lifelong Learning noted that psychiatry, from residency training to clinical practice, is in a process of change at this point brought upon by the new residency Milestone accreditation system and to a greater degree, the anticipated changes in the health care system. It is difficult to know what the practice will be like in 3-5 years and what skills and training are required. The Council supports that spirit of this paper but suggests that the action of surveying graduates and preparing the findings be deferred for approximately 5 years until after we know more fully what the practice landscape will look like. Further, the Council would like to emphasize the realignment of education (from undergraduate to graduate to MOC) in light of the changes in healthcare systems and integrative care system. The Council is making its major project/and focus understanding how to educate our students and residents for Integrated Care. To that end, they are collaborating with the Board of Trustees workgroup on integrated care, and have a new appointed consultant to the council who is a training director in a well-developed integrated care system at University of Washington, Deborah Cowley, MD. In response to this Action Paper, the Council submitted these related questions to be included in the upcoming Member Survey: • How well did your residency training prepare you for real-life practice? (likert scale) • What education-practice gap did you see when you started practice? (open-ended) • What products/resources can the APA provide to help members fill that gap? (open-ended)	The Joint Reference Committee thanked the CEO for this information. It was requested that Dr. Levin provide the Assembly with a detailed report in May 2014. The report may include the potential for instituting partnering with business to create programs for members (including ECPs/RFMs) on a number of issues including negotiating contracts, selecting a first practice, etc. Additionally, the Office of the CEO will request that the Division of Research check that the questions were included within the PRN surveys.	Office of the CEO Detailed Report to Assembly – May 2014 Staff responsible: Dr. Saul Levin Ian Hedges

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4.F	Referral Update: JRCOCT134.C Charge to the Council on Global Psychiatry The CEO/Medical Director agreed to assign appropriate staff to develop a charge for the Council on Global Psychiatry based on the information provided by the Work Group on International Psychiatry, the Board of Trustees and the JRC. The proposed charge will be disseminated to the JRC by email for review and approval prior to consideration by the Board of Trustees in December 2013. **Response**: The Charge has been drafted and is currently being finalized by the President-Elect and members of the JRC.	The Joint Reference Committee thanked the Office of the CEO for the referral update. Please see item 9.A for the proposed charge to the Council on Global Psychiatry.	N/A
4.G	Referral Update: JRCOCT138.F.1 Council Communication to Members The Joint Reference Committee approved that all APA councils provide a brief summary of useful information relevant to individual members after each council meeting that is published in a timely manner through appropriate venues. The JRC referred this item to the Office of Communications and Public Affairs, Information Systems and the CEO's Office for coordination of efforts. **Response**: The October 2013 JRC referred action item 8.F.1 to OCPA, which stipulates that the work and activities of APA councils be disseminated to members so that they are aware of a broad range of activities that each of the APA councils have undertaken. The action was brought forward by the Council on Healthcare Systems and Financing. OCPA met with HCSF staff to discuss the action and recommends the following: 1. Each council has a page located on psychiatry.org, which can be updated by the relevant staff posting each JRC report executive summary as it is written. OCPA staff would do the necessary follow-up to ensure that each staff liaison regularly updates their council's page when a new JRC report is generated. 2. We recommend that Psychiatric News interview council chairs and regularly include articles in the print publication and/or newsletter highlighting the activities of the councils. 3. Ask RFMs, ECPs and Fellows who are appointed to councils to report their council's activities in one of the Community Forums on psychiatry.org.	The Joint Reference Committee thanked the Office of the CEO for the detailed referral update on this action paper and considered the action paper implemented. The JRC suggested that the APA Alerts may be a useful communication tool for disseminating information about the work of the councils to the APA membership.	Office of Communications and Public Affairs – implementation Staff responsible: • Office of Communications and Public Affairs • Staff Liaisons to Councils

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4.H	<u>Referral Update: JRCOCT138.H.1</u> <u>Request for a BOT Ad Hoc Work Group on MUR Issues</u> The Joint Reference Committee recommended that the Board of Trustees approve the request for a BOT Ad Hoc Work Group on MUR Membership Issues to look at how to attract and retain MURs in APA comparable to the work group that addressed ECP membership issues. A charge to the Work Group will be developed prior to the Board of Trustees meeting. **Response**: The Charge for the BOT Appointed Ad Hoc Work Group on M/UR Membership Recruitment and Retention has been written as follows: Provide recommendations to increase the actual and perceived value of APA membership to M/URs to enhance their recruitment and retention throughout phases of their careers. (this was the original #6) The AHWG will accomplish this charge by the following activities: 1. Review current research on dues paying, voluntary membership organizations, including what the most successful ones have done to increase their membership and, in consultation with the Membership Committee and the APA Membership Department, apply this research to the recruitment and retention of M/URs. 2. Review the report of the Ad Hoc Workgroup on MIT and ECP Membership. 3. Review the Council on Minority Mental Health/Health Disparities report on M/UR membership in the APA (developed by Francis Lu, MD) 4. Review previous membership recruitment and retention analyses and plans with a focus on M/UR membership from the Membership Committee and the APA Membership Department 5. Identify barriers to recruitment and retention of M/UR psychiatrists as members of APA 6. Promote engagement to enhance shared learning and leadership to achieve participation of all APA members. 7. Determine the actual and perceived value of membership in the APA for M/UR psychiatrists and trainees, as well as determine what current, potential and dropped M/UR members will need from the APA for their future success as psychiatrists. The Council on Minority Mental Health and Health Disparities supports the BOT's desire for substantial representation of Assembly members on the Work Group to work with Council on Minority Mental Health and Health Disparities members. Further, we support inclusion of leaders of the M/UR caucuses. The composition should include representation of all the M/UR groups as well as members in different stages of their careers. Finally, the Council suggests that Dr. Annelle Primm, or her designee, be named a consultant to the workgroup.	The Joint Reference Committee thanked the CEO for the update on the referral and noted that the Board of Trustees approved the formation and charge for a BOT AHWG on MUR Membership Issues at its meeting in December 2013. Appointments to the work group will be forthcoming.	Office of the CEO Association Governance/Appointments Dr. Saul Levin – to identify staff support to the work group Staff responsible: Laurie McQueen

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
4.I	Referral Update: JRCOCT138.H.3 Internet Access in Council Meetings during APA Annual Meetings The Joint Reference Committee referred the request that internet access be available in council meeting rooms during the APA Annual Meetings (May and September) to the CEO's office for a formal cost estimate for internet access to include council meeting rooms AND the Assembly plenary sessions during the APA Annual Meetings, with a report to the JRC in January 2014. **Response**: There are about 12 councils with 240 members plus staff (about 20-25 depending). One time connection fees ranges from $125-$200 per room per day and then $50 per person for a wireless connection plus 22% service charge (labor) and 8.75% tax. A meeting for 50 people will average about $10K. For the 3 days of the Assembly Plenary in New York in May, the cost for 200 wireless connections will be $19,924.13.	The Joint Reference Committee thanked the CEO for the referral update. After a brief discussion, the JRC suggested that the OCEO research other options for providing wireless/internet to component and Assembly meetings.	Office of the CEO Referral Update to the JRC – May 2014 (deadline 5/16/2014) Staff responsible: Information Systems – Eric Fishman Department of Meetings and Conventions – Cathy Nash
6	Assembly Report		

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.1	Establishing Guidelines for Interacting with Caregivers (ASMNOV1312.C) Will the Joint Reference Committee refer Assembly action paper ASMNOV1312.C Establishing Guidelines for Interacting with Caregivers to the appropriate Component(s) for input or follow-up? (Please see attachment 6.1) The action paper asks the American Psychiatric Association to establish a work group which, working with relevant Councils, will •Identify barriers to communication with caregivers of mentally ill persons, including persons with neurodevelopmental and neurocognitive disorders, and substance use disorders •Investigate clinical, ethical, and legal problems unique to communication with caregivers, and •Develop resource documents to advocate and assist psychiatrists in their interaction with caregivers	The Joint Reference Committee referred the action paper to the Council on Geriatric Psychiatry, Council on Children, Adolescents and Their Families, and the Council on Psychiatry and Law. The Council on Geriatric Psychiatry was designated as the lead council. The JRC expects a progress report from the lead council by the May 2014 JRC meeting and a final product for the October 2014 JRC meeting.	OMNA DGR Council on Geriatric Psychiatry (**LEAD**) Council on Children, Adolescents and Their Families Council on Psychiatry and Law Council on Psychosomatic Medicine Progress update – JRC May 2014 (deadline 5/16/14) Final Product – JRC October 2014 Staff responsible: Sejal Patel (lead) Alison Bondurant Lori Klinedinst Diane Pennessi
6.2	Protecting Privacy and Confidentiality in the Age of the Electronic Medical Record (ASMNOV1312.D) Will the Joint Reference Committee refer Assembly action paper ASMNOV1312.D Protecting Privacy and Confidentiality in the Age of the Electronic Medical Record to the appropriate Component(s) for input or follow-up? (Please see attachment 6.2) The action paper asks the American Psychiatric Association to amend its Position Statement on Confidentiality of Computerized Records to include language strongly opposing back-door access to electronic medical records by any third party, including government agencies.	The Joint Reference Committee referred the action paper to the Council on Quality Care for referral to the Committee on Mental Health Information Technology for revision of the Position Statement on Confidentiality of Computerized Records as requested by the Assembly. The JRC expects a progress report from the committee by the May 2014 JRC meeting and a final product for the October 2014 JRC meeting.	Office of Research Council on Quality Care Committee on Mental Health Information Technology (LEAD) Council on Psychiatry and Law Progress update – JRC May 2014 (deadline 5/16/14) Final Product – JRC October 2014 Staff responsible: Lisa Greiner Lori Klinedinst

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.3	VA Loan Forgiveness Program (ASMNOV1312.G) Will the Joint Reference Committee refer Assembly action paper ASMNOV1312.G: VA Loan Forgiveness Program to the appropriate Component(s) for input or follow-up? (Please see attachment 6.3) The action paper asks the American Psychiatric Association to advocate at the highest level for appropriate benefits, including loan repayment, for recruitment and retention of psychiatrists within the VHA, commensurate with the benefits provided by other federal agencies.	The Joint Reference Committee was informed that the Council on Advocacy and Government Relations discussed the paper at their September 2013 Meeting. The Department of Government Relations (DGR) is working with interested Congressional offices to develop federal legislation to improve recruitment and retention of psychiatrists in the VA through a loan forgiveness program modeled on that of the Department of Defense. DGR continues to press the VA to remedy pay scale disparities in their system adversely impacting psychiatrists. Currently the VA Work Force bill has a democratic sponsor in the Senate and a republican sponsor is being sought. The Joint Reference Committee considers the action paper in progress and implemented.	DGR Report to the Assembly – May 2014 Staff responsible: Lizbet Boroughs
6.4	Development of Patient Log Templates in the Context of Milestones (ASMNOV1312.I) Will the Joint Reference Committee refer Assembly action paper ASMNOV1312.I Development of Patient Log Templates in the Context of Milestones to the appropriate Component(s) for input or follow-up? (Please see attachment 6.4) The action paper asks that the Council on Medical Education and Lifelong Learning be charged with making available for residency programs, a template for logging patient encounters that will be beneficial for program directors and MITs in light of the ACGME push for milestones without being unnecessarily cumbersome to MITs or including any protected health information.	The Joint Reference Committee referred the action paper to the Council on Medical Education and Lifelong Learning and requested that they make available a patient log template for use within the context of Milestones. The JRC expects a progress report by the May 2014 JRC meeting that will include a timeline for the submission to the JRC of a final, implementable product.	Division of Education Council on Medical Education and Lifelong Learning Progress update – JRC May 2014 (deadline 5/16/14) Staff responsible: Nancy Delanoche

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.5	Providing at Least One Complimentary CME Article in The American Journal of Psychiatry to APA Members (ASMNOV1312.J) Will the Joint Reference Committee refer Assembly action paper ASMNOV1312.J Providing at Least One Complimentary CME Article in The American Journal of Psychiatry to APA Members to the appropriate Component(s) for input or follow-up? (Please see attachment 6.5) The action paper asks the APA to provide at least one complimentary CME article in The American Journal of Psychiatry to APA members.	The Joint Reference Committee referred the action paper to the Office of the CEO to gather additional information from the relevant APA departments to develop an action plan to implement this action paper. The JRC expected an action plan for their meeting in May 2014.	Office of the CEO Information Systems Division of Education Publishing Action plan – JRC May 2014 (deadline 5/16/2014) Staff responsible:?
6.6	CPT (ASMNOV1312.M) Will the Joint Reference Committee refer the Assembly passed action paper ASMNOV1312.M CPT to the appropriate Component(s) for input or follow-up? (Please see attachment 6.6) The action paper asks that the Assembly establish, through the Committee on RBRVS, Codes and Reimbursement, a mechanism by which the experience of our grass roots psychiatrists is gathered so that their work is appropriately codified.	The Joint Reference Committee referred the action paper to the Office of the CEO to develop a potential plan for implementation. It was suggested that the IT "Communities" functionality may be useful for implementation of the action. The JRC expects an implementation plan for their meeting in May 2014.	Office of the CEO Progress update – JRC May 2014 (deadline 5/16/14) Staff responsible: Becky Yowell
6.7	Proposed Position Statement: Improving Patient Access through MCO Provider Panels (JRCJUNE128.F.2; ASMNOV124.B.5; JRCJUNE138.F.3; ASMNOV134.B.3) Will the Joint Reference Committee refer the Proposed Position Statement: Improving Patient Access through MCO Provider Panels to the appropriate Component(s) for input or follow-up? The Assembly voted to refer the Proposed Position Statement: Improving Patient Access to MCO Provider Panels back to the Council on Healthcare Systems and Financing. The Assembly felt further work was needed to create a more nuanced statement, and for the statement to address issues related to accessibility and payment.	The Joint Reference Committee sent the proposed position statement back to the Council on Healthcare Systems and Financing for revision based on the comments from the Assembly and asked that they work with Dr. Larry Miller, the Assembly member on the Council to liaise with the Assembly.	Office of HSF Council on Healthcare Systems and Financing Revised Position Statement to JRC – May 2014 (deadline 5/16/14) Staff responsible: Becky Yowell

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.8 Info Item	Assembly Nominating Committee Report The Assembly voted to approve the slate of candidates for the May 2014 Assembly election as follows: Speaker-Elect: James R. Batterson, M.D., Area 4 Glenn Martin, M.D., Area 2 Recorder: Daniel Anzia, M.D., Area 4 Stephen Brown, M.D., Area 7	The Joint Reference Committee thanked the Assembly for this information.	N/A
6.9 Info Item	Revised Position Statement on Marijuana as Medicine (JRCJUNE138.A.1; ASMNOV134.B.1) The Assembly voted, on its consent calendar, to approve the Revised Position Statement on Marijuana as Medicine. This was forwarded to the Board of Trustees for consideration in December 2013. The Board of Trustees approved the revised position statement.	The Joint Reference Committee thanked the Assembly for this information. It was noted that new APA position statements could be highlighted on the APA home page and mentioned in APA alerts.	Office of the CEO To direct staff as to appropriate vehicles to publicize new APA Position Statements.
6.10 Info Item	Retire 2009 Position Statement on Marijuana as Medicine (JRCJUNE138.A.2; ASMNOV134.B.2) The Assembly voted, on its consent calendar, to approve the retirement of the 2009 Position Statement on Marijuana as Medicine. This was forwarded to the Board of Trustees for consideration in December 2013. The Board of Trustees approved the retirement of the position statement.	The Joint Reference Committee thanked the Assembly for this information.	N/A
6.11 Info Item	Proposed Position Statement on Issues Related to Homosexuality (JRCJUNE138.H.1; ASMNOV134.B.4) The Assembly, on its consent calendar, voted to approve the Proposed Position Statement on Issues Related to Homosexuality. This was forwarded to the Board of Trustees for consideration in December 2013. The Board of Trustees approved the proposed position statement.	The Joint Reference Committee thanked the Assembly for this information.	N/A
6.12 Info Item	Revised Position Statement: Somatic Cell Nuclear Transfer (SCNT) Research (JRCJUNE138.K.2; ASMNOV134.B.5) The Assembly voted to approve the Revised Position Statement: Somatic Cell Nuclear Transfer (SCNT) Research. This was forwarded to the Board of Trustees for consideration in December 2013. The Board of Trustees approved the revised position statement.	The Joint Reference Committee thanked the Assembly for this information.	N/A

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
6.13 Info Item	Proposed Position Statement on Detained Immigrants with Mental Illness (JRCOCT128.H.1; ASMMAY134.B.6; ASMNOV134.B.6) The Assembly voted to approve the proposed Position Statement on Detained Immigrants with Mental Illness. This was forwarded to the Board of Trustees for consideration in December 2013. The Board of Trustees approved the proposed position statement.	The Joint Reference Committee thanked the Assembly for this information.	N/A
6.14 Info Item	Revised Position Statement on School-Based Health Clinics (SBHCs) (JRCOCT138.C.2; ASMNOV134.B.7) The Assembly voted, on its consent calendar, to approve the Revised Position Statement on School-Based Health Clinics (SBHCs). This was forwarded to the Board of Trustees for consideration in December 2013. The Board of Trustees approved the revised position statement.	The Joint Reference Committee thanked the Assembly for this information.	N/A
6.15 Info Item	Proposed Position Statement: Legislative Intrusion and Reproductive Choice (JRCOCT138.I.2; ASMNOV134.B.8) The Assembly voted, on its consent calendar, to approve the Proposed Position Statement: Legislative Intrusion and Reproductive Choice. This was forwarded to the Board of Trustees for consideration in December 2013. The Board of Trustees approved the proposed position statement.	The Joint Reference Committee thanked the Assembly for this information.	N/A
6.16 Info Item	Revised Position Statement on Newborn Infant Adoptions (JRCOCT138.C.4; ASMNOV134.B.9) The Assembly voted, on its consent calendar, to approve the Revised Position Statement on Newborn Infant Adoptions. This was forwarded to the Board of Trustees for consideration in December 2013. The Board of Trustees approved the revised position statement.	The Joint Reference Committee thanked the Assembly for this information.	N/A
8.A	Council on Addiction Psychiatry		

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.A.1	<u>American Society of Addiction Medicine's Standards of Care for the Addiction Specialist Physician</u> Will the Joint Reference Committee recommend that the Board of Trustees (APA) not endorse the American Society of Addiction Medicine's Standards of Care for the Addiction Specialist Physician? The American Society of Addiction Medicine invited APA to review its Standards of Care for the Addiction Specialist Physician and offer its official endorsement of the document. The invitation and the Standards of Care are appended as Attachments #1 and #2.	The Joint Reference Committee accepted the recommendations of the Council and will work with the Council on Addiction Psychiatry to draft a letter to be sent to ASAM by the APA.	Office of Research Report to Board of Trustees – March 2014 (deadline 2/12/2014) Staff responsible: Bea Eld
8.A.2 Info Item	<u>Referral Update: JRCJAN138.A</u> <u>Decriminalization of Marijuana – Development of Position Statement</u> A workgroup of the Council on Addiction Psychiatry and Council on Psychiatry and Law remains involved in developing a position statement and resource document on decriminalization of marijuana. A first draft is currently being reviewed and edited by a workgroup of the two councils. As soon as it is completed, the document will be circulated to the membership of both Councils for input and approval. The document is expected to be provided to the Joint Reference Committee in June 2014.	The Joint Reference Committee thanked the Council for its work on this position statement. A question arose regarding whether or not to include within the position statement that the APA does not endorse the legalization of marijuana. The JRC requested a final draft document for their consideration so that it may be reviewed prior to the action item deadline for the May 2014 Assembly meeting.	Office of Research Council on Addiction Psychiatry Draft position statement to JRC – February 2014 (deadline 2/20/2014) Staff responsible: Bea Eld
8.B	Council on Advocacy and Government Relations	The Joint Reference Committee thanked the Council for its report.	
8.C	Council on Children, Adolescents and Their Families		
8.C.1	<u>Referral Update: JRCJUNE138.K.1</u> <u>Need to Train Psychiatrists in the Provision of Care to Individuals with Disorders of Sex Development and Their Families</u> In early December Council submitted feedback directly to Dr. William Byne (Gender Dysphoria Work Group) with regard to the proposed position statement on the Need to Train Psychiatrists in Provision of Care to Individuals with Disorders of Sex Development (DSD) and Their Families. Please see the comments in the Council's report.	The Joint Reference Committee thanked the Council for the update. Please see item 8.H.2 in this report for additional information regarding referrals.	N/A

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.C.2	Referral Update: JRCJUNE138.K.1 Revision to Choosing Wisely: Five Things Physicians and Patients Should Question Will the Joint Reference Committee recommend to the Board of Trustees that item #5 of APA's Five Things Physicians and Patients Should Question submitted for the ABIM Foundation's Choosing Wisely campaign be revised to incorporate key points made in Dr. Louis Kraus's commentary attached as item 8.C.2?	The Joint Reference Committee reviewed the language presented by the Council. There was concern expressed about the process and that the Council on Children, Adolescents and Their Families had not provided input when the Choosing Wisely language was being developed. The Joint Reference Committee referred the proposed language to the Council on Quality Care, which oversaw the development of the original language and requested that the Choosing Wisely organization be contact to determine the process and feasibility of revising the language. A report back to the JRC in May 2014 is requested with final replacement language and information from Choosing Wisely. The language proposed by the Council on Children, Adolescents and Their Families will be sent to the AACAP for their input.	Office of Research OMNA Council Quality Care (**LEAD**) Consult with • Council on Children, Adolescents and Their Children • AACAP Staff responsible: Council on Quality Care – William Narrow, MD Council on Children, Adolescents and Their Families -- Alison Bondurant
8.D	Council on Communications	The Joint Reference Committee thanked the Council for its report.	
8.D.1 Info Item	Council on Communications Member Communications Award The Board of Trustees approved nominations in December, granting the 2013 Member Communications Award to: Arizona Psychiatric Society for the e-Newsletter category, North Carolina Psychiatric Association for the Website category and Washington Psychiatric Society for the Innovative & Emerging Technology category. Each DB/SA will be notified and will receive a certificate.	The Joint Reference Committee thanked the Council for this information.	N/A
8.D.2 Info Item	Communications Audit The public relations firm Porter Novelli is conducting an organization-wide audit of the APA's communications efforts. Members of the Council on Communications were interviewed via telephone to obtain their perceptions of APA communications with its membership.	Please see the CEO's report, item 4.B	N/A

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.D.3 Info Item	RFM & ECP Communities Portal The Council on Communications will participate in the soft launch of the new member collaboration and document-sharing Communities platform with other APA groups. The soft launch is intended to ensure that good content is available for the wider launch and will serve as a pilot so that members can familiarize themselves with the portal before the full launch to RFM and ECP members. A brief, generic overview of the Communities product is available at Customer Communities - Feature Overview Video.	The Joint Reference Committee thanked the Council for this information.	N/A
8.D.4 Info Item	Understanding the Evidence: Off-label Use of Atypical Antipsychotics Educational Program Staff, along with the Council on Communications, will work with APA's Department of Education on ways to promote the eFocus atypical educational program to APA members and other physician groups via digital communication and social media.	The Joint Reference Committee thanked the Council for this information.	N/A
8.E	Council on Geriatric Psychiatry	The Joint Reference Committee thanked the Council for its report.	
8.E.1 Info Item	Revision of Position Statement on Antipsychotic Use in Dementia The council is reworking the position statement on antipsychotic use in dementia based on feedback from the Board of Trustees requesting a more expansive and balanced statement. The Centers for Medicare and Medicaid services (CMS) is interested in the position of the APA on the use of antipsychotics in dementia. The Council is working to come up with a position statement and literature review that might be available sooner for CMS and APA members.	The Joint Reference Committee appreciated the work of the Council and requested that this be a resource document rather than a position statement. The JRC requested the document in 6 weeks.	OMNA Council on Geriatric Psychiatry Report to JRC by February 28, 2014 Staff responsible: Sejal Patel
8.E.2 Info Item	Literature Review on Use of Antipsychotics in Dementia The Practice Guidelines Group is also doing an extensive literature review in advance of developing a guideline on use of antipsychotics in dementia. The council is engaged in conversation with the group to provide input for the guideline which will reflect ideas from people who treat elderly adults every day.	The Joint Reference Committee thanked the Council for the update.	N/A

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.E.3 Info Item	Informed Consent Discussions Re: Use of Antipsychotics in Dementia The council has identified the need for resources to assist APA members in pursuing informed consent discussions regarding the use of antipsychotic medications in patients with major neurocognitive disorders. The council members are working towards assembling supporting material and case studies which can be made available to APA members for their reference on the APA website.	The Joint Reference Committee thanked the Council for this information.	N/A
8.E.4 Info Item	Potential Reception for RFMs at APA Annual Meeting The council is discussing the possibility of a reception for RFMs at the Annual Meeting and working to procure funding for the event. The objective of this event is to encourage recruiting medical students and residents into geriatric psychiatry.	The Joint Reference Committee noted the request and APA staff will let the Council know of any funding streams.	Office of the CEO Staff responsible: Terri Swetnam, PhD
8.E.5 Info Item	Mental Health Needs of Elderly Adults Caring for Adult Children with Disabilities Discussions and efforts are underway to initiative a project to examine and describe mental health needs of elderly adults caring for the adult children with disabilities. The council is working towards finalizing a draft of a potential survey that can distributed to APA members and NAMI chapters for their input. This survey is expected to generate data that will give clear understanding about the scope of this problem. The resulting information may lead to the development of more refined tools and survey techniques that would help deal with this problem.		N/A
8.F	Council on Healthcare Systems and Financing		

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.F.1	<u>Referral Update: JRCOCT128.K.2; ASMMAY134.B.11; JRCJUNE136.4</u> <u>Proposed Position Statement: Psychotherapy as an Essential Skill of Psychiatrists</u> Will the Joint Reference Committee recommend that the Assembly approve the revised (text and title) position statement "Psychotherapy as an Essential Skill of Psychiatrists"? APA Position [all changes accepted- note that the redlined version may be seen as attachment #1 pp. 5-10] 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 ACGME/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. Background: A position statement titled "Medical Psychotherapy" was put forward to the JRC by the Council on Research and Quality Care in early 2013. The JRC approved the statement as written below and sent it on to the Assembly in May 2013. Concerns were expressed about the title "Medical Psychotherapy" and so the paper was referred to the CHSF for review with the suggestion a new title be considered. As part of this effort, the Assembly Work Group on Psychotherapy was also asked to weigh in on the item. The Work Group on Psychotherapy suggested the following title: "Psychotherapy as an Essential Skill of Psychiatrists." The authors of the original position, the Council on Quality Care (formerly part of the Council on Research and Quality Care), and the CHSF support this title as well. The CHSF suggests a friendly amendment which we believe clarifies the statement. (Attachment 1, pp 5-10)	The Joint Reference Committee recommended that the Assembly approve the proposed position statement *Psychotherapy as an Essential Skill of Psychiatrists.*	Association Governance Report to Assembly – May 2014 Staff responsible: Laurie McQueen

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.F.2	Referral Update: JRCOCT138.F.3; Revision to the Proposed Position Statement: Prior Authorizations for Psychotropic Medications Will the Joint Reference Committee recommend that the Assembly approve the revised position statement on "Prior Authorizations for Psychotropic Medications"? APA Position [all changes accepted- note that the redlined version may be seen as attachment #2 pp. 11-13] **The American Psychiatric Association is therefore opposed to any requirement of prior authorization for psychotropic medications prescribed by psychiatrists prior to payment by insurers, except for instances of clear outlier practices or an established evidence base which implicates concern for patient safety. In those instances, the decision to initiate ~~require~~ prior authorization or request documentation should be made only by a Board Certified Psychiatrist.** Background: At their last meeting the JRC referred the proposed position statement on Prior Authorization for Psychotropic Medications back to the Council on Healthcare Systems and Financing for further revisions. The Council reviewed and revised the proposed position statement to make it consistent with the format required by the Operations Manual. Robert Feder, MD, author of the original APA action paper suggesting the development of a position statement, concurs with the revisions. The CHSF is submitting the revised document for review by the JRC.	The Joint Reference Committee recommended that the Assembly approve the revised proposed position statement *Prior Authorizations for Psychotropic Medications.* The Joint Reference Committee requested that Dr. Benson and Dr. Martin speak to the reasons why the position statement is going back to the Assembly for consideration prior to submission to the Board of Trustees.	Association Governance Report to Assembly – May 2014 Staff responsible: Laurie McQueen
8.G	Council on Medical Education and Lifelong Learning	The Joint Reference Committee thanked the Council for its report.	

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.G.1 Info Item	Integrated Care Education The Council is partnering with ADMSEP and AADPRT to conduct an environmental scan within the next 6 months and will prepare a report on how (or whether) medical schools and psychiatry residency programs make clinical experience in integrated care a part of the curriculum and current best practices for education about integrated care. The report will be presented at various allied education meetings such as AAP, AACDP, ADMSEP and AADPRT. The goal is to stimulate the development of educational materials and resources for both undergraduate and graduate medical education, as well as CME, on integrated care for practicing psychiatrists.	The Joint Reference Committee thanked the Council for this update. Dr. Levin will provide a report to the Assembly in May 2014 and will include this information, in addition to the information contained within item 4.E as it relates to action paper ASMNOV1212.M.	Office of the CEO Report to Assembly – May 2014 Staff responsible: Dr. Saul Levin Ian Hedges
8.G.2 Info Item	Education for Members: Division of Education has created resources for APA members to meet ABPN MOC requirements: •At no cost: Online PIP modules and eFocus Self-Assessment (via email) •With Annual Meeting Registration: Self-Assessment Exam •Focus Journal subscription: meets all MOC requirements, continuous over subscription •Focus MOC Workbooks: by topic, meets 3 years of ABPN requirements Learning Management System (LMS) - The past year the APA have made modifications to www.APAeducation.org that have enhanced user experience and also resolved technical issues with the current learning management system. A number of new courses were developed in 2013. There are a number of upcoming courses for 2014. Please see the Council's report for lists of these courses.	The Joint Reference Committee thanked the Council for this information.	N/A

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.G.3 Info Item	Referral Update: JRCUNE138.K.1 Position Statement Review: The Council is current reviewing the "Position Statement on Need to Train Psychiatrists in Provision of Care and Support to Individuals with Disorders of Sex Development and Their Families" by the Workgroup on Gender Dysphoria. We will be sending our comments to the Council on Quality Care by the end of January.	The Joint Reference Committee thanked the Council for this information and requested that the Council on Medical Education and Lifelong Learning send its feedback to the Council on Minority Mental Health and Health Disparities by the end of January 2014. Send comments to the Council on Minority Mental Health and Health Disparities by end of January.	Division of Education Council on Medical Education and Lifelong Learning Report to Council on Minority Mental Health and Health Disparities – 1/31/2014 Staff responsible: Nancy Delanoche
8.G.4 Info Item	Collaboration with the ABPN: Council leaders will join the APA leadership in a regular meeting with the ABPN to discuss recent and upcoming changes in Board Certification and Maintenance of Certification requirements. The Council will bring up the following issues for discussion: member concerns with MOC, combined residency programs and fast tracking in residency.	The Joint Reference Committee thanked the Council for this information.	N/A
8.H	Council on Minority Mental Health and Health Disparities	The Joint Reference Committee thanked the Council for this information and looks forward to receiving updates on the status of the position statement on rape and the position statement on human trafficking by the end of January.	OMNA Council on Minority Mental Health and Health Disparities Updates to the JRC – January 31, 2014 Staff responsible: Alison Bondurant
8.H.1	Referral Update: JRCOCT138.H.1 Development of a Charge to the BOT AHWG on MUR Issues A subcommittee of the Council met by conference call in November to develop a charge for the proposed Board-appointed work group on MUR membership recruitment and retention which was submitted to the CEO's Office in time for the Board's consideration at its December meeting. In addition the Council conveyed its recommendation that the work group's composition include representation of members from the Assembly, all MUR groups as well as members in different stages of their careers. The proposal for a work group was initiated the Council.	The Joint Reference Committee thanked the Council for the update, noting that the AHWG and its charge were approved by the Board of Trustees at its December 2013 meeting.	N/A

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.H.2	<u>Referral Update: JRCUNE138.K.1</u> <u>Need to Train Psychiatrists in Provision of Care to Individuals With Disorders of Sex Development and Their Families</u> Council provided feedback directly to Dr. William Byne (Gender Dysphoria Work Group) with regard to the proposed position statement on the Need to Train Psychiatrists in Provision of Care to Individuals with Disorders of Sex Development and Their Families, as follows: •The title can be construed to imply that the families of persons with DSD are disordered. •It would be very important to make mention of DSM-5 since it just came out to help readers situate the disorders of sex development discussed in the position statement and resource document. Since the last recommendation is made to residency and fellowship programs, this position statement would benefit from comments from the Council on Medical Education and Lifelong Learning. For JRC's information, the Caucus of GLB Psychiatrists also commented on the proposed position statement: "We agree that this is such a rarely encountered phenomenon that most psychiatrists have no experience or expertise and there is a need for training, or at least access to some guidance when faced with these dilemmas. We agree that residencies are stretched with required didactic teaching and would suggest that this training be incorporated in training on other sexual and gender issues (LGBT) issues, which is currently not required or available in many programs, and certainly affects a much wider range of patients. In asking for training, we would hope that the scope of this suggestion be broadened. In the past, this type of position statement would have come from the LGBT Committee which was terminated. It seems there is still a need for this type of work which cannot be accomplished by the Caucus and argues for reinstatement of the Committee, even if it is for limited tasks or duties. Thanks for asking for our input on this important issue."	The Joint Reference Committee thanked the Council for the update. Additionally, the JRC identified the Council on Minority Mental Health and Health Disparities as the Lead council for this referral and asked all councils to which this item was referred to send their feedback and comments to the Council on Minority Mental Health and Health Disparities by the end of January. Doing so will enable the Council on Minority Mental Health and Health Disparities to provide the JRC with a report in May 2014.	OMNA Division of Education Council on Minority Mental Health and Health Disparities Report to JRC – May 2014 (Deadline 5/16/2014) Council on Children, Adolescents and Their Families Council on Medical Education and Lifelong Learning (LEAD) Council on Research Staff responsible: Alison Bondurant Nancy Delanoche
8.H.3 Info Item	<u>Cultural Psychiatry Resources</u> Council member Kenneth Sakauye is leading a Council workgroup to create a cultural psychiatry resource clearinghouse on psychiatry.org. This work group held their first regular conference call in December and will be collaborating with the Office of Minority and National Affairs and the Information Technology Tech Department on this endeavor.	The Joint Reference Committee thanked the Council for this information.	N/A

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.H.4 Info Item	<u>AMA Resolution: Culturally, Linguistically, Competent Mental Health Care and Outreach for At Risk Communities</u> The Council gave feedback to the APA delegation to the November meeting of the AMA House of Delegates to support the AMA resolution re: Culturally, Linguistically, Competent Mental Health Care and Outreach for At-Risk Communities which asks: That American Medical Association support adequate attention and funds being appropriated towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk and that AMA encourage greater cultural and linguistic-competent outreach to ethnic communities that goes beyond in-language print materials to include partnerships with community-based ethnic organizations, health care advocates, and ethnic media outlets (e.g. print, radio, television and social media) that are well-respected and utilized by the members of these respective ethnic communities. The Council felt that: "The resolution, as proposed, addresses an important issue, but is far too vague as to specific steps that could have impact on the desired outcomes. The desired outcomes are also vague. For example, in the 2 "Whereas" sections, there are citations involving Asian Americans, but in the "Be it resolved" sections, actions are proposed for populations that are broadened considerably. As written, APA should not support this statement. It would not make it through our Assembly. However, [the Council] would recommend that our delegation bring these concerns back to the AMA and request that further work be done by a task force other means that they identify, to bring back a resolution with achievable goals and a defined set of recommendations that can be implemented, even if in pilot form."	The Joint Reference Committee thanked the Council for this information.	N/A

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.H.5 Info Item	Appointment Recommendations Council chairperson Sandra Walker submitted recommendations for 2014 appointments to the Council to Dr. Summergrad, emphasizing the rationale for having diverse representation on the Council as delineated in the APA Operations Manual: "These psychiatrists must be representative of these APA-recognized MUR groups and whenever possible be actively engaged with allied groups related to the MUR group to foster collaboration."	The Joint Reference Committee noted the Council's update.	Association Governance Staff responsible: Margaret Dewar Laurie McQueen
8.I	Council on Psychiatry and Law		
8.I.1	Referral Update: JRCOCT138.I.1 Proposed Resource Document: Telepsychiatry and Related Technologies in Clinical Psychiatry (See Attachment #1) Will the Joint Reference Committee approve the updated Resource Document: Telepsychiatry and Related Technologies in Clinical Psychiatry? The Council on Psychiatry and Law updated the previously submitted resource document with the JRC recommended changes, to include information about encryption.	The Joint Reference Committee approved the resource document.	Library and Archives Association Governance FYI – Board of Trustees – March 2014 Staff responsible: Gary McMillan Laurie McQueen
8.I.2 Info Item	Council on Psychiatry and Law's Workgroup on Gun Control The Council on Psychiatry and Law has formed a workgroup that is chaired by Dr. Debra Pinals. The workgroup has been task with reviewing all APA position papers and resource documents that are related to gun control. The workgroup is currently working on a draft document that will be presented to the Council in May, in hopes to present a document to the JRC in June.	The Joint Reference Committee appreciated the work of the Council to date.	DGR Council on Psychiatry and Law Report to JRC – May 2014 (deadline 5/16/2014) Staff responsible: Lori Klinedinst
8.I.3 Info Item	Council on Psychiatry and Law Workgroup on Segregation of Prisoners with Mental Illness Related to Children and Adolescents The Council on Psychiatry and Law developed a workgroup on Segregation of Prisoners with Mental Illness Related to Children and Adolescents, in May, chaired by Dr. Charles Scott. The workgroup continues to work to review the current APA position paper on Segregation of Prisoners (adult) and developing a proposed paper on children and adolescents. The workgroup will present a report with a proposed draft to the Council in May, with hopes to present a document to the JRC in June.	The Joint Reference Committee thanked the Council for the update and looked forward to receiving a report for its meeting in May 2014 and preferably within a month.	DGR Council on Psychiatry and Law Report to JRC – May 2014 (deadline 5/16/2014) Staff responsible: Lori Klinedinst

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.J	Council on Psychosomatic Medicine (Consultation-Liaison Psychiatry)	The Joint Reference Committee thanked the Council for its report.	
8.K	Council on Quality Care		
8.K.1	<u>Referral Update: JRCJUNE136.7; ASMMAY1312.G "Polypharmacy"</u> The Steering Committee on Practice Guidelines welcomes suggestions for guideline topics at any time from the APA Assembly. The committee agrees that the pharmacological treatment of some patients, e.g., patients with more severe illness that does not respond to initial treatments, may require the use of multiple psychiatric medications from different classes and sometimes may require the use of more than one psychiatric medication from the same class, e.g., two antipsychotic medications. There is little evidence to inform guidelines on this topic. The committee suggests that consensus on the appropriate use of polypharmacy would also be difficult to achieve, leading to a nonspecific statement that "polypharmacy is sometimes appropriate." The committee is reluctant to use the formal APA guideline development process, including conducting a systematic evidence review, to develop such a general statement. Polypharmacy for specific disorders has been addressed in some existing APA guidelines, e.g., on schizophrenia, dementias, bipolar disorder, and obsessive-compulsive disorder. The Steering Committee agrees to continue to address the appropriate use of polypharmacy in future APA guidelines on specific disorders whenever feasible. At the present time, APA guidelines are in development on psychiatric evaluation and on the use of second-generation antipsychotics to treat behavioral symptoms of dementia. APA has also nominated clinical questions related to the treatment of bipolar disorder for systematic review of evidence by the Agency for Healthcare Research and Quality.	The Joint Reference Committee thanked the Council for the information on the action paper. The Council was requested to send a report to the Assembly noting that the Practice Guidelines do discuss polypharmacy when appropriate. Currently there is not a strong evidence-base for a practice guideline on polypharmacy, however this information will be folded into the guidelines when possible. The JRC considered the action paper implemented.	Office of Research Council on Quality Care Steering Committee on Practice Guidelines Report to Assembly – May 2014 Staff responsible: Rob Kunkle
8.L	Council on Research		
8.L.1	<u>Revised Charge to the Council on Research</u> Will the Joint Reference Committee recommend that the Board of Trustees approve the revised charge to the newly reconstituted Council on Research? (Please see item 8.L, attachment #1)	The Joint Reference Committee reviewed the revised charge to the Council on Research and had some additional language. The JRC referred the revised charge back to the Council on Research for additional revision and requested a reworked charge for the JRC meeting in May 2014.	Office of Research Council on Research Report to JRC – May 2014 (deadline 5/16/2014) Staff responsible: Harold Goldstein

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
8.L.2	Name Change of Caucus on Alternative and Complementary Medicine Will the Joint Reference Committee recommend that the Board of Trustees vote to approve the change in the name of the Caucus on Alternative and Complementary Medicine to the Caucus on Complementary and Alternative Medicine? (Please see item 8.L attachment #2) This terminology mirrors that used by NIH's National Center on Complementary and Alternative Medicine?	The Joint Reference Committee recommended that the Board of Trustees vote to rename the Caucus on Alternative and Complementary Medicine the Caucus on Complementary and Alternative Medicine.	Association Governance Report to Board of Trustees – March 2014 Staff responsible: Laurie McQueen
8.L.3	Position Statement on the Psychiatric Implications of HIV/HCV Co-Infection Will the Joint Reference Committee recommend that the Assembly approve the Position Statement on the Psychiatric Implications of HIV/ HCV Co-infection? (Please see item 8.L, attachment #3)	The Joint Reference Committee recommended that the Assembly vote to approve the Position Statement on the Psychiatric Implications of HIV/HCV Co-Infection.	Association Governance Report to Assembly – May 2014 Staff responsible: Laurie McQueen
9.A	Charge to the Council on Global Psychiatry Will the Joint Reference Committee recommend that the Board of Trustees approve the charge to the Council on Global Psychiatry? (Please see item 9.A)	The Joint Reference Committee revised the proposed charge to the Council on Global Psychiatry and recommended that the revised version be sent to the Board of Trustees for consideration.	Association Governance Report to Board of Trustees – March 2014 Staff responsible: Laurie McQueen
9.B	Membership Committee Report		
9.B.1	Referral Update: ASMNOV1212.Q; JRCJAN136.13 ECP Member Dues Structure The following information was reported to the BOT in March: The Membership Committee supports the recommendations in the Assembly Action Paper ASMNOV1212.Q regarding the ECP Member Dues Structure. When the Finance and Budget Committee recommends a dues increase in the dues rate for the highest amount, the rates for the first six years of General Membership should be allocated with the following percentage of the full rate: Year Percentage 1 25% 2 35% 3 45% 4 60% 5 75% 6 90%	The Joint Reference Committee thanked the Membership Committee for the update on the referral. It was unclear to the JRC the current status of the ECP dues structure. It was thought that a revised ECP dues structure was approved by the Board of Trustees, and then subsequently fine-tuned by the Finance and Budget Committee. Dr. Swetnam will research this item and report back to the JRC.	Finance and Business Operations Report to JRC – May 2014 (deadline 5/16/2014) Staff responsible: Terri Swetnam, PhD

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
9.8.2	<u>Referral Update: ASMMAY1312.E; JRCJUNE136.5 APA Membership Central Billing Allowing for Voluntary Contributions by Members</u> In June 2013, the Joint Reference Committee referred an Assembly Action Paper entitled "APA Membership Central Billing Allowing for Voluntary Contributions by Members" to the Membership Committee for their opinion on the content of the paper and the potential impact on dues billing. The paper asked that the APA adopt a membership dues statement for which the total bill would include an amount for a DB/SA PAC contribution, upon request from the DB/SA. **Response**: The committee reviewed the paper as well as input from Dr. Wernert, on behalf of the APAPAC Board. Committee members believe that a "negative check-off" for DB/SA PAC contributions would be confusing for members and they do not support it as a means to increase local PAC contributions. The Committee was asked to provide a report to the JRC in October 2013; however, the deadline for the October JRC Meeting was prior to the fall meeting of the Membership Committee when this item was discussed, so the information could not be reported at that time. This information was reported to the Board of Trustees at its December 2013 meeting.	The Joint Reference Committee thanked the Membership Committee for the referral update and noted that no action was taken on the paper therefore the action paper is considered closed.	N/A

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
9.B.3	Referral Update: ASMMAY1312.H; JRCJUNE 136.8 APA MIT 100% Club Benefits In June 2013, the JRC also referred an Assembly Action Paper entitled "APA MIT 100% Club Benefits" to the Membership Committee for evaluation. [Note: MITs are now referred to as RFMs.] The paper asks that residents in the 100% Club be given access to Psychiatry Online at a 50% discount off the current Resident-Fellow Member (RFM) price for that membership year. **Response**: At the Fall meeting of the Membership Committee, the committee agreed that APA should do more to support RFMs in their last year of training and as they transition to Early Career Psychiatrist (ECP) status for the first few years. They also agreed that the support should not be limited to RFMs in the 100% Club. Dr. Amiel appointed a new work group to focus on retention of members as they transition from residency to early career status. No other action was recommended for this paper. This information was reported to the Board of Trustees at its December 2013 meeting.	The Joint Reference Committee thanked the Membership Committee for the referral update and noted that no action was taken on the paper. The Membership Committee has formed a new work group to focus on the retention of members as they transition from residency to early career psychiatrist. The JRC considered this action paper closed.	N/A

Agenda Item #	Action	Comments/Recommendation	Referral/Follow-up
9.D	<u>Elections Committee Report</u> <u>Referral Update: ASMMAY1312.V; JRCJUNE136.19</u> Use of District Branch/State Association/Area Council Electronic Communications by APA Election Candidates Steven Daviss, M.D., the author of the Action Paper, Robert Kelly, M.D., and Barry Herman, M.D., the past and current Chairs of the Election Committee, began correspondence since March 2013 to clarify the current APA Election Guidelines, and the position of the Maryland Psychiatric Society (MPS) listserver for permitted use in campaign communication. According to Dr. Daviss, the MPS listserver is the only listserver associated with the MPS DB and is not maintained using MPS funds. The listserver was set up by a member who volunteered services and funds for this purpose, and is therefore not used for "official" communication with DB members by DB staff. Direct email communication is used for official communication by DB staff. The Election Committee met via conference call in December 2013 to discuss the official response to the Action Paper. **Overview/Summary** The Election Guidelines state that campaigning may not take place on listservers used for Area Council/State Association or DB functions. Campaigning on the MPS listserver would therefore be a violation of the Election Guidelines. Although the MPS listserver is not used for 'official' DB functions, it is the only listserver being used to exchange information, and is, therefore, an important means of communication amongst DB members. Whether it is funded or staffed by MPS or not, the Elections Committee agreed that the listserver is still used for DB functions, especially when it is called the "MPS" listserv with a membership restricted solely to MPS members. The Elections Committee discussed other fundamental issues to consider when reviewing the Action Paper: 1) Could campaign communication occur in the same channel used for other DB communication?; 2) Could campaigning on DB listservers offer unfair advantage to some DBs and candidates in DBs that use listservers?; and 3.) Fair and balanced communication: Should members be allowed to freely express strong opinions for one candidate or the other? The Elections Committee agreed to edit and provide clarification to the current Election Guidelines about whether the DB can use their official listservers to host a discussion among the candidates or respond to questions.	The Joint Reference Committee thanked the Elections Committee for the update on the referred action paper. The Elections Committee will report their feedback on the action paper to the Board of Trustees in March 2014. The action paper is in progress.	Association Governance Elections Committee will report their information on this action paper to the Board of Trustees for the March 2014 meeting. Staff responsible: Chiharu Tobita

1. Joint Reference Committee (JRC)

Composition

Voting members:	• President-Elect (Chairperson) • Speaker-Elect (Vice-Chairperson) • Immediate Past President of the Board of Trustees (one-year term) • One (1) additional member of the Board of Trustees (appointed by the President) • Two (2) additional members of the Assembly (customarily the Immediate Past Speaker and the Recorder) • Medical Director
Ex-Officio members (nonvoting):	• Chairpersons of the Councils • An American Psychiatric Leadership Fellow as Observer • An APA/SAMHSA Fellow or Diversity Leadership Fellow as Observer • An APA Public Psychiatry Fellow as Observer

Functions

(1) Serve as a clearinghouse between the Board and/or Assembly and the councils. The JRC refers matters to and from the Board and/or Assembly. Referrals may be made directly from the Assembly to the Board only in rare instances and at the request of the Assembly Executive Committee. Such referrals should be reported to the JRC to enable it to track where issues are in the governance process.
(2) Refer problems to the appropriate council for assignment and study by a component. Issues may also be referred to the Assembly, district branches and/or area councils for study and reporting back.
(3) Serve as a judicial body for the solution of administrative problems arising between councils.
(4) Authorize the disbursement of funds from the JRC Contingency Fund to councils either to support new programs or supplement ongoing ones. (Requests for monies from this fund are prioritized and voted on during meetings of the JRC; if necessary a mail or telephone ballot may be used between meetings.)
(5) Receive position statements that have been approved by a council and make recommendations to the Board and Assembly for discussion and/or adoption; and receive directly reports by councils that do not involve policy without additional referral to the Board and/or Assembly (as councils have authority to operate within existing Association policy.)
(6) Consider the merits of a project or problem referred by the Board and/or Assembly and reach a conclusion without further reference to other APA components.
(7) Consolidate the reports of two or more of its councils or of overlapping task forces with a recommendation for policy and action to the Board and/or Assembly.
(8) Define areas and functions of the various task forces when more than one council is involved, handling the overlapping concerns of several councils.
(9) Monitor and evaluate functioning of components with annual reports to the Board (see also Appendix U of the Operations Manual, "Component Activity Plan" for the instrument used to monitor and evaluate components.
(10) In 2009, the JRC subsumed the charges of the Award and Award Lecture Corresponding Committee:
    (a) Receiving reports/award nominees from all components that administer the awards given by the Association and forwarding these to the Joint Reference Committee (JRC) for review prior to formal approval by the Board of Trustees;
    (b) Reviewing the funding mechanisms for all awards on a periodic basis;
    (c) Maintaining, overseeing and revising the Award Rotation Schedule. Changes to the Award Rotation Schedule must be approved by the Board of Trustees;
    (d) Receiving proposals for new awards from the JRC, the Assembly and the Board as well as individual members;
    (e) Establishing a protocol for reviewing new award proposals and then evaluating the proposal;
    (f) Reviewing the process by which a name is selected for the new award and for determining the name's appropriateness;
    (g) Reviewing periodically the selection process utilized for selection of awardees for each award;
    (h) Determining a schedule by which these awards are reviewed; and
    (i) Establishing a calendar to carry out its responsibilities.

Final responsibility for the creation and continuation of awards remains with the Board of Trustees.

Attachment #1
Item 2014A112.A
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Multiple Co-payments Charged for Single Prescriptions

WHEREAS:
Reports exist of patients being charged two co-payments when pharmacies fill a single prescription in two increments because of inadequate supply;

This practice may disproportionately affect our patients requiring stimulant medications as supplies of these medications are often low and more often require dispensing in multiple allotments to fill one written prescription;

This practice may effectively double the monthly out of pocket expense to our patients.

BE IT RESOLVED:
That our APA research the reasons for and legality of the practice of charging two co-payments for a single prescription when pharmacies dispense medications in divided increments because of supply limitations.

That our APA advocate for patients not paying more than one co-payment for a one-month supply of a medication, even if dispensed in multiple allotments.

That our APA draft policy opposing the charging multiple co-payments for one prescription and communicate its concerns to relevant stakeholders (State Commissioners of Insurance, pharmacy benefit management companies, state Medicaid directors, etc.).

That this draft policy be sent to the APA AMA Delegation for submission to the AMA House of Delegates.

AUTHORS:
Jacob Behrens, M.D., RFM Representative, Area 4
Justin Schoen, M.D., ECP Representative, Area 4
Steve Koh, M.D., ECP Deputy Representative, Area 6
Bob Batterson, M.D., Deputy Representative, Area 4

ESTIMATED COST:
Author: $1,500
APA: $12,533.33

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: pharmacy, prescription, co-pay

APA STRATEGIC GOAL: Advocating for Patients

REVIEWED BY RELEVANT APA COMPONENT: Council on Healthcare Systems & Financing

Attachment #2
Item 2014A112.B
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Elimination of Tobacco Products Sold by National Retailers

WHEREAS:
Whereas, 18.1% of all U.S. adults aged 18 years or older were current cigarette smokers (in 2012)

Whereas, Cancer, stroke, heart disease and lung diseases are among the results of smoking, according to the CDC. More than 5 million deaths per year are caused by tobacco use. Smokers also tend to die 10 years before nonsmokers, according to the CDC.

Whereas, according to the Surgeon General's report approximately 8.6 million persons in the United States had an estimated 12.7 million smoking-attributed serious medical conditions in 2000.

Whereas, Cigarette smoking increases the risk for many types of cancer, including cancers of the lip, oral cavity, pharynx, esophagus, pancreas, larynx, lung, uterine cervix, urinary bladder, and kidney.

Whereas, If sales of cigarettes at pharmacies continue rising at the current rate, by 2020 almost 15% of all U.S. cigarette sales will occur at pharmacies.

Whereas, More than 32% of pharmacies sold cigarettes, and traditional chain pharmacies were far more likely to sell cigarettes than independently owned pharmacies.

Whereas, 36% of people with mental illness smoke cigarettes.

Whereas, nicotine is the primary psychoactive agent in tobacco smoke and smokeless tobacco and has powerful physical and psychological addictive properties that is similar to that of opiates and other substances of abuse.

Whereas, 31% of all cigarettes are smoked by adults with mental illness.

Whereas, nicotine may have negative impact on the efficacy of medications prescribed to treatment mental disorders e.g., increase the clearance of first generation antipsychotic medication.

Whereas, the overall reduction in smoking rates in the general population has not been matched by proportional reductions amongst individuals with psychiatric disorders.

BE IT RESOLVED:
That the American Psychiatric Association publicly support all national pharmacies or retailers that discontinue the sale of tobacco products to support health and wellness instead of contributing to disease and death caused by tobacco use, and be it further resolved

That this action paper is referred to the American Psychiatric Association's delegates to the American Medical Association House of Delegates for review.

AUTHOR:
Dionne Hart, M.D., Representative, Minnesota Psychiatric Society

ESTIMATED COST:
Author: $500

APA: $1,558.67

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 4

KEY WORDS: tobacco, advocacy

APA STRATEGIC GOALS: Advocating for Patients

REVIEWED BY RELEVANT APA COMPONENT: Council on Addiction Psychiatry

Attachment #3
Item 2014A112.C
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Maintaining Community Treatment Standards in Federal Correctional Facilities

WHEREAS:
Whereas the nation's jails and prison are turning into de facto treatment centers for the mentally ill, with the three largest jail systems housing more than 11,000 prisoners under treatment at any given day.

Whereas, there are a total of 215,030 federal inmates housed in the federal correctional system, the Bureau of Prison (BOP).

Whereas an estimated 60% of the mentally in federal prisons receive some form of mental health treatment.

Whereas the American Psychiatric Association mandates, each correctional agency should employ or contract with a sufficient number of qualified medical, dental, and mental health professionals at each correctional facility to render preventative, routine, urgent, and emergency health care in a timely manner consistent with accepted community standards.

Whereas BOP is revising policy related to the treatment of mentally ill inmates that deviates from community standards by designating a psychologist as the sole discipline authorized to assign mental health care levels meant to indicate and explain the frequency of mental health care contacts required.

Whereas the BOP policy would create treatment teams that include a mental health treatment coordinator (no medical or mental health training required) and a psychiatrist as co-leaders or decision makers in treatment planning.

Whereas, there are thirty-six psychiatrists on staff in BOP facilities. One-third of who are mandated to retire in the next five years.

Whereas the Federal Physicians Association noted psychiatrists in the BOP are paid considerably less than their community counterparts and all other federally employed physicians leading to difficulty recruiting good candidates thus policy changes that reflect the current staffing levels of psychiatrist rather than the needs of the patients.

BE IT RESOLVED:

- That the APA lobby the Bureau of Prisons to ensure any policies and procedures for the delivery of mental health services do no less than comply with existing federal regulations and community standards of evidenced-based treatment, and be it further,

- That the APA publicly oppose any treatment guidelines that minimize the necessity of biological treatment for severe mental health disorders and its management by a medical provider be it further,

- That the APA lobby the Bureau of Prisons to increase the number of employed psychiatrists by increasing compensation packages for BOP employed psychiatrists on par with other federally employed psychiatrists and community psychiatrists.

AUTHOR:
Dionne Hart*, M.D., Representative, Minnesota Psychiatric Society

ESTIMATED COST:
Author: $4,484.67
APA: $1,191.67

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Area 4, Area 6

KEY WORDS: correctional institution, health care disparities, physician shortage

APA STRATEGIC GOALS: Advocating for Patients, Enhancing the Scientific Basis of Psychiatric Care, Advocating for the Profession

REVIEWED BY RELEVANT APA COMPONENT: Submitted to Council on Advocacy and Government Relations

*Dr. Hart is a full-time participant in the National Health Service Corps Loan Repayment Program and completing her service commitment at a Bureau of Prisons facility.

Attachment #4
Item 2014A1 12.D
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: HIPAA and State Restrictions on Duty to Warn

WHEREAS:

Whereas the incidence of dangerousness of the mentally ill is small in proportion to the violence seen in larger society and

Whereas our patients' emotional and psychiatric problems may reach a point of ideation, urge, intent, plan, or preparatory behaviors to harm self and/or others and

Whereas access to deadly force is now readily available to patients with impulsive or planned desire to harm self or others and

Whereas when a psychiatrist has assessed the presence of a serious threat, the ability to predict the timing and 'whether or when', is extremely limited and

Whereas the public wants to be protected from such dangerous behaviors and

Whereas a psychiatrist assesses risk of harm to self and/or others and concludes there is significant risk, and when the risk is serious but not clearly imminent and

Whereas federal and state laws variably mandate duty to warn if a threat is 'imminent' and federal HIPAA exception clause involves 'serious and imminent' danger and

Whereas psychiatrists find themselves conflicted in facing liabilities between an ethical duty to maintain confidentiality, to warn after assessment of danger, then restrictions in doing so if not clearly immediate or imminent, and facing liability in both failure to warn and in warning, and therefore,

BE IT RESOLVED:

That the APA continue to work at the federal and state level to review and if appropriate, advocate for change to regulations and laws, such as HIPAA, in order to maximize the ability to hold psychiatrists harmless, who in good faith and in their best reasonable clinical judgment want to warn or report serious threat as a means to protect the public and our patients.

AUTHORS:
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Roger Peele, M.D., DLFAPA, Representative, Washington Psychiatric Society

ESTIMATED COST:
Author: $0
APA: $7,466.67

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: HIPAA; Duty to Warn; Liability; High risk patient; Violence Risk

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession, Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT:
Reviewed by Dr. Steven Hoge, Chair of Council on Psychiatry and the Law with comments sent to the authors by email, as recommended by Area 3 Council.
Dr. Hoge offered comments on the semantics and structure of the Action Paper.

Attachment #5
Item 2014A112.E
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Psychiatric Education with Respect to Patients at Risk of Violent Behavior

WHEREAS:

Whereas psychiatrists seek increased knowledge in self-protection, assessment skills, and ability to identify, diagnose, determine etiology, immediately manage, treat, and resolve dangerousness and its precipitating factors in patients with a violent mind set and

Whereas there is need to reduce cultural and racial bias in diagnosis, management, and treatment of violent mind set and

Whereas the patient with suicidal and/or homicidal ideation presents the most challenging and stressful clinical situation and

Whereas when the dangerous situation includes existential threat to the patient, specific other, the public, as well to the psychiatrist and

Whereas specifically in relation to neuropsychiatric disorders, continuing education and freedom to order imaging and other relevant studies is desired by psychiatrists, therefore,

BE IT RESOLVED:
That the APA promote expanded access to ongoing research findings with respect to etiology of dangerousness, and guidelines for self-protection of the treating psychiatrist.

That promotion of the knowledge of these issues be accomplished through a track devoted to these topics at the APA Annual Meeting, a course on this topic at the Annual Meeting and articles in the AJP and attend to these topics in all relevant practice guidelines.

AUTHORS:
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ESTIMATED COST:
Author: $0
APA: $35,736

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: $0
ENDORSED BY: Washington Psychiatric Society

KEY WORDS: Violence Research, Psychiatric education about high risk assessment

APA STRATEGIC GOAL:
Advocating for Patients, Advocating for the Profession, Supporting Education, Training and Career Development, Defining and Supporting Professional Values, Enhancing the Scientific Basis of Psychiatric Care

REVIEWED BY RELEVANT APA COMPONENT: Sent to Council on Psychiatry and Law

Attachment #6
Item 2014A112.F
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Psychiatrist Patient Relationship and Adverse External Influences in Resolving Danger

WHEREAS:

Whereas insurance policies and payments of hospital stay and outpatient psychiatric treatment can adversely affect the achievement of successful outcomes, and increase risk to the community, and

Whereas there are payment restrictions that prevent a therapy visit on the same day as a psychiatric visit, which reduce the possibility of successful outcome,

BE IT RESOLVED:
The APA promotes expansion of length of stay for inpatient treatment, when necessary to determine if a patient is or remains at risk or to initiate or continue treatment to reduce potential for violence; and promotes expansion of coverage for outpatient treatment for patients at risk of harm to self or others.

AUTHORS:
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ESTIMATED COST:
Author: $0
APA: $21,066.67

ESTIMATED SAVINGS:$0

ESTIMATED REVENUE GENERATED: $0

ENDORSED BY: Washington Psychiatric Society

KEY WORDS: Insurance influence on treatment; legislative intrusion

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession, Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT: Sent to Council on Psychiatry and Law

Attachment #7
Item 2014A112.G
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Increasing Buprenorphine Prescribing Limits

WHEREAS:

1. Opiate dependency is reaching epidemic proportions in many areas of the United States
2. The increasing prevalence of opiate dependency results in significant morbidity and mortality
3. Buprenorphine is an effective maintenance treatment for opiate dependency
4. Buprenorphine has many advantages over methadone for treatment of opiate dependency, including:
    a. Patients are not required to attend a clinic every day, thereby increasing their occupational potential, reducing stigma, and reducing contact with other addicts
    b. Buprenorphine does not produce opiate intoxication symptoms to the same degree that methadone does
    c. Buprenorphine alone, or when combined with other opiates, is much less likely to lead to fatal overdose than methadone
5. Opiate dependent patients are increasingly seeking buprenorphine treatment
6. The Drug Enforcement Administration (DEA), in an attempt to limit the diversion of buprenorphine and ensure appropriate treatment monitoring, has limited the number of patients that any buprenorphine provider can prescribe to at 100
7. It is unclear how much effect that this DEA policy actually has on diversion of buprenorphine to the community
8. The number of buprenorphine providers in many areas is far below the patient demand for this service. This results in many patients continuing to use opiate street drugs, rather than buprenorphine, in order to avoid withdrawal, with significant ongoing morbidity and mortality

BE IT RESOLVED:

That the JRC refer the issue of increasing buprenorphine prescribing to the needed population to the Council on Addiction Psychiatry for further consideration such as increasing the limits on the prescriber and the number of prescribers and request a report back to the Assembly in November 2014.

AUTHOR:
Robert Feder, M.D., DLFAPA, Representative, New Hampshire Psychiatric Society

ESTIMATED COST:
Author: $0
APA: $55,673.33

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: New Hampshire Psychiatric Society, Area 1 Council

KEY WORDS: Buprenorphine, prescribing limits, opiate dependency, Drug Enforcement Administration (DEA)

APA STRATEGIC GOAL: Advocating for Patients

REVIEWED BY RELEVANT APA COMPONENT: Sent to Council on Addiction Psychiatry

Attachment #8
Item 2014A112.H
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: No Punishment for Choosing Not to Adopt Electronic Medical Records

WHEREAS:

1. The electronic medical record (EMR) generally involves significant cost and time to adopt, especially for a small or solo private practice
2. Once adopted, the EMR involves increased time on the part of the physician to enter data and interact with the computer, rather than looking at and interacting with the patient
3. There remains no clear data that the EMR in the outpatient setting has improved the quality, or reduced the cost of, medical care in any way
4. EMRs are particularly poorly suited to the efficient entering and storing of information relevant to the outpatient practice of psychiatry
5. As a result of the above, the percentage of small or solo outpatient psychiatric practices that have adopted EMRs remains low
6. Medicare has actively begun punishing physicians who do not use EMRs by reducing payments to them
7. This is unfair and illogical, as it involves punishing physicians for failure to adopt a process with no proven value

BE IT RESOLVED:

1. The APA will adopt as a general policy, and begin advocating for, the elimination of penalties of any kind for physicians who choose not to use EMRs.
2. The APA will begin immediate discussions with CMS and any other relevant governmental or private agencies regarding this policy.

AUTHOR:
Robert Feder, M.D., DLFAPA, Representative, New Hampshire Psychiatric Society

ESTIMATED COST:
Author: $0
APA: $620

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: New Hampshire Psychiatric Society, Area 1 Council

KEY WORDS: electronic medical record (EMR), CMS, policy

APA STRATEGIC GOALS: Advocating for Patients, Advocating for the Profession

REVIEWED BY RELEVANT APA COMPONENT: Sent to Council on Healthcare Systems and Financing

Attachment #9
Item 2014A112.J
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Patient Satisfaction Surveys and Physician Pay

WHEREAS:

The Affordable Care Act partially bases Medicare reimbursement on patient satisfaction survey results;

Patient satisfaction surveys have been demonstrated to be unscientific and their results statistically insignificant;

Physicians report being pressured to order unnecessary procedures and prescribe inappropriately in order to increase patient satisfaction scores;

Favorable survey results have been associated with higher costs and poorer health outcomes, rather than lower costs and favorable outcomes;

BE IT RESOLVED:

APA shall advocate that patient satisfaction surveys should not be used as a basis for determining physician remuneration.

AUTHOR:
Joshua Sonkiss, M.D., ECP Deputy Representative, Area 7

ESTIMATED COST:
Author: $55,693.33
APA: $2,266.67

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: antidepressants, suicide, black box warning

APA STRATEGIC GOAL: Advocating for Patients, Advocating for the Profession

REVIEWED BY RELEVANT APA COMPONENT: Submitted to: Council on Quality Care, Council on Healthcare Systems and Financing, Council on Advocacy and Government Relations

References

Why Rating Your Doctor is Bad For Your Health
http://www.forbes.com/sites/kaifalkenberg/2013/01/02/why-rating-your-doctor-is-bad-for-your-health/2/

Attachment #10
Item 2014A112.K
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Remove Black Box Warning from Antidepressants

WHEREAS:

In 2004 the Food and Drug Administration placed a "Black Box" warning on all antidepressants warning that these medications could increase suicidal behavior in patients under age 25;

Many patients with depression and anxiety have foregone treatment with these safe and effective medications because they, their parents or their doctors feared the medicine would cause suicidal behavior;

Subsequent research findings support a favorable risk-benefit profile for antidepressant treatment in patients under age 25, and have not borne out fears of increased suicidal behavior;

BE IT RESOLVED:

APA shall:
In view of recent research findings, urge the FDA to revisit the inappropriateness of the Black Box warning about suicidality with antidepressants.

AUTHOR:
Joshua Sonkiss, M.D., ECP Deputy Representative, Area 7

ESTIMATED COST:
Author: $55,693.33
APA: $79,133.33

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: antidepressants, suicide, black box warning

APA STRATEGIC GOAL: Advocating for Patients

REVIEWED BY RELEVANT APA COMPONENT: Council on Quality Care, Council on Advocacy and Government Relations

References

Antidepressants for Patients and Adolescents: Information for Patients and Caregivers
http://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/antidepressant-medications-for-children-and-adolescents-information-for-parents-and-caregivers.shtml

Attachment #11
Item 2014A112.L
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: American Psychiatric Association & Primary Care Organizations Collaboration in the Affordable Care Act Implementation

WHEREAS:
Whereas, the APA Board of Trustees has a *Work Group on Health Reform* since 2013

Whereas, this WG will deliver a *toolkit on collaborative care* for APA members in 2014,

Whereas, the APA has had a standing Position Statement on *Psychiatry and Primary Care Integration Across the Lifespan* since the autumn of 2010,

Whereas, collaboration and integration of behavioral health & primary care would enhance access & quality of care

BE IT RESOLVED:
That the APA will develop educational & policy collaborations on primary care and behavioral health integration with relevant primary care educators and primary care organizations regarding the *Affordable Care Act*

Be it further resolved, that these collaborations will be reviewed and reported annually by the Board of Trustees and the Assembly to the APA membership.

AUTHORS:
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Roger Peele, M.D., Representative, Washington Psychiatric Society
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Layan Zhang, M.D., APA Member
Urooj Saeed, M.D., RFM Representative, Area 3
Rajeev Sharma, M.D., APA Member
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Mary Jo Fitzgerald, M.D., Representative, Louisiana Psychiatric Medical Association

ESTIMATED COST:
Author: $19,940
APA: $179,041.67

ESTIMATED SAVINGS:

ESTIMATED REVENUE GENERATED:

ENDORSED BY: Area 3 Council, Washington Psychiatric Society, Area 6 Council

KEY WORDS: collaborative care, integrated care, psychiatric & primary care collaboration

APA STRATEGIC GOAL: Advocating for Patient, Advocating for the Profession, Supporting Education, Training, Career Development

REVIEWED BY RELEVANT APA COMPONENT: Council on Healthcare Systems & Financing

Attachment #12
Item 2014A112.M
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Addressing the Shortage of Psychiatrists with Sources of Funding

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)

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)

3. 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 scholarship funds or other means of reducing debt for qualified students who will commit themselves to completing a psychiatry residency and who might, for example, agree to practice as a psychiatrist for a defined number of years in an underserved area.

2. The task force will report its findings to the Assembly and the Board of Trustees at the 2015 Annual Meeting.

AUTHORS:
Lisa Catapano-Friedman, M.D., Deputy Representative, Vermont Psychiatric Association
Jonathan Weker, M.D., Representative, Vermont Psychiatric Association

ESTIMATED COST:
Author: $17,754
APA: $28,344

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Vermont Psychiatric Association

KEY WORDS: psychiatrist, shortage, scholarship

APA STRATEGIC GOAL: Supporting Education, Training and Career Development

REVIEWED BY RELEVANT APA COMPONENT: Presented to: Council on Medical Education

<u>References</u>:
(1) NIMH website, cited in *Psychiatric News* Alerts 2/10/14

Attachment #13
Item 2014A112.N
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Area RFM Representative Modality and Opportunity for APA Updates and Education

WHEREAS:
RFM leaders have direct access to training programs and have a potential opportunity to speak directly to constituents about the APA Assembly and Area RFM updates.

The APA Assembly has established the desire to increase leadership involvement of junior APA members.

There exists detailed and independent material for specific APA components such as leadership structure, membership benefits, PAC, etc. As a result, this information can further be utilized to reach out to all constituents.

BE IT RESOLVED:
That the Council on Communications be charged with the formulation of an APA approved PowerPoint slide set using the current information already established.

That the slide set contains the following information:
APA goals and mission statement, RFM membership benefits (i.e. discounts from APPI, etc.), basic structure of the leadership hierarchy within the APA, information about the PAC, RFM key leaders with contact information, RFM leadership opportunities within the APA, RFM informational guides and/or handbook link, a brief description of the APA Assembly and it's role/function, brief description/definition of an action paper and how to submit an action paper, and hot action paper topics (action papers that have passed the assembly)(the hot action paper topic slide can be very basic as this will change frequently).

That this slide set be used as a template for RFM leaders to add further information specific to his/her area.

That dissemination of the slide set be required of the RFM Representative after each Assembly Meeting. As a result, this requirement should be added to the job duties of the RFM Representative.

AUTHORS:
Edward Thomas Lewis, III, M.D., RFM Deputy Representative, Area 5
Mark Haygood, D.O., M.S., RFM Representative, Area 5
Shalice McKnight, M.D., RFM Deputy Representative, Area 3

ESTIMATED COST:
Author: $840
APA: $4,930

ESTIMATED SAVINGS: $0

ESTIMATED REVENUE GENERATED: Unknown

ENDORSED BY: ACORF

KEY WORDS: Communications, membership, member benefits, PAC, RFM

APA STRATEGIC GOALS: Supporting Education, Training and Career Development, Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT: submitted to the Council on Communications for review

Attachment #14
Item 2014A112.P
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: ABPN 2015 Exam Expectations

WHEREAS:

1. ABPN has announced:
   Examinations administered in 2013 and 2014
   Will continue to use *DSM-IV-TR*
   Examinations administered in 2015 and 2016
   classifications and diagnostic criteria that have *not* changed from DSM-IV-TR to DSM-5

   Examinations administered in 2017
   Will use *DSM-5* classifications and diagnostic criteria

2. The declaration that "only Disorders in which the wording of the diagnostic criteria and classification has not changed" is confusing. There are only ten Disorders that so meet that definition. Since this was pointed out to the ABPN, additional information has been added to the ABPN website, information that is confusing, leaving the candidates to figure out what is to be covered and what is not to be covered.

3. Subsequent to the original draft of this Action Paper, an expansion of the statement above appeared at the ABPN website in mid-February including the "clarification" that: "*Diagnoses and diagnosis subtypes from DSM-IV-TR that are obsolete with the publication of DSM-5 will not be tested.* Example: Substance-induced mood disorder is obsolete*."*
This is quite unclear. DSM-5 points out that only two Disorders were removed. About thirty became obsolete in that they were combined with other disorder. Many had their names altered. Their example, substance-induced mood disorder, was replaced with about fourteen DSM-5 entities. None to be tested?

4. It reflects poorly on psychiatry in general and the APA specifically for ABPN to take the position that it is not important that Board candidates be current as to psychiatric diagnosis for three years. The APA took the position last May that DSM-5 should be used beginning last May, a position consistent with any field, medical or others, in which currentness is important.

5. DSM-5 does not in any way represent a major change in the way psychiatric diagnoses are made and consists entirely of many relatively small changes that reflecting scientific evidence about psychiatric diagnoses that have been accrued over the past 15 years. There is thus no reason to delay its implementation in the ABPN examination.

6. Requiring those taking the examination to recall which version of the DSM applies to which diagnoses, especially given the arbitrary and confusing "criteria" used by the ABPN which goes against what clinicians practicing in the field will be doing, will more likely than not lead to some incorrect answers being given based entirely on this confusion.

7. It is alleged that ABPN is reluctant to base their exam on DSM-5 because of concerns that would outdate some of the questions in their bank of questions [BQ]. It seems more reasonable to ask an ABPN leader to review the BQ and remove questions than to expect candidates to review the vast literature in psychiatry and use the "classifications-and-diagnostic-criteria-that have-*not*-changed-from-DSM-IV-TR-to-DSM-5"decision to decide what to study.

8. The American College of Psychiatrists' PRITE will begin using DSM-5 in 2015. This suggests it is feasible for ABPN to do so too.

9. Candidates should be told clearly what to study. The present ABPN website's wording does not clarify what to study, e.g. the DSM-IV TR version of Sadock and Sadock or the new, DSM-5, version of Sadock and Sadock?

BE IT RESOLVED:
That the APA ask the ABPN to use DSM-5 in its written examinations beginning in 2015.

AUTHORS:
Roger Peele, M.D., DLFAPA, Washington Psychiatric Society Assembly Representative
Richard Ratner, M.D., DLFAPA, Liaison, American Society of Adolescent Psychiatry

ESTIMATED COST:
Author: $0
APA: $233.33

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY: Washington Psychiatric Society Board of Directors, March 10, 2014
Area 3, March 1, 2014

KEY WORDS: ABPN

APA STRATEGIC GOALS: Education, Training, Career Development, Enhancing the Scientific Basis of Psychiatric Care

REVIEWED BY THE RELEVANT APA COMPONENT: Sent to Council on Medical Education and Lifelong Learning

Attachment #15
Item 2014A112.S
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: APA Referendum Voting Procedure

WHEREAS:
Whereas: The referendum process is a critical component in maintaining the American Psychiatric Association as a member driven organization and allows the membership to determine the need for even major structural or policy changes in the organization, similar to the purpose of the amendment process in the U. S. Constitution.

Whereas: The referendum process is currently operationalized by attaching the referendum for membership vote to the APA National officer election ballot.

Whereas: The election of officers occurs by a simple majority of those eligible members who choose to vote, while the passing of a referendum requires a majority of at least 40 percent of all eligible voters.

Whereas: Forty percent of all eligible voters have not voted in an APA national election in 15 years with only 19 percent voting in the 2013 election. Thereby, no referendum has passed since 1980, even when the affirmative percentage of voting members was as high as 80 percent, as occurred in 2011.

Whereas: A referendum to change the voting percentage requirement would, itself, have to go through the above-referenced process which has clearly been shown to not be functional for establishing the predominant will of the membership in regard to proposals.

Whereas: There is a stipulation in the American Psychiatric Association bylaws, Section 8.4, which states that referenda are "to be voted on in the next annual ballot." It does not specifically stipulate that this "annual ballot" refers to, or only to, the national election ballot. Thus, it seems possible that a referendum ballot could be included with the dues statement.

Alternatively, the Assembly could request that the Board of Trustees, as per Section 1.2 of the bylaws, pass an amendment to the bylaws stipulating that referenda may be distributed for member voting in a yearly mailing which includes the dues statement and/or solicitation for contributions (for non-dues paying but voting members).

Whereas: The cost of attaching referendum voting ballots to the dues notice process should not be inherently more expensive that the current practice of attaching them to the officers' election ballot process, beyond that of establishing the transition.

Whereas: This action paper as amended by reference committee 5 was approved in May 2013 by the Assembly without dissenting votes but was then not referred to the Board by the Joint Reference Committee. This version contains all the reference committee 5 changes made and approved at that time.

Whereas: At the request of reference committee 5 to the authors at the November 2013 assembly meeting this action paper was referred to the Assembly Executive Committee with the charge to "address feasible implementation of this action paper." To date, no results have occurred and the paper was not listed on the action paper "follow up" web site.

BE IT RESOLVED:
1. That the Assembly of the American Psychiatric Association requests that the ballot for a referendum be distributed not with the yearly officer election ballot, but with the yearly dues statement which is responded to by all APA members who wish to retain membership except those with dues-exempt status. Additionally, those voting members not getting a dues notice currently will need to be included in the mailing.

2. That it is the will and intent of the Assembly that this action paper, now reaffirmed, be passed on by the JRC to the Board of Trustees.

AUTHORS:
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(jshemomd@hotmail.com)
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Ramakrishnan Shenoy, M.D., DLFAPA, Representative, Psychiatric Society of Virginia

ESTIMATED COST:
Author: $35,510
APA: $35,466.67

ESTIMATED SAVINGS: Not relevant for this paper

ESIMATED REVENUE GENERATED: Not relevant for this paper

ENDORSED BY: Psychiatric Society of Virginia, Area 5 Council

KEY WORDS: APA referendum, membership driven governance

APA STRATEGIC GOALS: Defining and Supporting Professional Values/Governance Issues

REVIEWED BY RELEVANT COMPONENT: Has been submitted to the By-Laws Committee and the Elections Committee.

May 2014 Assembly
Agenda Item # 2014 A1 12.S, APA Referendum Voting Procedure

Issues for Consideration by the JRC

1. The first APA Membership Renewal Notice and supporting materials are sent to the mail house by the third week of September. All materials must be ready for pick-up by September 19. Any delay in the mailing results in a delay receiving dues revenue for the APA and the district branches.
2. Renewal notices are not sent to all voting members. Excluded are:
    a. 4,200 dues-exempt members in Life Status (Life Members, Life Fellows, Distinguished Life Fellows).
    b. 1,200 new Resident-Fellow Members with a one year dues waiver.
    c. 2,200 members on the Scheduled Payment Plan
3. Members reaching Life status for the first time do not receive a renewal notice until mid to late October (approximately 400 members).
4. The first Membership Renewal Notice currently includes the following:
    a. Dear Colleague letter from APA President and CEO/Medical Director
    b. Dear Colleague letter from the district branch, if provided (34 provided in 2014)
    c. Membership Invoice
    d. Scheduled Payment Plan Enrollment Form
    e. Return envelope
5. Matching personalized voting forms with the personalized invoices during the mail house process could potentially delay the mailing because of the extra time involved in making sure the pieces match up correctly.
6. Membership would need to provide to Association Governance staff with a mailing list of the approximately 8,000 members excluded from the initial Renewal mailing so that the referendum ballot could be mailed separately.
7. If approved by the JRC and the BOT, it is recommended that the inclusion of the ballot for a referendum with the Membership Renewal mailing be conducted as a pilot project to determine if it has the measured result anticipated.

Attachment #16
Item 2014A112.U
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Creation of President's Awards for the District Branch and Area with the Highest Percentage of Voting

WHEREAS:
Whereas: Voter turnout has been unacceptably low for several years, now dropping to less than 20%.

Whereas: Even important referenda have not elicited an adequate number of voters for election outcomes to be actionable

Whereas: A healthy democratic institution requires a robust participation by its general body

Whereas: The causes of voter apathy are multiple and solutions have to be diverse and many pronged.

Whereas: Appealing to local group identity and pride might be one such measure in encouraging higher participation.

BE IT RESOLVED:
1. APA institute and publicize a President's Award for the District Branch with the highest voting rate (highest percentage) in the election, and for the Area with the same criteria.
2. These awards (a trophy or plaque along with a certificate), be presented at the Annual meeting immediately following the election each year.
3. The awards and the presentation will be duly publicized in Psychiatric News and in other appropriate avenues.

AUTHORS:
Seeth Vivek, M.D., Representative, Area 2
Richard Altesman, M.D., Deputy Representative, Area 2

ESTIMATED COST:
Author: $500
APA: $1,173.33

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None directly

ENDORSED BY: Queens County Psychiatric Society

KEY WORDS: Elections, Awards

APA STRATEGIC GOALS: Advocating for the Profession, Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT: Referred to the Elections Committee

Attachment #17
Item 2014A112.V
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Reinstatement of the Committee on Persons with Mental Illness in the Criminal Justice System

WHEREAS:

1. The sunsetting of the APA's Committee on Persons with Mental Illness in the Criminal Justice System (hereinafter referred to as "The Committee") has left the APA without a component which is specifically dedicated to be the proactive and dynamic voice of organized psychiatry to advocate for our patients with mental illness who are in the criminal justice system.

2. It is necessary and indeed urgent that the American Psychiatric Association have an proactive and dynamic voice with which to advocate on behalf of persons with mental illness in the criminal justice system.

3. There is a clear and present danger that the APA is being left behind in the presently dynamic context in which changes such as broad-ranging diversion programs and comprehensive re-entry programs are being developed.

4. Studies indicate that there are at present an estimated 350,000 inmates with serious and persistent mental illnesses in our nation's jails and prisons. This number rises to an estimated 1.1 million patients when it includes all those under correctional supervision, e.g., on probation or on parole and it is important to note that every correctional institution in the United States is constitutionally mandated to provide mental health care and treatment. (There are approximately 5,000 correctional institutions - about 3500 jails and 1500 prisons).

5. The APA's Committee on Persons with Mental Illness in the Criminal Justice System had an outstanding record of activities including, for example, two editions of the APA guidelines: APsychiatric Services in Jails and Prisons@ as well as an acclaimed, forward looking, invitational conference: AThe Fiscal Issues of the Involvement of People with Serious Mental Illness in the Criminal Justice System@

6. The Committee over the years had worked actively with organizations such as The Substance Abuse and Mental Health Services Administration, The Gains Center, The Council of State Governments, The National Council of State Legislatures, The National Association of Counties, The Bazelon Center, The American Association of Community Psychiatrists, The National Association of State Mental Health Program Directors, as well as The American Medical Association, The American Psychological Association, The American Bar Association, The National Association of Social Workers, The National Commission on Correctional Healthcare and, of course, NAMI. (The members of the Committee received the NAMI Exemplary Psychiatrist Award in 2005 and it should be noted that one member of The Committee - who is not a physician - was a renowned leader in NAMI.)

7. The Position Statement of 1988 authored by The Committee stated that:

   1. The fundamental goal of a mental health service should be to provide the same level of care to patients in the criminal justice process that is available in the community. [Note: this phrase

was changed in the text of the Second Edition to "ought to be available in the community."]
2. The effective delivery of mental health services in correctional settings requires that there be a balance between security and treatment needs. There is no inherent conflict between security and treatment.
3. A therapeutic environment can be created in a jail or a prison setting if there is clinical leadership, with authority to create such an environment.
4. Timely and effective access to mental health treatment is a hallmark of adequate mental health care. Necessary staffing levels should be determined by what is essential to ensure that access.
5. Psychiatrists should take a leadership role administratively as well as clinically. Further, it is imperative that psychiatrists define their professional responsibilities to include advocacy for improving mental health services in jails and prisons.

8. At one point, among its projects, in an effort to prevent psychologists from prescribing medications, the Committee tracked and opposed psychologists' efforts to expand their scope of practice to be allowed to prescribe medications in correctional facilities. Another ongoing project was to develop a model of liaison of correctional psychiatrists with the primary care physicians who treat patients in jails and prisons;

9. The reinstatement of the Committee on Persons With Mental Illness in the Criminal Justice System will emphatically demonstrate the intent of the APA to energetically carry out the Vision, Mission, Values and Strategic Goals of the APA as they apply specifically to this very important and substantial group of patients, whose likelihood of recidivism – returning back into the criminal justice system - is of such concern.

10. The Committee is the ideal means of focusing the expertise of APA members on this important work as well as furthering the recruitment and retention of psychiatrists into this work.

11. The Committee had an extensive track record of educating the membership through numerous courses, workshops and other presentations at the APA's Annual Meetings and at the APA's Institute of Psychiatric Services.

12. The achievements of The Committee have been and will be of considerable value to the APA not only in regard to the public relations aspects of its dedication to public service but also in regard to its internal marketing: the recruiting correctional psychiatrists who are not members of the APA to join the APA - with the message that the APA accords a high priority to this population and the psychiatrists who serve them.

BE IT RESOLVED:
That the Assembly urges the Board of Trustees to reinstate the Committee on Persons with Mental Illness in the Criminal Justice System which will resume being the proactive and dynamic voice of the APA to advocate for the efforts to provide for and improve the care and treatment of persons with mental illness in the criminal justice system, and to provide deliverables such as a new Position Statement and a Plan of Action for the APA internally - to the APA members and the other APA components, and nationally - to organizations such as NAMI, The National Association of State Mental Health Program Directors - and internationally to such organizations such as Penal Reform International and the UN Economic and Social Council.

The Committee on Persons with Mental Illness in the Criminal Justice System would report to the Council on Advocacy and Governmental Relations and would provisionally have the following charge:

1. Develop a Plan of Action consistent with the Strategic Goals of the APA to improve psychiatric services for persons with mental illness involved with the

criminal justice system.

2. Develop coordinated advocacy efforts by the APA to decriminalize many of the large number of persons with mental illness involved in the criminal justice system.

3. Review current and emerging research data relating to persons with mental illness in the criminal justice system to develop a system of evidence based policies and treatment.

4. Develop a model of liaison of correctional psychiatrists with the primary care physicians who treat patients in jails and prisons;

5. Revise and update the Position Statement of 1988.

AUTHOR:
Henry C. Weinstein, M.D., Representative, New York State Psychiatric Association

ESTIMATED COST:
Author: $14,701.30
APA: $18,990

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: Criminal Justice System, Jails, Prisons, Diversion, Mental Health Courts, Reentry

APA STRATEGIC GOALS: Advocating for Patients, Advocating for the Profession, Supporting Education, Training and Career Development, Defining and Supporting Professional Values

REVIEWED BY RELEVANT APA COMPONENT:

Attachment #18
Item 2014A112.X
Assembly
May 2-4, 2014

ACTION PAPER

FINAL

TITLE: Patient Safety and Veterans Affair Medical Center (VAMC) Participation in State Prescription Monitoring Programs (PMP)

WHEREAS:
Whereas, there is a significant problem with diversion of prescription controlled substances because of so-called 'doctor shopping'

Whereas, at present, there is a limited demonstration project involving several VAMCs participating in their respective state PMPs,

Whereas, those VAMCs that provide clinical services including prescriptions of controlled substances to patients residing in multiple states, but their clinicians need only be licensed in a single state that may not be the state in which their VAMC facility is located,

Whereas, all VAMC prescribers of controlled substances are required to have a federally issued DEA controlled substances [so-called 'narcotic] license, and if they are licensed in the state in which their facility is located, then they are also required a state issued controlled substance license, if one is required, they are not able to access to contiguous states' PMP because they lack a medical license in that state,

BE IT RESOLVED:
That the APA will request the Council on Advocacy and Government Relations to explore federal legislation and regulatory opportunities for the APA to advocate for the Veterans Health Administration to create a program that would allow licensed prescribers universal access to state PMPs, and

That APA's resources, including the Offices of the APA CEO/Medical Director, the Council on Advocacy and Government Relations and the Council on Addiction become engaged in this endeavor.

The APA will advocate for more open access to state PMPs, initially by VA health care providers not licensed in that given state.

AUTHOR:
Harold Ginzburg, M.D., J.D., MPH, Deputy Representative, Oklahoma Psychiatric Physicians Association

ESTIMATED COST:
Author: $1,020
APA: $850

ESTIMATED SAVINGS: None

ESTIMATED REVENUE GENERATED: None

ENDORSED BY:

KEY WORDS: patient safety, addiction, controlled substances, veterans

APA STRATEGIC GOAL: Advocating for Patients

REVIEWED BY RELEVANT APA COMPONENT:

ASSEMBLY REFERRED BACK TO THE JOINT REFERENCE COMMITTEE

POSITION STATEMENT
Psychiatric Implications of HIV/ HCV Co-infection

Background

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

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

The most common route of HCV infection is injection drug use. Sexual transmission is less common but also occurs. For unclear reasons the cohort of "baby-boomers" born between 1945 and1965 has an elevated rate of HCV infection independent of their reporting risk factors. The CDC therefore recommends HCV testing in those with risk factors and at least once for those born between 1945 and1965 regardless of reported risk factors. CDC guidelines for Hepatitis C testing can be found at *www.**cdc**.gov/**hepatitis**/hcv/**GuidelinesC**.htm*

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

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

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

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

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

At present in 2012 pegylated interferon α and ribavirin are still needed for the treatment of HCV. Interferon free and ribavirin free treatments are being tested but are not yet available outside of clinical trials.

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

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

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

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

Co-morbid substance use disorders need to be addressed aggressively if treatment rates for HCV are to be improved in the HIV-HCV co-infected populations. Integrated patient-centered care involving an interdisciplinary team of mental health professionals and substance abuse counselors may enhance eventual treatment eligibility rates.

Recommendations:

1. Psychiatrists should stay current in their medical knowledge of the psychiatric and neuropsychiatric manifestations of HIV and HCV disease and the complications of their treatments.

2. Psychiatrists should consider, encourage, facilitate and in certain instances (such as inpatient psychiatric care) provide both HIV and HCV testing.

3. Patients should be treated for current mood disorders prior to initiating HCV treatment. Patients with a past history of depression may benefit from prophylaxis with appropriate psychotropic medications. It is also desirable to ensure that the patient is as stable as possible with regard to psychiatric symptoms, substance use, psychosocial support and housing, as these factors are associated with adherence to treatment.

4. Psychiatrists have a responsibility to advocate for necessary access to HCV treatment for their infected patients. In addition, psychiatrists should be involved in closely monitoring changes in neuropsychiatric functioning, such as mood, behavior and cognition.

5. Psychiatrists are encouraged to collaborate with hepatologists, infectious disease physicians and other primary care providers for the HIV/HCV infected.

6. Because of the increased hepatotoxicity in the HCV co-infected patient, psychiatrists should actively monitor the potential for drug – drug interactions and overlapping toxicities of treatments for HCV, HIV and psychiatric disorders. In addition, attention should be paid to the potential for the interaction of substances of abuse with HIV/HCV antiretroviral treatment and psychiatric medications.

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

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Attachment #20

Assembly
May 2-4, 2014
New York, New York

DRAFT SUMMARY OF ACTIONS

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 1.A.1	Ratification of APA Bylaws: Ratification of the Recommended Amendments to the Bylaws Complying with the "The Non-profit Corporation Act of 2010"	The Assembly ratified the recommended amendments to the Bylaws complying with the "The Non-profit Corporation Act of 2010".	FYI – Board of Trustees, July 2014
2014 A1 4.B.1	Proposed Position Statement: Psychotherapy as an Essential Skill of Psychiatrists	The Assembly approved the Proposed Position Statement: *Psychotherapy as an Essential Skill of Psychiatrists* on the Consent Calendar.	Board of Trustees, July 2014
2014 A1 4.B.2	Proposed Position Statement: Prior Authorizations for Psychotropic Medications	The Assembly approved the Proposed Position Statement: *Prior Authorizations for Psychotropic Medications* on the Consent Calendar.	Board of Trustees, July 2014
2014 A1 4.B.3	Position Statement on the Psychiatric Implications of HIV/HCV Co-Infection	The Assembly voted to refer the Position Statement on the *Psychiatric Implications of HIV/HCV Co-Infection* back to the Joint Reference Committee.	Joint Reference Committee, May 2014
2014 A1 4.B.4	Proposed Position Statement: The Need to Monitor and Assess the Public Health and Safety Consequences of Legalizing Marijuana	The Assembly approved the Proposed Position Statement: *The Need to Monitor and Assess the Public Health and Safety Consequences of Legalizing Marijuana* on the Consent Calendar.	Board of Trustees, July 2014
2014 A1 5.A	Will the Assembly vote to approve the minutes of the November 8-10, 2013 meeting?	The Assembly voted to approve the Minutes & Summary of Actions from the November 8-10, 2013 meeting.	Chief Operating Officer • Association Governance
2014 A1 6.B	Will the Assembly vote to approve the Consent Calendar?	Items 2014A1 4.B.3, 8.L.1, 8.L.2, 8.L.3, 8.L.4, 8.L.5, 8.L.6, 8.L.7, 8.L.8, 8.L.9 and 12.K were removed from the consent calendar. The Assembly approved the consent calendar as amended.	Chief Operating Officer • Association Governance
2014 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
2014 A1 7.A	2014-2015 Election of Assembly Officers	The Assembly voted to elect the following candidates as officers of the Assembly from May 2014 to May 2015: Speaker-Elect: Glenn Martin, M.D. Recorder: Daniel Anzia, M.D.	Chief Operating Officer • Association Governance
2014 A1 7.B.1	Will the Assembly vote to approve the application of the Southern Psychiatric Association (SPA) to become an Assembly Allied Organization (AAO)?	The Assembly voted to approve the application of the Southern Psychiatric Association (SPA) to become an Assembly Allied Organization (AAO).	Chief Operating Officer • Association Governance
2014 A1 7.B.2	Will the Assembly vote to approve the removal of the American Association of Practicing Psychiatrists (AAPP) from the APA Assembly?	The Assembly voted to approve the removal of the American Association of Practicing Psychiatrists (AAPP) from the APA Assembly.	Chief Operating Officer • Association Governance

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014A1 8.L.1	Assessment of Suicide Risk as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Assessment of Suicide Risk as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.2	Assessment of Risk for Aggressive Behaviors as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Assessment of Risk for Aggressive Behaviors as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.3	Substance Use Assessment as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Substance Use Assessment as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.4	Assessment of Cultural Factors as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Assessment of Cultural Factors as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement
2014A1 8.L.5	Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Review of Psychiatric Symptoms, Trauma History, and Psychiatric Treatment History as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.6	Assessment of Medical Health as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Assessment of Medical Health as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.7	Involvement of the Patient in Treatment Decision-Making as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Involvement of the Patient in Treatment Decision-Making as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.8	Quantitative Assessment as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Quantitative Assessment as Part of the Initial Psychiatric Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014A1 8.L.9	Documentation for the Initial Evaluation: Clinical Practice Guidelines of the American Psychiatric Association	The Assembly did not approve Documentation for the Initial Evaluation: Clinical Practice Guidelines of the American Psychiatric Association.	Chief of Policy, Programs & Partnerships • Office of Quality Improvement (For information)
2014 A1 9.A	Ethics Annotation: Proposed Annotations to Section 9 of the "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry"	The Assembly did not approve the Proposed Annotations to Section 9 of the "Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry."	Chief of Membership & RFM-ECPs • Office of Ethics & DB/SA Relations (For information)

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 12.A	Multiple Co-payments Charged for Single Prescriptions	The Assembly voted to approve action paper 2014A1 12.A which asks That our APA research the reasons for and legality of the practice of charging two co-payments for a single prescription when pharmacies dispense medications in divided increments because of supply limitations. That our APA advocate for patients not paying more than one co-payment for a one-month supply of a medication, even if dispensed in multiple allotments. That our APA draft policy opposing charging multiple co-payments for one prescription and communicate its concerns to relevant stakeholders (State Commissioners of Insurance, pharmacy benefit management companies, state Medicaid directors, etc.). That this draft policy be sent to the APA AMA Delegation for submission to the AMA House of Delegates.	Joint Reference Committee, May 2014
2014 A1 12.B	Elimination of Tobacco Products Sold by National Retailers	The Assembly voted, on its consent calendar, to approve action paper 2014A1 12.B, which asks that the American Psychiatric Association publicly support all national pharmacies or retailers that discontinue the sale of tobacco products to support health and wellness instead of contributing to disease and death caused by tobacco use, and That this action paper is referred to the American Psychiatric Association's delegates to the American Medical Association House of Delegates for review.	Joint Reference Committee, May 2014
2014 A1 12.C	Maintaining Community Treatment Standards in Federal Correctional Facilities	The Assembly voted to approve action paper 2014A1 12.C, which asks • That the APA lobby the Bureau of Prisons to ensure any policies and procedures for the delivery of mental health services do no less than comply with existing federal regulations and community standards of evidenced-based treatment, and be it further, • That the APA publicly oppose any treatment guidelines that minimize the necessity of biological treatment for severe mental health disorders and its management by a medical provider be it further, • That the APA lobby the Bureau of Prisons to increase the number of employed psychiatrists by increasing compensation packages for BOP employed psychiatrists on par with other federally employed psychiatrists and community psychiatrists.	Joint Reference Committee, May 2014
2014 A1 12.D	HIPAA and State Restrictions on Duty to Warn	The Assembly voted to approve action paper 2014A1 12.D, which asks that the APA continue to work at the federal and state level to review and if appropriate, advocate for change to regulations and laws, such as HIPAA, in order to maximize the ability to hold psychiatrists harmless, who in good faith and in their best reasonable clinical judgment want to warn or report serious threat as a means to protect the public and our patients.	Joint Reference Committee, May 2014

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 12.E	Psychiatric Education with Respect to Patients at Risk of Violent Behavior	The Assembly voted to approve action paper 2014A1 12.E, which asks that the APA promote expanded access to ongoing research findings with respect to etiology of dangerousness, and guidelines for self-protection of the treating psychiatrist. That promotion of the knowledge of these issues be accomplished through a track devoted to these topics at the APA Annual Meeting, a course on this topic at the Annual Meeting and articles in the AJP and attend to these topics in all relevant practice guidelines.	Joint Reference Committee, May 2014
2014 A1 12.F	Psychiatrist Patient Relationship and Adverse External Influences in Resolving Danger	The Assembly voted to approve action paper 2014A1 12.F, which asks that the APA promotes expansion of length of stay for inpatient treatment, when necessary to determine if a patient is or remains at risk or to initiate or continue treatment to reduce potential for violence; and promotes expansion of coverage for outpatient treatment for patients at risk of harm to self or others.	Joint Reference Committee, May 2014
2014 A1 12.G	Increasing Buprenorphine Prescribing Limits	The Assembly voted to approve action paper 2014A1 12.G, which asks that the JRC refer the issue of increasing buprenorphine prescribing to the needed population to the Council on Addiction Psychiatry for further consideration such as increasing the limits on the prescriber and the number of prescribers and request a report back to the Assembly in November 2014.	Joint Reference Committee, May 2014
2014 A1 12.H	No Punishment for Choosing Not to Adopt Electronic Medical Records	The Assembly voted to approve action paper 2014A1 12.H, which asks that: 1. The APA will adopt as a general policy, and begin advocating for, the elimination of penalties of any kind for physicians who choose not to use EMRs. 2. The APA will begin immediate discussions with CMS and any other relevant governmental or private agencies regarding this policy.	Joint Reference Committee, May 2014
2014 A1 12.I	Psychiatric Treatment of High Risk Patient-Community Role	The Assembly voted to postpone action paper 2014A1 12.I until its November, 2014 meeting,	Assembly, November 2014
2014 A1 12.J	Patient Satisfaction Surveys and Physician Pay	The Assembly voted to approve action paper 2014A1 12.J, which asks that APA shall advocate that patient satisfaction surveys should not be used as a basis for determining physician remuneration.	Joint Reference Committee, May 2014
2014 A1 12. K	Remove Black Box Warning from Antidepressants	The Assembly voted to approve action paper 2014A1 12.K, which asks that APA shall: In view of recent research findings, urge the FDA to revisit the inappropriateness of the Black Box warning about suicidality with antidepressants.	Joint Reference Committee, May 2014
2014 A1 12.L	American Psychiatric Association and Primary Care Organizations Collaboration in the Affordable Care Act Implementation	The Assembly voted to approve action paper 2014A1 12.L, which asks that the APA will develop educational & policy collaborations on primary care and behavioral health integration with relevant primary care educators and primary care organizations regarding the *Affordable Care Act*. That these collaborations will be reviewed and reported annually by the Board of Trustees and the Assembly to the APA membership.	Joint Reference Committee, May 2014

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 12.M	Addressing the Shortage of Psychiatrists with Sources of Funding	The Assembly voted to approve action paper 2014A1 12.M, which asks: 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 scholarship funds or other means of reducing debt for qualified students who will commit themselves to completing a psychiatry residency and who might, for example, agree to practice as a psychiatrist for a defined number of years in an underserved area. 2. The task force will report its findings to the Assembly and the Board of Trustees at the 2015 Annual Meeting.	Joint Reference Committee, May 2014
2014 A1 12.N	Area RFM Representative Modality and Opportunity for APA Updates and Education	The Assembly voted, on its consent calendar, to approve action paper 2014A1 12.N, which asks that the Council on Communications be charged with the formulation of an APA approved PowerPoint slide set using the current information already established. That the slide set contains the following information: APA goals and mission statement, RFM membership benefits (i.e. discounts from APPI, etc.), basic structure of the leadership hierarchy within the APA, information about the PAC, RFM key leaders with contact information, RFM leadership opportunities within the APA, RFM informational guides and/or handbook link, a brief description of the APA Assembly and it's role/function, brief description/definition of an action paper and how to submit an action paper, and hot action paper topics (action papers that have passed the assembly)(the hot action paper topic slide can be very basic as this will change frequently). That this slide set be used as a template for RFM leaders to add further information specific to his/her area. That dissemination of the slide set be required of the RFM Representative after each Assembly Meeting. As a result, this requirement should be added to the job duties of the Area RFM Representative.	Joint Reference Committee, May 2014
2014 A1 12.O	An Electronic Handbook or "Best Practices" Guide for Individual Training Programs	The paper was withdrawn by the author.	N/A
2014 A1 12.P	ABPN 2015 Exam Expectations	The Assembly voted to approve action paper 2014A1 12.P, which asks that the APA ask the ABPN to use DSM-5 in its written examinations beginning in 2015.	Joint Reference Committee, May 2014
2014 A1 12.Q	Industry Sponsored (Supported) Symposia	The Assembly did not approve this item by a vote by strength.	N/A
2014 A1 12.R	Allow Deputies to Vote	The Assembly voted to postpone action paper 2014A1 12.R, *Allow Deputies to Vote* until its November 2014 meeting.	Assembly, November 2014

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 12.S	APA Referendum Voting Procedure	The Assembly vote to approve action paper 2014A1 12.S, which asks: 1. That the Assembly of the American Psychiatric Association requests that the ballot for a referendum be distributed not with the yearly officer election ballot, but with the yearly dues statement which is responded to by all APA members who wish to retain membership except those with dues-exempt status. Additionally, those voting members not getting a dues notice currently will need to be included in the mailing. 2. That it is the will and intent of the Assembly that this action paper, now reaffirmed, be passed on by the JRC to the Board of Trustees.	Joint Reference Committee, May 2014
2014 A1 12.T	Task Force on DSM-5 Conflict-of-Interest Management Processes	The Assembly did not approve action paper 2014A1 12.T.	N/A
2014 A1 12.U	Creation of President's Awards for the District Branch and Area with the Highest Percentage of Voting	The Assembly voted to approve action paper 2014A1 12.U, which asks that 1. APA institute and publicize a President's Award for the District Branch with the highest voting rate (highest percentage) in the election, and for the Area with the same criteria. 2. These awards (a trophy or plaque along with a certificate), be presented at the Annual meeting immediately following the election each year. 3. The awards and the presentation will be duly publicized in Psychiatric News and in other appropriate avenues.	Joint Reference Committee, May 2014

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 12.V	Reinstatement of the Committee on Persons with Mental Illness in the Criminal Justice System	The Assembly voted, on its consent calendar, to approve action paper 2014A1 12.V, which asks that the Assembly urges the Board of Trustees to reinstate the Committee on Persons with Mental Illness in the Criminal Justice System which will resume being the proactive and dynamic voice of the APA to advocate for the efforts to provide for and improve the care and treatment of persons with mental illness in the criminal justice system, and to provide deliverables such as a new Position Statement and a Plan of Action for the APA internally - to the APA members and the other APA components, and nationally - to organizations such as NAMI, The National Association of State Mental Health Program Directors - and internationally to such organizations such as Penal Reform International and the UN Economic and Social Council. The Committee on Persons with Mental Illness in the Criminal Justice System would report to the Council on Advocacy and Governmental Relations and would provisionally have the following charge: 1. Develop a Plan of Action consistent with the Strategic Goals of the APA to improve psychiatric services for persons with mental illness involved with the criminal justice system. 2. Develop coordinated advocacy efforts by the APA to decriminalize many of the large number of persons with mental illness involved in the criminal justice system. 3. Review current and emerging research data relating to persons with mental illness in the criminal justice system to develop a system of evidence based policies and treatment. 4. Develop a model of liaison of correctional psychiatrists with the primary care physicians who treat patients in jails and prisons; 5. Revise and update the Position Statement of 1988.	Joint Reference Committee, May 2014
2014 A1 12.W	A Revision in the Identification of American Psychiatric Association-Affiliate Associations or Societies	The Assembly did not approve action paper 2014A12 12.W.	N/A
2014 A1 12.X	Patient Safety and Veterans Affair Medical Center Participation in State Prescription Monitoring Programs	The Assembly voted to approve action paper 2014A1 12.X, which asks that the APA will request the Council on Advocacy and Government Relations to explore federal legislation and regulatory opportunities for the APA to advocate for the Veterans Health Administration to create a program that would allow licensed prescribers universal access to state PMPs, and That APA's resources, including the Offices of the APA CEO/Medical Director, the Council on Advocacy and Government Relations and the Council on Addiction Psychiatry become engaged in this endeavor. The APA will advocate for more open access to state PMPs, initially by VA health care providers not licensed in that given state.	Joint Reference Committee, May 2014

Agenda Item #	Action	Comments/Recommendations	Governance Referral/Follow-up
2014 A1 12.Y	An Electronic Orientation Manual and Orientation Conference Call for ACORF	The Assembly voted, on its consent calendar, to approve action paper 2014A1 12.Y which asks that the Chief RFM-ECP officer and the Department of Association Governance develop an electronic orientation packet specifically tailored to incoming RFM Deputy-Representatives which focuses on enhancing organizational structure at the level of the Assembly Committee of Resident Fellows (ACORF). That after ACORF elections take place, and before the first committee conference call, the Chief RFM-ECP officer and the newly elected Chair of ACORF facilitate an orientation conference call with newly elected Deputy-Representatives. That the purpose of this handbook is to provide members of ACORF with the guidelines that are needed to work effectively as a team and to disseminate information between the Area Council and the individual training programs. The orientation packet and meeting could help ACORF members to: 1. Understand the committee mission and purpose; specifics of committee membership; officer expectations; meeting expectations; voting procedures; committee responsibilities. This could be facilitated by developing an ACORF constitution. Please see my other action paper for suggestions on developing a constitution. 2. Understand the process of soliciting, writing and submitting action papers. 3. Develop a communication plan for maintaining an accurate contact list and facilitating institutional and area communication. 4. Understand travel responsibility, reimbursement for travel and other necessary facets of committee membership. That this manual be reviewed and updated by the Chief RFM-ECP officer on a pre-determined schedule.	Chief of Membership & RFM-ECPs Chief Operating Officer • Association Governance
2014 A1 12.Z	Facilitating Communication among Psychiatrists and APA Leadership	The Assembly voted to approve action paper 2014A1 12.Z, which asks that the APA make readily available and easily accessible the contact information of all Assembly members on the APA website; This information would be available only to APA members; That this information would be provided in a way which would protect the confidentiality of the all Assembly members That this information be displayed in a way which will require only minimal annual upkeep in order to simplify the required upkeep process.	Chief Operating Officer • Information Systems
2014 A1 12.AA	Creation of a New APA Affiliate Group	The Assembly did not approve action paper 2014A1 12.AA.	N/A

Item JRC #8.A
Joint Reference Committee
May 31, 2014

Executive Summary
Council on Addiction Psychiatry

Referral Update/Action Item:
(JRCOCT128.A.1/ASM Item #2013A1 4.B.1)

The Council developed a Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist. It was approved by the Joint Reference Committee and submitted to the Assembly for review and approval. Assembly reviewers noted several areas of suggested improvement and returned the statement to the Council for revision. The statement was subsequently modified and is again submitted for JRC, Assembly, and Board approval. The Council wishes to emphasize that the position statement and background materials are intended to assist residency training directors in developing content to meet the Accreditation Council for Graduate Medical Education (ACGME) requirements for training in Addiction Psychiatry. (**Attachment #1**)

Will the Joint Reference Committee recommend that the Assembly and Board of Trustees approve the Position Statement on Residency Training Needs in Addiction Psychiatry for the General Psychiatrist?

Information Items:

- The council continued its longstanding tradition of meeting with leadership of the National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, SAMHSA, White House Office of National Drug Control Policy, and the Veterans Health Administration. Summaries of the discussions are included in the attached minutes.
- Dr. Nora Volkow, NIDA Director, strongly urged the Council to develop a curriculum for residency programs that will advance residents' competence in assessing and treating substance use disorders. She pointed to the very successful Centers of Excellence for Physician Information as a possible model of such an effort. NIDA will incentivize development through a grant or a contract. A Council workgroup of members was formed to consider options and advance planning.
- Though not yet assigned to the Council by the JRC, an **assembly action paper 2014A1 12.G** that urges APA to advocate for mechanisms to expand the accessibility of buprenorphine treatment was discussed. The subject is complex and challenging. A workgroup was formed to consider all aspects of the issue and formulate recommendations. The Chief Medical Officer of SAMHSA was present for the discussion and indicated that the issue will be discussed at a Buprenorphine Summit that will be convened by SAMHSA in August. Council will keep the JRC apprised of its deliberations on this subject.
- The Council formed a workgroup on smoking cessation. APA member and smoking cessation expert, Doug Ziedonis, MD, volunteered to assist the council's work on the topic. Further, he will outreach to the Smoking Cessation Leadership Center and its President on APA's behalf and facilitate a more formal collaboration with the SCLC.

Minutes
Council on Addiction Psychiatry
May 5, 2014
New York, NY

Attendance:

Members: Drs. Frances Levin (chair), Kathleen Brady, Oscar Bukstein, Patricia Dickman, Karen Drexler, Timothy Fong, Marc Galanter, Shelly Greenfield, Mark Gold, Kimberly Gordon, Kevin Hill, Herbert Kleber, Petros Levounis, Robert Milin, Edward Nunes, John Renner, Andrew Saxon, Mandrill Taylor, Ronald Thurston
Guests: Michael Botticelli (ONDCP), Lizbet Boroughs (APA), Janice Brannon (APA), Kathryn Cates-Wessel (AAAP), Smita Das, Robert Feder, Bob Huebner (NIAAA), George Kolodner, Kristen Kroeger (APA), Saul Levin (APA), Elinore McCance-Katz (SAMHSA), Nora Volkow (NIDA), Susan Weiss (NIDA), Douglas Ziedonis
Staff: Beatrice Eld

Saul Levin, MD, APA's CEO/Medical Director, opened the meeting with his greetings and appreciation for the work being done by the Council. He reminded the group of his professional roots in SAMHSA's predecessor organization and his long-standing interest in and work related to substance use disorders. He acknowledged and thanked the representatives of ONDCP, NIDA, NIAAA, SAMHSA, and VA for their ongoing collaboration with the APA and the Council and indicated his commitment to the partnerships.

Position Statement on Training Needs in Addiction Psychiatry for the General Psychiatrist

The Council developed a Position Statement on Training Needs in Addiction Psychiatry for the General Psychiatrist. It was approved by the Joint Reference Committee and submitted to the Assembly in May 2013 for review and approval. Assembly reviewers noted several areas of suggested improvement and returned the statement to the Council for revision (**JRCOCT128.A.1/ASM Item #2013A1 4.B.1**). The statement was subsequently modified. The position statement and background materials are intended to assist residency training directors in developing content to meet the Accreditation Council for Graduate Medical Education (ACGME) requirements for training in Addiction Psychiatry.

> **Will the Joint Reference Committee recommend that the Assembly and Board of Trustees approve the Position Statement on Training Needs in Addiction Psychiatry for the General Psychiatrist?**

White House Office of National Drug Control Policy – Michael Botticelli, PhD, Acting Director

Acting Director Botticelli joined the meeting by phone and provided an overview of ONDCP's priorities and activities. The Affordable Care Act and the Parity law provide opportunities to greatly expand access to treatment. He urged APA and its Council on Addiction Psychiatry to assist by providing information regarding the kinds of care patients are receiving, to what extent the provisions of the ACA and parity law are implemented, and if insurers are meeting their obligations.

The magnitude prescription drug misuse and heroin addiction is huge. In 2011 ONDCP released a governmental plan to reduce and prevent prescription drug abuse that built on the drug strategy. It emphasized provider education, appropriate disposal of unused drugs, and Prescription Drug Monitoring Programs. Each of those areas continues to be actively addressed.

ONDCP and other Federal agencies are working to assure that information regarding overdose prevention is provided to people at risk. It is encouraging that a number of states have passed legislation regarding naloxone distribution and protection of those who report an overdose.

Forty-eight states have operational Prescription Drug Monitoring Plans. ONDCP is working with SAMHSA and the Office of the National Coordinator to advance interstate operability as well the ability to link PDMPs to electronic health records. It is imperative to make PDMPs easier and more accessible for prescribers.

ONDCP remains significantly concerned about the States that have implemented medical marijuana laws, as well as those that have legalized use. It is working with federal partners and state health departments in Colorado and Washington to compile data bases and study information to look at the impact of legalization and its effects on public health and public safety. Of particular concern is the impact of medicalization and legalization on adolescents, their mental health issues, and how use exacerbates them. Data from the Monitoring the Future show youth ages 12 to 17 smoke more marijuana than tobacco and there is a dramatic decline in the perception of harm. ONDCP is optimistic that there are very few additional states that are pursuing legalization.

Increasing access to medication assisted treatment is a top priority. A treatment coordination group, comprised of all the federal partners that play a role, was convened. It is acutely aware that there are too few people trained to use the medications and access to treatment in rural areas is severely lacking. Acting Director Botticelli called attention to a commentary recently published in the New England Journal of Medicine regarding access to medication assisted treatment and announced that innovative state and local models will be highlighted in an upcoming SAMHSA webinar.

National Institute on Drug Abuse – Nora Volkow, MD, Director

Many psychiatry residents go through their training without learning how to screen for and evaluate substance use disorders. To address this, Dr. Volkow's top priority for NIDA's collaboration with the APA is to incentivize the development of curriculum that can be utilized by residency training programs and exported nationwide. If this is achieved, it can transform the way SUD and co-morbid conditions are treated in the United States.

In addition to soliciting the support of APA's elected and staff leadership, Dr. Volkow called on the Council to work with NIDA to develop the curriculum and invited the Council to discuss ideas and strategies with her or Susan Weiss, PhD. She observed that NIDA's Center of Excellence for Medical School Curriculum Resources on Drug Abuse and Addiction is an example of the project NIDA would like the APA to pursue. Support for the project may be available through a NIDA contract or a R25 grant.

Members discussed the desirability of outreaching to the American Association of Directors of Psychiatric Residency Training (AADPRT); the need to pursue inclusion of SUD-related questions on the Psychiatry Resident-in-Training Exam (PRITE), licensing, and Board exams;

the difficulty in modifying the program requirements for general psychiatry programs; and the initiatives of other organizations, e.g., the Providers' Clinical Support Systems as well as COPE, which develops medical school curriculum and other training resources. Once approved by the Board of Trustees, members believe Position Statement on Training Needs in Addiction Psychiatry will serve as a facilitator to the effort.

The Council enthusiastically embraced Dr. Volkow's suggestions and a workgroup was formed to undertake the initiative. Members include Dr. Frances Levin, chair, John Renner, Karen Drexler, Ned Nunes, Rob Milin, and Patricia Dickman.

Dr. Volkow further encouraged the Council to formulate a proposal for a mentorship program in substance abuse research. NIDA has a number of mechanisms that can incentivize the APA to develop and implement a program.

Additional topics addressed by Dr. Volkow include: the NIH Brain Initiative; marijuana legislation and its likely impact on future psychiatric treatment; a large research longitudinal study on brain development in children and the effects of substance abuse; the management of chronic pain; and prescription drug monitoring programs.

She reported that Members of Congress are very concerned about the large number of deaths caused by opioid overdoses and there have been several Congressional hearings on drug monitoring programs as a mechanism to address the epidemic.

National Institute on Alcohol Abuse and Alcoholism – Bob Huebner, PhD, Director, Treatment and Recovery Research

Dr. George Koob was appointed NIAAA Director in January 2014. He has an appreciation for the full spectrum of research, including translational work, medication development, and implementation science. His appointment will strengthen and facilitate the functional integration of NIAAA and NIDA. Ken Warren, who served as interim director, will remain at NIAAA as the Acting Director.

Dr. Huebner highlighted a number of NIAAA's areas of focus, including screening and brief intervention, adolescents and youth, co-occurring use of alcohol and marijuana, and the comorbidity of alcohol use disorder and PTSD. The functional integration of NIAAA and NIDA was discussed and the studies that will be undertaken under Collaborative Research on Addiction (CRAN).

NIAAA will plan and organize the featured research track at the 2015 APA Annual Meeting.

Substance Abuse and Mental Health Services Administration – Elinore McCance-Katz, MD, PhD, Medical Officer

Dr. McCance-Katz, Chief Medical Officer, announced that SAMHSA is planning a buprenorphine summit to be held in August 21 and 22. It will be co-sponsored with NIDA and include the Office of National Drug Control Policy, Food and Drug Administration, and the Drug Enforcement Administration. A representative of each of the DATA organizations will be invited. The issue of patient limits will be included on the agenda,

DEA regularly communicates its concerns about diversion to SAMHSA. They and the Office of the Inspector General are currently investigating a number of physicians for inappropriate

prescribing of buprenorphine and benzodiazepines. DEA is also very concerned about the increasing number of buprenorphine "mills."

The Providers' Clinical Support System for Medication Assisted Treatment is the mechanism SAMHSA supports to provide ongoing waiver trainings. The trainings are conducted by AAAP, AOAAM, and APA.

SAMHSA developed and makes widely available its Toolkit on Overdose Prevention. Additionally, it is urging Opioid Treatment Programs to provide kits when people start on methadone as well as to chronic pain patients. The FDA recently approved a new formulation of naloxone, which is similar to an EpiPen. The pricing is not yet available.

SAMHSA is very interested in the integration of care primary care and mental and substance use disorders. The Affordable Care Act provides opportunities for health homes. SAMHSA believes that SUD treatment programs are a good place to implement Behavioral Health homes. She indicated that SAMHSA intends to bring HIV care into Behavioral Health homes and they hope that this takes root as a model.

Veterans' Health Administration – Karen Drexler, MD, Deputy National Mental Health Program Director, Addictive Disorders

Dr. Drexler discussed:

- Alcohol remains the most prevalent substance use disorder in the VA
- An increase in the number of veterans with opioid use disorder who are receiving medication assisted treatment.
- Progress made in VA providers' use of prescription drug monitoring systems
- VA's movement toward the use of CPT codes
- New programs in pharmacotherapies, including academic detailing
- Working toward adding naltrexone to the VA's national formulary
- Training VA providers on how they can educate their patients regarding opioid treatment in an attempt to decrease the number of overdoses
- The evolving interest in measurement-based care
- Initiation of an advanced fellowship training program in addictions

Assembly Action Paper: Increasing Buprenorphine Prescribing Limits

The author of an Assembly Action Paper (action paper 2014A1 12.G), Dr. Robert Feder, visited with the Council to discuss the paper and its goal of expanding access to buprenorphine treatment. In Dr. Feder's experience, the patient limit severely hinders his ability to treat the number of patients who seek treatment and ultimately save lives. He urged the Council and APA to strongly advocate for an increase in the current patient limits.

The Assembly debated the paper and passed a modified version that calls on the JRC to refer to the Council on Addiction Psychiatry for consideration and recommendations.

Members discussed the many factors that must be carefully considered, among them diversion, increasing the cadre of trained physicians, and the proliferation of "pill mills." Concerns were raised that some physicians are just prescribing buprenorphine but not treating the addiction and the possible incursion of corporations that see this treatment modality as a lucrative capital investment.

A Council workgroup will study the issues and formulate recommendations for the Council and the APA. Members are: Drs. Frances Levin, John Renner, Herbert Kleber, and Ron Thurston. APA members Robert Feder, George Kolodner and Patricia Dickmann volunteered to participate as well.

ASAM's Standards for the Addiction Specialist

Dr. John Renner reported ASAM invited APA's review of the document and solicited its formal endorsement. He highlighted that the standards are deficient in that they do not include screening for suicidal ideation and other psychiatric illness. The group that developed the document did not include a representative appointed by the APA. Based on the noted deficiencies, APA endorsement was not provided.

ASAM recently announced its intention to develop a National Practice Guideline on the treatment of opioid addiction and invited APA's participation. The Council discussed the invitation at length and noted the variations in the ways in which practice guidelines are developed and the importance and validity provided to them. APA has developed practice guidelines for more than 20 years and utilizes a rigorous process to assess the evidence base. The Council recommends that the APA not participate in the development of the ASAM guideline but offer to review and comment on the document prior to it being finalized and published.

The Council is open to collaborating with ASAM and other organizations to produce short policy statements that can enhance the advocacy efforts of participating organization. However, the group noted that ASAM's processes related to development of standards and guidelines do not permit the full partnership of related organizations. Therefore, it is advisable for the APA to decline participation in the development efforts, but participate by reviewing drafts and submitting comments.

Updates from APA's Division of Government Relations – Janice Brannon and Lizbet Boroughs

Janice Brannon, Deputy Director of State Affairs, provided an overview of the variety of legislation under consideration by the States regarding substance use disorders. There are 217 bills on substance use disorders in general, 117 related to prescription drug monitoring programs, and 60 on medical marijuana. Many of the bills address treatment of opioid use disorder, particularly in states where prescription drug and heroin abuse has been deemed an epidemic. Examples include Wisconsin, which increased the number of treatment centers, to Massachusetts which outlined steps in their war against drug abuse.

Dr. Renner discussed developments in Ohio as an example of regulations that are being implemented in a variety of states that place onerous rules on physicians who treat opioid use disorders. Many of these regulations dramatically increase the burden of treatment and will likely negatively impact the number of physicians who are willing to provide the treatment. He suggests that information packets be developed that can be quickly disseminated to states where such legislation is under active consideration. He suggested that one or more of the residents take on this project. Dr. Patricia Dickman volunteered.

Ms. Boroughs, Deputy Director of Government Relations, updated the council on her advocacy for State prescription drug monitoring programs and their interstate operability. This is

particularly important for the Veterans Health Administration facilities. Additional topics included funding for SAMHSA and the Institutes, collaboration with other provider association and advocacy groups, FDA's recent approval of zohydro, and legalization and medical use of marijuana.

Members suggested that workforce development is an area of great concern. Staff will investigate the possibility of inviting a HRSA representative to attend the September council meeting.

Providers' Clinical Support Systems for Medication Assisted Treatments and Opioid Therapies

Kathryn Cates-Wessel gave an overview of both projects, the collaboration of a variety of organizations, and the products produced by them. John Renner and Beatrice Eld discussed the highly successful webinar series that APA has offered for about 4 years. The PCSS-MAT webinars now offer free CME and are promoted widely. An average of 400 people participate in each live session. Additionally, the sessions are recorded and are accessible on both the PCSS-MAT and APA websites.

Workgroup on Smoking Cessation

APA member, Doug Ziedonis, M.D., asked the Council to form a workgroup on smoking cessation. He observed that there is a renewed interest in this important area by Dr. Saul Levin, APA's CEO, and Dr. Paul Summergrad, APA's incoming President. Dr. Ziedonis has a long-standing relationship with Dr. Steve Schroeder, president of the Smoking Cessation Leadership Center, a Robert Wood Johnson program headquartered at the University of California-San Francisco. Dr. Schroeder is in a position to grant APA $100,000 but the organization must demonstrate its interest and commitment to pursuing meaningful initiatives. Formation of a workgroup of the Council would be an important step in that demonstration. Dr. Ziedonis volunteered to chair the group and Drs. Andy Saxon, Tim Fong, Mark Gold, and Smita Das expressed interest in joining.

Dr. Ziedonis reported that AAAP recently developed a Performance in Practice module on smoking cessation that is targeted toward the addiction psychiatrist. He hopes that APA can produce a PIP that will be geared toward the general psychiatrist.

Recognition of Herbert Kleber, M.D.

Dr. Kleber has participated and provided leadership to the council for many years. Though his official tenure has ended, he will remain an active volunteer and be available to assist and advise Council efforts.

Attachment #1

Title: Residency Training Needs in Addiction Psychiatry for the General Psychiatrist

Issue: Substance use disorders (SUDs) are a major cause of morbidity and mortality among patients with mental illness and a major risk factor in dangerousness to self and others. Despite the availability of effective treatments, most patients with these disorders are not being treated. Providing appropriate training in screening, brief intervention, and treatment for the general psychiatrist could help close this treatment gap and improve outcomes for patients with co-occurring mental illness and SUDs. This position statement and background materials are intended to assist residency training directors in developing content to meet the Accreditation Council for Graduate Medical Education (ACGME) requirements for training in Addiction Psychiatry.

APA Position: General psychiatry residency training programs should optimize training such that general psychiatrists are competent in providing screening, brief intervention, referral to treatment (SBIRT); management of psychoactive substance intoxication and withdrawal; evidence-based pharmacotherapy for substance use disorders; management of co-occurring substance use and other psychiatric disorders; and should have exposure to evidence-based psychotherapy and other psychosocial interventions for substance use disorders such as motivational interviewing, cognitive-behavioral therapy, twelve-step programs, among others."

Authors: Karen Drexler, M.D.; Michael Ketteringham, M.D., M.P.H.; Keith Hermanstyne, M.D., M.P.H.

Adoption Date: TBD

Background Information:

This background information is provided as a resource for program directors, faculty, and trainees to assist in developing content for general psychiatry training in assessment, diagnosis and treatment of substance use disorders and related conditions in accordance with ACGME program requirements.

The evidence supporting detailed recommendations is constantly evolving. Program directors are advised to use this along with critical reviews, clinical practice guidelines and other resources to provide the latest, evidence-based training for psychiatry residents.

The Rationale for Addiction Psychiatry Training for General Psychiatrists

Substance Use Disorders (SUDs) are highly prevalent in the United States. In 2010, of people aged 12 and older, an estimated 9% or approximately 22.6 million used illicit drugs, 7% or 17.9 million could be classified as having alcohol dependence, and 27% or 69.6 million people used tobacco. (SAMSHA 2011) Substance abuse treatment modalities have been shown to be effective in treating these populations. One study showed that medications used to treat persons with SUDs can be as effective in terms of relapse rates and adherence as medications used to treat chronic medical illnesses such as DM, asthma, and hypertension. (McLellan 2000) However, despite the efficacy of available treatments, approximately 90% of Americans with treatable SUDS are not in active treatment. (SAMSHA 2011)

A proportion of this under treatment can be attributed to the under surveillance and treatment of patients who are already in active treatment for a non-substance use related mental disorder. Indeed, greater than half of those with a lifetime SUD have a mental illness. (Regier 1990, NIDA 2011) However, despite the fact that many persons with SUDs are already in psychiatric care settings, they are not being screened, diagnosed, and treated**.** (Ewing 1999, Fleming 1991) One survey found that psychiatrists reported alcohol and drug abuse patients to constitute only 10% of their caseloads. (Dorwart 1992) Many general psychiatrists report they do not feel they have the adequate core competency skills to treat SUDs. (Ewan 1982) This may explain why the treatment gap for alcohol abuse is estimated at 78% as compared to other mental disorders like schizophrenia that has an estimated treatment gap of 32%. (Kohn 2004)

The under treatment of SUDs has major implications for the morbidity and mortality of mentally ill individuals. Failure to treat an SUD in the comorbid patient leads to worse outcomes in terms of the severity and longitudinal course of the other treated mental illness. (Hser 2007) Medical comorbidities that are highly prevalent in patients with serious mental illness also have worse outcomes in those patients with a comorbid SUD. (Viron 2010, Batki 2009) Consider the under treatment of tobacco use in persons with mental illness who are twice as likely to smoke as persons without a mental illness. (Lasser 2000) Tobacco use alone accounts for one in five deaths each year in the U.S. (CDC 2008)

The under-treatment of SUDs also increases the likelihood of the mentally ill to harm themselves or others. Mental illness is associated with increased rates of violence towards others, but this association is largely explained by the increased rates of substance abuse by the mentally ill. (Swanson 1990, Cuffel 1994) Mentally disordered individuals with substance abuse comorbidity are significantly more likely to be violent than those with mental disorder alone. (Swanson 1994) Furthermore, across the spectrum of affective and psychotic illness, comorbid substance abuse significantly increases the risk of suicide compared to people with mental disorders that do not abuse substances. (Cornelius et al 1995, Dassori 1990, McIntyre et

al 2008, Oquendo 2010, Sublette 2009) Alcohol dependency alone increases suicide risk six fold compared to those who do not abuse alcohol, leading to arguments that drinking habits must be considered in any suicide risk prevention effort. (Schneider 2009, Pompili 2010, Vijayakumar 2011)

Therefore, general psychiatrists who are competent in substance abuse diagnosis, prevention, and treatment would be able to increase the proportion of persons with an SUD receiving treatment and improve the morbidity and mortality while reducing the dangerousness of their comorbid patients. Proper treatment of SUDs can also reduce recidivism, emergency room visits, inpatient days, and psychiatric and substance use relapses, while improving medication adherence and treatment retention. To meet this end, more attention must be paid to training the psychiatry resident in outpatient treatment of patients with SUDs. A survey conducted in 2008 showed that the total number of curricular hours over the 4 years of training has increased since the 1990s. However, more than 80% of resident encounters with patients with SUDs occur in the psychiatric ER, CL service, and inpatient units. Furthermore, in a majority of outpatient training clinics, only 20% of patients have an SUD as their chief complaint. This is far below the expected 50% co-occurrence of SUDs with mental disorders and is explained partly by under surveillance and diagnosis. However, the study also revealed that 70% of residency clinics refer SUD patients out to substance abuse programs. More exposure to and supervision in the treatment of outpatients with SUDs would improve general psychiatrist confidence and competence in treating these disorders. (Fleming 1994, Shorter 2008)

Recommendations:

General psychiatry residency training programs should optimize training such that general psychiatrists are competent in providing the following interventions:

1. **Screening, brief intervention, referral to treatment (SBIRT)**

Rationale: Since the 1970s, evidence has accumulated that brief advice from a physician is an effective strategy to reduce harmful psychoactive substance use. (Whitlock, Polen et al. 2004; Kaner, Beyer et al. 2007; Schonfeld, Lawrence et al. 2010) Screening and brief intervention (SBI) for high-risk alcohol use has been shown to be a cost-effective strategy with similar positive health impact as colorectal cancer screening and influenza and pneumococcal vaccinations. (Solberg, Maciosek et al. 2008; Estee, Sharon et al. 2010) SBIRT for alcohol and other drug use improves mental and physical health and prevents other negative consequences such as absenteeism and legal problems. (Madras, Bertha et al. 2009; Quanbeck, Lang et al. 2010)

Despite strong evidence of effectiveness, health systems and individual providers have been slow to adopt these practices. (Davoudi and Rawson 2010). Persons with mental illness have a higher risk of tobacco, alcohol and other psychoactive substance use. (Farrell, Howes et al. 2003; Grant, Hasin et al. 2004; Kessler, Chiu et al. 2005) Persons with serious mental illness are at increased risk for medical consequences of smoking.(Dixon, Medoff et al. 2007) Yet despite the high prevalence of tobacco smoking in persons with mental illness, interest in reducing or quitting smoking is also significant.(Lasser, Boyd et al. 2000; Moeller-Saxone 2008) Brief interventions are more effective when provided by someone who has an ongoing relationship with the patient. Thus, psychiatrists are in a prime position to make a profound impact on their patients' mental and physical health by screening for and providing brief counseling for psychoactive substance use.

Key Recommendation: Every psychiatry residency training program should include formal didactic training and clinical experience in providing SBIRT for alcohol and tobacco use in patients with mental illness.

Resources:

For SBIRT for at-risk alcohol use, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has published the *Clinician's Guide for Helping Patients who Drink Too Much*. (Willenbring, Massey et al. 2009) In addition to the paper version, there are Powerpoint slide sets and a video tutorial available at http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Pages/guide.aspx.

For tobacco cessation, the US Public Health Service has published an evidence-based clinical practice guideline that includes information on brief interventions for smoking cessation as well as guidelines for medications and specific recommendations for special populations including the mentally ill. (Anderson, Jorenby et al. 2002) These are available on-line as well at http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf

For alcohol, tobacco and other psychoactive substances, the National Institute on Drug Abuse (NIDA) hosts a website with a variety of clinical and teaching tools for healthcare professionals. NM Assist is a web-based tool for screening for substance use disorders, there are other training tools including an objective structured clinical examination (OSCE), web-based interactive trainings and PowerPoint slide sets. These are available on-line at http://www.drugabuse.gov/medical-health-professionals.

2. Management of psychoactive substance intoxication and withdrawal

Rationale: The common co-occurrence of substance use disorders among the mentally ill means that psychiatrists are often responsible for discerning whether acute psychiatric symptoms are induced by psychoactive substance intoxication or withdrawal and for managing these states during psychiatric stabilization in emergency departments and inpatient settings. Textbooks and clinical practice guidelines provide guidance on diagnosis and management of intoxication and withdrawal from psychoactive substances. (American Psychiatric Association 2000; American Psychiatric Association 2006; Galanter and Kleber 2008; Ries 2009; Ruiz, Strain et al. 2011)

Key recommendations:

a. General psychiatry training must include recognition of common signs and symptoms of intoxication and withdrawal for the major categories of psychoactive substances. (American Psychiatric Association 2000; Galanter and Kleber 2008)
b. Psychiatrists should have basic knowledge of major medical complications of psychoactive substance intoxication such as cardiac arrhythmias, acute myocardial infarction, hyperthermia (for stimulants, inhalants and hallucinogens) and respiratory depression (for opioids, alcohol and sedatives). (Ries 2009)
c. Psychiatrists should have a basic knowledge of laboratory testing for psychoactive substance use and of laboratory signs of heavy alcohol use. Examples include liver function tests, complete blood count, drug screening, ethyl glucuronide and common causes of false positive and false negative tests. (Ruiz, Strain et al. 2011)

d. Psychiatrists should be able to manage alcohol and sedative-hypnotic withdrawal to provide comfort, to facilitate entry into comprehensive addiction treatment, and to prevent severe medical complications such as seizures and delirium. Components of this include:
    a. Using vital signs and standard scales for quantifying withdrawal symptoms such as the Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-A). (Sullivan, Sykora et al. 1989)
    b. Assessing whether a patient is in need of hospitalization to manage alcohol withdrawal. (Mee-Lee and American Society of Addiction Medicine. 2001)
    c. Managing alcohol withdrawal using benzodiazepines and other evidence-based medications for management of alcohol withdrawal. (Mayo-Smith 1997; Mayo-Smith, Beecher et al. 2004)
e. Management of opioid withdrawal includes use of opioid agonists, partial agonists, and non-opioid medications for management of individual symptoms of opioid withdrawal. Components of this include:
    a. Quantifying withdrawal severity with scales such as the Clinical Opiate Withdrawal Scale (COWS) or the Clinical Institute Narcotic Assessment (CINA). (Wesson and Ling 2003; Tompkins, Bigelow et al. 2009)
    b. Weighing risks and benefits of using long-acting pure mu-opioid agonists versus partial agonists versus non-opioids for managing opioid withdrawal. Long-acting pure mu-opioid agonists such as methadone carry an inherent risk of overdose by accumulation if repeated doses of medication are administered before the peak onset of action is achieved. Partial mu opioid agonists such as buprenorphine provide a substantially lower risk of overdose, but a risk of precipitated withdrawal, if the patient is not already in withdrawal at the time of the first buprenorphine dose. (Amass, Ling et al. 2004; Ang-Lee, Oreskovich et al. 2006) Psychiatrists should be trained in induction of buprenorphine for both maintenance and management of withdrawal.
f. Management of nicotine withdrawal using the major evidence-based approaches for nicotine dependence including nicotine replacement therapies, bupropion, and varenicline. (Fiore, Jaen et al. 2008)

3. Evidence-based pharmacotherapy for substance use disorders

Rationale: Psychoactive substance use is associated with violence, medical morbidity and mortality, and poor psychiatric outcomes in persons with mental illness.
Pharmacotherapy to treat tobacco, alcohol, and opioid use disorders is effective and could be mastered during residency training. The data below is reference from a review by Ross and Peselow. (Ross 2009)

Key Recommendation: General psychiatrists should be proficient in managing FDA-approved medications for the major categories of mental disorders, including psychoactive substance use disorders.

NICOTINE

Nicotine replacement therapy and treatment with bupropion have both been shown to double the chance of abstinence and diminish cravings at 6 months. Varenicline increased the odds of abstinence by a factor of 4 and a factor of 2 when compared to placebo and bupropion respectively. Furthermore, varenicline was 2.5 times more effective than placebo at maintaining abstinence at one year. There may be some hesitancy to prescribe varenicline due to it carrying a black-box warning for depression, suicidal thoughts and actions. However, the medication has been shown to be effective and proper training during residency should lead the general psychiatrist to be effective in its use. Several recent well-designed research studies have shown that varenicline has no increased risk in patients with stable depression and other mental disorders compared to placebo or other FDA-approved therapies.

Key Recommendation: Psychiatry residents receive didactic and clinical supervision in managing tobacco cessation using brief counseling and FDA approved medications including nicotine replacement, bupropion and varenicline.

Resources:
Fiore, M. C., C. R. Jaen, et al. (2008). "Treating Tobacco Use and Dependence- 2008 Update." Agency for Health Care Policy and Research Retrieved Jan 3, 2010, 2010, from http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hsahcpr&part=A28163.

CDC. (2008). "National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, Department of Health and Human Services. Smoking and Tobacco Use—Fact Sheet: Health Effects of Cigarette Smoking." from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm.

ALCOHOL

There are 3 FDA approved medications for alcohol dependence. Disulfiram is safe and well tolerated, and when compliance is maintained, it is effective in promoting abstinence. Naltrexone (both oral and long-acting injectable) compared with placebo reduces drinking frequency and relapse to heavy drinking. European studies have shown acamprosate to be superior to placebo in rates of total abstinence, cumulative abstinence duration, and time to first drink in recently detoxified patients.

There are areas that are not FDA approved but show some promise in recent studies. Baclofen studies show it to have a positive effect in relapse prevention, abstinence maintenance, and craving in patients who have recently been detoxified from alcohol. Topiramate was better than placebo in two double-blind placebo-controlled studies in reducing heavy drinking and increasing percentage of abstinent days.

Key Recommendation: Psychiatrists receive didactic training and clinical supervision in management of FDA approved medications and brief counseling for alcohol dependence.

Resources:
National Institute on Alcohol Abuse and Alcoholism (NIAAA) *Clinician's Guide for Helping Patients Who Drink Too Much*. (Willenbring, Massey et al. 2009) PowerPoint slide sets and a

video tutorial available at
www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Pages/guide.aspx.

OPIOIDS

Appropriately dosed buprenorphine is superior to placebo in diminishing illicit opiate use and treatment retention.

Key Recommendation: 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.

Resources:
APA Resident-Fellow Members have free access to the APA's 8-hour on-line training for buprenorphine.

4. Evidence-based psychotherapy and other psychosocial interventions for substance use disorders

Several behavioral and psychotherapeutic strategies have shown efficacy in treating substance use disorders and can be applied in varied settings (individual, group, or family therapy), mutual help groups, and substance abuse classes. Behavioral strategies can have many benefits including increasing a patient's motivation, exploring their ambivalence in reducing his drug use, identifying situations that might trigger relapse, developing alternatives to substance use, and improving compliance to pharmacotherapy and treatment structure. Research has supported the importance of actively instructing clinicians in evidence-based behavioral strategies (Carroll 2006). Psychiatry residents should receive training in these specific modalities and how they can be applied to clients with substance use disorders.

Key Recommendation: Psychiatrists should develop expertise in evidence-based psychotherapy techniques that they will use frequently (such as motivational interviewing) and familiarity with basic principles of other evidence-based psychotherapies so that they can work collaboratively with their patients and with other providers who may be using evidence-based psychotherapies.

Motivational Interviewing

Motivational interviewing uses empathy and reflective listening in order to enhance a client's recognition of discrepancy between their stated goals and current behaviors. Using this technique often involves "rolling with the resistance" and examining both sides of a patient's ambivalence in changing his substance use behavior, which can lead to a client's perceived sense of self-efficacy and increase their motivation to reduce or abstain from substance use. In addition, clinicians can use motivational techniques in targeted, brief interventions in order to promote their tendency to change in a non-confrontational manner. While there has been strong evidence supporting the use of motivational interviewing for clients with alcohol-related disorders, there is also evidence that it can be effective for opioid, stimulant, and polysubtance users.

Contingency Management

Contingency management follows a model that provides incentives to promote abstinence or reduced drug use, with the philosophy that reinforcement (both positive and negative) can improve a client's success in repeatedly avoiding drug use behaviors. Incentives in previous studies have included vouchers redeemable for specific goods, chances to enter lotteries, or treatment-related benefits (ex. increased methadone doses or ability to take methadone doses home) and research has shown efficacy across different substances including cocaine, opiates, and marijuana. Cost is often cited as a significant barrier to implement technique, but recent research has shown benefits in variable-reinforcement schedules or using lower-cost alternative incentives.

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) can be an effective modality that provides both effective skills training to promote abstinence while also helping the client examine the functional components that influence his drug use such as triggers and potential consequences. CBT can have many benefits including helping the client examine behavioral patterns, increase their self-monitoring of thoughts and behaviors that can occur prior, during, or after drug use episodes, recognizing cognitive patterns that reinforce drug use, and enhancing problem-solving skills that can improve both drug use outcomes and general life conflicts. Research has shown wide-ranging efficacy in alcohol, opioid, nicotine, and cocaine use disorders and have shown durable benefit after ending treatment.

Twelve Step Facilitation and Mutual Help Participation

Participation in Alcoholics Anonymous is associated with better abstinence rates and reduced substance-related problems (Kaskutas 2009). Treatment programs that encourage 12-step participation are associated with improved abstinence and decreased healthcare costs compared to those that are primarily cognitive-behavioral therapy based (Humphreys and Moos, 2007). Alcoholics Anonymous and other 12-step groups promote development of social networks that reinforce abstinence more effectively than family support (Kaskutas 2009). Twelve-step facilitation is an evidence-based, manually-driven individual therapy that encourages active involvement in Alcoholics Anonymous and other 12-step programs (Nowinski et al 1995) and is available through the NIAAA (http://pubs.niaaa.nih.gov/publications/match.htm). A succinct summary of Twelve-step Facilitation for general psychiatrists is available in the APP Textbook of Substance Abuse Treatment (Galanter and Kleber 2008).

Additional Comments

Substance use disorders occur in the context of personal and family dynamics; several strategies such as interpersonal therapy, family behavioral therapy, and multidimensional family therapy have shown benefit in treating substance use disorders. Familial involvement can be especially helpful in adolescent populations. Given the efficacy of various techniques, researchers are also examining whether combining "ingredients" from different modalities can further optimize treatment efficacy.

5. Management of co-occurring substance use disorders and severe mental illness

Residents should be trained to recognize the importance of comorbid substance use and how it can affect treatment. Although comorbid substance use may lead to diagnostic ambiguity when a present initially presents to a mental health provider, patients with severe psychiatric

symptoms may need prompt treatment with antidepressant or antipsychotic medication despite this uncertainty. Therefore, concurrent treatment of both psychiatric illness and substance use disorder is important for optimum treatment efficacy. Residents should also recognize the multiple benefits of specific pharmacotherapy (ex. the use of bupropion for both depression and nicotine cessation) and how certain behavioral strategies can be effective for patients with specific comorbid disorders (ex. use of integrated group therapy for patients with bipolar disorder or PTSD and substance use disorders). Exposure to assertive community treatment, which often involves integrative treatment for patients with both severe mental illness and substance use disorders, can also improve residency training in how to manage patients whose comorbid substance use and severe mental illness lead to significant treatment complexity.
Key Recommendation: Psychiatry residents should receive didactic training and clinical supervision in evidence-based management of co-occurring substance use disorders and severe mental illness.

Resources:
Review of co-occurring depression and SUDs:
Nunes, E. V. and F. R. Levin (2006). "Treating depression in substance abusers." Current Psychiatry Reports **8**(5): 363-70.

Review of psychotic disorders and SUDs:
Brady, K. and M. Verduin (2005). "Pharmacotherapy of comorbid mood, anxiety, and substance use disorders." Substance Use and Misuse **40**: 2021-2041; 2043-2048.
NIDA. (2010). "NIDA Research Report: Comorbity: Addiction and Other Mental Illnesses." from http://drugabuse.gov/researchreports/comorbidity/treatment.html

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Alford, D. P., P. Compton, et al. (2006). "Acute pain management for patients receiving maintenance methadone or buprenorphine therapy." Annals of Internal Medicine **144**(2): 127-34.

Andreas, J. B. and T. J. O'Farrell (2009). "Alcoholics Anonymous attendance following 12-step treatment participation as a link between alcohol-dependent fathers' treatment involvement and their children's externalizing problems." Journal of Substance Abuse Treatment **36**(1): 87-100.
Anthenelli RM, Morris C, Ramey TS, et al (2013). Effects of varenicline on smoking cessation in adults with stably treated current or past history of depression. Annals of Internal Medicine **159**: 390-400.

Arndt, T. (2001). "Carbohydrate-deficient transferrin as a marker of chronic alcohol abuse: a critical review of preanalysis, analysis, and interpretation." Clinical Chemistry **47**(1): 13-27.

Barry, D. T., K. S. Irwin, et al. (2009). "Integrating buprenorphine treatment into office-based practice: a qualitative study." Journal of General Internal Medicine **24**(2): 218-25.

Batki, S., Z. Meszaros, et al. (2009). "Medical comorbidity in patients with schizophrenia and alcohol dependence." Schizophrenia Research **106**: 139-146.

Blonigen, D. M., C. Timko, et al. (2009). "Treatment, alcoholics anonymous, and 16-year changes in impulsivity and legal problems among men and women with alcohol use disorders." Journal of Studies on Alcohol and Drugs **70**(5): 714-25.

Brady, K. and M. Verduin (2005). "Pharmacotherapy of comorbid mood, anxiety, and substance use disorders." Substance Use and Misuse **40**: 2021-2041; 2043-2048.

Carrol, K. (2005). "Recent advances in the psychotherapy of addictive disorders." Current Psychiatry Reports **7**(5): 329-336.

Carroll, K. M., L. R. Fenton, et al. (2004). "Efficacy of disulfiram and cognitive behavior therapy in cocaine-dependent outpatients: a randomized placebo-controlled trial." Archives of General Psychiatry **61**(3): 264-72.

Carroll, K. M., C. Nich, et al. (2000). "One-year follow-up of disulfiram and psychotherapy for cocaine-alcohol users: sustained effects of treatment." Addiction **95**(9): 1335-49.
Carroll, K. M., C. Nich, et al. (1998). "Treatment of cocaine and alcohol dependence with psychotherapy and disulfiram." Addiction **93**(5): 713-27.

CDC. (2008). "National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, Department of Health and Human Services. Smoking and Tobacco Use—Fact Sheet: Health Effects of Cigarette Smoking." from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm.

Cinciripini PM, Robinson JD, Karam-Hage M, et al (2013): Effects of varenicline and bupropion sustained release use and intensive smoking cessation counseling on prolonged abstinence from smoking and on depression, negative affect and other symptoms of nicotine withdrawal. JAMA Psychiatry **70**(5): 522-533.

Comer, S. D., M. A. Sullivan, et al. (2006). "Injectable, sustained-release naltrexone for the treatment of opioid dependence: a randomized, placebo-controlled trial." Archives of General Psychiatry **63**(2): 210-8.

Cornelius, J., I. Salloum, et al. (1995). "Disproportionate suicidality in patients with comorbid major depression and alcoholism." American Journal of Psychiatry **152**(3): 358.

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COUNCIL ON ADVOCACY AND GOVERNMENT RELATIONS

Executive Summary:

The Council on Advocacy and Government Relations (CAGR) met on Tuesday, May 6 at the American Psychiatric Association's Annual Meeting in New York, NY. The Council received reports from the Department of Government Relations staff on major federal and state legislative and regulatory issues, and also received an update on APA*PAC*. The Council also discussed several key issues including:

- H.R. 3717: Helping Families in Mental Health Crisis Act of 2013;
- Medical Evaluation Parity for Servicemembers Act of 2014 (MEPS Act);
- Medicare hospital conditions of participation of liability;
- 2014 Advocacy Leadership Conference.

The Council brings the following Information Items to the Joint Reference Committee:

1. Review and Approval of 2014 January JRC Report and Minutes

The Council informs the Joint Reference Committee that the Council approved the 2014 January JRC report and minutes. (See Minutes page 3)

2. Review and Approval of 2014 May Assembly Report

The Council informs the Joint Reference Committee that the Council approved the 2014 May Assembly report. (See Minutes page 3)

Council on Advocacy and Government Relations
APA Annual Meeting
May 6, 2014
Sheraton Hotel, New York, NY
Meeting Minutes
Draft Until Approved by the Council

Members in Attendance:
Bob Cabaj, M.D., *Chair*
Barry Perlman, M.D., *Vice-Chair*
Ade Adelakun, M.D.
Cassandra Newkirk, M.D.
Charles Price, M.D.
Craig Zarling, M.D.
David Lowenthal, M.D.
Jerry Halverson, M.D.
John Bailey, D.O.
Yvonne Yang, M.D.

APA Staff in Attendance:
Chris Whaley
Deana McRae
Kristin Kroeger
Jennifer Tassler
Lizbet Boroughs
Matt Sturm
Pamela Thorburn
Scott Barnes

Guests in Attendance
Saul Levin, M.D., M.P.A., APA CEO and Medical Director
Sam Muszynski, APA Staff

I. Welcome & Review of Agenda

Dr. Cabaj welcomed the Council and provided an overview of the agenda. Ms. Kroeger introduced herself to the Council, elaborated on her prior experience and background, and noted that she will be serving as interim Director of the Department of Government Relations. Also, Ms. Tassler will be serving as the interim Deputy Director of Regulatory Affairs.

II. APA*PAC* Update

Mr. Barnes provided the Council with the current status of the APA*PAC.* 2013 was an average year with about $190,000 raised. So far in 2014, about $121,000 has been raised with around $16,000 coming solely from fundraising efforts at the 2014 APA Annual Meeting. The participation rate of APA members contributing to the APAPAC is still low — about four percent of members. Mr. Barnes also informed the Council of the current political landscape for the upcoming 2014 midterm elections, and a brief overview of the disbursements to come. Dr. Cabaj added that Dr. Levin has been making a strong push to increase the participation level, especially among APA leadership. Dr. Zarling added that face-to-face solicitations seem to be more effective than solicitation emails, and it would be beneficial to have an APAPAC representative at area meetings as well.

III. Review and Approval of January 2014 JRC Report Minutes, May 2014 Assembly Report

Dr. Cabaj recapped the January 2014 JRC Report and the May 2014 Assembly Report for Council members. The Council unanimously approved the January 2014 JRC Report, and the May 2014 Assembly Report.

IV. Spotlight: H.R. 3717, Helping Families in Mental Health Crisis Act of 2013

Mr. Sturm provided the Council with an overview of the legislation introduced by Rep. Tim Murphy (R-PA) — H.R. 3717, the Helping Families in Mental Health Crisis Act of 2013. The legislation has a few provisions that the APA supports, opposes, or has no policy on. Political concerns have also been taken into consideration, including forthcoming, similar legislation by Rep. Ron Barber (D-AZ). The CAGR had significant discussion around the Murphy bill, our consensus group recommendations to his bill, the Democratic bill, as well as the politics, both current and future, involved.

Dr. Levin joined the meeting, and discussion. Speaking to the Council, Dr. Levin offered insight on his conversations with Rep. Murphy. There are provisions in this legislation that is concerning to the APA, including but not limited to the “Medicaid bump”, and funding for mental health first aid. The Council will be looked at to provide guidance on whether to support/oppose/acquiesce the bill, or whether to focus on specific provisions in the legislation. Dr. Levin thanked the Council for their time, and looks forward to hearing their feedback.

Dr. Cabaj posed the following question to the Council: "Do you advise to leadership that staff work with Representative Murphy's office to improve H.R. 3717 by requesting the inclusion of amendments from

the consensus group, as well as asking for amendments specifically affecting APA and our membership, in return for endorsement of the bill?" The council unanimously agreed.

V. Federal Legislative Update

The Medical Evaluation Parity for Servicemembers Act of 2014 (MEPS Act)

Mr. Sturm provided the Council with an overview of the MEPS Act. The bill was introduced in the House by Representatives Glenn Thompson (R-PA) and Tim Ryan (D-OH), and in the Senate by Senators Rob Portman (R-OH) and Jay Rockefeller (D-WV). Language in the bill requires pre-enlistment "mental health assessments", but is silent on the details of the proposed assessments. Assessments are required to be used as a baseline for future mental health examinations; they may not be used to inform assignment or promotion. Concerns have been raised by Uniformed Services District Branch leaders on the effectiveness and accuracy of assessments given prior attempts at testing pre-enlistment mental health evaluations have proven ineffective. There is, however, strong stakeholder and congressional support, including other mental health and veterans' organizations, and bipartisan cosponsors in Congress respectively.

Dr. Yang asked if the bill's intent is to prevent individuals who are prone to violence from entering the military. Mr. Sturm replied that the bill's intent is unclear of preventing any particular mental illness. Dr. Bailey added that research is developing to the point where there could be possible biological parameters to determining who is more susceptible to mental health disorders (e.g., Post-Traumatic Stress Disorder), but the medical community is not at that point yet. Dr. Perlman asked if there is anything we could offer the bill's authors, or ask them to clarify their position. Mr. Sturm answered that the APA will continue to ask for clarifications. Also, we could consult with the APA's Uniformed Services caucus for guidance on pre-enlistment assessments from years past. Dr. Cabaj asked if there is a rush on this bill. Mr. Sturm replied that there is no rush. Dr. Cabaj asked the Council if they would support DGR staff working with Rep. Thompson on the details on the bill's language, and offer no formal support/opposition until more clarification is obtained. The Council unanimously agreed.

VI. Regulatory Update

Mr. Muszynski informed the Council of the regulatory landscape since The Mental Health Parity and Addiction Equity Act (MHPAEA) Final Rule was released late 2013. While the final rule provided some clarity on transparency and disclosure requirements, the big question is how it will be implemented. There are two priority areas right now: payment equity and non-quantitative treatment limitations. While the federal government (under the Affordable Care Act) created health exchanges and essential health benefits, they will most likely not get involved with enforcing parity issues at the state level. The rollout of the exchanges has encountered many problems so it is still too early to identify parity issues. Dr. Price asked what the APA will be doing to identify, evaluate, and rectify parity issues at the state level. Mr. Muszynski responded that the APA will need to build up its resources, and, perhaps most importantly, become more hands on with assisting District Branch/State Association executives. This includes being proactive with information for DB/SA executives. Also, the final rule was silent on its

mandate to be included under Medicaid plans, which is a priority to the APA. For now, the APA will have to examine the implementation process going forward.

VII. State Legislative Update

Ms. Thorburn provided the Council with an update on legislation around the country at state levels. DGR is monitoring legislation introduced, and working with DB/SA executives to provide any assistance possible. DGR will be helping DB's/SA's with grassroots advocacy efforts through its Capwiz system. Current legislation being tracked includes involuntary/voluntary commitment, scope of practice, Prescription Drug Monitoring Program, substance abuse and use, parity, tele-health, and medical marijuana.

VIII. New Business

Medicare Hospital Conditions of Participation of Liability

Dr. Perlman informed the Council about a number of hospital closures in New York. This has raised the problem of hospitals not being able to cover costs of protecting patients and doctor liability. He added that perhaps the Council could examine this problem, and offer some possible solutions going forwarded. Dr. Cabaj agreed, and tabled the discussion for future Council meetings.

IX. Council: Transition and Future

Dr. Cabaj thanked the Council for their hard work and dedication to advocacy throughout the last several years. As chair, Dr. Cabaj led efforts to promote the field of psychiatry through his tireless advocacy efforts. He thanked members who will be leaving the Council, and passes the gavel to Dr. Perlman, incoming Chair.

The Council adjourned at 5:00 pm.

EXECUTIVE SUMMARY
Council on Children, Adolescents and Their Families

Council Overview
The work of the Council is directed toward maximizing the effectiveness of APA in addressing the mental health needs of children, adolescents, and their families. Its charge is primarily carried out through workshops, position statements, and liaison with allied children and adolescent organizations.

The Council met in New York, NY on May 5, 2014.

Action Items

None

Referrals/Updates

Position Statement on Child Abuse and Neglect by Adults (JRCOCT128.C.5/ASM Item #2013A1 4.B.4)
Revisions to the position statement were made to address the Assembly's recommendation that the position statement address in more detail the overall impact of poor treatment on children. However, the Council was unable to review the document at its May 5 meeting due to time constraints. The Council will take this up at its September meeting when it will also review a draft supporting resource document, which is currently in progress.

Minutes of the Meeting of Council on Children, Adolescents and Their Families
May 5, 2014
3:00 pm – 6:00 pm
New York, NY

Attendance:
Members Present: Drs. Louis Kraus (chairperson), Diana Antonacci, Clarice Kestenbaum, Elizabeth Newlin, Elias Sarkis, Gabrielle Shapiro, Jean Thomas, John Walkup, Cathryn Galanter.
Residents Present: Drs. Jon Lee, Celeste Lopez, Christina Khan, Courtney McMickens, Auralyd Padilla, Desiree Shapiro
Guests Present: Heidi Fordi (Executive Director, AACAP); Carmen Head (AACAP); Drs. Albert Sargent, Bill Wood
Staff Present: Dr. Annelle Primm, Alison Bondurant; Kristin Kroeger, Yoshie Davison, Samantha Shugarman.
Excused: Drs. Chris Kratochvil, Amy Ursano, Kayla Pope, Lin Sikich
Unexcused: Drs. Sarah Bougary, Dauda Griffin, Andres Martin

After introductions, Dr. Kraus called the meeting to order.

Council Composition. Dr. Kraus reviewed the current roster of the Council and acknowledged and thanked those Council members in attendance who are rotating off: Catherine Galanter and Diana Antonacci.

Choosing Wisely: Five Things Psychiatrists and Patients Should Question. In continuing discussion about revising the published list item # 5 which relates to medication use in children and adolescents, Council members expressed concern that the April 28 update proposed by a work group of the Council on Quality Care is quite different from the version this Council on Children penned last January. They felt that the April 28 document included new issues in a different tone which reduced it to a standard for practice that can be used in a legal way. As such, Dr. Walkup proposed alternative wording which eliminated language that had legal ramifications and softened the tone. After a bit of editing, the Council agreed to the following text:

> (Council rewrite May 5, 2014)
> **#5 Don't routinely prescribe an antipsychotic medication to treat behavioral and emotional symptoms of childhood mental disorders in the absence of approved or generally accepted indications.**
> There are both on and off label clinical indications for antipsychotic use in children and adolescents. FDA approved and/or evidence supported indications for antipsychotic medications in children and adolescents include psychotic disorders, bipolar disorder, tic disorders, and severe irritability in children with autism spectrum disorders; there is increasing evidence that antipsychotic medication may be useful for some disruptive behavior disorders. Children and adolescents should be prescribed antipsychotic medications only after having had a careful diagnostic assessment with attention to comorbid medical conditions and a review of the patient's prior treatments. Efforts should be made to combine both evidence-based pharmacological and psychosocial interventions and support. Limited availability of evidenced based psychosocial interventions may make it difficult for every child to receive this ideal combination. Discussion of potential risks and benefits of medication

> treatment with the child and their guardian is critical. A short and long term treatment and monitoring plan to assess outcome, side effects, metabolic status and discontinuation, if appropriate, is also critical. The evidence base for use of atypical antipsychotics in preschool and younger children is limited and therefore further caution is warranted in prescribing in this population.

Dr. Kraus resolved to present this version at the Council on Quality Care meeting on Wednesday, May 7.

Choosing Wisely® is an initiative of the ABIM Foundation. It aims to promote conversations between providers and patients about the need—or lack thereof—for many frequently ordered tests or treatments. Other national organizations representing medical specialists participate in the Choosing Wisely campaign.

Parents Medication Guide on Autism. Ms. Fordi reported that work had not yet started on the autism guide as the committee disclosure vetting process is still underway but nearing completion. She noted that Drs. Kraus and Bryan King represent APA on this joint APA/AACAP project.

AACAP Update. Ms. Fordi highlighted some AACAP happenings. She announced that AACAP's number one priority, Advocacy Day, is approaching and urged Council members not already signed up to attend. She noted that AACAP is considering rescheduling Advocacy Day at some time other than May so as not to abut the APA Annual Meeting, as participation in both so close together can be taxing for members. Ms. Fordi also announced that AACAP President Joshi's theme is partnering with the world's children and that the association's Membership Committee is exploring opening membership to international child psychiatrists. President-Elect Gregory Fritz's presidential initiative will focus on integrated care. She ended her report by introducing Carmen Head, AACAP's new head of research and education. Dr. Kraus told Ms. Fordi the Council will try hard to keep AACAP informed about opportunities for collaboration.

Work Group to Establish Guidelines for Interacting with Caregivers. Dr. Shapiro reported that she is the Council's representative on this work group, which is also comprised of individuals from the Councils on Geriatric Psychiatry and Psychiatry/Law. The guidelines are to help psychiatrists interact with caregivers of patients with psychiatric illness. She announced that the work group has decided NOT to address caregivers to children, as the issues and concerns for child caregivers differ a great deal from those who look after the elderly. She suggested that Council consider creating a version for caregivers to children.

APA Division of Government Relations Report. Ms. Boroughs gave her regular legislative update. She reiterated that the Murphy Bill, which is known as the Helping Families in Mental Health Crisis Act, is the first comprehensive mental health legislation in over 30 year but that prospects for the bill are uncertain given partisanship in the House and the Senate and the complexity of the mental health system. She added that the bill's support of involuntary outpatient treatment is drawing opposition from some advocacy groups, and the bill's call for reduced funding for protection and advocacy systems for mentally ill individuals is causing alarm. Other topics that Ms. Boroughs touched on were the media's rising attention to rape, alcohol access and opiate use on college campuses and legislative efforts to ensure

transgender youth protections. She also distributed an advocacy update highlighting recent APA advocacy accomplishments.

Resource Document on Adoption. Dr. Sarkis reminded Council that at the last meeting he agreed to take the lead on a project to develop a resource document on adoption, one that can support current and future APA position statements on the subject. He conceded that a preliminary literature review proved adoption to be a very broad topic and that it would behoove the Council to narrow the focus before moving forward. Dr. McMickens suggested and will propose to the AACAP adoption and foster care committee that the two organizations work collaboratively on a document that psychiatrists can benefit from, such as a practice parameter.

Kristin Kroeger. Ms. Kroeger introduced herself in her new capacity as the APA Chief of Policy, Programs, and Partnerships. She gave an overview of her responsibilities and offered her personal assistance to Council whenever needed. Ms. Kroeger had a previous connection with the Council during her tenure at AACAP.

APA Child and Adolescent Psychiatry Fellowship Program. Dr. Galanter, faculty advisor to the fellowship, named the new class of fellows and their mentors. She mentioned that she wants to develop a database of psychiatrists who can serve as mentors to fellows. Dr. Kraus commended her efforts on behalf of the fellowship program.

Proposed APA Caucus on Infant Mental Health. Dr. Thomas reported that she with the help of Dr. Bill Wood has collected the name nine individuals who support the formation of this caucus. Ten letters of support are needed to formally begin the process. She hopes to be able to submit the request for the caucus's formation with the required back up material in September.

Revisions to Child Abuse and Neglect Position Statement. Dr. Newlin circulated by email during the meeting a version of the position statement which added a bit more detail on how abuse and neglect can affect children, based on feedback from the Assembly. However, as the Council meeting was about come to a close, discussion of the document was postponed. Dr. Newlin briefly called attention to reports of abuse at wilderness programs and the dangers of non-certified residential programs. Dr. Kraus will consider the need for APA position statements which address these problems. Dr. Newlin was advised to present a workshop on this subject.

Next Meeting. Council members selected Friday, September 12, as the date of its next meeting, in Arlington, VA.

Executive Summary:

Council on Communications

The Council on Communications (COC), chaired by Jeffrey Borenstein, M.D., met at the Annual Meeting on Sunday, May 4 and Monday, May 5. This meeting marked that last in which Dr. Borenstein would be chair, and the incoming chair, Ray DePaulo, joined the meeting and was introduced. The items mentioned herein were discussed.

The agenda focused on an audit of APA and DSM coverage for 2013, public education initiatives being implemented by the American Psychiatric Foundation (APF), anticipated changes to the APA website and many of the ongoing communications activities for which the council plays an advisory role. Guests included Eric Fishman, Senior Director of Information Services and Strategies, who gave a presentation on website changes and Linda Bueno and Clare Miller, both of APF, who gave an overview of the foundation's Typical or Troubled?, the Judges Criminal Justice and Behavioral Health Leadership Initiative and the Partnership for Workplace Mental Health initiative.

The council brings no action items to the JRC at this time.

Information Item: APA & DSM Media Coverage, 2013

An overview of APA and DSM-5 media coverage for 2013 was presented by Eve Herold, who is director of the Office of Communications and Public Affairs (OCPA). The period covered was January 1, 2013 through December 31, 2013, which included the launch of DSM-5 in May 2013. Drawing upon analytics for frequency, types of coverage (print, online news sources, blogs, etc.) and tone, it was found that APA and the DSM-5 garnered 30,625 mentions in the media, with a huge spike in coverage in May. Comparisons were made of APA stories vs. DSM stories, and it was shown that by far most of the coverage was in new media, including online news sites and blogs, while daily newspapers accounted for only a small percentage of coverage. Stories on DSM-5 had considerably greater coverage on blogs, which accounts for much of the negative and controversial coverage of the DSM.

A brief history of DSM benchmarks was given to show the rise and fall of interest in the DSM over time. Significant developments, such as the 2008 announcement of DSM work group members and an article by Lisa Cosgrove on DSM conflicts of interest in PLoS Medicine all influenced the frequency and tone of coverage, as various controversies emerged, peaked and tended to be resolved over time. There were similar surges in interest that focused on changes to the criteria for autism spectrum disorder and the removal of the bereavement exclusion from Major Depressive Disorder. Most council members had followed these developments and were

able to add their own observations. The May 2013 release of the DSM-5 led to the largest surge in media coverage, led by the New York Times, which ran 15 DSM-related stories in the month of May alone. Ms. Herold reported that in that month, the OCPA fielded more than 150 media inquiries from newspapers, TV, radio, magazines and online media sources throughout the world. This was in addition to the proactive pitching of DSM issues to top-tier U.S. press, which also garnered a great deal of coverage. The majority of the coverage was balanced, neutral or positive, while 36% was seen as negative.

Much of the coverage demonstrated that although it was a challenge getting the APA's key messages out in such a noisy and contentious environment, May 2013 coverage actually reflected APA messaging to a great extent. These messages were:

- DSM-5 reflects the best science available (34 articles)
- Changes to the DSM-5 are based on solid research (33 articles)
- DSM-5 is the best tool available for clinicians and their patients (30 articles)
- DSM-5 is a clinical guidebook (22 articles)
- DSM-5 improves diagnostic criteria (8 articles)
- DSM-5 reflects a broad, open and inclusive development process (6 articles)

Ms. Herold reported that the lasting result of DSM media coverage is that more attention is now focused on mental health issues; the conversation has moved beyond DSM-5 to parity implementation, health care reform and mental illness and violence; and the general public is both more informed and more interested in mental health issues than ever before.

Information Item: APF Public Education Initiatives

Linda Bueno, who is Director of Corporate and Community Relations for APF, then spoke about the foundation's Typical or Troubled? program for early identification and intervention for troubled adolescents through the public school system. Implementation of the Typical or Troubled? program involves presenting an evidence-based school curriculum which educates the school community – including parents, school personnel and other adults to take three important steps: Notice (behavior that may be a sign of emerging mental illness), talk (with the teenager about what he or she is feeling) and act (by connecting those who need it with appropriate services that can help them). So far the curriculum has been presented in nearly 2,000 urban, suburban and rural schools.

Ms. Bueno then gave an overview of the foundation's Judges Criminal Justice and Behavioral Health Leadership Initiative, a campaign that educates judges in how to deal with mentally ill people who are caught up in the criminal justice system. The program helps judges collaborate with psychiatrists and psychologists and others in the mental health community to provide appropriate and humane treatment of justice-involved individuals with mental illnesses. In the course of the discussion, Ms. Bueno said that she would like for the OCPA to produce a new brochure in its "Let's Talk Facts" series about the incarceration of the mentally ill.

Clare Miller, the foundation's director of the Partnership for Workplace Mental Health, gave a presentation on the program, which works with employers to help support employee mental health. She also presented the Right Direction campaign, an initiative aimed at helping employees who have depression to get help. The Right Direction campaign provides a very engaging website, poster series, squeeze toy and coasters depicting a bear who is lost in the woods and also just "going through the motions" at work.

On the second day of the meeting, Shaun Snyder, Chief Operating Officer of APA joined the meeting and introduced himself to the council. He spoke about the reorganization of the APA and how the collaboration of OCPA, Psychiatric News and Marketing is already resulting in improved efficiency and will better position the APA to become the thought leader in mental health.

Information Item: Discussion of APA Disaster Response

The discussion turned to the need for the APA to respond quickly to disasters in the news, and David Spiegel, M.D. noted that when an emergency occurs, the APA's response is hindered by the need to go through many layers of approval. Dr. Rose suggested that OCPA produce pre-prepared messages to respond to tragedies, and Ms. Herold noted that there are pre-prepared responses to things like mass shootings but that each situation is unique and will inevitably need a unique response. Mr. Snyder said that there is concern about the APA jumping in too quickly in the event of disasters like mass shootings when mental illness may play no role at all. By automatically putting out a statement about such tragedies, the APA could be implying that the problem was caused by mental illness when that may not be the case. Dr. Spiegel said that whatever the tragedy, the APA should quickly send out a message to help people cope, and Dr. Vahabzadeh noted that the most effective messages are those with vivid emotional content.

Information Item: Changes to Website

For the next item on the agenda, Eric Fishman led a discussion of changes coming to the APA website. He explained that there was a complete redesign about two years ago but that, in the meantime, a great deal of unneeded material has been accumulated on the site and that all APA departments posting material there will be called upon to do a "spring cleaning." The first step, now in progress, is to assess what information is on the site. He explained that, since the last redesign, the content was driven by a web development team of 24 people, and all of the messaging is not cohesive. A new team of eight people is doing a full content inventory and focusing on identifying the correct audience for each item, style and consistency, the presence of dead links and the question of whether promised resources are where they are supposed to be. The assessment will also help identify the most relevant and important content. At the end of the process, it is hoped that the new website will show consistency of tone and style, relevance, greater optimization for mobile devices and easier navigation.

Mr. Snyder informed the council that the APA is changing the way the website is run, putting content under the purview of a new Digital Content Manager who will be hired by the Marketing

Department. This person will review everything and manage the content. Mr. Fishman said that ISS is developing an inventory spreadsheet, which analyzes each page, including page visits, date posted, number of hits, time visitors spend on the page and identifying whether the page is unique or redundant. This spreadsheet will assist all the departments in doing their spring cleaning. Another new resource being developed is a page-by-page site map. Mr. Fishman said that overall, the APA needs to approach content and branding strategically—i.e., with a clear vision of what it wants the website to do.

In the ensuing discussion, Dr. Borenstein observed that it is not clear on the home page which section of the website is for the public, and Dr. Sederer noted that in its mission statement, which is posted on the site, the APA needs to put helping patients first in its hierarchy of goals. Mr. Snyder shared that during its communications audit, consultants from Porter Novelli thought that the mission statement is both dated and defensive in tone. Dr. Rose commented that the Ben Rush seal should be changed and that the APA needs a modern logo. Mr. Snyder noted that the seal could be maintained to honor the past alongside a new logo. He said that active discussions are going on to address this issue. Dr. Spiegel said that the Ben Rush seal clashes with the modern photos on the website, and Dr. Borenstein observed that what matters is the level of engagement that will welcome people to click through the site.

Information Item: Discussion of Social Media

Dr. Vahabzadeh gave the council a presentation on social media strategy, in which he noted that social media platforms are increasingly integrated and that video is more important than ever. User engagement is crucial and analytics should guide us by measuring how much time people look at a page. The most effective messages are those that have emotional content. One should not abuse users by bombarding them with messages; if they feel overwhelmed by how much information we send them, they can unfollow us. He stated that it is increasingly difficult for things to go viral due to the sheer volume of content on social media and that we should consider paid advertisement of our social media sites.

To keep social media sites growing, Dr. Vahabzadeh recommended increasing the capacity of our sites to host videos, to increase visual and graphic-rich content such as infographics, to engage with currently trending issues and to engage with key decision makers who have “high impact handles.” He also suggested that the Council on Communications develop a social media subgroup. Ms. Herold asked if the council feels that APA’s social media sites be centralized within OCPA or disbursed throughout the organization to draw upon differing kinds of expertise, and noted that leadership needs to become comfortable with the fact that one has limited control over social media sites. Consequently, staff needs to be empowered to speak for the organization in order to do efficient and effective social media.

Dr. Vahabzadeh concluded his talk with the following recommendations: The APA should invite the membership to tweet and should develop a network of medical schools and foundations who would send out content with us. He also suggested that the APA should invest in advertising its sites.

Information Item: Changing Council Leadership

Dr. Borenstein delivered a hearty thanks to the council and the APA staff for their hard work during his tenure as chair, and announced that at the end of the Annual Meeting, Dr. Ray DePaulo would be the new chair of the council. Dr. Borenstein remains as a member of the council, so the council will continue to benefit from his participation and input.

Summary

Council on Geriatric Psychiatry

Description of the Council:

The Council provides leadership in the field of geriatric psychiatry and undertakes this task by initiatives related to geriatric psychiatry education, research, and clinical care. The Council also strives to work collaboratively with other professional and advocacy groups to develop best practices in geriatric psychiatry while providing education and training to other physicians (including but not limited to psychiatrists), residents, and medical students, as well as to other allied mental health professionals (including but not limited to nurses and social workers) at scientific meetings and in other settings focused on the special needs of geriatric populations with mental illness.

Information Items:

- The council offered its active participation to the Guideline Writing Group of APA in the development of the Guideline on the use of antipsychotics in dementia.
- The council requested the establishment of a permanent venue to present Hartford-Jeste Award for Future Leaders in Geriatric Psychiatry.

Action Items:

- Will the JRC approve having a standing position for a Resident Fellow member on council?
    - The expenses to attend two council meetings in a year will be approximately $1500 and this cost can be taken from the operating budgets.

Referral:

Establishing Guidelines for Interacting with Caregivers (ASMNOV1312.C; JRCJAN146.1)

The Joint Reference Committee has referred the action paper, Establishing Guidelines for Interacting with Caregivers, to the Council on Geriatric Psychiatry, Council on Children, Adolescents and Their Families, and the Council on Psychiatry and Law. The Council on Geriatric Psychiatry was designated as the lead council and has put a workgroup together comprising of members from all three councils. The workgroup met twice over conference call to discuss the background of the referrals, available references and primary outline for the action paper.

A few members of the workgroup also met during the Annual Meeting in NY to discuss the final outline. Now the workgroup members will start writing the first draft of the action paper and discuss it further in next conference call.

Council of Geriatric Psychiatry- September Component Meeting

Sheraton Times Square, NY

Friday, September 20, 2013

Council Members Present:

- Robert Paul Roca, MD (Chair)
- Brent Forester, MD
- Blaine Stuart Greenwald, MD
- Bret R Rutherford, MD
- Bruce L Saltz, MD
- Keith R Stowell, MD
- Ipsit Vihang Vahia, MD
- Helen Lavretsky, MD
- Anand Kumar, MD
- Uyen-KhanhQuang-Dang, MD MS (UK)

Staff in Attendance:

- Sejal Patel (Staff), APA

Council Members Absent with excused absence

- Susan Schultz, MD

Council Members Absent with unexcused absence

- Maria Llorente, MD
- Mohit Chopra, MD
- Olivia I Okereke, MD
- Alexander Threlfall, MD

Guests in Attendance:

- Gary Small, MD, President-Elect, American Association of Geriatric Psychiatry (AAGP)
- Victor Reus, MD, Chair, Guideline Committee Group, APA

APA Staff in Attendance

- Ellen Jaffe, Editor & Production Manager, Healthcare Systems & Financing, APA
- Karen Sanders, Associate Director for Publicly Funded Services, Healthcare Systems & Financing, APA
- Samantha Shugarman, Performance Measure Specialist, APA
- Matt Sturm, Dy. Director, Department of Government Relations, APA

Introductions:

The meeting began with introductions of all participants and review of the agenda for the meeting.

Dr. Robert Roca reviewed the council work plan and updated the members about the progress of each activity.

Review of Council Charge and Discussion of Potential Projects

The Council then began discussing potential activities that would be responsive to that charge.

The topics included

1. **Practice Guidelines on use of antipsychotics in elderly**

   Victor Reus, MD who is chairing the guideline writing group at APA provided an update about the progress on Practice Guidelines on use of antipsychotics in elderly patients. As he mentioned the process started in September 2013. The committee follows the IOM protocol for developing guidelines has teleconference meetings on bi-weekly basis. The committee created survey to capture the attitudes and practices of experts regarding the use of antipsychotics in the treatment of dangerous and non-dangerous agitation and psychos among persons with dementia. The survey has been sent out to 600 individuals who were selected using snowball sampling. The last date to receive these surveys is May 22, 2014. Dr, Reus mentioned that the guidelines creation process is lengthy and time consuming, and he is doing his best to expedite it. He also added that the process has been guided by an extensive review of the relevant literature.
   The council is keenly interested in providing input regarding the guidelines prior to publication, and Dr. Reus indicated that he would welcome this.

2. **Call with the Government Accountability Office:**

   The Senate Committee on Homeland Security and Governmental Affairs asked the GAO to examine antipsychotic drug use in elderly persons, specifically the extent of and rationale for antipsychotic drug prescribing to elderly persons with dementia living in nursing homes and in the community. Pursuant to this, the GAO requested a phone meeting with APA experts in this area. Dr. Robert Roca, Dr. Ipsit Vahia, and Dr. Blaine Greenwald from the Council on Geriatric Psychiatry participated in the call with Jeffrey Regan from Government Affairs division of APA. In the course of the call it became clear that the GAO has little understanding of the clinical issues and was grateful for the education. The Council offered to continue to provide input as the investigation goes forward.

3. **Choosing Wisely:**

The council has shown interest in updating the Choosing Wisely document on antipsychotic use. The council has observed that the document suggests that the antipsychotics should not be used as first line therapy to treat behavioral and psychological symptoms of dementia under any circumstances, and it is the view of the Council that there are circumstances in which they may indeed be a first line treatment. Samantha Shugarman, who serves as a liaison to Choosing Wisely, said that the Council can suggest a revision. This will be added to the Council work plan.

4. **Guidelines for Interacting with Caregivers**

The Joint Reference Committee has referred the action paper, Establishing Guidelines for Interacting with Caregivers, to the Council on Geriatric Psychiatry, Council on Children, Adolescents and Their Families, and the Council on Psychiatry and Law. The Council on Geriatric Psychiatry was designated as the lead council and has put a workgroup together comprising of members from all three councils.

Dr. Roca briefed the council members about the progress on the task and discussed further action plan with Dr. Bruce Saltz and Dr. Helen Lavretsky who are part of the workgroup, after the council meeting. Drs. Roca, Lavretsy, and Saltz also met with members of the Council on Psychiatry and the Law on May 6th to create an outline of the document. It is anticipated that a draft will be ready for review by the September components meeting.

5. **Sample Survey Questions about Caregivers:**

Dr. Bruce Saltz developed a sample survey questions to evaluate the mental health impact on elderly adults of the need to care for their disabled children. The objective of this survey is to understand the scope and magnitude of the problem. The council members agreed that there is a lack of literature in this area and so it should be explored further. As the council is already working on a resource document to guide members on interacting with caregivers, the members decided to hold this project for few months until that project is complete.

Update on Integrated Care

Karen Sanders gave a brief update on Integrated Care. CMS has launched a initiative aimed at improving behavioral health and safeguarding nursing home residents from unnecessary antipsychotic drug use. As part of the initiative, CMS is developing a national action plan that will use a multidimensional approach including public reporting, raising public awareness, regulatory oversight, technical assistance/training and research. The action plan will be targeted at enhancing person-centered care for nursing home residents, particularly those with dementia-related behaviors. Guideline Writing Group (Dr. Victor Reus) and Dr. Roca have been part of the discussions. HCSF is scheduled to meet with CMS in Baltimore to discuss this issue. Several council members volunteered to make themselves available to participate in this meeting.

Karen also explained the APA's "Train the Trainer" initiative on Healthcare Reform and Psychiatric Practices. The program aims to educate psychiatrists interested in working in integrated settings. The District Branches are invited to send representatives to Chicago for "Train the Trainer

workshops. It is expected that those who are trained will then serve as training resources in their District Branches.

She also described the APA sponsored press briefing and roundtable discussion on "Integrated Primary and Mental Health Care: Reconnecting the Brain and the Body." The event brought together national leaders in the movement toward integrated and collaborative care. They emphasized that a key to addressing rising costs in American health care is integrated care that seeks to meet the mental health needs of patients in primary care as well as the primary care needs of those in specialty mental health settings.

She also explained about the Patient-Centered Primary Care Collaborative and highlighted APA's association with the program. She also invited the council member to join the discussions.

Medicare and PQRS Update:

Samantha Shugarman, APA Quality Measure Specialist, updated the Council about the incentive program introduced by CMS to improve quality reporting. The incentive is awarded for reporting on applicable measures. The incentive program ends in 2014. Thereafter, starting in 2015, there will be a 1.5% downward payment adjustment (financial penalty) on all Medicare payments for physicians who do not participate; the tracking for those who receive the 2015 penalty began in 2013. 2014 will serve as the performance year for the 2016 penalty adjustment of 2%. To avoid the PQRS penalty adjustment of 2% for 2016, physicians must report on 3 measures for 50% of their applicable patients.

Ellen Jaffe brief the Council about the Medical Learning Network of CMS. The network helps health care professionals gain knowledge from resources and products related to Medicare and the Centers for Medicare & Medicaid Services (CMS) website. She offered to send more details to the members through email.

Report from AAGP

Dr. Gary Small, President-Elect, AAGP, provided an update on the AAGP activities at the AAGP Annual Meeting 2014 in Florida. He also invited council members to attend AAGP's Annual Meeting in 2015 and briefed about the due dates to submit abstracts.

Gary briefed about the Geriatric Mental Health Foundation's (GMHF) Scholar Fund of AAGP which aims to encourage residents and medical students to pursue specialized training in Geriatric Psychiatry.

He highlighted the need to incentivize the payment system to get more psychiatrists interested in Geriatrics.

Dr. Roca reminded Dr. Small that AAGP is an Allied Organization and is entitled to representation in the Assembly.

APA government relations update

Matt Sturm informed the Council of various APA Advocacy accomplishments in past year. In March, APA hosted over 80 of its members at the annual Advocacy leadership Conference in Washington DC. Here members learned and advocated for support and passage of a recently introduced bill to incentivize the hiring of more psychiatrist in the Veterans Administration, federal funding of mental health services and research, fixing Medicare's reimbursement system and bring the stakeholders together on comprehensive mental health reform legislation.

Developing Educational Contents for APA Members:

Council members have agreed to develop educational content for APA members which can be available in various formats. One of the most successful formats of APA CME is eFocus. Dr. Helen Lavretsky agreed to contact interested colleagues to assist in developing eFocus materials in geriatric psychiatry. A former Council member, Dr. Helen Kyomen, has already expressed interest in helping. Dr. Roca and Dr. Kyomen will be meeting with Dr. Deborah Hales on May 6 to speak about this in more detail. The possibility of developing a Master Course on Geriatric Psychiatry for the coming Annual Meeting will also be discussed.

Recruitment Efforts:

Uyen-Khanh Quang-Dang (UK) gave an update on recruitment efforts for geriatric psychiatry. A number of Council members attended the PsychSIGN meeting in New York on May 3 to give medical students attending the Annual meeting an opportunity to interact with geriatric psychiatrists. UK also attended the Brown Bag Lunch session for subspecialty groups and residents at the Resident Resource Center. The program included Curriculum Vitae (CV) Boot Camp where the students and residents had an opportunity to have their CV read by experts and get their input.

In the discussing these recruitment efforts, the Council observed how valuable it was to have a Resident Fellow Member at the table. It was very helpful to have the input of a RFM in our discussions of many issues, especially how to develop educational programs and membership recruitment strategies and how to relate to AAGP, which focuses special attention on trainees. UK noted that her presence was an accident of her interest and that the Council would not otherwise have had a RFM. She suggested that we consider having a permanent spot for a RFM on the Council in the same way that we have a permanent position for an ECP. A motion was made, seconded, and passed to request that the JRC consider asking the Board to create a permanent RFM position on the Council on Geriatric Psychiatry – if not on all the Councils.

Awards in Geriatric Psychiatry

The Council discussed the fact that the Jack Weinberg Award fund is running out. It was agreed that the Award should not be allowed to sunset. It was proposed that the award may be given without prize money; this would be one way to reduce the expense. The members also agreed to look for options to raise funds. The Council also discussed the need to identify a permanent venue for Hartford-Jeste Award Presentation and proposed the "Advances in Geriatric Psychiatry "session for it.

American Psychiatric Association

Council on Healthcare Systems & Financing

Harsh Trivedi, MD, MBA, Chair

Executive Summary

The Council on Health Care Systems met during the APA Annual Meeting in New York. Council members heard presentations on several emerging payment/care delivery models. One focused on the work of an ACO (a large system) and their efforts to impact expenditures through care coordination/integration; another similar small-scale effort within a community setting; and a third which provided an overview of an episode-based payment model currently in place within a state Medicaid system. An Aetna medical director provided the current perspective of a private payer. The Council was briefed on a number of important issues including the ongoing work to ensure parity for mental health services; the current activities and evidence around integrated care; the train the trainer session on health reform; and current legislation impacting psychiatry and mental health and substance use care.

Action Item #1:
Recommendations of the BOT Ad Hoc Work Group on the Role of Psychiatry in Health Reform

As part of a discussion on psychiatry and health reform, the CHSF reviewed some of the recommendations from the APA BOT Ad Hoc Work Group on the Role of Psychiatry in Health Reform (Paul Summergrad, MD, chair). Members of the Council wondered what had happened with the recommendations and if there had been an implementation plan and/or group. A suggestion was made to do an inventory of the work currently underway that relates to the recommendations in the report as a first step in developing an action plan. The Council suggests there be coordination across the APA to cluster together around meaningful items. That led to the following motion which was approved by the members of the Council:

Motion: The CHSF moves that there be an inventory by the relevant APA Councils of the recommendations in the Ad Hoc Work Group on the Role of Psychiatry in Health Reform to determine what is and isn't being addressed by the APA and to bring those items back to the JRC for discussion and referral back to the appropriate Councils to begin to address the gaps.

JRC Action: Will the JRC ask the relevant APA Councils to review and create an inventory of the recommendations of the Ad Hoc Work Group on the Role of Psychiatry in Health Reform?

Will the JRC review this inventory and recommend a lead Council for important and actionable recommendations and state appropriate areas of the APA to include for each recommendation?

Financial Implications: The initial inventory would require member and staff time; possibly an additional conference call. The costs could likely come from existing budgets. Note that there is currently a staff-led association-wide work group that meets regularly to discuss issues related to integrated care (one element of this work). Once the inventory is complete an assessment (including financial implications) and prioritization of the current activities along with the gaps will need to occur.

Background: See pp 8-9 for the notes from the discussion. The recommendations (from the report) can be found in Attachment 2.

Action Item #2:
Plenary at the Fall Meetings on the Recommendations of the BOT Ad Hoc Work Group on the Role of Psychiatry in Health Reform

The discussion noted above was followed by a suggestion to provide a plenary for all Councils at the fall meetings on the report (including the recommendations) from the Ad Hoc Work Group on the Role of Psychiatry in Health Reform. The plenary would provide a mechanism to provide the context for moving forward with specific recommendations and could inform discussion within and amongst Councils at the fall meetings. The following motion was made and approved by the Council:

Motion: The CHSF moves that a plenary session be held at the Fall Meetings with a focus on the implementation of the recommendations from the Ad Hoc Work Group on the Role of Psychiatry in Health Reform report.

JRC Action: Will the JRC recommend to the appropriate APA body that a plenary session be held at the Fall Meetings (2014) focusing on psychiatry and health reform and the recommendations from the Ad Hoc Work Group on the Role of Psychiatry in Health Reform report?

Financial Implications**:** Recognizing that not all Councils are meeting on the same days, the plenary should be scheduled during the group meal function with the maximum anticipated attendance (in an effort to reach the maximum number of attendees possible). The cost would be the audio/visual needs (microphone, power point setup, etc.). The presentation(s) would be done by individuals already in attendance.

Background: Same background as above

Action Item #3:
Ad Hoc Group to Assist with APA Response to the Excellence in Mental Health Act/Demonstration Project

The Council discuss this legislation which creates a pathway for CMHCs to become CCBHCs (Certified Community Behavioral Health Centers) in eight states. These CCBHCs would provide "intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostics, treatment, prevention, and wellness services" among other requirements. CCBHC services then become federally eligible for Medicaid matching reimbursement. There are $25 million dollars in planning grants available to states looking to apply to serve as a demonstration state. The deadline for HHS to issue regulations on the criteria for eligible 'CCBHCs,' including staffing requirements, is September 1st, 2015. Feedback from multiple members of the Council on Healthcare Systems and Financing was that APA should be actively engaged and involved, as much as is permissible, in the rule writing process. This is an important activity and one that APA must take the lead on. Members were concerned that should APA fail to become engaged in the process that the organization would have missed an important opportunity to shape something psychiatrists will have to be actively involved in. It is critical to make sure psychiatrists in these new CCBHCs have responsibility for the overall quality of clinical services. Members expressed concern that this will not happen if other non-physician led organizations do this without our involvement. The following motion was made and approved by the Council:

Motion: The CHSF recommends that a qualified ad-hoc group of members experienced with CMHCs/integrated care be identified and charged with being actively engaged (with appropriate APA staff) in the rule writing phase of the Excellence in Mental Health Act.

JRC Action: Will the JRC support the request of the CHSF to establish a qualified ad-hoc work group to collaborate with appropriate APA staff to advocate APA's position with regard to the Excellence in MH Act?

Financial Implications**:** This would require member and staff time including 1 to 3 conference calls. The costs could likely come from existing budgets.

Background: See pp 10-11 for the notes from the discussion.

American Psychiatric Association

Council on Healthcare Systems & Financing

Harsh Trivedi, MD, MBA, Chair

Sheraton New York Times Square Hotel, Conference E, Lower Level

Tuesday, May 6, 2013 9:00 a.m. – 5:00 p.m.

Draft Minutes

Participants

Council Members: Harsh Trivedi, MD, MBA, Chair;, Mary Anne Badaracco, MD; Karen Hopp, MD, Lisa Hovermale, MD; Susan McLeer, MD; Laurence Miller, MD; Grant Mitchell, MD; Anand Pandya, MD; Lori Rainey, MD; Ole Thienaus, MD; Paul Wick, MD

Corresponding Members: Anita Everett, MD

Fellows: Debanjana Bhattacharya, MD; Phillip Murray, MD

AHA Representative: Anand Pandarangy, MD

APA Staff: (OHSF) Sam Muszynski, JD; Becky Yowell; Karen Sanders; Ellen Jaffe;

Guests: Saul Levin, MD, MPA, APA CEO/Medical Director; Kristin Kroeger (APA Chief Policy, Programs, Partnerships); Matthew Sturm and Jenny Tassler (DGR); Carol Alter, MD; Sabina Lim, MD; and Bruce Schwartz, MD (Newly appointed members/consultants); Mark Friedlander, MD, Aetna (Guest speaker); Ronald Burd, MD (Committee on RBRVS, Codes and Reimbursements); Gregory Dalack, MD (Council on Quality); Alan Axelson, MD (Partnership for Workplace Mental Health); and Melissa Staats (OHSF)

Absent**:** Eliot Sorel, MD; Gary Gottlieb, MD

Welcome/Administration

Harsh Trivedi called the meeting to order at 9:00 AM. Council on Healthcare Systems and Financing (CHSF) members and guests introduced themselves.

Dr. Trivedi recognized those members of the CHSF who were retiring from the Council and thanked them for their valuable contributions to the efforts of the Council and the APA as a whole. Retiring members and fellows are: Anita Everett, MD; Gary Gottlieb, MD; Karen Hopp, MD; Lisa Hovermale, MD; Laurence Miller, MD; and Phillip Murray, MD.

Dr. Trivedi reviewed the agenda. The minutes from the September 2013 meeting were reviewed and approved as written.

Invited Speakers

The CHSF had invited a number of individuals to speak to the group.

Bruce Schwartz, MD, Deputy Chairman and Professor of Clinical Psychiatry, CEO and Medical Director, University Behavioral Associates

Bruce Schwartz, MD, a returning CHSF member who previously served as chair, spoke to the Council about behavioral health integration as done by Montefiore Medical Center, one of the CMS Pioneer ACOs. Montefiore is located in the Bronx, which is the poorest urban county in the United States. Its population has a high burden of chronic illness, high healthcare spending, and 80% of healthcare costs are paid for by a government program.

Dr. Schwartz described the formation of University Behavioral Associates (UBA) in 1995 to "transform behavioral managed care into a quality-driven, provider friendly, and patient-centered practice." UBA afforded an opportunity for psychiatry and all of behavioral health to align itself with the population health initiatives that were being developed at Montefiore. Part of the effort was to include behavioral health care in primary care through the delivery of mental health services in primary care settings, monitoring and improving the care provided if appropriate, and providing case management services as needed. Attention was paid to the impact of behavioral care on the medical costs. Dr. Schwartz reported that clinicians engaged in the collaborative effort between primary care and behavioral care found the work rewarding, personally and financially, when done under the established conditions. It was in part the experience with UBA that has allowed Montefiore to create an effective ACO.

The Montefiore ACO is an example of a successful model. The keys to success identified by Dr. Schwartz are to manage the care of high-risk patients. Interested parties need to have the ability to analyze patient-level data (clinical and billing), the ability to manage sentinel events, and have some input/control over physician referrals and patient self-referrals. He pointed out that the care coordination, if done correctly, can have a positive impact on readmission rates, a large percentage of which are for patients with mental health or substance use disorder diagnoses.

Dr. Schwartz went on to list the types of behavioral health integration models that do not work: 1) primary care management alone; 2) screening in primary care and then an external behavioral health referral; and 3) "simple" co-location of a behavioral health clinician in or near a primary care practice.

Evidence-based models such as IMPACT, RESPECT-D, TEAMcare and SBIRT are effective and possibly cost-saving for those patients with chronic medical and mental health disorders. These models, however, are not sustainable on fee-for-service payments alone. Dr. Schwartz ended his presentation by acknowledging some of the challenges and opportunities the ACO has made apparent: the fact that efficiencies can result in savings that may not be shared with the clinicians; reduced re-admissions may mean less revenue for the hospital system; parity could increase demand and exceed existing resources. He noted there is a need to strengthen HIT processes and content to include/support behavioral health; that there is an opportunity for C/L psychiatry to expand its role; and that there is a need to develop and implement appropriate outcomes measures.

Laurence Miller, MD, Senior Psychiatrist, Department of Medical services, Arkansas - Arkansas Payment Improvement Initiative, ADHD Episode

Larry Miller, MD, a member of the CHSF, provided an overview of Arkansas Medicaid's episode-based payment initiative for the treatment of ADHD. This is the state government's first foray into episode-based payments. The question for them was how to improve quality while decreasing cost. They looked at cost for ADHD episodes and discovered that it cost 10 times as much to treat a patient with ADHD when care was provided by a mental health provider rather than a primary care provider.

In designing the episode, the state looked at the range of services involved in the treatment of the disorder (with the exception of the initial evaluation), the Principal Accountable Providers (PAP) (primary care physicians, psychiatrists or licensed clinical psychologists), how to deal with client severity and/or any exclusions, and gain- and risk-sharing thresholds were set based on historical practice patterns and guideline informed care. This program is only for those individuals with ADHD and *no* co-occurring behavioral health conditions. PAPs are required to certify they have completed the appropriate assessments and also must certify if the patient has had an inadequate response to treatment, which then moves the patient to a Level II episode. The reporting requirements are mandatory and the state has attempted to make it easy comply with them.

Reports to the PAPs on the first year of performance were sent the end of April. There was an overall decrease in spending in the first year of approximately 29%. The state will be looking at the patient outcomes, which has not been done to this point.

There was a lot of hostility toward this project in the psychiatric community, with some doctors changing diagnoses to keep kids out of the program, which determined a child would be switched into the Initiative after two claims based on an ADHD diagnosis. The state is in the process of developing a similar episode-based payment program for Oppositional Defiant Disorder.

Mark Friedlander, MD, Chief Medical Officer for Behavioral Health, Aetna

Dr. Friedlander provided a brief overview of what Aetna was seeing from a payer perspective. He indicated that Aetna is working closely with ACOs but that most of Aetna's in-network psychiatrists are in small groups or are solo practitioners. Some of the challenges faced when working with these smaller practices are:

- There is a misunderstanding of HIPAA, which creates a lack of communication
- Small practices don't see the value of EMRs, and
- There is a fear of assessment/measurement

Aetna has gathered a lot of valuable data about practices but has difficulty getting this information out to its doctors. There is a great variation in practices that Aetna is unable to account for. Dr. Friedlander told of Aetna's experience with reaching out to doctors about their patients' medication adherence. First they reached out to those doctors' whose patients had the highest adherence, and these doctors had no idea what they were doing to make their patients compliant. Then Aetna reached out to those doctors whose patients had the lowest adherence, and these doctors argued with the data. Aetna has looked at the pharmacy data on prescriptions for ADHD medications and found that more than half are for adults. He noted that behavioral health care is dominated by fee for service delivery, that it is difficult to communicate with these doctors, and that patients are troubled by the lack of communication between their providers.

What can Aetna do about this?

- Each patient can be provided with a personal health record that can be shared with various providers
- The technology is there to eliminate lack of communication but doctors are resistant
- Data collection is essential, but both doctors and patients must support this—Dr. Friedlander noted that when data was collected on Suboxone treatment there was an increase in costs for behavioral health care and for medications, but that this was more than made up for by a decrease in major medical events. He remarked that it took some time for the data to reveal this cost saving.

Dr. Friedlander ended by stating a willingness and interest in continuing to work with the APA, stressing that there are current opportunities for payers and clinicians. The Council thanked him and noted its interest in exploring an ongoing dialogue and agenda with Aetna.

Saul Levin, M.D., MPA, APA CEO and Medical Director

Dr. Levin thanked the members of the CHSF for their work, emphasizing they are handling some of the most critical issues faced by psychiatry and medicine today. He stressed the need for APA to continue to be involved in the ongoing reforms and to be an influential voice for psychiatry. He noted the importance of numerous ongoing developments within the Council's purview: CPT/RUC, Parity, Integrated Care, and Physician Payment Reform among others. He encouraged the Council to keep him posted about key priorities and potential resource needs to facilitate substantive APA work regarding these.

Grant Mitchell, MD, Associate Vice Chair for Clinical Services, Department of Psychiatry and New York State Psychiatric Institute - Psychiatry in the Age of Health Reform: What are the opportunities for APA?

As a follow-up to a recent article he coauthored with APA President Jeffrey Lieberman, MD, Dr. Mitchell talked about the current environment in psychiatry and the emerging opportunities. He started by talking about the disconnect between physician expectations--what they thought they would be doing-- and the current healthcare environment with its focus on resource management and high expectations. He noted a study by Edwards et al that found that medical training is based on individuals and does not prepare physicians to function successfully as part of a larger group. Most physicians are not prepared to function as part of an integrated system, but rather tend to "practice alone together." Per Dr. Mitchell, "the environment is different today than what most physicians expected and what patients, employers, and society now want."

Dr. Mitchell went on to talk about ways to increase the involvement of psychiatrists in the reform of the healthcare system that is occurring. He stressed the need to focus on providing person-centered care -- full attention to the patient's needs at the time of the visit; working/collaborating with others, including the patient as a person (and not a child) to achieve positive outcomes.

Dr. Mitchell went on to provide an overview of an initiative developed as an idea to positively impact care. This voluntary program, the Westchester County Care Coordination Project, was created by the Westchester Department of Community Mental Health to improve outcomes and reduce costs for the highest users of services. The focus was on person-centered, recovery-focused, care coordination. Every enrollee had an individual treatment plan with access to a care coordinator to assist with any medical and mental health, housing, and/or legal needs, among other things. There was access to peer mentors, a peer-operated employment program, and access to "self-determination" funds that could be used to cover expenses for programs designed to improve health and wellness that were not already covered by Medicaid. Forty-eight enrollees took advantage of the program. The end results to date include:

- A tripling of abstinence from alcohol;
- A decrease in homelessness from 50% to 7% after two years;
- A 96% decrease in days incarcerated;
- A dramatic decrease in the cost of care
    - Medicaid -35%
    - Incarceration – 53%
    - State hospital inpatient care - 78%;
- An increase in staff satisfaction; and
- Recognition by AHRQ as a national innovation.

As highlighted by the success of this one program, Dr. Mitchell pointed out that all members can participate in reform. It can and should occur at a local level. It doesn't require a large research study but rather a close look at your individual practice to see why care isn't working. Communication (vision/goals), the creation of a shared vision for change, and involvement of others (including the patient and family), is important. He stressed the opportunity that is currently available to the APA and psychiatry to lead and direct new health initiatives.

Dr. Mitchell and members of the Council then spent the next portion of the meeting discussing how APA can assist the membership in moving ahead and getting more involved. There was discussion of developing a newsletter similar to the "Integrated Care News Notes" that is focused more specifically on practice issues (for individual and group practices). The question was raised as to what happened to the recommendations made in the report from the Ad Hoc Work Group on the Role of Psychiatry in Health Reform (Paul Summergrad, MD, chair). There was a brief discussion as to what the role of the Council was in implementing the recommendations. Council members were asked to look at the recommendations that were provided as a handout and identify those that seemed of most interest. One member remarked on the move to population health and suggested there might be a need to provide some technical assistance to individuals and small groups to begin to develop a different mindset. Outcomes and the role of data were raised as well as looking at the practicality of the outcomes. The question was raised as to what constitutes a good quality outcome. Is it improving function/activities of daily living? What is it the Council would recommend? Others raised the issue of the large evidence base supporting integrated care but the lack of a payment mechanism in place to cover its cost. There is greater access to data but physicians don't necessarily know what to do with it. There was a longer discussion of the issue of electronic health records and the need for some way to interface with other physicians/clinicians; the importance of interconnectivity. A recommendation was made to pull together an implementation group from various parts of the APA. This was followed by a recommendation to do an inventory of what is currently happening. The following motion was made and approved by the Council:

Motion: The CHSF moves that there be an inventory by the relevant APA Councils of the recommendations in the Ad Hoc Work Group on the Role of Psychiatry in Health Reform to determine what is and isn't being addressed by the APA. And further asks that the JRC review this inventory and recommend a lead Council for important and actionable recommendations and state appropriate areas of the APA to include for each recommendation.

The Council suggests there be coordination across the APA to cluster together around meaningful items. [Recommendations can be found in Attachment 2]

JRC Action: Will the JRC ask the relevant APA Councils to review and create an inventory of the recommendations of the Ad Hoc Work Group on the Role of Psychiatry in Health Reform?

Will the JRC review this inventory and recommend a lead Council for important and actionable recommendations and state appropriate areas of the APA to include for each recommendation?

A suggestion was made to provide a plenary for all Councils at the fall meetings since the current reform efforts impact the work of many, if not all, of the groups present. The plenary could set up an implementation plan, or at a minimum provide the context for moving forward with specific recommendations. The following motion was made and approved by the Council:

Motion: The CHSF moves that a plenary session be held at the Fall Meetings with a focus on the implementation of the recommendations from the Ad Hoc Work Group on the Role of Psychiatry in Health Reform report.

JRC Action: Will the JRC recommend to the appropriate APA body that a plenary session be held at the Fall Meetings (2014) focusing on psychiatry and health reform and the recommendations from the Ad Hoc Work Group on the Role of Psychiatry in Health Reform report?

There was a discussion of the resources, are there sufficient resources and/or expertise within the Office of Healthcare Systems and Financing or other APA offices to achieve implementation? It is difficult to try to address the needs of the varying groups (solo private practice vs larger systems).

Health Reform and Psychiatry – Sam Muszynski, JD, Director, OHSF

April 4, 2014 National Press Club Event

With the integration of medical and psychiatric care showing significant promise for addressing challenges of rising health care costs and inadequate access to quality mental healthcare, the APA convened a special event to gather leaders in the medical and mental health fields to introduce this approach to care and help frame the discussion around it.

The April 4 event, *"Integrated Primary and Mental Health Care: Reconnecting the Brain and the Body,"* hosted by the American Psychiatric Association, established a national conversation for advancing the implementation integrated care models, and furthered APA's leadership on this issue. The event included brief remarks by Drs. Saul Levin and Jeffrey Lieberman before the keynote was delivered by Michael Hogan, PhD, former Commissioner of the New York State Office on Mental Health. Dr. Paul Summergrad presented findings from the Milliman report, *"Economic Impact of Integrated Medical-Behavioral Healthcare,"* and a report by the APA Board of Trustees' Work Group on Health Care Reform, *"The Role of Psychiatry in Healthcare Reform,"* before turning to the first of two panel discussions.

The eight panelists, representing healthcare economists, government health program leaders, patient advocates, family medicine and pediatric providers, and behavioral health providers, participated in an eye-opening discussion about the opportunities and obstacles surrounding integrated care models. Panelists highlighted key issues at the national level and for individuals and healthcare settings using this model of care.

The breakfast event attracted a standing-room-only crowd of 90 people including medical and mental health thought leaders, HHS staff, APA members and staff, as well as members of the media. In addition to in-person attendance, well over 400 people watched the live webcast of the event. Webcast viewership represented a diverse group, including APA members and district branches, but also a wide swath of mental healthcare advocates, providers, health insurance professionals, and others. Also, many webcast viewers watched in groups with their colleagues, increasing the audience.

(http://www.psychiatry.org/practice/professional-interests/integrated-care/integrated-care-reconnecting-the-brain-and-the-body)

BOT Ad Hoc Work Group on Health Reform and Psychiatry

A lot of the recommendations in the Ad Hoc Work Group on Psychiatry and Health Reform report are being worked on but not all. Several products will be coming out of the second BOT work group. For Medicaid, an advocacy toolkit was identified as a key thing the Work Group thought could be done. Another product was to work with Sherry Gleid to develop a concept paper for the APA on outcome measurement. *How should the APA get involved in the development of outcomes? What should we be doing?* The third product is a series of online educational modules for APA members on collaborative care models that are being developed by the AIMS Center.

Train the Trainer Event - Healthcare Reform and Psychiatric Practice

OHSF in collaboration with Assembly leadership will conduct a two-day training/educational event on June 21 and 22 in Chicago. The key purpose of the program is to provide training and materials to DB designated "trainers" that can then serve as the basis for local educational events on key health reform topics.

The program will consist of three (3) modules:

- General overview of Healthcare Reform and key trends with implications for psychiatry
- In depth review of emerging integrated care delivery arrangements and psychiatry's role, e.g., health homes, ACOs, collaborative care.
- A review of important practice management issues and APA resources and technical assistance available for same.

Given the breadth of the topic, the course will be general but will identify with specificity how to secure additional information and/or assistance. The event will serve as a launching point for the ongoing rollout of materials for APA members.

Government Relations Update – Matthew Sturm, APA Department of Government Relations

Mr. Sturm provided the Council with an overview of key legislative initiatives:

SGR – There was an unprecedented bipartisan, bicameral effort at passing legislation that would repeal the flawed Medicare SGR formula in late 2013 and early 2014. There was broad support for the repeal from all the major medical societies. The repeal legislation, if passed, would have meant a full SGR repeal, a 0.5% update on physicians' fees through 2018 and it would have collapsed and rebalanced the multiple Medicare incentive/penalty programs (HIT MU, PQRS, VBM) into one "Merit-Based Incentive Payment System" (MIPS). It would have allowed for medical associations to identify and submit quality measures to CMS for consideration in a transparent process and authorized $200 million for technical assistance for small practices. In the end, there appeared to be no political will to overcome the $150 billion dollar price tag. Instead, Congress passed legislation to delay the SGR cuts until April 1, 2015, with no fee update and a delay in the implementation of ICD-10 until October 2015.

Excellence in Mental Health Act/Demonstration Project - This legislation creates a pathway for CMHCs to become CCBHCs (Certified Community Behavioral Health Centers) in eight states. They must provide "intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostics, treatment, prevention, and wellness services" among other requirements. CCBHC services then become federally eligible for Medicaid matching reimbursement. There are $25 million dollars in planning grants

available to states looking to apply to serve as a demo. The deadline for HHS to issue regulations on the criteria for eligible 'CCBHCs,' including staffing requirements, is September 1st, 2015. September 1 is also the deadline for HHS to develop a prospective payment system for CCBHCs.

Feedback from multiple members of the Council was that APA should be actively engaged and involved, as much as is permissible, in the rule writing process. This is an important activity and one that APA must take the lead on. Members were concerned that should APA fail to become engaged in the process that the organization would have missed an important opportunity to shape something psychiatrists will have to be actively involved in. It is critical to make sure psychiatrists in these new CCBHCs have responsibility for the overall quality of clinical services. Members expressed concern that this will not happen if other non-physician led organizations do this without our involvement. The following motion was made and approved by the Council:

Motion: The CHSF recommends that a qualified ad-hoc group of members experienced with CMHCs/integrated care be identified and charged with being actively engaged (with appropriate APA staff) in the rule writing phase of the Excellence in Mental Health Act.

JRC Action: Will the JRC support the request of the CHSF to establish a qualified ad-hoc work group to collaborate with appropriate APA staff to advocate APA's position with regard to the Excellence in MH Act?

Helping Families in Mental Health Crisis Act (H.R. 3717) – This legislation was introduced by Representative Timothy Murphy (R-PA) who is a psychologist by training and chairman of the powerful Energy and commerce Oversight and Investigation Committee and co-chair of the House Mental Health Caucus. Among other things it asks for the creation of an Assistant Secretary for MH/SUD (a psychiatrist or clinical psychologist) to: "oversee and coordinate" all HHS mental health activities including SAMHSA; make recommendations for outside HHS activities; and prioritize the integration of MH services. It creates an Interagency Serious Mental Health Coordinating Committee (ISMICC) and a National Mental Health Policy Laboratory (NMHPL); allows for HIPAA and FERPA treatment of caregivers as personal representatives; includes Department of Justice reforms and reauthorization of the Mentally Ill Offender Treatment and Crime Reduction Act, provides for a partial raise of the 'IMD' Medicaid reimbursement exclusion, and for provides new protections for coverage of Medicare part D psychiatric medications. If passed there would be a boost in authorized funding for NIMH by $40m annually along with block grant reform including tying state eligibility to assisted outpatient treatment requirement and additional SAMHSA reforms.

Reaction to this legislation by the mental health community is mixed. The Treatment Advocacy Center and NAPHS support the legislation. APA and the American Psychological Association, National Council, NAMI, and NASMHPD believe there is a need for further refinements. Stakeholders have convened with the support of both Representative Murphy and the Democrats (who will be offering alternative legislation – see below) to find consensus improvements. Provisions that have been flagged for review include those items dealing with changes to the IMD exclusion, the SAMHSA cuts and reorganization, and provisions that touch on commitment standards.

The Democratic alternative includes the establishment of a White House Office of Mental Health (instead of an Assistant Secretary position); no change to the IMD exclusion but an increase in the number of lifetime

inpatient days (190 days); similar Justice system reforms; and new provisions that include parity enforcement language and extension of parity throughout Medicaid.

Registries

OHSF staff noted that this is still a work in progress. A number of APA members have been identified as possible participants in a work group to take a closer look at registries and what is involved and to then make recommendations as to next steps.

Private Payers/MBHOs

CT and NYSPA Lawsuits

Mr. Muszynski reviewed key parity developments for the Council. He noted that given the issuance of the Final Parity regulation in November, APA will have several key priorities that will drive parity initiatives going forward:

- Pursuing payment equity under the terms of the Parity regulation
- Securing compliance with the requirements of the rule's nonquantitative treatment limitation provisions
- Pursuing increased transparency of enforcement actions/non-action by Federal and State regulatory authorities
- Lobbying for the issuance of a parity rule that applies to Medicaid managed care plans and to the newly established Medicaid expansion plans.

He noted that the forgoing tasks remain rather daunting given the range of issues and the continued lack of disclosure or transparency concerning the documentation needed to review parity compliance. This is at present especially problematic with the Exchange Plans where accessing meaningful plan data has been nearly impossible thus far.

He briefly mentioned the NYSPA lawsuit against UnitedHealthcare/Optum, which had been dismissed by the judge. It is now being appealed to the second Circuit. The AMA, APA, and Department of Labor filed amicus briefs in support of NYSPA.

He also noted that a decision on the motion to dismiss APA's lawsuit against Anthem Connecticut is pending. The District Court judge conducted a hearing April 22 with the parties. APA feels the hearing went well but that is not predictive of the judge's decision. We hope to have the decision in June.

Other Outreach

Mr. Muszynski and Ms. Yowell briefly discussed APA's substantive interactions with Optum concerning its audit practices and pending adverse decisions against a number of APA members. Colleen Coyle, APA's General Council, has been part of the primary team. In short, an agreement was reached to stay any potential adverse actions by Optum until we have had time to review and discuss the full range of audit protocols and medical record documentation issues inherent in the matter. It was noted that thus far the meetings have resulted in favorable modifications by Optum and there is a guarded optimism as to the final outcome. The matter will be reviewed in more detail with the Council once we have reached decision points. The committee on RBRVS, Codes and Reimbursements is serving as consultants to staff throughout the process.

Staff also noted they have had discussions with Aetna's executive staff respecting various issues. These are exploratory only at this point with the end point being the development of a potential substantive agenda for dialogue.

Integrated Care Developments

Work Group on Integrated Care – Lori Raney, MD
Dr. Raney provided an overview of the ongoing work of the Work Group. The Work Group has finalized [?] its mission statement and charge:

> Mission - The mission of the APA's Workgroup on Integrated Care is to identify evolving roles and best practices for psychiatrists in emerging organizational models of care at the interface of physical and behavioral health, and to provide support for psychiatrists in those new settings. The Workgroup's vision is an integrated continuum of care that is population-based, whole-person, and patient-centered. To achieve this vision, psychiatrists will need to develop new areas of expertise with policies established to support them in these emerging roles. The Workgroup aims to promote this mission and vision by identifying best practices and training opportunities, and by supporting financial and advocacy efforts that make these practices sustainable.
>
> Charge - The Council's Work Group on IC shall review and summarize current and emerging:
> 1. models and structures for integrated care;
> 2. payment/reimbursement methodologies; and
> 3. quality assurance methods.
>
> This Work Group will identify priority issues and considerations for the APA and recommend for the Council's consideration APA strategies regarding the following:
> - member education and technical assistance;
> - advocacy and communication efforts directed at key public and private stakeholders;
> - further research and analyses efforts needed; and
> - gaps in current official APA policy.

Members have been working collaboratively with the Association of Medicine and Psychiatry on a position statement titled *The Role of Psychiatrists in Reducing Physical Health Disparities in Patients with Mental Illness*. Members of the Councils on Aging and Psychosomatic Medicine have asked to review and provide input into the draft document. The work group is open to feedback from others as well. They would like to move the final document forward to the JRC at their fall meeting.

Members continue to provide educational opportunities not only for those interested in working in integrated care settings but for anyone interested in a better understanding of the basic concepts of integration/collaboration.

The Patient Centered Primary Care Collaborative (PCPCC) work group is functioning as a subgroup of the Work Group on IC. The PCPCC work group is made up of eight members and three staff who participate in monthly APA strategy calls. Each member covers an assigned PCPCC project center. This centers are made up of the Executive Committee, five Stakeholder Groups, and the Behavioral Health Special Interest Group.

The Integrated Care Work Group continues to communicate and collaborate with other organizations such as AAFP, AACAP, NASMHPD and so on. Frank deGruy, MD, of AAFP requested input from the APA on AAFP's Joint Principles of Integrating Behavioral Health into the Patient Centered Medical Home. The APA Ad Hoc Work Group on Health Reform and Psychiatry took the lead and authored the response. The response will be published in June in the Journal of Families, Systems and Health. The work group also continues to expand its membership with the most recent member being a child and adolescent psychiatrist.

Health Insurance Coverage Expansion under the ACA (FYI only)
Interactive map *Where States Stand on Exchanges* https://www.statereforum.org/where-states-stand-on-exchanges

Medicaid Expansion (FYI only)
Interactive map, *Where States Stand on Medicaid Expansion Decisions*
https://www.statereforum.org/Medicaid-Expansion-Decisions-Map

Review of Outstanding Assembly/JRC Action Items (See Attachment 1)

Adequacy of Health Insurance Provider Networks and *Improving Patient Access to Psych Services thru MCO Provider Panels*
The CHSF will continue to discuss the issue of network adequacy to determine appropriate means to address the problem. This will include collaborating as appropriate with the AMA. APA staff including the APA General Counsel are reviewing the parity issues embedded in the network adequacy matter.

APA Position Statement on Carve-Outs
The CHSF will continue to discuss this issue. Members (Sue McLeer and Paul Wick) have volunteered to work with Sam to review the existing position statement and revise it as appropriate based on the parity legislation. This will include a review of any evidence as to the bases for APA opposition. The larger piece of work is to identify the clinical, fiscal and administrative benchmarks of a system that works (carve-in or out).

CHSF Committee and Work Group Reports

Committee on RBRVS, Codes & Reimbursement – Ronald Burd, MD
Dr. Burd began by summarizing the actions of CMS in the Final Rule on the 2014 Physician Fee Schedule. CMS adopted all of the RUC recommended work and practice expense values for the new and revised CPT codes and in doing so increasing payments by Medicare from 2013 to 2014 for all services. The committee continues their educational outreach to APA members through seminars, webinars, and online learning. There were two committee sponsored educational sessions at the APA Annual Meeting, and one will be submitted for the IPS in the fall. The committee continues to respond to coding questions from members and refers payment related issues to APA's work on parity. The committee has also been advising staff in their discussions with Optum. The committee will continue its work in reviewing CPT coding proposals related to services provided by psychiatrists. They will continue their ongoing representation at the AMA CPT and RUC meeting occurring several times a year. Dr. Burd asked the Council for their continued support in ensuring appropriate coverage of the CPT Editorial Panel and the AMA RUC, which requires a lengthy learning process that can result in committee tenures ending just as individuals are solidly in place.

Committee on Reimbursement for Psychiatric Care – Sam Muszynski [no report at this meeting]

Work Group on Integrated Care – Lori Raney, MD [See report on integrated care above]

Work Group on Medicaid/State Mental Health Programs – Laurence Miller, MD
Dr. Miller reported that the workgroup had an opportunity to review and provide feedback on the two toolkits created by the BOT Ad Hoc Work Group. The overall consensus of the work group was that though these were tools that any state could use, there is no mention of fidelity scales and outcome measures and it important to look at that. Overall the Work Group believed the toolkits will be an excellent and timely

resource. The group believes that technical assistance and/or ongoing following would be important to ensure movement going forward. A council member also noted that Section 2703 of the Affordable Care Act which seeks to develop health home services for Medicaid beneficiaries with chronic conditions is something the APA should look at.

Work Group on Health Reform and Parity – Paul Wick, MD [See Parity update above]

Wrap Up & Adjournment

Conference Call – May 20, 2014
The Council will continue to the work plan discussion and follow-up on the inventory of BOT Ad Hoc Work Group report (what would be practical moving forward).

Referrals from the JRC to Other Entities 2013 – RESPONSE TO JRC REQUIRED

JRC Agenda Item #	JRC JANUARY 2013 Action	Comments/ Recommendation	Referral/ Follow-up	Due Date	FEEDBACK	STATUS
6.1	Adequacy of Health Insurance Provider Networks (**ASMNOV1212.A**) Action paper ASMNOV1212.A asks that the APA study the extent of the problem of misleading carrier network practices and in coordination with other agencies/entities identify potential solutions.	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing requesting that they study the extent of the problem and identify potential solutions. A report to the Joint Reference Committee is expected by June 2013. JRC January 2013: Action paper Adequacy of Health Insurance Provider Networks (ASMNOV1212.A) – see item 6.1 – was referred to the Council requesting that they study the extent of the problem and identify potential solutions. Given enormity of studying this issue and the potential costs involved, it was thought that perhaps an initial survey using Survey Monkey could be used and based on those results a more thorough study/survey may occur.	Council on Healthcare Systems and Financing Report to Joint Reference Committee – June 2013 **JUNE JRC 2013** The Joint Reference Committee referred the action to the Medical Director's Office for the development of a cost estimate for the action plan. **JRC JANUARY 2014** APA AMA Delegation General Counsel Office of Research	Referral Update to JRC – May 2014 (deadline 5/16/2014) Staff responsible: Becky Yowell	**JRC JANUARY 2013** ASMNOV1212.A was referred to the Council requesting that they study the extent of the problem and identify potential solutions. Given enormity of studying this issue and the potential costs involved, it was thought that perhaps an initial survey using Survey Monkey could be used and based on those results a more thorough study/survey may occur. **JRC JUNE 2013 – CHSF** The JRC was asked to endorse the Council on Healthcare Systems & Financing's plan of action outlined below to collect more detailed information on the adequacy of health insurance provider networks? (Please see p 9-10 of the Council's report) The Council had a thorough discussion with Drs. Steve Daviss and Bob Roca about the issue of network adequacy. Together the Council and authors of an Assembly action paper on this issue developed a plan of action to better understand the issue. **NOVEMBER 2013** **OCEO/MDO Response:** A cost estimate is very difficult to gauge given the fact gathering necessary to move anything forward and the fact that there is no federal standard as to what is considered "adequate," means this falls to each state. PRN is gathering some preliminary data as to network involvement and we are monitoring the roll-out of the exchange plans. Thus far we've had reports of inflated networks (names of individuals who were unaware they were in the network or who had resigned previously) as well as terminations of existing contracts by plans. A cost estimate would be $25,000 to $40,000 for what would be the engagement of an outside contractor to do a secret shopper survey of a provider network. **JRC JANUARY 2014** The JRC referred the action paper to the APA AMA delegation and requested that they craft a resolution on the adequacy of health insurance provider networks for the AMA House of Delegates in time for the next HOD meeting. The JRC requested that the resolution be reviewed by APA General Counsel, Colleen Coyle. . In addition, a review by the Office of Research is requested.	**AMA House of Delegates:** **The APA AMA Delegation submitted a resolution for the AMA HOD meeting in June 2014. The resolution asks for the AMA to study the issue of network adequacy including tiered and narrow networks and report back with recommendations.** **CHSF/Office of Research:** **The CHSF will monitor the work of the AMA and will review the data from the recent PRN study – National Study of Psychiatric Practice Under Health Care Reform – once available.**

Referrals from the JRC to Other Entities 2013 – RESPONSE TO JRC REQUIRED

JRC Agenda Item #	JRC JANUARY 2013 Action	Comments/ Recommendation	Referral/ Follow-up	Due Date	FEEDBACK	STATUS
6.3	Mental Health Parity Act Compliance & Insurance Accreditation Organizations (ASMNOV1212.C) Action paper **ASMNOV1212.C** asks that the APA work with National Committee for Quality Assurance (NCQA) and other health insurance accreditation organizations to encourage them to incorporate appropriate standards that require a proactive demonstration of compliance with Mental Health Parity and Addictions Equity Act, including the nonquantitative treatment limitations; and that the Council on Research and Quality Care issue a report at each of the Assembly meetings in 2013 and 2014 on the activities and progress towards achieving this goal.	The Joint Reference Committee referred the action paper to the Medical Director's Office for referral to the Department of Healthcare Systems and Financing and other appropriate departments within the APA. **It is likely that the requests contained within this action paper are tasks already underway within the APA.** The Joint Reference Committee requested that an update on this action paper be provided to the Assembly May 2013.	Medical Director's Office Report to the Assembly May 2013 During the **May 2013** Assembly Meeting, Dr. Young presented to the Assembly on Health Care Reform at the State level.	Report to Assembly May 2013	A referral update was not provided by the MDO on this item.	**OHSF: To be discussed**

Referrals from the JRC to Other Entities 2013 – RESPONSE TO JRC REQUIRED

JRC Agenda Item #	JRC JANUARY 2013 Action	Comments/ Recommendation	Referral/ Follow-up	Due Date	FEEDBACK	STATUS
6.4	Update on 2002 Position Statement on Carve- Outs & Discrimination (ASMNOV1212.D) Action paper **ASMNOV1212.D** asks that the APA convene a session at an Annual Meeting to discuss and review the 2002 Position Statement and all related information for the purpose of updating and revising the Position Statement, as well as to identify new strategies to achieve goals which have not yet been met; and that the APA summarize the results of this meeting for the membership and report back to the Assembly, as well.	The Joint Reference Committee stated that this is an important issue and referred the action paper back to the authors. It was suggested that a more productive methodology is to draft a position statement working with Council on Healthcare Systems and Financing and other relevant Councils and submit it for consideration to the Assembly in May 2013. A report from the Council on Healthcare Systems and Financing on the proposed position statement should be submitted with the statement.	Referred to the Assembly via the Recorder		**May 2013** Council on Healthcare Systems and Financing Meeting A workgroup was formed to come up with revised language. That wording has not yet come forward to the Council. We will confer with the group and be sure to address this on an upcoming conference call. APA Position Statement on Carve-Outs – Drs. Daviss and Roca A brief historical review of the years' long carve-out discussion in the APA introduced this discussion. It was determined because there is currently such flux in the way insurance is being done; no action should be taken about carve-outs at this point. It was noted, however, that the current dominant carve-out structure is a major issue going forward in trying to rationally address integrated care issues at a financial, administrative and clinical level. Dr. Murray will work with Drs. Wick, Hovermale, Roca, and Daviss to produce new wording for this statement to be presented at the next Council meeting and will report to the JRC in September [October]. Dr. Roca pointed out that a statement from the APA could have an influence on how carve-outs fare in the future.	**CHSF:** **The current APA position statement will be revised to reflect the changes as a result of Mental Health Parity and Addiction Equity Act (MHPAEA).** **A review of the existing evidence will be undertaken as well.** **Consideration as to what the necessary clinical, fiscal and administrative benchmarks are needed in either a carve-out or carve-in will be included as part of the process.**

Referrals from the JRC to Other Entities 2013 – RESPONSE TO JRC REQUIRED

JRC Agenda Item #	JRC JANUARY 2013 Action	Comments/ Recommendation	Referral/ Follow-up	Due Date	FEEDBACK	STATUS
6.19	Managed Care Misuse of FDA Labeling (ASMNOV1212.EE) Action paper **ASMNOV1212.EE** asks that, following review by the Council on Advocacy and Government Relations and/or the CHSF, the APA petition the FDA to inform health insurance entities, including managed care organizations and managed pharmacy entities, that they should cease using wording that implies to patients and their families that the insurance entities' refusal to provide coverage for medications based on diagnosis or dosage is supported or endorsed by the FDA. And, that the APA direct its Delegates to the AMA to get AMA support for similar AMA action. The Assembly suggested that the action paper be referred to Council on Advocacy and Government Relations and the CHSF.	The Joint Reference Committee referred the action paper to the Council on Quality Care and requested recommendations on how to address this issue. A report to the Joint Reference Committee is expected in June 2013. The recommendations and issue are to be forwarded to the APA AMA Delegation.	Council on Research and Quality Care Report to JRC June 2013 APA AMA Delegation	Report to JRC June 2013	**JRC JUNE 2013** The Council on Research and Quality Care requested that the action paper be reassigned. The Joint Reference Committee reassigned the action paper to the Council on Healthcare Systems and Financing with a report to the JRC October 2013. No referral update was provided by the Council on Healthcare Systems and Financing in October 2013.	**CHSF:** **The CHSF will review this action on an upcoming conference call and report back in October.**

Referrals from the JRC to Other Entities 2013 – RESPONSE TO JRC REQUIRED

JRC Agenda Item #	JRC JANUARY 2013 Action	Comments/ Recommendation	Referral/ Follow-up	Due Date	FEEDBACK	STATUS
6.21	Proposed Position Statement on Improving Patient Access to Psychiatric Services through MCO Provider Panels (JRCJUNE128.F.2; ASMNOV124.B.5) (Please see attachment 21) The Assembly voted to refer the Proposed Position Statement on *Improving Patient Access to Psychiatric Services through MCO Provider Panels* back to the Council on Healthcare Systems and Financing. Will the Joint Reference Committee refer the Proposed Position Statement on *Improving Patient Access to Psychiatric Services through MCO Provider Panels* to the appropriate Component(s) for input or follow-up?	The Joint Reference Committee referred the Proposed Position Statement back to the Council on Healthcare Systems and Financing as requested by the Assembly. The comments from the Assembly will be provided to staff of the Council. A report to the Joint Reference Committee is expected June 2013.	Council on Healthcare Systems and Financing Report to Joint Reference Committee – June 2013	Report to JRC June 2013	**JRC OCTOBER 2013** The Council on Healthcare Systems and Financing submitted a proposed position statement to the JRC. The Joint Reference Committee referred the position statement to the Assembly for consideration. **ASSEMBLY NOVEMBER 2013** The Assembly voted to refer the proposed position statement back to the Council on Healthcare Systems and Financing. The Assembly felt that further work was needed to create a more nuanced statement and for the statement to address issues related to accessibility and payment.	**CHSF: See 6.1 above**

Referrals from the JRC to Other Entities 2013 – RESPONSE TO JRC REQUIRED

JRC Agenda Item #	JRC JANUARY 2013 Action	Comments/ Recommendation	Referral/ Follow-up	Due Date	FEEDBACK	STATUS
6.4	Revised Position Statement: Medical Psychotherapy (JRCOCT128.K.2/ASM Item #2013A1 4.B.11) [attachment 4] The Assembly voted to refer the Revised Position Statement: Medical Psychotherapy to the Council on Healthcare Systems and Financing for revision.	The Joint Reference Committee referred the revised position statement back to the Council on Healthcare Systems and Financing for consideration and potential integration of the Assembly's comments. The JRC also referred the position statement to the Assembly Work Group on Psychotherapy and to the Council on Medical Education and Lifelong Learning requesting that they provide feedback on the revised position statement to the Council on Healthcare Systems and Financing.	Council on Healthcare Systems and Financing (LEAD) Assembly Work Group on Psychotherapy Council on Medical Education and Lifelong Learning Report to JRC – October 2013	Report to JRC 10/2013 Report to Assembly – May 2014	A referral update was not provided by the council. **JRC JANUARY 2014** The JRC recommended that the Assembly approved the proposed position statement *Psychotherapy as an Essential Skill of Psychotherapists.* In June, the Council and the Assembly Work Group on Psychotherapy to revise the statement and the title.	**Assembly: The Assembly approved the position statement at the May 2014 meeting. It will be sent to the BOT for review at their next meeting.**

Referrals from the JRC to Other Entities 2013 – RESPONSE TO JRC REQUIRED

JRC Agenda Item #	JRC JANUARY 2013 Action	Comments/ Recommendation	Referral/ Follow-up	Due Date	FEEDBACK	STATUS
6.17	Use of New CPT Codes in Health Insurance Exchanges (ASM Item # 2013A1 12.S) Action paper **ASMMAY1312.S** asks: 1. That the APA Division of Government Relations and the APA Division of Healthcare Systems and Financing shall jointly advocate that the Exchanges must cover all CPT® codes and coding conventions (including the new combination codes for psychotherapy services) and must use the Medicare RVU values as the basis for reimbursement for physician services in any fee-for-service plan; and 2. That the APA Division of Healthcare Systems and Financing shall prepare draft language and additional supporting material for use by district branches and state associations in advocating at the state level for both use of CPT® codes and coding conventions and for use of the Medicare RVUs in Exchanges established by states.	The Joint Reference Committee referred this action paper to the Medical Director's Office to determine what elements of this action paper are already implemented by the Division of Healthcare Systems and Financing.	Medical Director's Office Report to the Joint Reference Committee – October 2013	Report to JRC 10/2013	**NOVEMBER 2013** OCEO/MDO Response: We will be monitoring what is happening in the exchange plans; all laws which address these issues have been compile and based on a review of those laws, exchange plans have no special status. HIPAA already requires the use of CPT codes. APA regularly advocates access to all CPT codes using CPT coding conventions. We anticipate CMS finalizing the Medicare values for the CPT codes in the Final Rule on the 2014 Physician Fee Schedule, published in November 2013; APA will need to develop an action plan based on what CMS publishes in the Final Rule.	**CHSF/OHSF:** **We will continue to monitor what is happening in the exchange plans through the APA Practice Management line. The exchange plans have been operational only a few months; this will take some time to get a clear picture of how the exchange plans will operate as detailed information as of yet has been unobtainable. A follow-up study to the National Study of Psychiatric Practice Under Health Care Reform would be helpful in terms of gaging the impact of reform.**

Referrals from the JRC to Other Entities 2013 – RESPONSE TO JRC REQUIRED

JRC Agenda Item #	JRC JANUARY 2013 Action	Comments/ Recommendation	Referral/ Follow-up	Due Date	FEEDBACK	STATUS
8.F.3	Proposed Position Statement: Prior Authorization for Psychotropic Medications Will the Joint Reference Committee recommend that the Assembly approve the position statement on prior authorization for psychotropic medications as prepared by the Assembly and reviewed by the Council on Healthcare Systems and Financing?	The Joint Reference Committee referred this position statement back to the Council on Healthcare Systems and Financing and requested that they look at the degree to which this is consistent versus disparate from other medical practices and medical organizations. Further, it was recommended that the position statement be a more encompassing statement on pharmacy benefit control. The JRC requested that the document adhere to the current position statement format.	Council on Healthcare Systems and Financing Report to Joint Reference Committee – January 2014	JRC 1/2014 Report to Assembly – May 2014	**JRC JANUARY 2014** The Council on Healthcare systems and Financing forward a revised proposed position statement to the Joint Reference Committee. The JRC recommended that the Assembly approve the statement.	**Assembly The Assembly approved the position statement at the May 2014 meeting. It will be sent to the BOT for review at their next meeting.**

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-14)

Introduced by: American Psychiatric Association
American Academy of Child and Adolescent Psychiatry
American Academy of Psychiatry and the Law

Subject: Network Adequacy

Referred to: Reference Committee A
(Gary L. Bryant, MD, Chair)

Whereas, The stated goals of health care reform include increasing access to care; and

Whereas, A recent study by McKinsey & Company[1] found that approximately two-thirds of health plans effectively decrease access by utilizing narrow or ultra-narrow hospital networks; and

Whereas, Some insurers are further limiting access to providers by significantly narrowing or tiering provider networks; and

Whereas, Inadequate networks force patients to incur higher out-of-pocket costs if they access services outside the narrow networks; and

Whereas, Physicians have been forced to take legal action against insurers for being excluded from plan networks; and

Whereas, This has led several states to intervene by preventing insurers from selling narrow network plans; therefore be it

RESOLVED, That our American Medical Association study the issue of network adequacy, including the impact on access to and quality of care, with a report back by the 2014 Interim Meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for adherence to existing statutory and regulatory measures designed to ensure network adequacy, and work with state medical societies to advocate for the same in states where measures do not currently exist (Directive to Take Action); and be it further

RESOLVED, That our AMA support the right of patients and physicians to seek appropriate recourse when and if harmed by inadequate networks. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 04/30/14

The topic of this resolution is currently under study by the Council on Medical Service.

[1] McKinsey Center for U.S. Health System Reform. (2013, December) Intelligence Briefs - Hospital networks: Configurations on the exchanges and their impact on premiums. Retrieved from: www.mckinsey.com/client_service/healthcare_systems_and_services/latest_thinking

RELEVANT AMA POLICY

H-373.999 Patient Advocacy/Protection Activities
The AMA will continue to aggressively pursue legislative, regulatory, communications and advocacy opportunities to identify and correct patient care and access problems created by new health care delivery mechanisms. (BOT Rep. 55, A-96; Reaffirmed: Rules and Cred. Cmt., I-97; Renumbered: CMS Rep. 7, I-05; Reaffirmed in lieu of Res. 815, I-13)

H-285.911 Health Insurance Safeguards
Our AMA will advocate that health insurance provider networks should be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (CMS Rep. 8, A-10; Reaffirmed in lieu of Res. 815, I-13)

D-165.989 Managed Care Organization Reimbursement Formulas
Our AMA will continue to assist states medical associations in their efforts to enact meaningful legislation that protects patients and patient access through network adequacy provisions. (CMS Rep. 6, A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed in lieu of Res. 815, I-13)

D-285.972 Tiered, Narrow, or Restricted Physician Networks
Our AMA will: (1) seek to have third party payers disclose, in plain language, the criteria by which the carrier creates a tiered, narrow or restricted network; (2) monitor the development of tiered, narrow or restricted networks to ensure that they are not inappropriately driven by economic criteria by the plans and that patients are not caused health care access problems based on the potential for a limited number of specialists in the resulting network(s); and (3) seek legislation or regulation which prohibits the formation of networks based solely on economic criteria and ensures that, before health plans can establish new panel networks, physicians are informed of the criteria for participating in those networks, with sufficient advance time to permit them to satisfy the criteria. (Res. 806, I-06; Reaffirmed in lieu of Res. 729, A-08; Reaffirmation I-10; Reaffirmed in lieu of Res. 815, I-13)

H-160.952 Access to Specialty Care
The AMA: (1) continues to encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for initial or ongoing specialist care, and direct patient self-referral to other specialists are appropriate, timely, and cost-effective; (2) encourages the medical specialty organizations that develop referral guidelines to document the impact of the guidelines on the quality, accessibility, timeliness, and cost-effectiveness of care; and (3) urges all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such collaboratively developed guidelines. (CMS Rep. 1, A-94; Reaffirmed and Modified: CMS Rep. 7, A-05; Reaffirmation A-09; Reaffirmed in lieu of Res. 815, I-13)

Report of the Work Group on the Role of Psychiatry in Healthcare Reform

Executive Summary to the APA Board of Trustees

RECOMMENDATIONS

Integrated Care (IC): A Healthcare Reform Imperative

Recommendations

1. APA must actively lead the development of integrated models on several levels: with government and private agencies, academia, and researchers; at the implementation level where federal and private groups are piloting new systems; and at the advocacy and communication level to inform psychiatrists, other mental health professionals, the public, the media, and legislators about the changes at hand. To sit on the sidelines as healthcare reform evolves is not a viable option.

2. APA should support the value of integrated medical and psychiatric care for patients with psychiatric illness in all treatment settings: This support should be based on best evidence regarding optimal care for all patients and care that is patient-centered and consistent with goals of the Triple Aim.

   Particular attention should be paid to the distinct needs of patients of varying ages, in different care settings and, in particular, in the public sector:
   - There is clear evidence from a large body of well-designed studies that psychiatrists have vital roles to play in integrated care models in a variety of settings.
   - These roles include oversight of population-based psychiatric care in integrated medical psychiatric settings, including the public sector, and an important consultative role with other primary-care based specialists and other mental health caregivers.

3. APA needs to produce a clear, simple set of statements for psychiatrists and their patients regarding integrated care; define the role of psychiatrists as team leaders and/or team partners and/or consultants; state how psychiatry's role in integrated care will benefit patients; and clarify this role vis-à-vis other physicians, allied health practitioners, and other mental health clinicians.

4. APA should consider developing a formal vision statement to address these recommendations.

5. APA should develop a specific internal program function to monitor and ensure that it has input on policies and standards that will impact the practice of psychiatry as part of integrated care models. In addition, monitoring policy efforts at the state level in coordination with state associations and providing targeted expertise when requested will be essential.

   A number of key public and private entities are shaping standards, policy, and reimbursement for development of alternative delivery systems, which include various integrated care models. These include, but are not limited to, CMS, the Agency for Healthcare Research and Quality (AHRQ), the Center for Integrated Health Solutions (CIHS), the Medicare Payment Advisory Commission (MEDPAC), the Medicaid and CHIP Payment and Access Commission (MACPAC), the National Association of Medicaid Directors (NAMD), the Institute of Medicine (IOM), commercial payers, managed behavioral healthcare organizations (MBHOs), the Patient Centered Primary Care Collaborative (PCPCC), accrediting bodies, and so on. Currently, the APA does not have a deliberate, coordinated effort to monitor and advocate for issues of import to psychiatry concerning integrated care model development.

6. APA should maintain particularly close working relationships with the AMA, major primary care medical associations, and specialty collaboratives. APA should take a lead role with CMS and other federal agencies in developing any quality metrics for integrated care and the patient registries needed to implement these. This should include a priority focus on monitoring projects funded by CMMI.

7. APA should establish an ongoing inventory of current models of integrated care for all populations and promulgate that information to psychiatrists, other physicians, healthcare leaders, and policy makers. This should include data on best evidence for integrated care and its implementation. The APA should work closely with psychiatric and medical specialty organizations in this effort. The APA should pay particular attention to models that achieve the Triple Aim, are well-designed, incorporate evidence-based care for psychiatric and medical-psychiatric care, and feature psychiatrists in leadership roles. The APA should establish an interdepartmental capacity to inform members and state associations/district branches about:
   - New models of care;
   - Results of current research;
   - Implications for their practices, including barriers to adoption; and
   - Ways to participate or at least influence the future practice of psychiatry given these reform initiatives.

Guidance on related aspects of healthcare system change, including practice organization, contracting payer issues, coding, and related matters should be included to the extent legally permissible.

Psychiatrists will need assistance in forming new practice relationships if healthcare reform shows evidence of significantly affecting the flow of and payment for clinical care. Although the Work Group does not believe that self-pay private practices or even insurance-based solo or small group practices will disappear, it is likely that control over payments and practices may shift to larger health system entities. Other specific recommendations related to assessing the exact nature of current psychiatric practice, EHR adoption, and financing are addressed elsewhere in this report.

8. Given the unique nature of psychiatric practice, including its direct access and public sector roles, a robust communications strategy will need to be a goal of these efforts. The APA should develop specific communications strategies to promote the value of integrated care and psychiatric physician leadership with key stakeholder audiences.

The Financing of Psychiatric Care: Structure, Payment, and Administration

Recommendations

We strongly support payer and insurance mechanisms that integrate the payment, use of standard CPT codes, and systems of managing psychiatric care with the broader medical healthcare budgets.

1. In any system that integrates care, the value of psychiatric care in improving total healthcare quality and reducing costs needs to be accounted for in such a way that the psychiatric care system, our patients, and psychiatrists can benefit from the improvement in cost of total care.

2. Appropriate payment arrangements that recognize necessary psychiatric clinical and case management functions as well as other infrastructure costs for care in integrated care models are essential. This is an **absolute prerequisite** for the sustainability and participation of psychiatry.

3. The APA should support payment streams for psychiatric care that are not carved out of existing medical budgets or, if carve-out payers continue to operate, the credentialing, CPT codes, and payment for psychiatric physician services must be integrated with the overall medical budget. Accreditation and related standards should be developed.

4. The APA should work with other medical societies to support ongoing improvements to evaluation and management (E/M) coding to bring reimbursements for these codes in line with procedural valuations.

5. Contracts for ongoing carve-out services should be structured in such a fashion as to place performance expectations on the quality and cost of medical as well as psychiatric care.

6. Integrated care budgets — particularly for public sector patients — must have formal budget and quality mechanisms to protect existing mental health budget resources.

7. The APA will need the capacity to track changes to payment systems, the results of demonstration projects, delivery and payment reform, and formal research and the impact on sustainability and various payment sectors. This will include alternative payment methodology developments and their implications for psychiatric care and reimbursement.

8. The APA should develop a core program function that specifically monitors and reports on Medicare and Medicaid policy and related program developments regarding state Medicaid plans and program efforts directed at the dual-eligible population in support of federal advocacy and APA's state associations.

9. The APA needs a more active and strategic presence in the many nongovernmental groups that will define policy and accreditation standards. This will also require more intensive work with the employer community and a focused public relations strategy.

10. The APA should continue strategic efforts to utilize MHPAEA to secure equity for psychiatrists and their patients.

Quality and Performance Measurement

Recommendations

The recommendations that follow are rooted in the foregoing findings and their implications for the future credibility of organization and payment for psychiatric care.

1. Clarify and articulate the APA's vision for mental health quality measures. Psychiatric measures must not be separated from the rest of medical care.

RECOMMENDATIONS

2. Undertake a systematic review and analysis of quality and performance measures that are used to accredit and/or certify alternative care delivery models and/or for healthcare reimbursement purposes.

3. Broaden the range of quality measures to include outcome measures and measures of integrated care for individuals with multiple comorbidities.

4. Engage where appropriate in research activity on quality in psychiatric practice.

5. The APA should consider a leadership role in the development of EHR and registry quality capacity.

6. Disseminate psychiatric outcome measures that are meaningful and actionable.

7. Continue/expand educational outreach on performance measurement targeting APA membership.

8. Continue/expand participation in national initiatives at all levels (federal, private insurance, local, etc.).

9. Continue/expand APA efforts in monitoring and participation in health plan certification/accreditation.

10. The APA will need to lead on quality metrics for psychiatric care and their consistent adoption across payers and other regulatory entities. This could be approached by identifying a few priority areas for improvement and/or by identifying a series of goals covering various areas of practice.

Electronic Health Records (EHR) and Related Technology

Recommendations

The Work Group believes that the failure to integrate psychiatric and medical records into EHRs subject to the limitations and safeguards noted below will permanently impair improvements in our patients' health and wellbeing. Recognizing the sensitivity of these issues, communication and education of the membership, patients, policy makers, and the general public is essential. Opt out provisions, limitations on sharing of psychotherapy notes as opposed to general psychiatric records, and ongoing recommendations regarding law and policy will be essential for the APA and its state associations. It is also essential that policymakers understand that more ambulatory psychiatric services are provided by non-psychiatric physicians than by psychiatrists or other mental health providers and that their electronic records already contain both mental health and other sensitive medical information.

1. The APA should develop resources that help members select, implement, maintain, and use EHRs and other forms of HIT. Possibilities could include written resources and online instruction videos, software reviews, accounts of members' experiences with HIT, telephonic consulting and technical support services, and in-person support services.

2. Standardized templates for electronic medical records and personal health records should include the data elements needed to manage and coordinate general medical care and mental health and substance abuse care. These systems must be carefully designed to ensure that critical information on health status and services can be extracted for measuring service patterns and performance.

3. The APA should continue/expand activities pertaining to HIT privacy. Activities include feedback to the federal government through submission of public comments and responses to requests for information, development of educational content on how to maintain HIT privacy and discuss privacy issues with patients, and talking to HIT vendors about privacy functionality.

4. The appropriateness and feasibility of APA developing patient registries for psychiatric patients should be explored. This should include due consideration of various structures and uses and recommendations as to options for the APA. The Council on Research and Quality Care will address this at its May 2013 meeting.

5. The APA should explore developing an RFR to vendors with specific technical capacities that would be needed for endorsement and should consider evaluation of its role in the development of EHR products. This activity could be a valuable resource to members, but APA must be aware of the risks involved in dealing with an immature industry.

6. The APA should continue/expand quality and performance measurement activities as under the quality performance measurement topic: Performance measurement is a key function of HIT and includes a variety of components related to payment, quality, and research through patient registries.

7. The APA should assess the adoption of and impact of HIT on quality in psychiatric practice and identify strategies to maximize findings that indicate the positive impact.

RECOMMENDATIONS

8. The APA should develop policy and training on EHRs and privacy/confidentiality. The importance of electronic health records going forward is self-evident. There are, however, numerous privacy/confidentiality issues for psychiatric records.

   The Work Group believes that psychiatric records should be integrated into medical records provided there is patient consent and this is consistent with statutory requirements. (It must be noted that Medicare/Medicaid patients do not have the option to opt out of EHRs.) Confidentiality is essential to proper psychiatric patient care and psychiatrists will need to differentiate between psychiatric notes that can be included in the medical record and psychotherapy notes that cannot. APA members will need authoritative guidance on content/inclusion in the medical record and the role of state versus federal regulation.

9. The APA should make policy development for confidentiality of MH/SUD records and HIT a priority matter. Development of training and technical assistance materials for members will be essential.

10. The APA should engage with Health Information Exchange (HIE) efforts. Currently, HIEs are forming at the local level, and each locale is handling psychiatric health information differently. In order to realize the potential of HIE to facilitate integrated care, APA could participate in oversight bodies at the national level and develop educational material for APA members.

11. The APA should continue/expand efforts to develop resources that help members select, implement, maintain, and use Electric Health Records and other forms of HIT. Possibilities include an RFR process as noted above, written resources and online instructional video, software reviews, accounts of member experiences with HIT, telephonic consulting and technical support services, and in-person support services.

12. The APA should continue/expand its efforts to advocate for expansion of HIT to all aspects of the mental healthcare system. Non-physician mental health clinicians and many specialty mental health settings are currently excluded from current national initiatives. Specific advocacy efforts are needed to correct federal policy.

13. The APA should assess the feasibility of maintaining patient registries. Given CMS's interest, APA should do pilot work to assess these more fully. This assessment has begun through APA's Council on Research and Quality.

Workforce, Work Environment, Medical Education and Training

Recommendations

1. Future workforce: The APA should work with the American Association of Directors of Psychiatric Residency Training (AADPRT), the Academy of Psychosomatic Medicine (APM), and the American Academy of Child and Adolescent Psychiatry (AACAP) to facilitate the development and implementation of a curriculum for residents that includes the core competence/skill sets for integrated care practice, including the maintenance of core medical skills.

2. The APA should work with the Accreditation Council for Graduate Medical Education (ACGME) to develop accreditation standards to establish specific milestones for psychiatric residents to achieve proficiency in core competencies for integrated care practice and settings, or highlight existing milestones that are relevant for these efforts.

3. Current workforce: Within the healthcare reform movement, many opportunities exist for psychiatrists who have the necessary skills and experience to participate in the new models of integrated care. However, many lack the core competencies respecting a number of necessary skills.

4. The APA should develop practice management modules (CME) for its members to enhance their skills in the following areas: reviews of common medical problems in general medical care and public sector populations, leading teams of mental health professionals, setting up and/or participating in integrated care settings, teaching PCPs about identifying and screening for mental health illnesses and substance use disorders, and health information technology.

5. Non-psychiatrist physicians and allied practitioners: the APA should explore potential collaboration with primary care personnel (both MD and non-MD) regarding needed education and alliances regarding care delivery development (especially for shortage areas).

Research and the Mental Health Evidence Base

Recommendations

Clearly there are important research questions across the topical areas discussed in this report. The Work Group has identified many of what it considers important research questions. The Work Group believes this should be regarded as a starting point for further deliberation to identify priority areas and the development of a plan to advance an agenda regarding needed research. It is evident that a variety of entities will perform these needed research projects.

RECOMMENDATIONS

Research Issues Covering Topical Areas Involved in Health Reform

A. Integrated Care
   1. Develop standards for classifying models of integrated care and measuring outcomes of such models.

   2. What is the effectiveness of integrated care in general medical and related psychiatric practice settings?

   3. What is the effectiveness of integrated care for those with severe mental illness? What models will work best in this population and help with medical disorders found in them?

   4. What models of integrated care can be used in rural areas with underserved populations?

   5. What models work best with various age groups (e.g., children and the elderly population)?

   6. What accounts for the effectiveness of integrated care – clinician integration, introduction of evidence-based practice, care management, system integration, etc.?

   7. What organizational models of care are best for certain populations and settings? (Note this goes beyond "integrated" care – perhaps there are other ways that work best for certain groups and settings.)

   8. What models could ensure sustainability?

   9. What other factors (e.g., clinician/staff beliefs) may impact effectiveness of integrated care models?

   10. Support increased research into the mechanisms of increased morbidity and mortality with co-occurring medical and psychiatric disorders.

   11. Support/conduct epidemiologic studies of co-morbidity (medical, mental illness/substance use) including prevalence and impact of care

B. Financing of Psychiatric Care
   1. What is the cost-effectiveness of integrated care models in various populations and settings?

   2. What are the best models for financing integrated care models?

   3. What reimbursement models lead to the best outcomes for people with mental illness?

   4. What models of financing will ensure appropriate care under healthcare reform for those within the current public mental health system?

   5. What is the contribution of mental illness/substance abuse to overall healthcare costs and the effect of appropriate behavioral healthcare interventions on those costs? How do these differ by population (e.g., those with dual eligibility, co-morbid conditions)? How do different mental health clinicians affect these costs?

   6. What models of payment by Medicaid/Medicare are best for those with mental illness?

   7. What interventions should be covered? Identify those interventions with the highest cost-effectiveness and include not only clinical treatments but others like case management, peer navigators, etc.

   8. How do various coding schemas affect delivery of care, costs of care, and outcomes?

   9. What mental health and substance abuse interventions should be part of a basic package of insurance coverage (this becomes especially relevant with health exchanges and expansion of Medicaid)?

   10. What are the barriers to the adoption of best practices?

C. Quality and Performance Measurement
   1. Increase research to build an evidence base for treatment of various illnesses. There is a need to identify gaps in knowledge that should be a priority for clinical research. Which outcome measures most predict improvement, reduced morbidity and mortality from all causes?

   2. What personalized treatment options are available now or could be developed in the near future?

RECOMMENDATIONS

3. Increase the number of quality and performance indicators with a clear link to improved outcomes in those with mental illnesses and substance use disorders.

4. Develop pay for performance models in MH/SUD, including integrated models.

5. Increase development of patient-centered outcome measures.

6. What are the best risk adjustment models? (also relevant to financing)

7. What implementation/dissemination models are effective in improving practice?

8. What models of person-centered care lead to better outcomes for patients?

D. Health Information Technology (HIT)
1. Develop EHR applications to improve quality of care in various treatment settings. What applications actually improve care and outcomes?

2. Develop EHR applications that can monitor individual practice and patient outcomes.

3. What EHR data related to those with mental health/substance use disorders are critical for improved treatment outcomes?

4. Develop large data network(s) to be used for research on various conditions and to monitor changes in population health.

5. Expand practice-based research network for practice research. Incorporation of EHR and other data systems will expand opportunities within this network.

6. Expand support for novel and entrepreneurial capacity to assess wellbeing, symptoms, and response to treatment.

7. Ethical considerations in HIT.

E. Workforce, Training, and Education
1. What is the projected demand for services given the increase in coverage under the ACA?

2. What is the projected available number of psychiatrists and other mental health care professionals?

3. What is the projected available number of primary care physicians, non-physician primary medical caregivers, and specialists who will be providing mental health and substance use disorder services?

4. What range of disorders will primary care physicians, non-physician primary care medical caregivers, and specialists treat? What are existing and expected skill sets and training they will need?

5. What skill sets are needed now for psychiatrists to practice in future models of health care?

6. What are unique skill sets for psychiatrists vs. other mental health clinicians vs. other physicians?

7. What recruitment and retention models work best to ensure an adequate number of psychiatrists?

8. What education models are most effective in training psychiatrists, primary care physicians currently practicing and those in training?

F. DSM-V
1. How does adherence to DSM-V criteria improve practice and outcomes for patients?

2. What changes need to be made in DSM criteria? (This would come from longitudinal studies once DSM-V is implemented.)

3. What new coding/payment/performance methods are most effective using DSM-V?

RECOMMENDATIONS

Healthcare Reform: Organizational Implications for the APA

Recommendations

1. The APA should establish a set of health reform priority activities (developmental and implementing) consistent with the major findings and recommendations of this report and a strategy/plan of action to implement them.

2. The APA should establish an ongoing working group within the current governance structure to oversee this plan of action and regularly report on developments and actions. This should include a plan to ensure a rapid response capability.

3. The Medical Director/CEO, under the oversight of the board, should assess how current staff can best be configured to ensure that the functions of this work group are appropriately executed. This should include recommendations concerning additional staff and/or consultant expertise that may need to be retained (with the budget implications). There are various recommendations in other sections of this report that concern internal staffing. These should receive due consideration as part of this effort.

4. The APA should develop a communications campaign that addresses how to best advance the APA agenda, internally with its members and externally with key stakeholder audiences. This campaign will likely require external communications expertise. Psychiatry's value proposition for health reform is not self-evident to key policy/payer audiences and members. Moreover, a fully informed and educated membership will be essential to fulfill the demands for psychiatric services that the APA's agenda embodies.

5. A centralized strategy for assistance to the APA's state affiliates will have to be developed.

6. Governance implications of these efforts, including the rapid response capability, will need to be carefully and directly assessed.

FORM TO PROPOSE A NEW APA COMPONENT

This is a request to establish the American Psychiatric Leadership Fellowship Selection and Advisory Committee that will be on par with and have the same role and privileges as the APA Public Psychiatry Fellowship Selection Committee and the APA/SAMHSA Minority Fellowship Selection and Advisory Committee.

Background: The American Psychiatric Leadership Fellowship Program is the former APA/GlaxoSmithKline (GSK) Fellowship Program which had been overseen for many years by the APA/GSK Selection and Program Corresponding Committee until 2007 when GSK withdrew funding. In 2010 the fellowship program was restored with APPI (now APF) reserves and renamed the American Psychiatric Leadership Fellowship. An advisory component for the resurrected fellowship was never established by APF. The members of the previous selection committee continue to serve that capacity but are not recognized publicly (e.g. in the Components Directory) as their counterparts.

Type: *Committee*
Proposed Name: *American Psychiatric Leadership Fellowship Selection and Advisory Committee*
Justification:

1. **How is the component's charge consistent with current APA goals?**
   The work of the committee aligns with APA's mission to serve the professional development needs of its young and early career membership by providing high quality extramural opportunities to enhance learning and professional growth.

2. **Why is it needed?**
   To provide expertise and experience needed to identify best qualified fellowship award recipients; to ensure a transparent and unbiased selection process is followed; and to develop program policy to ensure program excellence consistent with APA's values and goals.

3. **How long will it take to produce?** *Not applicable*.

4. **What is currently available?**
   Drs. Leah Dickstein, Sheldon Benjamin, Carl Cohen, and Keith R. Stowell for the past 5 years have been fellowship advisors and reviewers.

5. **Potential benefits of the component's work product to APA members**
   The grooming of talented, exceptional young psychiatrists for leadership in APA and in the field.

6. **The cost involved and the available funds for new components.**
   $500 – conference calls and UPS mailing of fellowship applications to committee members

Recommended Charge:
The purpose of this committee is to select outstanding residents with a potential for leadership. The committee will be charged with the selection of residents from among nominees submitted in response to an invitation sent to all accredited residency training programs in psychiatry. The committee will also set policy for effective program management and improvement and advise staff on development of germane and beneficial fellowship activities.

Tenure and Size: *5 members with experience training residents; staggered tenures*

Source of Funding: *The modest expenses associated with the committee will be covered by the fellowship, which is funded ($65K).*

Proposed by: *Leah Dickstein, MD*

COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING
May 5, 2014

Attendance:
Richard F. Summers, MD, Chair
Mark Rapaport, MD, Vice Chair
Marcia Verduin, MD, Member
Art Walaszek, MD, Member
John Q. Young, MD, Member
Chris Varley, MD, AADPRT
Larry Faulkner, MD, ABPN
David Bressler, PsychSIGN Outgoing President
Robert Rymowicz, PsychSIGN New President
Karina Fajardo, MD, MD, APA/SAMHSA Fellow
Benjamin Angarita, MD, APA/SAMHSA Fellow
Alicia Barnes, DO, APA/SAMHSA Fellow
Kara Brown, MD, APA Diversity Leadership Fellow
Samantha Miller, MD, APA/SAMHSA Fellow
Juliet Muzere, DO, APA/SAMHSA Fellow

Excused:
Neisha D'Souza, MD
Mary Jo Fitzgerald, MD
Jon Lehrmann, MD, AAP
Steve Schlozman, MD
Shakeel Ahmed, MD, Member
Vishal Madaan, MD, Member
Lisa Mellman, MD, Member
Pedro Ruiz, MD, Member
Sandra Sexson, MD, Member
Tamara Gay, MD, ADMSEP
Deborah Cowley, MD
Mary Sciutto, MD

Guests:
Leah Dickstein, MD
Sarah Johnson, MD, Incoming Member

Staff:
Nancy Delanoche
Deborah J. Hales, MD
Kristen Moeller

CALL TO ORDER – Dr. Summers called the meeting to order at 3:00 p.m. and welcomed those present.

REVIEW AND APPROVAL OF MEETING MINUTES – The minutes of the September2013 meeting minutes (held in Arlington, VA) were reviewed and approved.

ABPN REPORT – Dr. Faulkner reported on the following updates from the American Board of Psychiatry and Neurology.

1. New ABPN Director - Dr. Jeffrey Lyness from Univ. Rochester was elected to replace Dr. Chris Colenda on January 1, 2014.

2. New Subspecialty in Brain Injury Medicine - The ABMS and the ACGME approved the application from the ABPMR/ABPN for a new subspecialty in Brain Injury Medicine (BIM). The ABPMR will take the lead in developing the BIM exam which will be administered in 2014 for candidates credentialed under "grandfathering". Both psychiatrists and neurologists will be eligible to take the BIM examination.

3. New Certification Examinations
   - The over-all pass rates on the new certification examinations have been 83% for neurology, 77% for child neurology, 85% for psychiatry, and 97% for CAP.
   - The standard expected to be demonstrated on ABPN certification and MOC examination is "competence" (equivalent to ACGME standard of "proficiency").

4. Certification Fees - Candidate certification fees were decreased by 12% in 2008 (No increase in 2006, 2007, 2009, 2010, 2011, or 2012), were decreased another 10% in 2013 and another 7% in 2014, and will remain the same in 2015

5. Continuous MOC Program
   - Begins for diplomates certified or recertified in 2012.
   - No end date on certificate.
   - Requirements for Continuous MOC:
     - Unrestricted medical license(s)
     - Cognitive examination every 10 years
     - Specific MOC activities every 3 years
       - 24 CME hours of Self-assessment activities
       - 90 CME hours (includes the 24 SA CME)
       - 1 PIP Unit (Clinical and Feedback Modules)
   - Annual registration on the ABPN Folio.
   - Annual MOC fee ($175 for 2013).
   - No additional fee for one MOC cognitive examination in 10 years.

6. Reporting Diplomate MOC Status - beginning in 2012, all ABPN diplomates will be reported as one of the following:
   - "Meeting MOC Requirements"
   - "Not Meeting MOC Requirements"
   - "Not Meeting MOC Requirements and Not Required To Do So" (for "life-time" certificate holders)

7. MOC Credit for Diplomate Activities
   - Completion of institutional QI activities that meet ABPN requirements.
   - Participation in Organizational Recognition Project (ORP) (1 PIP credit).
   - Completion of ACGME-accredited subspecialty fellowship and passing ABPN subspecialty examination (3 years of MOC credit).
   - ABPN certification or MOC examination, peer reviewed grants and articles, or non-CME patient safety SA (1 year of SA credit).

8. Diplomates Now Choose Their Type of Feedback Module - diplomates may now choose one type of Feedback Module they want to complete for MOC Part 4.
   - Patient Survey (at least 5 patients selected by diplomate)
   - Peer Survey (of General Competencies)*
   - Institutional Peer Review (of General Competencies)*
   - Supervisor Evaluation (of General Competencies)
   - Resident Evaluation (of General Competencies)*
   - 360˚ Evaluation (of General Competencies)*

   *Must include at least 5 evaluators.

9. ABPN MOC Study Groups - the ABPN has established Study Groups to recommend activities and standards for non-CME self-assessment and standards for patient safety modules.

10. Requirements to Re-issue Invalidated Certificates - diplomates who have had restrictions placed upon their medical licenses and thus had their ABPN certification invalidated must now fulfill specific requirements to have their certificates reissued:
    - Have all of their medical license restrictions removed (rare exceptions)
    - 24 Self-assessment CME credits
    - 90 CME Category 1 credits
    - 1 PIP Unit (Clinical and Feedback Modules)
    - Passing score on the MOC Examination

11. Combined Training - the ABPN decided to maintain its moratorium in the approval of NEW Combined Training Programs pending the recommendations of an ABPN Study Group that will report to the full ABPN in July 2014.

12. "Board Eligibility"
    - Graduates of ACGME-accredited or ABPN-approved residencies have 7 years to become board certified.
      . Begins January 1, 2012
      . Must meet all ABPN credentialing requirements
    - Graduates of residencies prior to January 1, 2012 will have until January 1, 2019 to become to become board certified.
    - If the deadlines for certification are not met, additional credentialing requirements must be fulfilled again to become eligible.
      . 90 CME Category 1 credits
      . 24 Self-assessment CME credits (can count toward the required 90 CME Credits)
      . 1 PIP Unit
      . Repeated in-residency evaluations

13. Milestones and ABPN Credentialing - the ABPN has decided to continue to accept the attestation of Program Directors that residency graduates have completed all required rotations in an acceptable manner. Specific performance on individual Milestones will not be required.

14. ABPN Faculty Fellowship - the ABPN has established a new Faculty Fellowship Program to promote innovative education and/or evaluation initiatives for psychiatry and neurology residents or practitioners. Four psychiatry and four neurology faculty will be supported per year. Each ABPN Fellow will receive $50,000 per year for two years. The first ABPN Faculty Fellows were selected for 2014.

    - Melissa Arbuckle, M.D., Ph.D.
      Associate Director of Psychiatry Residency Training, Columbia University

    - Michael Jibson, M.D., Ph.D.
      Director of Psychiatry Residency Education, University of Michigan

15. ABPN Senior Resident Administrative Fellowship - the ABPN has established a Senior Resident Administrative Fellowship for one senior psychiatry resident and one senior neurology resident each year. Fellows will spend three months at the ABPN office under the direct supervision of the President and CEO and will learn about the structure and function of the ABPN, complete a research project of their choice, participate in a weekly administrative seminar, and accompany the President and CEO to professional meetings. Salary (if necessary) and living and travel expenses will be paid by

the ABPN. The first ABPN Fellows were selected for the 2014-2015 year with Alexis Cohen-Oram, M.D. from the University of South Florida for Psychiatry.

16. ABPN Crucial Issues Forums - the ABPN will fund a series of Crucial Issues Forums during which representatives from various professional organizations and perspectives will discuss important issues pertinent to the ABPN. The first ABPN Crucial Issues Forum on Subspecialties was held on April 6-7, 2014.

CME REPORT – Dr. Rapaport noted that the Council has oversight for planning, coordinating, directing, and evaluating the continuing medical education (CME) efforts and activities of the Association and to review APA's CME Mission Statement on an annual basis.

The mission of APA's CME program is to engage members and other psychiatrists in educational activities that will assist them in improving patient care. The Accreditation Council for Continuing Medical Education expects providers of CME to not only evaluate individual programs but assess the outcome of the overall CME program. The Division of Education provided CME and MOC educational activities to psychiatrists through a variety of formats: live meetings, journal CME (AJP and FOCUS); online learning including recorded presentations and webinars, as well as practice guideline courses, self-assessment tests and clinical vignette surveys (MOC Part 2).

Performance in Practice (chart review MOC Part 4) self-designed improvement programs developed in collaboration with the Division of Research, were published in FOCUS and offered free to members online. Participants agreed they were able to identify areas for improvement and provided specific examples. Credit was given to peer reviewers for AJP and Psychiatric Services. Many jointly sponsored District Branch meetings had a focus on DSM-5 changes. Each of the CME activities provided an important component of a lifelong learning program, addressing advances in science and the latest research, or current clinical care and best practice while including specific competencies - Patient Care, Medical Knowledge, Practice Based Learning and Improvement, Systems Based Practice, Professionalism and Interpersonal Skills and Communication. Through analysis of program evaluations and hearing from program participants we determined that our activities are bringing about change in practice.

The Council has oversight of the continuing medical education (CME) efforts and activities of the Association.

- recommends general policy and standards for APA continuing education including the CME mission;
- assesses the educational needs of APA members; identify the key learning gaps for psychiatry; and assist in identifying appropriate quality measures and topics for educational programming

2013 APA Activity Summary

Type of Activity	Activities	Hours of Instruction	Physician Participants	Non-physician Participants
Live Meetings	3	81.00	12300	1202
Test Item Writing	1	10.00	1	0
Performance Improvement	6	120.00	1461	11
Internet Activity Enduring Material	40	678.50	3812	479
Enduring Material	10	239.00	2227	8
Journal-based CME (AJP & FOCUS)	48	168.00	7883	0
Manuscript Review	4	12.00	103	3
Sub-total Directly Sponsored	**112**	**1308.50**	**27787**	**1703**
Sub-total Jointly Sponsored	**75**	**397.50**	**3037**	**2198**
Total for all activities	**187**	**1706.00**	**30824**	**3901**

Source: ACCME's Program and Activity Reporting System (PARS) 2013

Accreditation Council for Continuing Medical Education (ACCME) Requirements
ACCME requires that CME programs should be designed to change physicians' competence, by teaching them strategies for translating new knowledge into action, or physicians' performance, what they actually do in practice, or patient outcomes. ACCME expects CME providers to do the following:

- Evaluate the effectiveness of the overall educational program.
- Gather data or information and conduct a program-based analysis.
- Identify, plan and implement the needed or desired changes in the overall program that are required to improve on ability to meet the CME mission.

2013 – 2014 Highlights of APA's CME and MOC programs

New Self-Assessment Program (MOC Part 2)

Connect via Social Media: [Twitter] Use #eFOCUS-atypicals

Understanding the Evidence: Off Label Use of Atypical Antipsychotic Medication
The Agency for Healthcare Research and Quality (AHRQ) has awarded the APA a grant (#5R18HS021944) to create and offer physicians a FREE CME program to educate them about evidence for effectiveness of atypical (second generation) antipsychotics, reviewed in the 2011 AHRQ Report as well as newer evidence. The goal of the program is to help physicians make informed treatment decisions when using these medications "off label". This interactive CME program begins with a Self-Assessment test and in the months that follow a series of multimedia clinical modules will be available for CME credit. The self-assessment test is available at www.apaeducation.org.

Annual Meeting and Institute on Psychiatric Services (IPS)
2013 Annual Meeting "Pursuing Wellness Across the Lifespan".

- The NIDA track highlighted the intersection of psychiatry and addiction science.
- The DSM-5 track consisted of 21 symposia, workshops, and a master course intended to help attendees incorporate the new manual into clinical practice.
- The Military track focused on issues surrounding members of the military, veterans, and their families, including traumatic brain injury, PTSD, and steroid use.
- The Integrated Care track featured sessions on effective models of collaborative care, practice innovations, and the implementation of national healthcare reform.

2013 IPS - "Transforming Psychiatric Practice, Reforming Healthcare Delivery" focused on the needs of the most vulnerable, disenfranchised, and difficult-to-serve patients. Collaboration with Drexel University to provide CE credit to non-physician healthcare professionals.

Highlights and CME opportunities from both meetings are available online through a partnership with Learners Digest, Inc.

Focus: Journal of Lifelong Learning in Psychiatry
The FOCUS program: the Journal, the annual self-assessment, Performance in Practice Chart Review Modules and eFOCUS clinical vignettes, as well as FOCUS books, help psychiatrists fulfill Maintenance of Certification (MOC) Requirements, stay up to date, and participate in a program of lifelong learning. APA members contribute as authors, peer reviewers, consultants, and question writers. An online FOCUS subscription is free to ECP members.

In 2014 FOCUS issues include Disorders of Sleep; Psychopharmacology: Evidence and Treatments; Psychotherapies; and Eating Disorders. FOCUS covers topics in psychiatry in four years.

APAeducation.org – APA Online CME

The Division of Education delivers online Continuing Medical Education (CME) courses, CME tests, and certificates, and maintains member transcript data. In 2013-2014 the Division introduced a variety of new courses on www.apaeducation.org:

- Annual Meeting Self-Assessment – Free MOC Part 2 activity for annual meeting registrants.
- DSM-5: What You Need to Know – (credit for multiple disciplines, also distributed through VA.
- Buprenorphine and Office-Based Treatment of Opioid Dependence (Updated 2013)
- Disaster Psychiatry
- Evaluation and Management Coding for Psychiatrists (2013 new codes)
- Patient Safety – coming in 2014
- Primary Care Updates for Psychiatrists
- Professionalism and the Internet
- Cognitive Therapy and Psychodynamic Therapy: More Alike Than Different? A Conversation Between Aaron Beck and Glen Gabbard
- Principles of Psychodynamic Psychotherapy
- eFocus Clinical Modules: “An Unhappy Man” and “Imaginary Friends”

District Branch CME Programs

In 2013-2014 the APA Department of CME provided credit to District Branch (DB) members of the Subcommittee on Joint Sponsorship for over 100 meetings. 22 District Branches receive CME credit from APA. Many of the DB meetings covered DSM-5 and changes to CPT coding.

Maintenance of Certification for Physician Assistants (PA)

In 2014, PAs will transition to a certification maintenance process. PAs must earn 20 Category 1 credits of performance improvement CME (PI-CME) and/or self-assessment CME every two years. Acceptable activities are certified for American Academy of Physician Assistants (AAPA) Category 1 PI-CME Credit or AAPA Category 1 Self-assessment CME Credit. The AAPA has certified APA’s Performance in Practice chart review Modules, and the FOCUS Self-Assessment as meeting MOC requirements for this group.

Council on Addiction Psychiatry Webinars

As part of the Physicians’ Clinical Support System-Medication Assisted Therapies (PCSS-MAT), the APA offers a series of 16 live and archived webinars offering CME credit. The topics and presenters are identified through: (1) suggestions of PCSS-MAT clinical directors and staff, (2) a summary of topics discussed on SAMHSA’s moderated Web Board for waivered physicians, (3) suggestions of members of APA’s Council on Addiction Psychiatry, and (4) questions and concerns expressed by buprenorphine waivered physicians. Topics include: The Psychology of AA and NA and Their Role in Clinical Care; Methadone and Buprenorphine: Clinical Impact of Drug Interactions; DSM-5: Substance Related and Addictive Disorders

APA’s Performance in Practice clinical modules approved by ABPN (MOC Part 4 Clinical Modules)

Physician Assessment Module for the Screening of Adults with Substance Use Disorder:
Feb 2011 - Feb 2017
Physician Assessment Module for the Assessment and Treatment of Adults with Substance Use Disorder: Feb 2011 - Feb 2017
Performance in Practice: Physician Assessment Tool for the Care of Adults with Schizophrenia:
June 2012 - June 2015
Physician Practice Assessment Tool for the Assessment and Treatment of Adults at Risk for Suicide and Suicide-Related Behaviors:
March 2011 - March 2017
Clinical Module for the Care of Patients with Major Depressive Disorder:
July 2012 - July 2015

Performance in Practice: Clinical Module for the Care of Patients with Posttraumatic Stress Disorder
Aug 2013 - Aug 2016

2014 APA Annual Meeting: Master Course 5: Psychopharmacology:
MOC Activities Related to the Course
PIP: Measures for Use of Selected Antidepressant Medications
PIP: Measures for Use of Second Generation Antipsychotics Medications
PIP: Measures for Use of Lithium/Anticonvulsant Mood Stabilizing Medications
PIP: Measures for Use of Benzodiazepine Medications

The Council on Medical Education formally commends the efforts and initiatives of the APA Department of CME, specifically Dr. Deborah Hales and Kristen Moeller, to create products and programs that assist APA members to meet their requirements.

Members of the Council also discussed the following topics for future exploration:

- How do we develop systems and/or mechanisms for training on interdisciplinary/interprofessional collaboration (relates to new LCME requirement for interprofessional training)?
- What skills are needed for psychiatrists for the future and how we educate them to function in the new healthcare era?

ADMSEP REPORT – Dr.Dube reported for Dr. Tamara Gay who was unable to attend. ADMSEP's mission is to champion excellence in medical student psychiatric education. ADMSEP members range from individual preceptors to course directors who are involved in education across the four years of the medical school curriculum, from behavioral science courses to psychiatry clerkships, 4th year electives, and career advising and currently have over 200 active members representing over 100 LCME-accredited medical schools.

Initiatives and Programs
Education Scholars Program - Six inaugural Education Scholars will complete the 2-year certificate program to develop educational research skills at this year's annual meeting. Five new scholars have been selected to start the 2-year program.

Research and Scholarship Grant - The Research and Scholarship Task Force is overseeing the application process for an annual $2,500 grant to support an educational research project. Projects that include collaboration among ADMSEP members at different institutions will be given priority. The award has been given to Jonni Gerkin and colleagues at the University of North Carolina. Their project is entitled, "Mindfully Targeting Burnout in Medical Students".

Clerkship Administrator Certificate Program - This program will focus on professional development for clerkship administrators. It was offered for this first time at our 2013 Annual Meeting, and was a success with 7 participants. The program is going to be offered every other year until they have more clerkship administrators attend on a regular basis.

Online Learning Modules - the ADMSEP Clinical Simulation Initiative Task Force continues developing on-line learning modules. Currently four have been published on MedEdPORTAL: Bipolar Disorder, Personality Disorders, Dementia, and PTSD. Nine additional modules are in final stages of development and will soon be submitted to MedEdPORTAL.

Child and Adolescent Psychiatry Resources - the Child and Adolescent Psychiatry in Medical Education Task Force has posted an on-line resource toolkit for medical student educators in collaboration with AACAP.

Organizational Liaisons - ADMSEP provided input on Level 1 Milestones to the Psychiatry Milestones Group. Council member John Spollen serves as liaison to AADPRT's Recruitment Committee and President Tamara Gay

serves on the joint APA/AADPRT/AACDP/Task Force on GME funding.

Governance - As of June 2013, officers are serving 1-year terms to provide more opportunities for the membership to serve in leadership roles.

2014 Annual Meeting - the 40th annual meeting will take place June 12-14, at the Keystone Conference Center, in Keystone, Colorado which is served by the Denver International Airport. The keynote speaker will be L. Dee Fink, PhD., of Fink Consulting. At their fall council meeting (Oct. 10-12) they will finalize the scientific program.

The 2015 meeting will be held at the Stoweflake Resort in Stowe, Vermont June 18-20, 2015.

ADMSEP has created on-line Clinical Simulation Educational Modules for teaching medical students using DSM 5. These modules are provided free on the ADMSEP website, and are also published on MedEdPortal for use by clerkship directors and medical students for general educational purposes and, in some cases, to meet LCME standards ED-2 and ED-8. For example, a module can provide the opportunity for a student unable to see a key condition in a clinical setting to learn about the condition and, therefore, meet clerkship requirements. However, the fee that APA requires for use of DSM criteria is not affordable for ADMSEP (a non-profit allied education organization). There is no monetary gain to anyone from these modules. There is not charge for their use and they were developed with the sole goal of improving psychiatric medical student education. Thus, ADMSEP is formally requesting that the American Psychiatric Association (APA):

1) Allow ADMSEP authored CSI educational modules to use DSM5 content, as appropriate to reasonable medical student learning objectives.
2) Allow ADMSEP members and their respective medical students to view these modules in a credential-controlled secure web site.
3) Allow publication of CSI modules on MedEdPortal.
4) With regard to requests 1,2, and 3 above: grant written release from APA rules regarding DSM-5 copyright restrictions.

The Council voted to support the request and will ask the JRC and Board of Trustees to waive the DSM5 copyright restrictions for allied, non-profit education organizations for use in non-commoditized teaching/educational resources specifically for medical student education.

AADPRT REPORT – Dr. Varley reported on AADPRT's programs and priorities:

<u>ACGME/RC Liaison</u>
ACGME Next Accreditation System (NAS): Phase I of the NAS began in July, 2012 for residencies in Internal Medicine, Pediatrics, Emergency Medicine, Neurosurgery, Orthopedics, Radiology, and Urology. General Psychiatry will join them as part of Phase II in July, 2014. The NAS represents the next phase of the residency competency movement. Programs will be evaluated every six months based on information gathered by the ACGME including the results of annual resident and faculty surveys and aggregate resident performance as measured by the Milestones. The previous practice of completion/submission of the very lengthy Program Information Forms and formal site visits of programs from the ACGME have been phased out. Distance from the norm will alert the ACGME to the need for intervention which may range from a letter of inquiry to a focused site visit. Institutional Site Visits, called CLER visits, will occur every 18 months. Attention will be paid to the learning environment, patient safety, quality improvement, transitions in care, supervisory standards, duty hour oversight, fatigue monitoring, and professionalism.

Milestones: The Psychiatry Milestones Working and Advisory Groups began their work in the fall, 2011. The Milestones for General Psychiatry have been completed. There have been multiple presentations about them at the last two AADPRT's Annual Meetings and elsewhere. Milestones tips are now routinely being posted on our listserv to guide training directors. With considerable anticipation of this major project the Milestones will be launched for General Psychiatry on July 1, 2014, with first reports to the ACGME due six months thereafter. The

Working Group will use its experience to guide future revisions of the Milestones. A Draft of the Milestones open to comment from the field is expected in the fall, 2013 with a final version around December, 2013. In addition, the CSV Task Force will become a subset of a new Assessment Tools Task Force which will work to solicit current tools and to develop new tools to assist programs in meeting the challenges presented by NAS implementation.

The ACGME has convened a Work Group to define Milestones for the Psychiatry Subspecialties with membership from the ACGME, the ABPN, AACAP and other Subspecialty representation. The President of AADPRT will provide input on AADPRT's behalf into the process as a member of the Advisory Group to the Work Group. This is very much on a fast track with a plan for implementation on July 1, 2015.

PG4 Fast-track into Fellowships: A sub-committee of the Psychiatry RC has been exploring the possibility of earlier entry into 1- year Fellowships in the PG4 year. AADPRT convened a Task Force to examine the implications of such a change to residency education. The AADPRT Regional Representative and Subspecialty Caucuses offered the initial window into the issues at hand.

The Task Force has studied the potential impact on empty positions, workforce demands, declining GME dollars as well as the impact on advanced general psychiatry milestone knowledge and skill acquisition and consolidation, on experience in continuous care, on junior resident supervisory needs, and on recruitment among others. A comprehensive survey was sent to AADPRT membership about the potential impact of such an action. Survey results were mixed but in general membership was not in support of the fast track option apart from the already existing mechanism for Child and Adolescent Psychiatry.

<u>NRMP All-in Policy</u>

As a consequence of the NRMP All-in policy, applicants to both PG1 and PG2 positions had to apply this past year apply though the Match. This leaves the majority of PG2 resident applicants unsure until March of where they will be living and for programs, what their resident complement will be. As a consequence, AADPRT requested that the Psychiatry RC change general psychiatry training classification from Advanced, its current status, to Categorical. This change back to the status quo ante permits the recruitment of PG2's outside of the Match in a rolling admissions fashion. The NMRP changed their policy to the place psychiatry in a Categorical status, an action viewed by AADPRT as universally positive.

<u>AADPRT at the APA Annual Meeting:</u>

For the 2013 APA Annual Meeting, Dr. Dilip Jeste invited AADPRT to partner with the APA in a Presidential Symposium. This co-sponsored symposium was entitled "DSM-5 and Residency Training: Opportunities and Challenges". The featured speakers in this very successful program included representatives from groups affected by these challenges. This year's sponsored session is entitled "Developing a National Neuroscience Curriculum – Planning for the Future of Psychiatry" co-chaired by Adrienne Bentman and Rick Summers.

AADPRT is formally requesting that a joint symposia continue for future APA Annual Meetings. The Council is in support of this and will formally ask the JRC to support regular joint symposia with allied psychiatric organizations to include subspecialty and education organizations.

<u>AADPRT Annual Meeting:</u>

The 43rd Annual AADPRT Meeting was held in Tucson, Arizona from March 6 -March 8, 2014, along with the related BRAIN Conference, which was on March 5. Next year's annual meeting will be held in Orlando, Florida on March 5, 6, 7 2015. Planning for this event is underway.

<u>Administrative Director:</u>

There was a major personnel change in AADPRT this past year with the announced retirement of Ms. Lucille Meinsler who has long been the Administrative Director of AADPRT, which will take effect on June 30, 2014. AADPRT wishes to formally recognize the very important contributions she has made to our organization helping guide and shape our growth and development.

AAP REPORT – Dr. Marcy Verdiun reported for Dr. Lehrmann's about current AAP programs and initiatives. The AAP Annual Meeting plans are well underway. The meeting is scheduled for September 17-20th in Portland, Oregon, at the Embassy Suites in Downtown Portland. The meeting theme is "Accountable Education Across the Continuum" and will include:

- 44 workshops
- 3 works-in-progress
- 5 media presentations
- 1 joint AAP-AADPRT session
- 1 joint AAP-AACDP session: "Education and Research Under Constrained Financing", Mark Rapaport, MD; Jed Magen, DO, MS

- Keynote Address: "Creating a Continuum of Learning for the 21st Century", Carol Aschenbrener, MD, Chief Medical Education Officer, Association of American Medical Colleges (AAMC)

- Plenary Session: Panel Discussion on Assessing Competency Across the Continuum
  Andrea Waddell, MD, Moderator
  Joan Anzia, MD
  Carlyle Chan, MD
  John Spollen, MD
  Marika Wrzosek, MD

- Mentorship Activities
  - CV Boot Camp
  - Mentor-Mentee Breakfast

- Cultural Competence and Diversity Consultations
- Master Educator Program focusing on "Putting Learning Theories into Practice"

AAP activities continue to focus on the areas of:

- Mentorship/Career Development
- Collaboration
- Diversity
- Organizational Health

AAP is in the midst of assessing ways to improve and update our website, and improving our selection of sites for annual meetings. The AAP Steering Committee will use this data to better understand what is needed and how AAP can improve the products and services provided to professionals involved in psychiatric education and/or academic psychiatry.

Dr. Verdiun also reported on AAP activities at the APA annual meeting which included sponsoring a CV boot camp at the Resident Resource Center. Ideas for the future included better advertisement of the CV boot camp, mentor buttons or ribbons to identify faculty who are open and willing to help/assist medical students and residents at the meeting and morning de-briefing for residents on highlights of the meeting on a daily basis.

PSYCHSIGN REPORT – David Bressler, a 3rd year medical student @ Tufts University and outgoing President informed the Council of PsychSIGN's mission & overview: PsychSIGN is a network of psychiatry interest groups at medical schools throughout North America. Since its founding in 2006, PsychSIGN has grown to represent over 400 active student members and an additional 300 alumni. The three-fold mission is to:

1) Promote medical student interest in psychiatry;
2) Foster mentorship and a sense of community among psychiatry faculty members and medical students;
3) Serve as liaison between the professional psychiatric associations and the medical student community.

The 9th annual conference took place in conjunction with APA's annual meeting in New York, May 3-4, 2014. Over

90 medical students attended a full day of psychiatry programming specifically for students. On Sunday, 40 psychiatry residency programs participated in a highly successful Residency Fair. Visit the PsychSIGN website for more information about new PsychSIGN leadership and initiatives for the coming year at www.PsychSIGN.org.

The PsychSIGN leaders are requesting for continued APA financial support of its programs and activities. The Council is in voted to approve this and will forward this request to the JRC.

INTEGRATION WITH PRIMARY CARE EDUCATION INITIATIVE – The Council's main project for this year is the integration with primary care education. The Council held a series of webinars with Drs. Lori Raney (November), Howard Goldman (December), Jürgen Unützer and Anna Ratzliff (in March) to educate and inform the Council members on integrated care education.

In June, the Council is convening a meeting with Specialty Society Education Directors from AAFP, ACP, AAP, ACOG and ACS to discuss what the major societies are doing to prepare their members for integrated medical and behavioral health care. We are particularly interested in GME initiatives, sharing information and exploring possible avenues of collaborative work among the societies.

The next step to this initiative is a report written by members of the Council. It is expected that the first draft of the report will be sent to Dr. Summers before the September 12 meeting. The final report will be released in the fall. The report will likely be published in Academic Psychiatry and section authors may submit articles for the upcoming special edition of AP on Integrated Care edited by Deb Cowley. The outline and section lead writers are as follows:

1) Overview – Art Walaszek (4-6 pages)
    a. Need
    b. New roles for psychiatrists
    c. Role of education in system transformation
    d. Purpose of this document – scan, increase awareness, encouragement, recommendations
2) Training Medical Students and Residents (10 pages)
    a. UME – Benoit Dube, Marcy Verduin (contributors: David Bresler and PsychSIGN leaders, Lisa Mellman)
        i. ADMSEP Survey results and analysis
        ii. ADMSEP Best practices
            1. Rotations/clinical experiences
            2. Didactics/supervision/mentoring
            3. Developmental aspect to learning about collaboration
        iii. Challenges
    b. GME – Deb Cowley, Claudia Reardon (15-20 pages)
        i. AADPRT Survey results and analysis
        ii. AADPRT Best practices
            1. Rotations/clinical experiences
            2. Didactics/supervision/mentoring
            3. Administrative and funding issues
            4. Leadership issues
        iii. Challenges
    c. CME – Deborah Hales (5 pages)
3) Educational Collaborations with Other Specialties, Role of Specialty Societies – Deborah Hales, Rick Summers (4-6 pages)
4) Summary and Recommendations – Rick Summers, Sandra Sexson, John Young (6-8 pages)
    a. General (Including re collaboration with medicine, family practice, pediatrics, etc. on training experiences)
    b. UME
    c. GME

d. CME

Total 50 pages double spaced, approx. 250 words/page – 12,500 words including references/links/attachments/ resource listing.

Collaborations:

1) ADMSEP
2) AADPRT
3) AACAP
4) AAP
5) AACDP
6) American College of Physicians
7) American Association of Family Practice
8) American Association of Pediatrics

Dissemination:

Presentation at meetings:

1) APA AM, IPS, ADMSEP, AADPRT, AAP, AACDP, AACAP, ACP
2) American College of Physicians, American Association of Family Practice, American Association of Pediatrics

Additions ideas and comments from the Council about the project:

- Add sections on RRC, regulatory issues (medicare, payer)
- Add section on methodologies for teaching millennial (longitudinal, student-run free clinics)

DATE AND TIME OF NEXT MEETING – The next face-to-face meeting is scheduled for Friday, September 12, 2014 from 9am to 5pm in Arlington, VA.

ADJOURNMENT – Dr. Summers thanked everyone for their participation and handed out Certificates of Appreciation to outgoing members and fellows of the Council. The meeting was adjourned at 6:00 p.m.

Executive Summary
COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING
Report to the Joint Reference Committee

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.

Joint Symposia at APA Annual Meetings
ACTION: Will the Joint Reference Committee recommend that the Board of Trustees approve to support formal and continued joint symposium with allied organizations at APA Annual Meetings?

AADPRT is formally requesting that a joint symposium continue for future APA Annual Meetings. The Council is in support of this and will formally ask the JRC to support regular joint symposia with allied psychiatric organizations to include subspecialty and education organizations.

Support for PsychSIGN
ACTION: Will the Joint Reference Committee recommend that the Board of Trustees affirm its continued financial support for PsychSIGN?

The PsychSIGN leaders are requesting continued APA support of its programs and activities. The Council is in support of this and will forward this request to the JRC.

American Psychiatric Leadership Fellowship
ACTION: Will the Joint Reference Committee recommend that the Board of Trustees approve reinstatement of the Committee to select and mentor the American Psychiatric Leadership fellows?

When the American Psychiatric Leadership Fellowship lost its industry funding, the selection committee was sunsetted. The Fellowship is now funded by the American Psychiatric Foundation and the former members of the sunsetted selection committee have continued to select and mentor fellows. They now request that the APA President formally appoint members to this now active selection committee.

Waive Copyright Restriction for DSM 5 Criteria
ACTION: Will the Joint Reference Committee recommend that the Board of Trustees approve waiving the DSM5 copyright restrictions for allied, non-profit education organizations for use in non-commoditized teaching/educational resources specifically for medical student education?

ADMSEP has created on-line Clinical Simulation Educational Modules for teaching medical students using DSM 5. These modules are provided free on the ADMSEP website, and are also published on MedEdPortal for use by clerkship directors and medical students for general educational purposes and, in some cases, to meet LCME standards ED-2 and ED-8. For example, a module can provide the opportunity for a student unable to see a key condition in a clinical setting to learn about the condition and, therefore, meet clerkship requirements. The modules reference DSM5. However, the fee that APA requires for use of DSM criteria is not affordable for ADMSEP (a non-profit allied education organization). There is no monetary gain to anyone from these modules. There is not charge for their use and they were developed with the sole goal of improving psychiatric medical student education.

INFORMATION ITEMS

Integration with Primary Care Education Initiative

The Council's main project for this year is education for integration with primary care. The Council held a series of webinars with Drs. Lori Raney (November), Howard Goldman (December), Jürgen Unützer and Anna Ratzliff (in March) to educate and inform the Council members on integrated care education.

In June, the Council is convening a meeting with Specialty Society Education Directors from AAFP, ACP, AAP, ACOG and ACS to discuss what the major societies are doing to prepare their members for integrated medical and behavioral health care. We are particularly interested in GME initiatives, sharing information and exploring possible avenues of collaborative work among the societies.

The next step to this initiative is a report written by members of the Council. It is expected that the first draft of the report will be sent to Dr. Summers before the September 12 meeting. The report, which we hope to release in the fall, will include sections on training medical students and residents (survey analysis, best practices and challenges) continuing medical education, and educational collaborations with other specialties. It will conclude with specific recommendations.

APA's CME and MOC Programs

Understanding the Evidence: Off Label Use of Atypical Antipsychotic Medication

The Agency for Healthcare Research and Quality (AHRQ) has awarded the APA a grant (#5R18HS021944) to create and offer physicians a FREE CME program to educate them about evidence for effectiveness of atypical (second generation) antipsychotics, reviewed in the 2011 AHRQ Report as well as newer evidence. The goal of the program is to help physicians make informed treatment decisions when using these medications "off label". This interactive CME program begins with a Self-Assessment test and in the months that follow a series of multimedia clinical modules will be available for CME credit. The self-assessment test is available at www.apaeducation.org.

Focus: Journal of Lifelong Learning in Psychiatry

The FOCUS program: the Journal, the annual self-assessment, Performance in Practice Chart Review Modules and eFOCUS clinical vignettes, as well as FOCUS books, help psychiatrists fulfill Maintenance of Certification (MOC) Requirements, stay up to date, and participate in a program of lifelong learning. APA members contribute as authors, peer reviewers, consultants, and question writers. In 2014 FOCUS issues include Disorders of Sleep; Psychopharmacology: Evidence and Treatments; Psychotherapies; and Eating Disorders. FOCUS covers topics in psychiatry in four years.

APAeducation.org – APA Online CME

The Division of Education delivers online Continuing Medical Education (CME) courses, CME tests, and certificates, and maintains member transcript data. In 2013-2014 the Division introduced a variety of new courses on www.apaeducation.org:

- Annual Meeting Self-Assessment – Free MOC Part 2 activity for annual meeting registrants.
- DSM-5: What You Need to Know – (credit for multiple disciplines, also distributed through VA.
- Evaluation and Management Coding for Psychiatrists (2013 new codes)
- Patient Safety – coming in 2014
- Primary Care Updates for Psychiatrists
- Professionalism and the Internet
- Cognitive Therapy and Psychodynamic Therapy: More Alike Than Different? A Conversation Between Aaron Beck and Glen Gabbard
- eFocus Clinical Modules: “An Unhappy Man” and “Imaginary Friends”

District Branch CME Programs

In 2013-2014 the APA Department of CME provided credit to District Branch (DB) members of the Subcommittee on Joint Sponsorship for over 100 meetings. 22 District Branches receive CME credit from APA. Many of the DB meetings covered DSM-5 and changes to CPT coding.

Maintenance of Certification for Physician Assistants (PA)

In 2014, PAs will transition to a certification maintenance process. PAs must earn 20 Category 1 credits of performance improvement CME (PI-CME) and/or self-assessment CME every two years. Acceptable activities are certified for American Academy of Physician Assistants (AAPA) Category 1 PI-CME Credit or AAPA Category 1 Self-assessment CME Credit. The AAPA has certified APA’s Performance in Practice chart review Modules, and the FOCUS Self-Assessment as meeting MOC requirements for this group.

Council on Addiction Psychiatry Webinars

As part of the Physicians’ Clinical Support System-Medication Assisted Therapies (PCSS-MAT), the APA offers a series of 16 live and archived webinars offering CME credit. The topics and presenters are identified through: (1) suggestions of PCSS-MAT clinical directors and staff, (2) a summary of topics discussed on SAMHSA’s moderated Web Board for waivered physicians, (3) suggestions of members of APA’s Council on

Addiction Psychiatry, and (4) questions and concerns expressed by buprenorphine waivered physicians.

APA's Performance in Practice clinical modules approved by ABPN (MOC Part 4 Clinical Modules)

- Physician Assessment Module for the Screening of Adults with Substance Use Disorder: Feb 2011 - Feb 2017
- Physician Assessment Module for the Assessment and Treatment of Adults with Substance Use Disorder: Feb 2011 - Feb 2017
- Performance in Practice: Physician Assessment Tool for the Care of Adults with Schizophrenia: June 2012 - June 2015
- Physician Practice Assessment Tool for the Assessment and Treatment of Adults at Risk for Suicide and Suicide-Related Behaviors: March 2011 - March 2017
- Clinical Module for the Care of Patients with Major Depressive Disorder: July 2012 - July 2015
- Performance in Practice: Clinical Module for the Care of Patients with Posttraumatic Stress Disorder Aug 2013 - Aug 2016

2014 APA Annual Meeting: Master Course 5: Psychopharmacology:

- MOC Activities Related to the Course
- PIP: Measures for Use of Selected Antidepressant Medications
- PIP: Measures for Use of Second Generation Antipsychotics Medications
- PIP: Measures for Use of Lithium/Anticonvulsant Mood Stabilizing Medications
- PIP: Measures for Use of Benzodiazepine Medications

The Council on Medical Education formally commends the efforts and initiatives of the APA Department of CME specifically Dr. Deborah Hales and Kristen Moeller to create products and programs that assist APA members to meet their requirements.

REFERRAL UPDATES

ASMNOV1312.I
Development of Patient Log Templates in the Context of Milestones
A patient log template has been developed and will soon be posted on the APA website. The Division of Education will disseminate the template to the residency training program and encourage their use.

ATTACHMENTS:

1. Form to Propose an APA Committee
2. Meeting Minutes, May 5, 2014

Executive Summary
Council on Minority Mental Health and Health Disparities

Council Overview

The Council has the responsibility for the representation of and advocacy for both minority and underserved populations and psychiatrists from minority and underrepresented groups. The Council seeks to reduce mental health disparities in clinical services and research, which disproportionately affect women and minority populations. The Council aims to increase awareness and understanding of cultural diversity and to foster the development of attitudes, knowledge, and skills in the areas of cultural competence through consultation, education, and advocacy within both the APA and the field of psychiatry and public policy. The Council aims to promote the recruitment into the profession and into the APA and retention/leadership development of psychiatrists from minority and underrepresented groups both within the profession and in the APA.

Action Items

1. **Will the Joint Reference Committee forward to the Board Executive Committee and the CEO/Medical Director the Council's urgent action item concerning the search process for the Director of the APA Division of Diversity and Health Equity, presented in Attachment 1, p. 6?**

2. **Will Joint Reference Committee recommend to the Chief Operating Officer that the main page of the APA website contain Diversity as navigation item as illustrated in Attachment 2, p. 8?**

Referrals

1. *Development of a resource document on human trafficking (ASMMAY1312.Q).* A draft of the document is currently in review by work group members. Feedback from interested persons on the Council on Children, Adolescents, and Their Families and Council on Psychiatry and Law, as well as other content experts is being sought at this time. The final document is expected to be submitted to Council by September.

2. The Development of a Resource Document on Rape (ASMNOV1212.U). In progress. The work group is currently being reconstituted.

   Ludmila De Faria, MD, is the chairperson of the work groups which are working on these projects.

Information Items

1. A report of the Council Subcommittee on Training on Cultural Issues in DSM-5, chaired by Dr. Francis Lu, is presented in Attachment 3, p. 9.

2. Council supports reestablishment of the Committee on Jails and Prisons given the significant disparities in incarceration rates and its impact on MUR communities.

Council Minority Mental Health and Health Disparities
Minutes
May 5, 2014, 8:00 am – 11:00 am
New York, NY

Members Present: Drs. Sandra Walker (chair), Ken Sakauye, Christina Mangurian, Jose Vito, Anand Pandya, Michelle Reid, Beverly Du, Ludmilla De Faria
Guests: Drs. Paul Summergrad, Henry Weinstein, Carole Warshaw, William Lawson, Gail Robinson
Staff: Dr. Annelle Primm, Alison Bondurant, Matt Sturm
Resident Fellows: Drs. Enrico Castillo, Rowena Mercado, Auralyd Padilla, Frank Clark, Paula Smith
Members Excused: Drs. Marie Claude Rigaud, Dan Martinez, Dinesh Mittal, Nyapati Rao, Francis Lu

Opening. Meeting attendees introduced themselves. Dr. Walker noted that a few Council members could not attend as their workshops conflict with Council meeting.

Visit by Dr. Summergrad. Council shared with Dr. Summergrad its concern that there be Council and Assembly MUR Committee input into the development of the job description and selection process for the new Director of the APA Division of Diversity and Health Equity. Dr. Summergrad cautioned that APA personnel matters are the responsibility of the CEO/Medical Director not the Board, but that the Council's interest in the selection process and outcome is legitimate. He continued that diversity is extremely important to him and that everyone must meet on a ground of respect and human dignity in ALL of our interactions.

Identifying the New Director of the Division of Diversity and Health Equity. Dr. Walker reviewed a proposed action item concerning the search process for the Director of the Division of Diversity and Health Equity, explaining that it is was brought forward in order to facilitate involvement of APA member groups that work closely and collaboratively with the Division. Recognizing the importance of the position to MUR groups and members and reflecting on Dr. Summergrad's feedback, the Council convened an Ad Hoc Work Group to reword the Action Item to more clearly reflect understanding of both fiduciary responsibilities and member concerns The revised action is presented in Attachment 1.

> **Will the Joint Reference Committee forward to the Board Executive Committee and the CEO/Medical Director the Council's urgent action item concerning the search process for the Director of the APA Division of Diversity and Health Equity?**

Dr. Walker suggested to Dr, Primm, and later to Dr. Levin, who was unable to attend the Council meeting, that it would be helpful to inform members of recruitment process. The Council was

subsequently alerted to Dr. Levin's interest in receiving names of potential applicants for the position and important questions for applicants to be posed during the interview process.

Report of the Board/Assembly Work Group on MUR Issues. Drs. Walker and Robinson highlighted the recommendations to enhance diversity and representation in APA enumerated in the work group report. It was noted that MUR caucus leaders were consulted in that process but not Council. Council expressed interested in reviewing these recommendations. Dr. Robinson urged Council members to send her names of good people who can be considered for appointment to components or nomination for APA office.

Dr. De Faria mentioned that the Assembly MUR Committee thought the report recommendations were too lofty and took issue with the concept that the Board MUR Trustee is not meant to be the voice for minority interests but is in fact a fiduciary position.

Carole Warshaw, MD. Dr. Warshaw, Director of the National Center on Domestic Violence, Trauma and Mental Health (Detroit), described what her agency is doing around culturally appropriate approaches to address domestic violence and trauma. Drs. Castillo, Pandya and Du exchanged business cards with Dr. Warshaw and expressed interest in pursuing collaborations with her on these topics. Dr. De Faria saw this as an opportunity to involve Dr. Warshaw in the rape and human trafficking document projects. Dr. Walker asked Council to develop a symposium on cultural issues in domestic violence and trauma; Dr. Robinson will propose likewise to the Assembly MUR Committee.

Cultural psychiatry clearinghouse. Dr. Sakauye reiterated that the clearinghouse will be a repository of resources for teaching cultural psychiatry and not simply a home for random material; individuals in the field will SUBMIT helpful teaching resources only. A challenge, he admitted, will be obtaining permissions to use proprietary information, as will developing a screening process.

There was agreement among Council that building and maintaining the database is time consuming, and concern was expressed about the staffing requirements – paid or volunteer (e.g. residents). The goal is to build in a function that allows site users to rate material after reading, which will allow for hands-off and ongoing assessment. Ms. Bondurant suggested that APA's new website coordinator be consulted for general insights.

Dr. Sakauye will forward the URL for the Dropbox folder that APA staff Deborah Cohen created for the project. He urged all present to contribute content as many more submissions are needed.

Increasing visibility of diversity on APA website. Dr. Sakauye observed that diversity materials are difficult to find on the APA website even if one knows what they want. After discussion, Council members agreed with his recommendation that diversity needs better visibility on the APA website and resolved to ask:

Will Joint Reference Committee recommend to the Chief Operating Officer that the main page of the APA website contain Diversity as navigation item as illustrated in Attachment 2?

Disparities in mental health care in the criminal justice system. Henry Weinstein, MD, shared a glimpse of the daunting disparities and general challenges in mental health care in the over 5,000 corrections facilities in the country. He reported that an action paper is being considered to resurrect the Committee on Jails and Prisons and asked for Council's support. Council agreed and resolved to relay to JRC it support for the reestablishment of the Committee on Jails and Prisons given the significant disparities in incarceration rates and its impact on MUR communities.

Work groups on resource documents on human trafficking and rape. Dr. De Faria, chairperson of these workgroups, reported that a draft of human trafficking document is currently being reviewed and edited by work group members. Feedback from interested members from the Council on Children and Council on Psychiatry/Law is being sought at this time. The resource document on rape is in process. In September Council will consider if these materials will inspire position statements or action items.

Division of Government Relations (DGR). Mr. Sturm informed Council that the division continues to diligently advocate for funding for the federally funded Minority Fellowship Program and Spurlock Congressional Fellowship, noting that this year's Congressional Fellow is Dr. Ellen Johnson. He announced that APA Advocacy Day will be in early 2015 and that DGR is rethinking how members are selected for Advocacy Day. The Council expressed interest in seeing greater representation of MUR members in Advocacy Day activities. He distributed copies of APA's Advocacy Accomplishments and passed out his business card.

Increasing diversity in clinical trials. Dr. Lawson reminded Council of the gross underrepresentation of diversity in clinical trials, as he described a recent launch of PhRMa's and the National Minority Quality Forum's campaign to increase diversity in clinical trials. Dr. Primm added that insufficient participation is a problem overall and not just among ethnic groups. She suggested that Council unite with the Council on Research to explore initiatives to address this issue, adding that Dr. Narrow, Acting Director of the Division of Research, is interested. She also noted that it was Dr. Levin who encouraged APA's presence at the campaign launch. Dr. Walker opted to follow up with the Chair of the Council on Research, and Dr. Lawson offered his support.

Report of the Division of Diversity and Health Equity (DDHE). Dr. Primm passed out a written summary of division activities. She enthusiastically reported that the division's disparities education programs (formerly known as OMNA on Tour) are enjoying vigorous turnouts, including the program held on Saturday evening which focused on Latinos in mental health research. The IMG Summit held two days earlier featured Dr. Darrell Kirch, AAMC CEO,

as keynote speaker along with other workforce experts; summit proceedings and policy recommendations stemming from the summit will be prepared. Dr. Primm also announced that APA's first ever Diversity Mental Health Awareness Month is launching at this Annual Meeting and a toolkit of related resources are available at the division's booth in the Member Center. Ms. Bondurant verbalized the toolkit's online location http://www.psych.org/diversity-month.

Next meeting. Council members agreed to meet during the Components Meetings in Arlington for half day on Friday, September 12, and all day on Saturday, September 13.

ATTACHMENT 1

From: Council on Minority Mental Health and Health Disparities (the Council)
To: Joint Reference Committee
Re: Urgent Action Concerning the Search Process for Director of the Division of Diversity and Health Equity (DDHE)
Date: May 6, 2014

Will the JRC forward to the Board Executive Committee and the CEO/Medical Director the following Action Item:

- Given that the current Director of the DDHE will be stepping down from the position with the CEO/Medical Director choosing a replacement in the near future.

- Given that this position and the DDHE are critical to the work of the APA in the areas relevant to working with the MUR psychiatrist groups (which is a substantial number of APA members), caring for underserved patient populations, advancing cultural and linguistic competence, and reducing mental health disparities.

- Given that this position in the APA Central Office must work collaboratively with the Board of Trustees, the Assembly, the Components, and APA members to function effectively in carrying out APA's responsibilities relevant to working with the MUR psychiatrist groups, caring for underserved patient populations, advancing cultural and linguistic competence, and reducing mental health disparities

- Given that it would be essential to the search process especially for this position as Director of the DDHE to have a clearly defined and transparent search process to ensure APA is an equal employment opportunity employer, which is an important value to many APA members.

Therefore, the Council strongly recommends the search process for the Director of the DDHE include the following steps:

1. Appointment of a search committee to include the MUR Trustee, the Chair of the Council on Minority Mental Health and Health Disparities, and the Chair of the Assembly MUR Committee among others.
2. Presentation of search committee recommendations to the CEO/Medical Director in an advisory capacity for his final decision.
3. Collaboration between the search committee and the APA Human Resources (HR) department to ensure that the search process adhere to equal employment opportunity and other HR policies of APA.
4. Review of and input by the search committee into the job description that includes both defined responsibilities and necessary and desired qualifications at the start of the search process.
5. Responsibilities of the search committee include:
   a. Ensuring wide advertising and conducting active outreach to increase the candidate pool.

b. Reviewing the applicants' CVs, letters of recommendation, and other information to decide whom to interview.
c. Inviting certain applicants for initial and follow up interviews.
d. Participating in the interview of applicants and providing feedback about the extent to which the person meets the necessary and desired qualifications stated in the job description.
e. Deliberating to make recommendations in an advisory capacity to the CEO/Medical Director for his final decision.

EXPRESSIONS OF SUPPORT FOR THE ACTION ITEM

I support the action item proposed by the Council on Minority Health and Health Disparities re the manner of selection of the new director of the Division of Diversity and Health Equity.
Gail Erlick Robinson MD, DPsych,FRCPC, O.Ont.
MUR Board Trustee

I strongly support the Council on Minority paper concerning the search committee to fill out the position for Director of DDHE. The DDHE is critical to promoting diversity within the APA and better understanding of minority and under-represented patient populations, advancing cultural and linguistic competence, and reducing mental health disparities. Under the current director, the DDHE works closely with the Council on Minority and the M/UR Committee to advance these goals. Therefore, the M/UR Committee believes that participation in the search process would ensure smooth transition and strong ongoing work relationship.
Respectfully,
Ludmila De Faria, M.D.
Chair, Assembly M/UR Committee

I support the action item.
Maureen Sayres Van Niel, MD, Deputy Rep, Women's Caucus

I strongly support the action item being submitted by Dr. Sandra Walker and the Council on Minority and Health Disparities to include the Assembly MUR Committee in the search for a new Director of the Division of Diversity and Health Equity. This is an extremely important position that is critical in not only promoting diversity within the APA and its leadership but also promoting improved mental health care among minority and under-represented populations. In order to achieve these goals, the director of this division will be working closely with the Council and the MUR Committee and I believe we can offer invaluable insight and advice during the search process which will lead to a smooth transition and a continued strong working relationship with the new director.
Philip A. Bialer
Representative, Caucus of Lesbian, Gay, and Bisexual Psychiatrists

ATTACHMENT 2

Proposal to increase visibility of diversity issues in the APA Website

Diversity references and materials seem scattered on the APA website and many feel items are difficult to find even if one knows what they want. The website needs better visibility and emphasize the importance that the APA has placed on these issues to provide help to the membership in understanding and addressing regulatory agency mandates (especially JCAHO, ABPN, LCME), and foster education on these topics. The Council on Minority Mental Health and Health Disparities authorized the formation of a Cultural Psychiatry Clearinghouse which will need to be a visible aspect of the APA diversity resources.

Action Item:

Will the JRC recommend to the Chief Operating Officer that main page of the APA website contain Diversity as a navigation item (example below)?

Navigation bar – Add "Diversity" as a tab

Content for "Diversity" topic needs to be defined, but could include –

- **Div. of Diversity & Health Equity**
- **Cultural Psychiatry Toolbox (=Cultural psychiatry curricula / clearing house references)**
- **Immigrant Issues**
- **GLBT Issues**

Attachment 3

To: JRC

From: Council on Minority Mental Health and Health Disparities

Date: May 15, 2014

Re: Report of the Council Subcommittee on Training on Cultural Issues in DSM-5

This Subcommittee was established in the Fall of 2013 with charged with creating and disseminating training materials on the cultural issues in DSM-5.

It was chaired by Francis Lu. Below is the original Task List/Timeline with updates in bold.

Task List/ Timeline:

1. Understand the cultural issues in DSM-5. **A 36-page PDF of materials from the DSM-5 was created and will be posted at the DDHE website**.

Section I: Basics: In the Introduction on pages 14 and 15, there are sections on "Cultural Issues" and "Gender Differences." This is good place to start for a concise overview.

Section II: Diagnostic Criteria and Codes: As can be found in the index on pages 923 to 924, some of the disorders have in their narrative descriptions sections on "Culture-Related Diagnostic Issues" and

"Gender-Related Diagnostic Issues." The index is a wonderful tool to rapidly assess this information. Secondly, some of the diagnostic criteria have incorporated cultural issues as well.

Section III: Emerging Measures and Models: A Cultural Formulation section appears from pages 749 to 759. First, there is an enhanced and revised Outline for Cultural Formulation from the DSM-IV that is an important tool for every clinical case formulation. For example, the first part on cultural identity is much more fully described, and the second part has the more inclusive title of "Cultural conceptions of distress." Secondly, the Cultural Formulation Interview provides a detailed guide to interviewers in how to obtain information relevant to the Outline for Cultural Formulation. There is a second version for interviewing informants. Finally, there is a description

of "Cultural Concepts of Distress" that replaces the DSM-IV Glossary of Culture-Bound Syndromes.

2. Liaison with Roberto Lewis-Fernandez (RLF) and colleagues to develop PowerPoint sets of varying lengths and scope. RLF and colleagues have presented extensively at the 2013 APA Annual Meeting and are coordinating the international field trials on the CFI. **A PowerPoint set was created and will be posted on the DDHE website. It was also presented at the Annual Meeting of AADPRT (see below). A second PowerPoint set focusing on the Cultural Formulation Interview was created by Stacia Mills, PGY-3 resident at USC (see below).**

3. Develop and disseminate additional materials that support training for the various target audiences (see below) on cultural issues in DSM-5 in conjunction with others. **See below.**

4. Advocate that APA-sponsored DSM-5 trainings include cultural issues. These include the Annual Meeting Master Course, Online course, District Branch trainings, etc. **This task remains to be done.**

5. Advocate that APPI-sponsored publications on DSM-5 include cultural issues. Clinical Manual of Cultural Psychiatry, 2nd edition, edited by Russell Lim is coming out May 2014. **The book will be published in August 2014 and focuses on the cultural issues in DSM-5. In addition, an APPI book on the Cultural Formulation Interview with Roberto Lewis-Fernandez as lead editor will be published in 2015.**

6. Advocate that CFI and other cultural issues documents be made accessible online. **The CFI is available online and require no permission from APA to use.**
http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Cultural

7. Prioritize training target audiences and develop dissemination strategies

a. Medical students: ADMSEP. **Don Hilty will lead a workshop at the 2014 ADMSEP meeting on the biopsychosociocultural model where the cultural issues in DSM-5 will be discussed.**

b. Psychiatry residents:

1. AADPRT Annual Meeting in March, 2014 (submission deadline Oct 25) **A workshop on the cultural issues in DSM-5 was accepted and presented by Francis Lu, Russell Lim, and Stacia Mills.**

2. Fellows on the Council could use materials at their own programs. Also, other Minority Fellows on other Councils.

The materials have been used at USC and Baylor for residency training. Stacia Mills presented the results at USC at the AADPRT workshop and will submitted to the journal Academic Psychiatry. At Baylor, Beverly Du used materials to present a lecture on "Disparities in Mental Health Care" to PGY2 residents. The residents rated it 4.95

out of 5 and thought it was quite useful, since it was the first time they had seen a lot of the material. Ali Asghar-Ali had two sessions on cultural formulation. The first session introduced the topic of cultural formulation and reviewed the CFI. It was rated 4.95/5 on the overall ratings. In the second session the presenters and the residents in attendance provided a snapshot of their own cultural identity. For the first time, some residents also shared photos of themselves and their families!

3. Resources for psychiatry training programs online

4. "How to utilize CFI in ongoing supervision of videos of resident-patient interactions"

5. "How cultural issues in DSM-5 tie in with other aspects of cultural psychiatry training"

6. ACGME Milestones document to be published in Jan 2014, effective July 2014: cultural issues. **Francis Lu presented on how the utilizing the Cultural Formulation Interview in DSM-5 could help residents achieve Milestones at the AADPRT workshop**.

c. Subspecialty Fellowship trainees

d. Psychiatrists in practice

e. Primary care MDs and other medical home workers

8. Evaluation of training materials to further refine training materials

9. Research re CFI

TO: JRC and Assembly

FROM: Council on Psychiatry and the Law

RE: APA Position Statement and Resource Documents related to firearms

Date: May 12, 2014

Proposal Rationale

At the Request of the Board of Trustees, the Council on Psychiatry and the Law reviewed the existing array of position statements and resource documents related to firearms and mental illness to determine which to sunset, consolidate, and/or update. Based on this review, the Council on Psychiatry and the Law proposes that the attached Position Statement and Resource Document be adopted and the following APA documents be retired.

- 1993 Position Statement on Homicide Prevention and Gun Control
- 2001 Position Statement on Doctors against Handgun Violence
- 2009 Resource Document: Access to Firearms by People with Mental Illness
- 2011 Position Statement on Proposed Legislation Permitting Guns on College and University Campuses
- 2012 Position Statement on Firearms Access: Inquiries in Clinical Settings
- 2013 Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services
- 2013 Resource Document on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services

The rationale is two-fold.

First, we believe that it is important to consolidate the several documents into a single Position Statement and Resource Document for ease of access and understanding. Currently someone looking to understand the APA's position on firearm issues would have to consult the several documents above. Simplification will improve the APA's communication of its views to members, policy makers, and other interested parties. The attached draft Position Statement and Resource Document attempt to achieve that consolidation. They take the prior documents and

place the same themes and positions together into one Position Statement and one Resource Document, and eliminate references to terms/issues that are obsolete.

Second, the landscape surrounding firearms and mental illness continues to evolve. As new issues emerge, it is important that the APA develop clear positions. The following section identifies new areas addressed by the proposed documents.

New Areas Addressed

Although the documents are primarily a consolidation of existing documents, the attached updated Position Statement and Resource Document addresses the following two areas, above and beyond what was included in the prior documents:

- States have moved to expand the grounds for restricting gun ownership to new groups of individuals with mental disorders. Some statutes disqualify individuals from gun ownership based merely on diagnosis, seeking voluntary care, or temporary detention for evaluation of need for commitment. The APA takes a stand against these developments.

- Under the NICS Improvement Act adopted in 2007, one of the conditions for states to receive federal grants for improving the National Instant Background Check System is that they establish procedures allowing individuals disqualified from firearm purchase based on their mental health histories to seek restoration of their rights. In this document, the APA recommends that states adopt a fair restoration process requiring a decision by a court or administrative authority based on an adequate clinical assessment.

These documents have been drafted and reviewed by the Council. In addition, the JRC reviewed the documents carefully and provided a number of suggestions that have been incorporated into the current versions.

DRAFT May 12, 2014

Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services

The American Psychiatric Association recognizes the critical public health need for action to promote safe communities and reduce morbidity and mortality due to firearm-related violence. Specifically, the APA supports the following principles and positions:

1. Many deaths and injuries from gun violence can be prevented through national and state legislative and regulatory measures. Recognizing that the vast majority of gun violence is not attributable to mental illness, the APA views the broader problem of firearm-related injury as a public health issue and supports interventions that reduce the risk of such harm. Actions to minimize firearm injuries and violence should include:

    a. Requiring background checks and waiting periods on all gun sales or transactions;
    b. Requiring safe storage of all firearms in the home, office or other places of daily assembly;
    c. Regulating the characteristics of firearms to promote safe use for lawful purposes and to reduce the likelihood that they can be fired by anyone other than the owner without the owner's consent;
    d. Limiting access to semi-automatic firearms, high capacity magazines and high velocity ammunition to law enforcement and security personnel as required by their duties;
    e. Banning possession of firearms on the grounds of colleges, hospitals, and similar institutions by anyone other than law enforcement and security personnel; and
    f. Assuring that physicians and other health care professionals are free to make clinically appropriate inquiries of patients and others about possession of and access to firearms and take necessary steps to reduce the risk of loss of life by suicide, homicide, and accidental injury.

2. Reasonable restrictions on gun access are appropriate, but such restrictions should not be based solely on a diagnosis of mental disorder. Diagnostic categories vary widely in the kinds of symptoms, impairments, and disabilities found in affected individuals. Even within a given diagnosis, there is considerable heterogeneity of symptoms and impairments. Only a small proportion of individuals with a mental disorder pose a risk of harm to themselves or others. The APA supports banning access to guns for persons whose conduct indicates that they present a heightened risk of violence to themselves or others, whether or not they have been diagnosed with a mental disorder.

3. Research and training on the causes of firearm violence and its effective control, including risk assessment and management, should be a national priority.

    a. Administrative, regulatory and/or legislative barriers to federal support for violence research, including research on firearms violence and deaths, should be removed.

b. Given the difficulty in accurately identifying those persons likely to commit acts of violence, federal resources should be directed toward the development and testing of methods that assist in the identification of individuals at heightened risk of committing violence against themselves or others with firearms.
c. The federal government should develop and fund a national database of firearm injuries. This database should include information about all homicides, suicides, and unintentional deaths and injuries, categorized by specific weapon type, as well as information about the individuals involved (absent personal identifiers), geographic location, circumstances, point of purchase, date and other policy-relevant information.
d. Funding for research on firearm injuries and deaths should draw on a broad range of public and private resources and support, such as the Centers for Disease Control, the National Institutes of Health, and the National Science Foundation.
e. All physicians and other health professionals should continue to be trained to assess and respond to those individuals who may be at heightened risk for violence or suicide. Such training should include education about speaking with patients about firearm access and safety. Appropriate federal, state, and local resources should be allocated for training of these professionals. Resources should be increased for safety education programs related to responsible use and storage of firearms.

4. Improved identification and access to care for persons with mental disorders may reduce the risk of suicide and violence involving firearms for persons with tendencies toward those behaviors. However, because of the small percentage of violence overall attributable to mental disorders (estimated at 3-5% in the U.S., excluding substance use disorders), it will have only a limited impact on overall rates of violence.

    a. Early identification and treatment of mental disorders, including school-based screening, should be prioritized in national and local agendas, along with other efforts to augment prevention strategies, reduce the stigma of seeking or obtaining mental health treatment, and diminish the consequences of untreated mental disorders.
    b. For those people with mental illness who may pose an increased risk of harm to themselves or other people, barriers to accessing appropriate treatment should be removed. Access to care and associated resources to enhance community follow up, which includes care and resources to address mental disorders, including substance use disorders, should be maximized to ensure that patients who may need to transition between service providers or settings, e.g., from an inpatient setting to community-based treatment, continue to obtain treatment and are not lost to care.
    c. Because privacy in mental health treatment is essential to encourage persons in need of treatment to seek care, laws designed to limit firearm possession that mandate reporting to law enforcement officials by psychiatrists and other mental health professionals of all patients who raise concerns about danger to themselves or others are likely to be counterproductive and should not be adopted. In contrast to long-standing rules allowing mental health professionals flexibility in acting to protect identifiable potential victims of patient violence, these statutes intrude into the clinical relationship and are unlikely to be effective in reducing rates of violence.

d. The President of the United States should consolidate and coordinate current interests in improving mental health care in this country by appointing a Presidential Commission to develop a vision for an integrated system of mental health care for the 21st century.

5. Given that the right to purchase or possess firearms is restricted for specific categories of individuals who are disqualified under federal or state law, the criteria for disqualification should be carefully defined, and should provide for equal protection of the rights of those disqualified. There should be a fair and reasonable process for restoration of firearm rights for those disqualified on such grounds.

   When restrictions are based on federal law, disqualifying events related to mental illness, such as civil commitment or a finding of legal incompetence, are reported to the federal background check database (National Instant Criminal Background Check System, NICS). Some states have expanded the scope of disqualifying events to be reported to NICS to include non-adjudicated events, such as temporary hospital detentions.

   a. Non-adjudicated events should not serve as sufficient grounds for a disqualification from gun ownership and should not be reported to the NICS system. The adjudicatory process provides important protections that ensure the accuracy of determinations (such as dangerousness-based civil commitment), including the right to representation and the right to call and cross-examine witnesses.
   b. Rational policy with regard to implementation of such restrictions calls for the duration of the restriction to be based on individualized assessment rather than a categorical classification of mental illness or a history of a mental health-related adjudication.
   c. Although the restrictions on access to firearms recommended in items 1 and 2 above would decrease the risk of suicide and violence in the population, extending restrictions to individuals who voluntarily seek mental health care and incorporating their names and mental health histories into a national registry is inadvisable because it could dissuade persons from seeking care and further stigmatize persons with mental disorder.
   d. A person whose right to purchase or possess firearms has been suspended on grounds related to mental disorder should have a fair opportunity to have his or her rights restored in a process that properly balances the person's rights with the need to protect public safety and the person's own well-being. Accordingly, the process for restoring an individual's right to purchase or possess a firearm following a disqualification relating to mental disorder should be based on adequate clinical assessment, with decision-making responsibility ultimately resting with an administrative authority or court.

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APA RESOURCE DOCUMENT

DRAFT

May 12, 2014

Access to Firearms by People with Mental Disorders

Gun violence is a major public health problem in our country. Recent data indicate that 19,392 people used a gun to kill themselves in 2010, and 11,078 killed someone else with a firearm.[1] In 2003, the homicide rate in the United States was seven times higher than the average of other high-income countries[2]. Although concern is understandably heightened when mass tragedies occur, the daily occurrence of scores of murders and suicides due to the use of guns rarely gets the attention afforded mass tragedies. Nevertheless, reports of mass shootings and other serious firearm-related violence, such as the Columbine shootings of 1999, the Virginia Tech shootings in 2007, the Aurora movie theater shooting of 2012, and the Newtown elementary school shooting in 2012, have focused on the perpetrators' alleged mental disturbance or mental disorder. Increasingly negative views of mental disorders have resulted from media coverage of these incidents.[3] Taken together, these tragic incidents have raised growing concern about access to firearms specifically by people with mental disorders. Along with these concerns have come a host of collateral issues that have the potential to expose persons

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[1] Center for Disease Control, 2010 Mortality Multiple Cause Micro-Data Files. Table 10. Number of deaths from 113 selected causes. Enterocolitis due to Clostridium difficile, drug-induced causes, alcohol-induced causes, and injury by firearms, by age. United States, 2010. Accessed at http://www.cdc.gov/nchs/data_access/vitalstatsonline.htm

[2] Richardson EG, Hemenway D: Homicide, suicide, and unintentional firearm mortality: comparing the United States with other high-income countries, 2003. J Trauma 2011; 70:238-243

[3] McGinty EE, Webster DW, Barry CL; Effects of news media messages about mass shooting on attitudes towards persons with serious mental illness and public support for gun control policies. Am J Psychiatry 2013; 170:494–501

with mental disorders to greater stigma based on erroneous views that mental disorder is a primary driver of firearm violence.

To be sure, firearm violence requires greater research and sustained attention by policymakers, regardless of who perpetrated the violence. The American Psychiatric Association (APA) has for many years emphasized the need to decrease overall access to firearms as one means of reducing violence and continues to adhere to this principle.[4] This Resource Document summarizes data on firearm usage and mental disorders and discusses several important issues affecting psychiatrists and their patients: the possible benefits and costs of using registries of excluded gun purchasers, including large numbers of people with mental disorders, as a tool for curtailing firearm-related violence and suicide; gaps in privacy protections of information submitted to firearm registries; and the need for fair procedures for restoring firearms rights to individuals with histories of mental illness whose treatment history and behavior indicate that they are no longer at elevated risk for suicide or violence.

The Relationship Among Mental Disorders, Firearms, Suicide, and Violence

The role of mental disorders in violence is often misunderstood. Mental disorders cover a broad range of conditions and are much more closely linked to suicide than to homicide. Diagnosable mental disorders are present in an overwhelming proportion of people who commit suicide. However, the vast majority of violence in our society is not perpetrated by persons with serious mental disorders. The best available estimates indicate that violent behavior attributable to mental disorder accounts for only 3 to 5% of

[4] American Psychiatric Association, Position Statement Firearm Access, Acts of Violence, and the Relationship to Mental Illness and Mental Health Services (pending approval)

the violence in the United States,[5] and that the rate of violence among people with mental disorders (without co-morbid substance abuse disorders) who have recently been discharged from psychiatric hospitals is about the same as the rate among people who live in the same neighborhoods.[6] Even among this minority of individuals who are violent, only a small percentage of those violent acts (2-3% in a major study) involve guns.[7] Additionally, if one were to look at cycles of violence in their entirety, people with mental disorders are far more likely to be the victims than the perpetrators of acts of violence.[8]

Active substance use substantially increases the risk of violence by anyone, and particularly by persons with mental disorders. Substance use and impulse control disorders may place people at greater risk of threatening violence using firearms.[9] The evidence also shows that the risk of violence among people with major mental disorders is elevated when they have histories of violence, psychopathic traits, and are experiencing violent ideation. Research suggests that individuals with mental disorders engaged in regular treatment are considerably less likely to commit violent acts than those who could benefit from, but are not engaged in, appropriate mental health treatment.[10, 11, 12, 13, 14, 15]

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[5] Swanson JW (1994). Mental disorder, substance abuse, and community violence: An epidemiological approach. In Monahan J and Steadman H (Eds.), *Violence and Mental Disorder*. Chicago: University of Chicago Press, 101-136.

[6] Steadman HJ, Mulvey EP, Monahan J, et al. (1998) Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Arch Gen Psychiatry* 55:393-401.

[7] Personal Communication, John Monahan, April 27, 2014, unpublished data.

[8] Teplin LA, McClelland GM, Abram KM, Weiner DA. Crime victimization in adults with severe mental illness: comparison with the national crime victimization survey. Arch Gen Psychiatry 2005; 62:911-921.

[9] Casiano H, Belik SL, Cox BJ, Waldman JC, Sareen J:: Mental disorder and threats made by noninstitutionalized people with weapons in the national comorbidity survey replication. J Nerv Ment Dis 2008; 196:437-445

[10] Elbogen MS, Van Dorn RA, Swanson JW, Swartz MS, Monahan J: Treatment engagement and violence risk in mental disorders. Br J Psychiatry 2006; 189: 354-360

[11] Monahan J, Steadman HJ, Silver E, Appelbaum PS, Robbins PC, Mulvey EP, Roth LH, Grisso T, Banks S. Rethinking Risk Assessment. New York, Oxford University Press, 2001

Suicide, in contrast to violence toward others, is much more often directly linked to mental disorders, which are major risk factors for suicide. According to the Centers for Disease Control and Prevention's 2010 mortality data[16], just over 51% of suicides were inflicted by firearms, and just over 61% of firearm-related deaths were due to suicide, compared to 35% attributed to homicide. Suicide was the 10th leading cause of death that year and the 3rd leading cause among those aged 15-25. Although data regarding suicide attempts are less comprehensive, suicide attempts vastly outnumber completed suicides. Although many suicide attempts involve firearms, the use of firearms is more likely to lead to a completed suicide than are other means of attempted suicide. These findings raise concerns about firearm access by persons with mental disorders who may be at risk of suicide. Furthermore, given the link between suicide and several mental disorders, it is of great importance that individuals who present an increased risk of suicide have access to appropriate psychiatric treatment.

Registries of Prohibited Purchasers as a Strategy for Preventing Firearm Suicide and Violence: The Issues

[12] Skeem J, Monahan J, Mulvey E: Psychopathy, treatment involvement, and subsequent violence among civil psychiatric patients. Law and Human Behavior 26:577–603, 2002

[13] Swanson JW, Swartz MS, Van Dorn RA, Volavka J, Monahan J, Stroup TS, McEvoy JP, Wagner HR, Elbogen EB, Lieberman JA: Comparison of antipsychotic medication effects on reducing violence in people with schizophrenia. Br J Psychiatry 2008; 193:37-43

[14] Swanson JW, Swartz MS, Elbogen E: Effectiveness of atypical antipsychotic medications in reducing violent behavior among persons with schizophrenia in community-based treatment. Schizophr Bull 2004; 30:3-20

[15] Swanson JW, Swartz MS, Borum RB, Hiday VA, Wagner HR, Burns BJ: Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. Br J Psychiatry 2000; 176: 324-331

[16] Murphy SL, Xu J, Kochanek KD:Deaths: Final Data for 2010. National Vital Statistics Reports 2013: 61(4), May 8, 2013. Available at http://www.cdc.gov/nchs/deaths.htm, accessed 1/28/14.

Current federal law[17] and the laws of several states[18] bar purchase of firearms by certain categories of people, and include among them persons with a number of types of mental health histories, particularly involuntary hospitalization after a formal adjudication or administrative determination. These laws require federally licensed firearms dealers to confirm a person's eligibility for purchasing firearms by running a "check" through the National Instant Criminal Background Check System (NICS). However, as became evident in the wake of the Virginia Tech shootings, most states had not been reporting complete information on relevant mental health histories to the NICS. By enacting the NICS Improvement Amendment Act of 2007,[19] Congress sought to encourage the states to establish registries of persons who by virtue of their mental health histories are ineligible to purchase firearms under federal law. Over the years since this latter Act was passed there have been growing efforts to enhance the usefulness of the NICS database by increasing the number of mental health records reported, and this has also led to a re-examination of the categories of persons that should be disqualified from purchasing firearms and included in the database.

The federal Brady Act disqualifies persons who have been "commit[ed] to a mental institution by a court or other administrative or lawful authority" and those

[17] NICS Improvement Amendment Act of 2007

[18] Bureau of Justice Statistics: Survey of State Procedures Related to Firearms Sales, 2005. NCJ 214645, November 2006

[19] By way of background, the Brady Handgun Violence Prevention Act of 1993 was enacted to provide a five-day waiting period in order to complete a background check of handgun purchasers. In 1998, the National Instant Criminal Background Check System (NICS) provisions replaced the waiting period of the Brady Act, and provided a mechanism for the Federal Bureau of Investigation (FBI) to maintain a database of individuals who could be prohibited from purchasing certain firearms. The NICS Improvement Act of 2007 (H.R. 2640), which was signed into law in January 2008, amends the Brady Handgun Violence Prevention Act in several ways, including a requirement for states to develop and improve automation and transmittal of record information to federal and state record repositories regarding background information of potential firearm purchasers, such as information related to mental health adjudications and commitment records. The law also directs the Attorney General to issue funding grants to assist states in the development of these record repositories and information sharing mechanisms

"adjudicated as mental defective"[20]; the latter category is defined by federal regulation to include persons adjudicated incompetent to manage their affairs in guardianship proceedings, incompetent to stand trial, or not guilty by reason of insanity.[21] Federal regulations also state that the disqualification does not apply to mandatory "observations" or voluntary admissions,[22] suggesting that judicial orders for emergency examination or precautionary hospitalization do not constitute "commitments" for Brady Act purposes. State laws, however, may require reporting of broader categories of persons with mental health histories who are banned from purchasing firearms under state law (but not under federal law). These reporting laws are distinct from so-called "Tarasoff" laws that recognize a duty to protect third parties believed to be at risk from a patient. Some state laws require reporting to a registry of adults who have sought voluntary inpatient psychiatric treatment, as well as persons who were committed as juveniles, and include individuals with intellectual disabilities regardless of mental health histories. [23] Thus, although NICS reporting is limited to a specific list of prohibitory statuses, federal laws do not preclude state laws from expanding the scope of persons included in the national database.

Striking the proper balance between the interest in protecting public health and safety and the individual's interest in owning and carrying a firearm is complex. No one doubts the importance of preventing violence and suicide. Yet, there is little evidence as to whether, and how much, maintaining registries of people with certain mental health

[20] Although the term "mental defective" is used in this document because of its ongoing use in federal law, the term is highly objectionable to the mental health community because it is antiquated and profoundly stigmatizing.
[21] The Brady Act, as well as many state registry statutes, use highly anachronistic and stigmatizing terminology to refer to persons with mental disorders. Even if these laws are retained, they should be amended to use more descriptive and less stigmatizing language.
[22] 27 C.F.R. Section 478.11
[23] Illinois Firearm Concealed Carry Act of 2013 (PA 98-063)

histories contributes to that goal.[24] On one hand, widespread availability of firearms in the United States, and the existence of a large secondary market outside current regulatory control, inevitably limit the effectiveness of a strategy of curtailing firearms purchases by any particular group of people. One might also question whether a comprehensive registry would have prevented any of the mass killings in recent years, and whether the expenditure of the more than one hundred million dollars[25] needed to create and maintain registries for persons with mental health histories could be better spent on broader public-safety targeted interventions that might yield greater overall benefits to society. On the other hand, it is also possible to argue that restrictions on firearms purchase by anyone at elevated risk for violence, including people with particular mental health histories – and the registries maintained to enforce these laws – are warranted if they reduce the chances of even one major incident of mass violence, not to mention reducing the everyday toll from firearm suicides and impulsive killings that often go unnoticed by the media.

Aside from debates about the effectiveness of mental health registries as a strategy for reducing firearm violence and suicide, major questions can also be raised about the fairness of singling out people with a broad range of mental health histories, including episodes that occurred many years ago and conditions that have been

[24] The limited data that are currently available suggest that the reduction in acts of violence (not just gun violence) by people with mental disorders as a result of such registries is quite small. Swanson JW, Robertson AG, Frisman LK, Norko MA, Lin H-J, Swartz MS, Cook PJ. Preventing gun violence involving people with serious mental illness. In Reducing Gun Violence in America: Informing Policy with Evidence and Analysis, edited by Webster DW, Vernick JS, 33-51. Baltimore: The Johns Hopkins University Press, 2013.

[25] Federal Bureau of Investigation. Statement before the Senate Appropriations Committee, Subcommittee on Commerce, Justice, Science, and Related Agencies, Presented by Robert S. Mueller, III, Director, Federal Bureau of Investigation, May 16, 2013, available at http://www.fbi.gov/news/testimony/fbi-budget-request-for-fiscal-year-2014, accessed February 23, 2014. The figure refers to expected federal expenditures and does not include estimated state expenditures.

effectively treated, or a single episode of involuntary hospitalization, as grounds for denying them a right to purchase and carry a firearm, especially in a society in which ownership of firearms is a constitutionally protected right.[26] The problem of over-inclusiveness is compounded when states require reporting of persons who have been hospitalized voluntarily, since many of them will have given no indication of intent to harm themselves or other people.[27] Concerns about discrimination are further heightened when the statutory exclusion is categorical rather than being based on an individualized risk determination.

Questions have also been raised about the possibly counterproductive effects of registries. Persons with treatable mental disorders may delay or avoid obtaining treatment because of concern about adverse consequences should their conditions become known to others or because they are unwilling to forfeit their right to use firearms for legitimate purposes (e.g., hunting), especially in regions of the country where recreational firearm use is deeply embedded in the culture. Although the statutes typically prohibit disclosures of registry information for purposes other than determining eligibility for firearms purchases, persons in need of psychiatric treatment may understandably question the security of the registries and the limitations on the use of the information they contain.

Whatever one's views about the justifiability of using registries of excluded gun purchasers as a strategy for preventing firearms violence, it appears that these approaches have been implemented and expanded over the last five years as federal grants have

[26] *District of Columbia v. Heller*, 554 U.S. ___ (2008)
[27] See, e.g, Illinois Firearm Concealed Carry Act, PA 98-063, amending Firearms Ownership Identification Card Act, 430 ILC 65/1.1.

funded states to improve databases and share information.[28] One promising development has been a recent effort by a consortium of experts in mental health and public health to shift the focus of policy discourse from histories of mental illness, per se, to the occurrence of adjudicated conduct indicative of elevated violence risk, such as conviction for violent misdemeanor or repeated convictions for driving under the influence of alcohol or drugs.[29] Such a shift in firearm access policies would represent a major advance, both legally and empirically.[30]

Making Registries of Prohibited Firearms Purchasers Fairer

In principle, properly tailored mechanisms for restricting firearm purchase by specific persons or groups at significantly elevated risk of violence or suicide are justified from a public safety perspective. Factors that could make registries more useful, and prevent unfair discrimination, include straightforward and well-founded parameters for inclusion, exclusion, removal, and appeal. Two specific needs are carefully designed procedures for removal from the registry and secure protection of registry records so that they are not used for purposes other than preventing access to firearms.

An individual who is legally prohibited from purchasing a firearm due to a mental health adjudication should have a fair opportunity for restoration of the right to

[28] NICS Act Record Improvement Program (NARIP) Awards FY 2009-2013 available at http://www.bjs.gov/index.cfm?ty=tp&tid=491#summaries

[29] Examples of such developments are delineated in The Consortium for Risk-Based Firearm Policy, Firearms, Public Health and Mental Illness: An Evidence-Based Approach for Federal Policy. December 2013, available at http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-gun-policy-and-research/publications/, accessed 2/23/14; and The Consortium for Risk-Based Firearm Policy, Firearms, Public Health and Mental Illness: An Evidence-Based Approach for State Policy. December 2013, available at http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-gun-policy-and-research/publications/, accessed 2/23/14

[30] For example, research demonstrates that people with misdemeanor convictions are at increased risk for future firearm-related crimes. See e.g., Wintemute GJ, Drake CM, Beaumont JJ, Wright MS, Parham CA: Prior misdemeanor convictions as a risk factor for later violent and firearm-related criminal activity among authorized purchasers of handguns. JAMA 1998; 280:2083-2087

purchase a firearm after a suitable waiting period. These time periods should be reflective of the person's need for and participation in recommended psychiatric care. Psychiatric evaluations and testimony should be required when persons seek restoration of their firearm-related rights because psychiatrists can describe and interpret the individual's mental health history and current mental health status, and the effects of treatment and other factors on improvement or exacerbation of the person's condition. However, ultimate decision-making about restoration of the right to purchase a firearm is best suited to administrative (e.g., review panels establish by state agencies) or judicial bodies that can weigh the right to bear arms against the considerations of public safety in making restoration determinations.[31]

Restricting Access to Firearms During a Crisis

The debate regarding creation and maintenance of a national registry as a primary legal tool for keeping firearms out of the hands of people with mental disorders has obscured a potentially useful strategy for reducing firearm violence or suicide -- temporary removal of a firearm from a person's custody during periods of acutely elevated risk.[32] Some states (e.g., California [33]) permit removal of firearms from people during mental health emergencies and restrict access during the period of commitment. Specified clinicians in these states can work with appropriate personnel to facilitate removal of firearms from persons they believe are at significant risk of harm to

[31] Ibid.
[32] States might consider statutes that authorize a permanent removal of firearms in cases when, based on an individualized determination, there is a significant probability that the person's violence-related symptoms will recur based on a prior history of relapse and deterioration. If a state statute authorized permanent removal based on such a finding, firearm purchase presumably would be forbidden as well.
[33] California Welfare and Institutions Code 8100-8108

themselves or others. Indiana and Connecticut[34] allow firearms to be removed from imminently dangerous individuals, whether or not they have mental disorders. Under the Connecticut statute, the state's attorney or two police officers can file a complaint in court whereby temporary seizure of firearms of persons posing risk of imminent personal injury to self or others may be authorized for up to 14 days. After the initial firearm removal period, a court can extend the order for up to a year if it finds, after a hearing, that the danger persists. Under this statute, a history of confinement in a psychiatric hospital is only one factor that the judge may consider, in addition to several non-clinical factors, in evaluating the danger that the person presents.

These firearm removal provisions have some attractive features. First, by focusing on immediate risk, rather than on a person's mental health history, they are more carefully tailored to prevent firearm violence and suicide. The approaches taken in Indiana and Connecticut are particularly commendable because they address dangerousness per se, and discard the mistaken premise that acute violence risk is associated exclusively or primarily with mental disorder; these laws thereby avoid the discrimination inherent in statutes that exclusively target people with mental disorders. Second, they provide clear legal authority for police to remove firearms from possibly dangerous individuals even if no crime has been committed. Third, they clearly establish the legal framework for psychiatrists and other clinicians to inform police of an apparent danger and the accompanying need to remove firearms. Moreover, the authority to initiate such a removal procedure provides a potentially useful source of leverage for psychiatrists and other clinicians trying to convince a patient to yield firearms voluntarily to a family member or other temporary custodian.

[34] Indiana Code 35-47-14-1; Connecticut General Statutes 29-38C

Laws permitting the temporary removal of firearms from individuals believed to be imminently dangerous are sensible from a public policy perspective, and would help psychiatrists respond prudently to genuine threats posed by their patients. However, other important issues must be addressed in drafting statutes related to firearm access, and the California, Connecticut and Indiana approaches differ from one another in relation to the criteria that trigger removal, whether the police may effectuate removal in the absence of a warrant, and whether the procedure is independent of the commitment process and necessarily triggers the reporting requirements of federal law.[35] All these issues merit further study.

Privacy Protections and Firearm-Related Mental Health Registries

As efforts have accelerated to create a more robust database envisioned under the NICS Improvement Amendment Act of 2007, new concerns have emerged about permissible breaches of confidentiality involved in reporting to the NICS or to public safety officials when individuals appear to be at increased risk of harm to themselves or others. For example, if mental health adjudications are to be one of the key disqualifying events reported to the federal databases, automated findings from court proceedings might comprise the minimally necessary information related to an individual. However, laws and regulations have been proposed and enacted requiring private practitioners or other clinical entities to transmit patient information to the database.[36,37] The APA and

[35] If properly crafted, a temporary seizure would not trigger the federal registry provision; reporting would be required only when the removal order is based on a formal finding, after adjudication, that the patient presents a danger to himself or others as a result of mental illness.
[36] Illinois Firearm Concealed Carry Act of 2013 (PA 98-063)
[37] Federal Register, Health and Human Services Department, Proposed Rule of 1/7/14: Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and the National Instant Criminal Background Check System (NICS), available at https://www.federalregister.gov/articles/2014/01/07/2014-

other professional organizations have reviewed federal regulatory initiatives governing information-sharing from providers to NICS data management systems and taken a strong position opposing the imposition of reporting mandates on clinicians and clinical facilities.

In addition, states have enacted legislation that requires mental health professionals to disclose to state officials the name of persons in treatment who are perceived as dangerous, requirements that exceed legal duties in some states to protect potential victims; such reporting may trigger gun removals[38]. These initiatives could undercut the treatment relationship and dissuade patients from seeking treatment and, if they do, from being open about their thoughts and actions. Moreover, such requirements preempt clinical approaches to dealing with the disorders that may underlie impulses to harm oneself or others.

Conclusion

Research focused on the public health aspects of firearms access, including the effectiveness of violence risk reduction interventions, has not been adequately funded in the past. However, a robust program of research on the issues identified in this document will be needed as legislation and policy related to firearms and mental illness continue to evolve.[39] It remains important to bear in mind that the risk of violence and suicide by individuals with mental illness could be reduced more effectively by investing in proven

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00055/health-insurance-portability-and-accountability-act-hipaa-privacy-rule-and-the-national-instant, accessed 2/23/14

[38] Ibid. at 38, and New York Secure Ammunition and Firearms Enforcement Act of 2013

[39] An agenda for research on gun violence is set forth in the Institute of Medicine and National Research Council (2013): Priorities for Research to Reduce the Threat of Firearm-Related Violence. For research recommendations specifically relating to the effects of firearm restrictions on violence by persons with disqualifying mental health histories, see Ibid, 28 above.

methods of prevention as well as treatment for people with mental illness who do not otherwise have access to care. As indicated above, improving access to care, treatment adherence and alleviating the symptoms of severe mental illness can be key factors in decreasing the small portion of community violence that is associated with serious psychiatric disorders. The most effective interventions for reducing risk of injuries that may occur when people experience crises are to provide them with services needed to prevent such crises in the first place and to defuse the crises when they occur. Measures that *increase* recognition, diagnosis, access to care, quality treatment, appropriate follow up, and community understanding of mental illness—and those that *decrease* underfunded and inadequate care, treatment dropout, premature discharge, and social stigma—will ultimately have the greatest yield in terms of reducing violence and suicide and other social costs associated with mental disorders.

Executive Summary
Council on Psychiatry and Law

The Council on Psychiatry and Law has continued its work evaluating legal developments of national significance, proposed legislation, regulations, and other government intervention that affect the practice of psychiatry, including the subspecialty of forensic psychiatry. The full Council met in New York to discuss a wide range of topics (draft minutes attachment #1), including gun control, mental health history and bar applicants, and mandatory outpatient treatment, and sex predator commitment laws, to name a few. The Council also heard reports the Workgroup on Persons with Mental Illness in the Criminal Justice System and an additional workgroup of the Council that was reviewing segregation of prisoners. In addition, the Committee on Judicial Action and the Isaac Ray/Human Rights Award held meetings.

The Council on Psychiatry and Law is bringing forward two documents for the review of the Joint Reference Committee. A detailed memo explaining the proposal rational of the proposed documents is attached. (Attachment #2)

1. **ACTION: Proposed Position Statement on Firearm Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services** (Attachment #3)

   Will the Joint Reference Committee approve the request of the Council to approve the Proposed Position Statement on Firearms Access, Acts of Violence and Relationship to Mental Illness and Mental Health Services?

2. **Action: Proposed APA Resource Document on Access to Firearms by People with Mental Disorders (**Attachment #4**)**

   Will the Joint Reference Committee approve the request of the Council to approve the Proposed Resource Document on Access to Firearms by People with Mental Disorders?

INFORMATION/FOLLOW-UP ITEMS

1. **Council on Psychiatry and Law Workgroup on Segregation of Prisoners with Mental Illness Related to Children and Adolescents**
   The Council on Psychiatry and Law workgroup, chaired by Dr. Charles Scott, continues to work to review the current APA position paper on Segregation of Prisoners (adult) and developing a proposed paper on children and adolescents. The workgroup presented a draft document to the Council in May and was provided further feedback. The workgroup will present a more finalized copy to the Council in September.

Council on Psychiatry and Law
APA Annual Meeting
Tuesday, May 6, 2014, 7:00 pm- 11:00 pm
New York Marriott Marquis
Lyceum/Carnegie, Fifth Floor

Present:

Members: Steven "Ken" Hoge, MD, Chair; Patricia Recupero, MD, JD; Carl E. Fisher, MD (ECP); Debra A. Pinals, MD; Li-Wen "Grace" Lee, MD; Wun Jung Kim, MD; Charles Leon Scott, MD; Joseph Penn, MD; Elizabeth B. Ford, MD; Robert Lee Trestman, MD, Ph.D; **Corresponding Members:** Paul S. Appelbaum, MD; Howard V. Zonana, MD **APA /Leadership Fellow:** Robert Scott Johnson, MD **APA/SAMHSA Fellows:** Marchone Sidor, MD; Tiffiani Bell, MD **Legal Advisor:** Richard Bonnie, JD **Incoming Members:** Stuart Anfang, MD (phone); David Lowenthal, MD**; Guest:** Jenny Boyer, MD, APA Incoming Speaker; Glenn Martin, MD, Incoming Speaker-elect; Harold Ginzburg, MD; Michael Champion, MD, Member, Committee on Judicial Action; Alan Stone, MD, Consultant, Committee on Judicial Action; Marvin Swartz, MD, Committee on Judicial Action; Robert Weinstock, MD; Jeffrey Janofsky, MD; Eugene Lee, MD; Tanuja Gandhi, MD; Reena Kapoor, MD; Ray Raad, MD **APA Staff:** Lori Klinedinst; Jennifer Tassler, JD; Matt Sturm.

I. Approval of the September Council Minutes:

Dr. Hoge presented the minutes from the September component meeting and asked if there were any amendments or changes required. Hearing none, a motion to accept the minutes as amended passed unanimously.

ACTION: The Council on Psychiatry and Law voted to approve the September 2013 minutes as written.

II. Gun Control

Dr. Deborah Pinals opened the discussion by reviewing the background on the gun control issue. She explained that in the wake of the Newtown school shooting and other similar incidents, the Council worked with the Assembly last May to pass a position paper: *Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services.* Since that time, the Council was tasked by the JRC to consolidate and update older APA documents to produce a current, comprehensive statement on gun issues and mental illness. The Council formed a workgroup, chaired by Dr. Pinals. The workgroup reviewed all of the APA documents and with the feedback of the Council, has developed a new proposed position statement, *Position Statement on Firearm Access, Acts of Violence and the Relationship to Mental Illness and Mental Health Services*, and a resource document, *APA Resource Document Access to Firearms by People with Mental Disorders*. The documents were sent to the Joint Reference Committee in April. The Joint Reference Committee provided further edits and asked that the Council solicit feedback from the Assembly in May. The document has been brought to the Council for

further feedback. Dr. Jenny Boyer, incoming Speaker of the Assembly and Dr. Glenn Martin, incoming Speaker-Elect of the Assembly, respectively, joined the Council's discussion on this issue.
Dr. Pinals highlighted some of the key APA concerns around the issue of gun control, namely how the government determines which individuals with mental illness are denied access to guns and how one can have this right reinstated. Currently, the federal laws deny access to those who are "adjudicated as mental defectives." While APA has long standing reservations over the use of the term "mental defective," Dr. Martin also mentioned that the incoming President, Dr. Paul Summergrad, had concerns around the issue of "adjudication." Apparently in different jurisdictions, individuals can be detained or committed involuntarily for reasons related to mental status at the time which may lead to an "adjudication" denying them the right to purchase a firearm. Dr. Boyer pointed out that in some rural areas, people are involuntarily detained simply for transport and could result in the unintended consequence of impinging on their right to bear arms.

Dr. Elizabeth Ford noted that the resource document focuses on schools, but many other mass shootings occurred in large public places and she questioned whether the documents' language should be broadened to include those areas as well. Dr. Pinals stated that that language had come from a JRC edit and could be changed. Dr. Mardoche Sidor brought up the issue of changing the characteristics of the firearm mechanisms to ensure that only the lawful owner can fire the weapon. Mr. Richard Bonnie said that was in reference to personalized weapon technology. Dr. David Lowenthal also brought up the carry and conceal laws and Dr. Howard Zonana discussed a case he was involved with where a student had a carry and conceal permit and brought a gun into school. In that case, the school had a rule about not bringing a weapon into the facility, but there was no state or local law against the act and there were no criminal charges. Dr. Zonana used this to illustrate that there are many levels of differing regulation surrounding gun control and that this can be a very complicated issue. Dr. Hoge concluded this section by encouraging the Council members to send any comments to Dr. Pinals or Lori. He went on to say that there don't seem to be any substantial unresolved issues. The plan is to move the document forward.

III. Human Trafficking

Dr. Wun Jung Kim stated that the work group on human trafficking has never met but they have recently received a draft of a document and will keep the Council updated.

IV. Decriminalization of Marijuana

Mr. Bonnie began the discussion by reviewing the background on the APA stance on the decriminalization and legalization of marijuana. He noted that both Colorado and Washington have passed laws decriminalizing the drug, but that currently only Colorado's law is in effect; Washington is still waiting. Further, the federal government has taken actions and put out statements indicating that they are not taking criminal action against certain drug crimes involving marijuana. While those are the only current actions with regard to recreation marijuana use, there have been several states advancing measures to allow the use of medical marijuana. Mr. Bonnie noted that he believed that this would be a good place for APA to have input and take an active position; however, it is a divisive issue within the membership. The proposed position paper, *Position Statement on the Need to Monitor and Assess the Public Health*

and Safety Consequences of Legalizing Marijuana, was a joint effort between the Council and the Council on Addiction, and was sent to the Assembly at this meeting in May.

Mr. Bonnie outlined some of the main concerns, including the increases in prevalence of use of marijuana, particularly in children and adolescents and the increase in addiction rates. Dr. Zonana pointed out that Dr. Nora Volkow of the NIMH has expressed her strong opposition to the decriminalization based on the brain changes demonstrated in marijuana users and the large increase in use. Dr. Grace Lee also noted that other physician specialty groups such as the American College of Obstetricians and Gynecologists were concerned about use in specific patient populations (i.e. pregnant women) where there is little to no research on the effects of these actions. Dr. Glenn Martin said that the Assembly passed the proposed position statement and that it would go to the Board of Trustees in July for final approval.

V. Mental Health History and Bar Applicants

Dr. Patricia Recupero reviewed the background: a Connecticut law review article about an attorney who was admitted to the bar under supervision and an investigation by the Department of Justice (DOJ) into the Louisiana attorney licensure system pursuant to the Americans with Disabilities Act. The DOJ issued a letter to the Louisiana courts administering attorney licensing regarding the process for determining which candidates are deemed as needing supervision. The character fitness evaluation asks many questions regarding the candidate's mental health history, including whether or not he/she has been diagnosed or treated for bipolar disorder, schizophrenia, paranoia or "any other psychotic disorder." The evaluation also asks about conditions which may have an effect on the candidate's ability to practice law and any treatment the candidate has received for such conditions. DOJ has taken the position that any questions on the application questionnaire which inquire about a candidate's mental or physical health are violations of the ADA and must be removed.

Dr. Recupero, in conjunction with the workgroup, developed a draft resource document for the Council to discuss which would update the current APA resource document from 1999, *APA Resource Document on Recommended Guidelines Concerning Disclosure and Confidentiality.* Dr. Recupero pointed out that her discussion with Mr. Bonnie had revolved around whether it was inappropriate to ask about diagnoses of mental disorders or to focus on the conduct which may indicate unfitness to practice law due to a mental condition. They also talked about what exactly is meant by a "current" time period in this context. The draft resource document follows the DOJ position but Dr. Recupero wanted to specifically discuss two questions: (1) if you ask about past treatment, can the licensing board ask about a clear and definite time period (2 years) or should the board simply not be permitted to ask the question; and (2) should someone who has a past history of mental illness but is now currently stable be subject to a conditional approval, and if so, should the government be required to bear the cost of that supervision.

Dr. Stone began the discussion by inquiring about the American Bar Association's position on this topic and Mr. Bonnie said that he was going to look into but did not know at this time. Dr. Weinstock noted that these types of questions cross over into medicine and Dr. Janofsky talked about the differences between the conditions and those which are likely to relapse. Drs. Bell and Trestman talked about the

singling out of mental disorders, particularly the assumption that any mental disorder would cause impairment, but there are many physical conditions which could cause more serious issues. Dr. Appelbaum raised the issue that he may have a conflict on this issue as he was consulted by DOJ in this case, but that his personal feeling was that it might not be a bad thing to allow inquiry as the resulting supervision could assist those who need help when being admitted to the bar. Dr. Hal Ginzburg, who was joining CPL as a guest, stated that he was involved in reviewing these cases for Louisiana and described some of the cases he worked on. An informal poll of the group revealed that very few members supported the DOJ position that any and all questions violated the ADA, but that several supported questions centering around conduct due to a physical or mental disorder indicating that the candidate needs supervision. Overall, Dr. Hoge commended the draft and asked that Dr. Recupero and Mr. Bonnie refine it based on the discussion, circulate via email and discuss it again at the September Component meeting.

VI. Unsafe and Uncontrolled Access to Mental Health Records Affecting Veterans

Dr. Grace Lee gave the background on the action paper referred to the Council regarding a position statement on patient access to mental health records. The Veterans Administration (VA) has a policy whereby patients of the VA can access their full health record online any time of day and there have been a number of differing perspectives on this issue. There are concerns that there is a grave potential for misunderstanding when a patient reads his record without consulting his physician, in addition to causing rifts in the therapeutic relationship, and revealing confidential third party information. However, Dr. Lee acknowledged that the trend, particularly with electronic medical records is for the patient to have full access to his record and, without the ability to segment data in a meaningful way, it is difficult to ensure that certain information remains private. The draft position paper focuses on alerting the physician to when the patient has accessed his record and to permit inpatients that are acutely ill to only access these records in consultation with his physician.

Dr. Stone began the conversation by noting that this has been the case for some time in Massachusetts where the law states that the patient owns the record and that the Harvard system makes everything available online. Several members, including Drs. Pinals, Boyer and Hoge, pointed out that it's not that the APA should want to prevent access to information, but that access rules should strike a careful balance regarding how the information is delivered. Moreover, the information should be provided with an appropriate amount of explanation to facilitate patient understanding and to promote the therapeutic alliance. Dr. Zonana noted that the trend to allow full access is permanent, but there should be some method to allow physicians to block access to the record through the courts if necessary in limited circumstances, where harm may result from access. Dr. Lee also raised the issue of who has the right to access the medical record, for example, do parents of an adolescent have the right to their child's medical record and what effect will that have on the open doctor-patient relationship? Dr. Lee will take all the comments of the Council back to the workgroup and will have a document for review by the September Components meeting.

VII. Workgroup on Persons with Mental Illness in the Criminal Justice System

Dr. Trestman delivered the update from the workgroup on Persons with Mental Illness in the Criminal Justice System along with the draft report from the group, *Psychiatric Services in Jails and Prisons: A*

Work Group Report of the American Psychiatric Association. He discussed that the focus of the group was to give guidance to mental health professionals working in jails and prisons and to state that the care provided in these settings should meet the standard of what should be provided in the community. The two questions that the group focused on were how to define "serious mental illness" and how to include recommendations on staffing levels for these settings. Dr. Trestman said that they also plan on addressing issues surrounding privacy and confidentiality, but would do so at a later date. Drs. Penn and Champion, who were also very involved in drafting the report, talked about staffing issues and the issues facing some of the psychiatrist working in correctional facilities, particularly surrounding gender identity disorder.

The discussion centered around the definition of "serious mental illness (SMI)" and the ramifications of defining the term in such a document. The definition in the work group report was taken from a list published by SAMHSA and NIMH. Dr. Appelbaum noted that the definition would have legal uses, be used in criminal settings, or by insurance companies, and could not be narrowly construed to apply only to correctional settings. Dr. Trestman acknowledged the potential for extrapolation to other entities, but that without such guidance from the APA, psychiatrists are on their own in these facilities and need more support. Dr. Scott pointed out that the document could attempt to restrict its recommendations to use in correctional settings.

The recommendation on staffing levels was also discussed at length. Dr. Kapoor spoke from her own experience about the difficulties in determining caseload in such settings and Dr. Appelbaum again expressed his concerns that these numbers would be pulled out and applied to other settings like CMHCs. Dr. Schwartz wanted to point out clearly in the document that the staffing recommendations were *minimum* levels, and did not define expectations. Dr. Hoge wrapped up the discussion by commending the draft report so far and emphasized the need to advocate for clinical decision making. He also asked that the work group abstract sections and circulate them to the group for further input on the two key issues.

VIII. Segregation of Prisoners with Mental Illness Related to Children and Adolescents

Dr. Scott presented a draft version of *Position Statement of Juveniles with Mental Illness in Juvenile Detention and Rehabilitation Facilities* to the Council. He noted that, like the workgroup on Persons with Mental Illness in the Criminal Justice System, they struggled with the definition of SMI and elected to use the same list of definitions as the *Coleman* case. Dr. Zonana pointed out that the draft document advocated a position not that different from the existing position statement regarding adult segregation. Dr. Scott agreed but pointed out that the length of time which is deemed appropriate for a child or adolescent was shorter and there are some different diagnoses. Dr. Pinals suggested that they add trauma-related illnesses to the list and that physicians should consider immaturity factors when making these decisions. Dr. Stone expressed concerns that there was no statement about working with the families on these decisions, but Dr. Scott responded that this was not intended as a general treatment document, which would have been too difficult. Dr. Scott will take the Council's comments back to the workgroup for further work and will have an up-dated draft for the September meeting.

IX. Isaac Ray Award

Dr. Hoge informed the Council that the Committee met on Sunday of the Annual Meeting and has a recommendation on the Isaac Ray Award. He also indicated that they have a process for identifying a candidate for the Human Rights Award. Further information will be provided at the September meeting.

X. Report of the Committee on Judicial Action

Dr. Appelbaum, Chair, gave the Council an update on the meeting of the Committee on Judicial Action, which met the prior evening at the Annual Meeting. The first case which the Committee reviewed was *North Carolina Board of Dentistry vs. Federal Trade Commission (FTC)*. The case arises from an antitrust suit against the state Board of Dentistry for interfering with the practice of trade. The Board, comprised of seven dental professionals and one member of the public, sent cease and desist letters to mall kiosks and other outlets which were offering teeth whitening services stating that they were practicing dentistry without proper licensure. The Board claimed that they were a state agency and therefore exempt from antitrust actions. The Fourth Circuit, hearing the case on appeal, disagreed and upheld the FTC action against the Board, holding that they were in fact a private group of business owners protecting their trade. The case has been granted certiorari by the Supreme Court and the APA has been asked to join the American Dental Association, the American Medical Association and several other medical specialty groups on a brief supporting the Board of Dentistry. The Council discussed the ramifications for supporting this brief, namely that there could be far reaching implications for APA, state boards of psychiatry, and individuals serving on these boards. Dr. Appelbaum pointed out that these boards are empowered by the state to regulate licensure and should be exempt from these types of antitrust suits. Further, those serving on these boards could be subject to individual liability and would discourage members from serving.

ACTION: The Council unanimously agreed to support the CJA's recommendation to sign on to the brief and the action should go directly to the Board of Trustees for approval.

Dr. Appelbaum gave a brief overview of the other cases CJA has reviewed and joined or filed since the September component meeting.

(1) *Rea vs. Blue Shield* challenges the CA parity law and is a suit under the federal parity law and whether it requires insurers to pay for residential treatment for eating disorders. The California Psychiatric Association wrote the brief and the APA provided financial assistance.

(2) *People vs. Rivera* revolves around whether a psychiatrist who reports child abuse can be forced to testify in the subsequent trial.

(3) *DYFS vs. YN* involves a civil action in New Jersey to deny a mother custody of her child when it was discovered that she tested positive for opioids during pregnancy. In this case, the opioids were part of a prescribed methadone program. There was discussion that this perpetuates a punitive approach to those who seek drug treatment, as opposed to constructively working with individuals with substance use disorder to stop using drugs.

(4) *Berghof vs. Schaefer* was a 4th Circuit case involving same sex marriage. This case is similar to the cases the APA has been involved in previously.

(5) *New York State Psychiatric Association vs. United Health* is a suit involving the federal parity law and who has the standing to sue under the law. In this case, the state psychiatric association sued on behalf of patients and providers alleging that the law was misapplied, stating that they were in the best position to receive complaints and be able to discover wrongdoing under the statute.

(6) *Bagnell vs. Sebelius* arises from the Centers for Medicare and Medicaid Services regulations which deny reimbursement for services provided while a patient is on "observation status." APA was unable to sign on to an AMA brief at a lower court due to time constraints, but Dr. Appelbaum said that the issues surrounding the case were compelling and that CJA would monitor the case and decide whether to get involved at a higher level.

XI. Mandatory Outpatient Treatment

Dr. Hoge raised the issue of mandatory outpatient treatment and the move to update the resource document from 1999. Dr. Hoge noted that this remains a divisive issue in the field and the current document is dated as there has been a great deal of work and research done in the last 15 years. Dr. Swartz, who was heavily involved in drafting the 1999 document, thought that an update would be worthwhile and several other members agreed. Dr. Pinals and Dr. Zonana suggested trying to create a position statement from the document and new literature. Dr. Hoge asked for volunteers for a workgroup to address the issue. The members of the work group that volunteered are: Dr. Marvin Swartz, Dr. Mardoche Sidor, Dr. Debra Pinals, Dr. Tiffani Bell, Dr. Elizabeth Ford, Dr. R. Scott Johnson, Dr. Eugene Lee, Dr. Grace Lee and Dr. Ken Hoge. A chair for the workgroup will be determined at a later date. (Dr. Swartz agreed later to chair the group.)

XII. Psychiatric "Boarding"

Dr. Recupero raised the issue about a news report on a case involving patients at a psychiatric emergency department in Washington State who were held without treatment in violation of their due process rights. The Council members agreed that this practice was outrageous if reported correctly, but there was difficulty obtaining all the information about this case. Dr. Zonana pointed out that "boarding" could have been a press term or a term used by emergency room personnel and this practice may not be "boarding" in the true sense of the word. Dr. Hoge said it had potential to be the subject for the joint CPL-CJA session at the September Component meeting.

XIII. Sex Predator Commitment Laws

Dr. Hoge raised the issue of sexual predator commitment laws and whether APA should develop additional policy to supplement the Task Force Report from 1999. Since that time, sex predator commitment has been in force in many states, additional court rulings have been handed down, and experience with the problems of state systems in implementing commitment has been accumulated. CJA recently was referred an appellate case regarding paraphilia NOS and rape disorder and whether the state can commit these individuals in community facilities. There were general concerns that there was no evidence of how many people had been committed under these laws with these diagnoses or how these

programs were being administered. Dr. Appelbaum raised the issue of one such facility in Houston, Texas, where no one was ever released and the program did not function on an outpatient basis as purported. The Council will form a workgroup to develop a resource document and potentially a position paper on the topic. The members that volunteered to serve on the work group are: Dr. Howard Zonana, Dr. Carl Fisher, Dr. Tanuja Gandhi, Dr. Reena Kapoor, Dr. Grace Lee, Dr. Debra Pinals and Dr. Hoge. A chair has yet to be determined.

XIV. New Business

Dr. Hoge distributed end of service certificates to Drs. Recupero and Zonana and thanked them for their service to the Council. Dr. Appelbaum also announced that he will be stepping down as the Chair of the Committee on Judicial Action as he has been asked to head the revision efforts for the next iteration of the DSM.

Dr. Hoge also concluded the meeting by discussing items on the agenda for the September Component meeting and potential topics for the Council's workshop application. Two potential topics discussed included the bed shortage issues (psychiatric "boarding") or the mental health history questions and licensure applications, where DOJ could potentially be a visitor to the workshop.

The meeting adjourned at 11:00 PM.

Encourage Recruitment and Retention into Psychosomatic Fellowships

- Annual Meeting RFM Center at APA- Dr. Vanderlip reported on the 2014 member center. The room was centrally located and generally busy. Unfortunately, security around Vice President Biden's visit meant that the brown bag meet and greet/networking event sponsored by the Academy of Psychosomatic Medicine had to be cancelled. Staff worked with the council to draft a new "recruitment" flyer as well as a brochure highlighting psychosomatic programming at the Annual Meeting for use in both the RFM Center and the APA Member Center in the Exhibit hall.
- Annual Meeting Council Session- Dr. Crone reported that Council's "Medical Mimics…" session, designed primarily for psychiatric residents drew a crowd of both RFMs and more experienced physicians.
- Psychosomatic Medicine Slots and the Match- Dr. Bialer said that 51/54 fellowships participated in the match which resulted in 95/104 positions being filled. Additional slots will be filled by other mechanisms. Residents reported satisfaction with the straightforward nature of the process and said that it helped to alleviate some of the pressure that they had felt under the prior system.
- Fellowship Questionnaire- Dr. Norris led a discussion on the survey designed to quantify the benefits of fellowship. The edited survey will be passed on to the Office of Research staff for their review and implementation.

Raise Visibility of Psychosomatic Medicine within APA

- Annual Meeting Psychosomatic Track- Dr. Crone highlighted the substantial increase in psychosomatic content at recent annual meetings making it more attractive for PM psychiatrists to attend.
- Council Review/Comments on Psychiatric Evaluation of Adults Guideline- Drs. Bialer and Gitlin, who sit on the APA Assembly, reported that the practice guideline did not pass the Assembly.
- Members discussed creating an educational program at next year's annual meeting in Toronto around the topic of depression and heart disease and suggested a variety of presenters expert in the field including Nancy Frasure-Smith, PhD who is at McGill University. Staff will contact APA education staff to determine how to proceed.
- APA Healthcare Reform Activity- Karen Sanders, MA, APA Director of Delivery Systems Initiatives & Integrated Care, described recent activity including the June training of trainers in Chicago. She also reiterated APA's desire to capture problems (including payer demands for treatment plans and prior authorization) via the APA Practice Management Helpline.

Improve Affiliation with Allied Groups

- Council discussed the development of a "Welcome" package for new chairs of departments of psychiatry to be jointly developed by APA/APM.
- APM Report- Dr. Worley updated the group on activities of the Academy of Psychosomatic Medicine and reported that APM has expressed its support of "fast tracking" fellowship in the 4th year of residency.
- AAFP Annual Meeting Lessons Learned- Dr. Crone reported that the Council's abstract submitted to AAFP was not accepted and discussed some of the barriers encountered.
- AAN Multiple Sclerosis quality measure development project- Dr. Schwartz has been invited to sit on this workgroup which convenes in June.
- ACGME Psychiatry Requirements- Dr. Boland updated the group on the new milestones and the challenges faced by fellowships with differing resources.
- Association of Medicine and Psychiatry- Robert McCarron, MD past president of AMP briefed the group on this organization. Since 1992, when AMP was established, it has been advocating for integrated

care by those trained in both psychiatry and some other branch of medicine (Internal Medicine, Family Medicine, Pediatrics, Neurology). Now that the APA is embracing integrated care in various forms, Dr. McCarron stressed the importance for the APA to make the most of its links to these branches of medicine that have already developed career paths and models of integrated care and a core group of leaders in this area.

Future areas for discussion

Dr. Gitlin elicited comments from the Council on what issues they would like to see addressed in the coming year. Some suggestions included: primary care integration into behavioral health; increased outreach to the Veterans Administration; advocacy around research and academic growth in psychosomatic medicine and development of research-oriented psychosomatic medicine psychiatrists.

Shortly after releasing the statement in September 2013, several member-experts in the area of child and adolescent psychiatry expressed concerns that the statement below is not wide-ranging and potentially problematic from a medico-legal standpoint.

Choosing Wisely Item #5 approved unanimously by the APA Board Executive Committee on 5/7/2013.

5. Don't routinely prescribe antipsychotic medications as a first-line intervention for children and adolescents for any diagnosis other than psychotic disorders.

> Recent research indicates that use of antipsychotic medication in children has nearly tripled in the past 10 to 15 years, and this increase appears to be disproportionate among children with low family income, minority children and children with externalizing behavior disorders (i.e., rather than schizophrenia, other psychotic disorders and severe tic disorders). Evidence for the efficacy and tolerability of antipsychotic medications in children and adolescents is inadequate and there are notable concerns about weight gain, metabolic side effects and a potentially greater tendency for cardiovascular changes in children than in adults.

Additional information on medication use in children and adolescents.

Use of an Antipsychotic Medication in Children and Adolescents for the Treatment of Bipolar Disorder or the Treatment of Irritability Associated With Autism

The *Choosing Wisely*® campaign is an initiative of the ABIM Foundation. For this campaign, the American Psychiatric Association has identified five uses of antipsychotic medications that physicians and patients should question, including "routine" prescription of an antipsychotic medication "as a first-line intervention for children and adolescents for any diagnosis other than psychotic disorders."

In this document, APA clarifies that an antipsychotic medication may be an appropriate first-line option for the treatment of bipolar disorder in children and adolescents or for the treatment of irritability associated with autism spectrum disorder in children and adolescents. Such uses are supported by clinical opinion as well as guidelines based on evidence from randomized, controlled trials, e.g., practice parameters by the American Academy of Child and Adolescent Psychiatry for the treatment of bipolar disorder (2007) and autism (in press). Furthermore, risperidone, aripiprazole, quetiapine, and olanzapine have specific approval from the Food and Drug Administration (FDA) for the treatment of mania in children and adolescents, and aripiprazole and risperidone are both FDA approved for the treatment of irritability (aggression, self-injury, severe tantrums) associated with autism in children and adolescents.

Through the Choosing Wisely campaign, APA invites physicians and patients to question the routine use of antipsychotics in specific populations of patients and for specific clinical circumstances, with

the aim of reducing unnecessary prescribing of these medications. As described in APA's Choosing Wisely statement, prescription of antipsychotic medications in children "has nearly tripled in the past 10 to 15 years, and this increase appears to be disproportionate among children with low family income, minority children and children with externalizing behavior disorders (i.e., rather than schizophrenia, other psychotic disorders and severe tic disorders)." Antipsychotics may be unnecessary, for example, when they are prescribed without a comprehensive assessment or accurate diagnosis, for behavior problems such as frequent temper tantrums, or before trying interventions with low potential for adverse effects, such as family-based, behavioral and environmental interventions. In contrast to these psychosocial interventions, antipsychotic medications in children and adolescents are associated with serious potential harms, including weight gain, metabolic side effects and cardiovascular change.

For any indication and for any patient, the potential harms of treatment must be weighed against the potential benefits. For the Choosing Wisely campaign, APA advises physicians and patients to question the routine use of antipsychotic medications in children and adolescents for clinical circumstances that are not endorsed by available clinical practice guidelines or for indications that do not have FDA approval. This advice is not inconsistent with the fact that for some young patients, an antipsychotic medication may an appropriate choice of treatment if the clinical benefits are judged to outweigh potential harms and if the patient receives appropriate initial evaluation and ongoing monitoring.

Subsequently, the members of the APA Councils on Quality Care and Children, Adolescents, and their Families convened a teleconference with members of the American Academy of Child and Adolescent Psychiatry to reach a consensus version that would more effectively help this patient population while removing the potential for controversy.

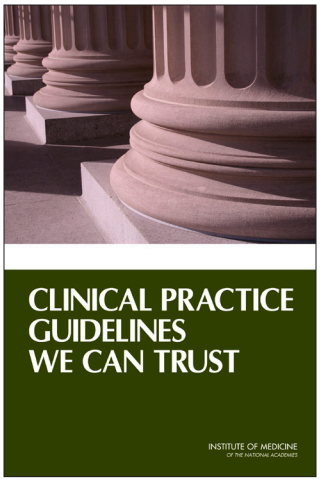
Further work on this statement, in addition to a vetting process that included approval by the Councils on Quality Care; Children, Adolescents, and their Families; and Research, has resulted in a new statement:

May 12, 2014 suggested revision of Choosing Wisely Item #5

5.Don't routinely prescribe an antipsychotic medication to treat behavioral and emotional symptoms of childhood mental disorders in the absence of approved or evidence supported indications.

There are both on and off label clinical indications for antipsychotic use in children and adolescents. FDA approved and/or evidence supported indications for antipsychotic medications in children and adolescents include psychotic disorders, bipolar disorder, tic disorders, and severe irritability in children with autism spectrum disorders; there is increasing evidence that antipsychotic medication may be useful for some disruptive behavior disorders. Children and adolescents should be prescribed antipsychotic medications only after having had a careful diagnostic assessment with attention to comorbid medical conditions and a review of the patient's prior treatments. Efforts should be made to combine both evidence-based pharmacological and psychosocial interventions and support. Limited availability of evidence based psychosocial interventions may make it difficult for every child to receive this ideal combination. Discussion of potential risks and benefits of medication treatment with the child and their guardian is critical. A short and long term treatment and monitoring plan to assess outcome, side effects, metabolic status and discontinuation, if appropriate, is also critical. The evidence base for use of atypical antipsychotics in preschool and younger children is limited and therefore further caution is warranted in prescribing in this population.

Clinical Practice Guidelines We Can Trust



Standards for Developing Trustworthy Clinical Practice Guidelines (CPGs)

STANDARD 1
Establishing transparency

1.1 The processes by which a CPG is developed and funded should be detailed explicity and publicly accessible.

STANDARD 2
Management of conflict of interest (COI)

2.1 Prior to selection of the Guideline Development Group (GDG), individuals being considered for membership should declare all interests and activities potentially resulting in COI with development group activity, by written disclosure to those convening the GDG.

- Disclosure should reflect all current and planned commercial (including services from which a clinician derives a substantial proportion of income), non-commercial, intellectual, institutional, and patient/public activities pertinent to the potential scope of the CPG.

2.2 Disclosure of COIs within GDG

- All COI of each GDG member should be reported and discussed by the prospective development group prior to the onset of their work.
- Each panel member should explain how their COI could influence the CPG development process or specific recommendations.

2.3 Divestment

- Members of the GDG should divest themselves of financial investments they or their family members have in, and not participate in marketing activities or advisory boards of, entities whose interests could be affected by CPG recommendations.

2.4 Exclusions

- Whenever possible GDG members should not have COI.
- In some circumstances, a GDG may not be able to perform its work without members who have COIs, such as relevant clinical specialists who receive a substantial portion of their incomes from services pertinent to the CPG.
- Members with COIs should represent not more than a minority of the GDG.
- The chair or co-chairs should not be a person(s) with COI.
- Funders should have no role in CPG development.

STANDARD 3
Guideline development group composition

3.1 The GDG should be multidisciplinary and balanced, comprising a variety of methodological experts and clinicians, and populations expected to be affected by the CPG.

3.2 Patient and public involvement should be facilitated by including (at least at the time of clinical question formulation and draft CPG review) a current or former patient and a patient advocate or patient/consumer organization representative in the GDG.

3.3 Strategies to increase effective participation of patient and consumer representatives, including training in appraisal of evidence, should be adopted by GDGs.

STANDARD 4
Clinical practice guideline–systematic review intersection

4.1 CPG developers should use systematic reviews that meet standards set by the Institute of Medicine's Committee on Standards for Systematic Reviews of Comparative Effectiveness Research.

4.2 When systematic reviews are conducted specifically to inform particular guidelines, the GDG and systematic review team should interact regarding the scope, approach, and output of both processes.

STANDARD 5
Establishing evidence foundations for and rating strength of recommendations

5.1 For each recommendation, the following should be provided:

- An explanation of the reasoning underlying the recommendation, including:
  - A clear description of potential benefits and harms.
  - A summary of relevant available evidence (and evidentiary gaps), description of the quality (including applicability), quantity (including completeness), and consistency of the aggregate available evidence.
  - An explanation of the part played by values, opinion, theory, and clinical experience in deriving the recommendation.
- A rating of the level of confidence in (certainty regarding) the evidence underpinning the recommendation.
- A rating of the strength of the recommendation in light of the preceding bullets.
- A description and explanation of any differences of opinion regarding the recommendation.

STANDARD 6
Articulation of recommendations

6.1 Recommendations should be articulated in a standardized form detailing precisely what the recommended action is and under what circumstances it should be performed.

6.2 Strong recommendations should be worded so that compliance with the recommendation(s) can be evaluated.

STANDARD 7
External review

7.1 External reviewers should comprise a full spectrum of relevant stakeholders, including scientific and clinical experts, organizations (e.g., health care, specialty societies), agencies (e.g., federal government), patients, and representatives of the public.

7.2 The authorship of external reviews submitted by individuals and/or organizations should be kept confidential unless that protection has been waived by the reviewer(s).

7.3 The GDG should consider all external reviewer comments and keep a written record of the rationale for modifying or not modifying a CPG in response to reviewers' comments.

7.4 A draft of the CPG at the external review stage or immediately following it (i.e., prior to the final draft) should be made available to the general public for comment. Reasonable notice of impending publication should be provided to interested public stakeholders.

STANDARD 8
Updating

8.1 The CPG publication date, date of pertinent systematic evidence review, and proposed date for future CPG review should be documented in the CPG.

8.2 Literature should be monitored regularly following CPG publication to identify the emergence of new, potentially relevant evidence and to evaluate the continued validity of the CPG.

8.3 CPGs should be updated when new evidence suggests the need for modification of clinically important recommendations. For example, a CPG should be updated if new evidence shows that a recommended intervention causes previously unknown substantial harm, that a new intervention is significantly superior to a previously recommended intervention from an efficacy or harms perspective, or that a recommendation can be applied to new populations.

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Principles for the Development of Specialty Society Clinical Guidelines

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September 2012

Table of Contents

CMSS Principles for the Development of Specialty Society Clinical Guidelines

1. INTRODUCTION

1.1. Recognizing that medical specialty societies (Societies), having a responsibility for leading the profession, often serve as an independent source of evidence based clinical practice guidelines, and can help to reconcile conflicting, high-quality guidelines, the Council of Medical Specialty Societies offers these principles as a resource for development of systematic review-based guidelines.

Core to these development principles are the following concepts:

1. Guideline recommendations should be informed by a review of available evidence and, where possible, should be based on an extensive, reproducible, and strong body of evidence;
2. Guideline panels should include knowledgeable, multispecialty/disciplinary development individuals;
3. Guideline development should incorporate transparent conflict of interest management; and
4. Guideline development should include broadly defined (including patient, when possible and if applicable) stakeholder involvement.

1.2. The charge to developers of clinical guidelines is generally much more complex than is often realized. There is an inverse relationship between the specificity of clinical questions and the availability of high-quality evidence. Commonly, there are many more clinical and appropriate use questions than there is clear evidence to answer them. Hence, the transparent interaction among knowledgeable stakeholders in evaluating evidence and developing guidelines is the basis for trustworthy guidelines.

Annotation: This document should serve as a broad roadmap or set of aspirations for guideline production; we acknowledge that it may be impossible to achieve every recommendation. Societies may meet member needs and further their missions through the use of other types of clinical guidance or applications thereof, such as quality measure development.

1.3. The recent CMSS Code for Interactions with Companies (CMSS Code) addressed some guideline principles: none of the principles here should be interpreted as superseding the CMSS Code. These additional principles have been developed without resource consideration. Specialty Societies generally do not have that luxury, but they can and should transparently document the manner in which their guidelines are developed. Reference to which of these principles were addressed and which were impractical to apply may be helpful in this regard.

2. DEFINITIONS

2.1. **Clinical Practice Guidelines**, as used in this document (also referred to in this document as "guidelines"), are statements that include recommendations intended to optimize patient care. They are created after a systematic review of evidence and an assessment of the benefits and harms of alternative care options. From Clinical Practice Guidelines We Can Trust http://www.nap.edu/catalog/13058.html. This definition may or may not apply to other Society deliverables, including appropriate use criteria, technology assessments, scientific statements, and Society position statements. Societies are encouraged to document these differences transparently.

2.2. **Guidelines Documents** are the collection of publicly available documents that define the guidelines, their development methodology, their supporting evidence and other relevant documentation.

2.3. **Guideline Development Group** consists of a panel of members with differing expertise responsible for utilizing systematic reviews to generate clinical practice guideline statements in an objective and unbiased manner.

2.4. **Writing Panel** consists of either the entire guideline development group or a smaller subset of the guideline development group charged with producing the guideline manuscript and all supporting documents.

2.5. **Systematic Review** is a scientific investigation that focuses on a specific question; it uses explicit, planned scientific methods to identify, select, assess, and summarize the findings of similar but separate studies; it may or may not include a quantitative synthesis (meta-analysis) of the results from separate studies.

2.6. **Methodologists** are writing panel advisors with expertise and/or training in evidence-based medicine and guidelines development methodology.

TRUSTWORTHY GUIDELINE PRINCIPLES

3. CONFLICT OF INTEREST Principles for Guideline Development Group

3.1. Organization Commitment/Responsibility

Annotation: Societies have a strong interest in demonstrating the independence and trustworthiness of their guidelines. Patients and the public need to be confident that Societies' guidelines are not biased towards the interests of their members. Societies' guidelines policies and procedures should result in balanced development groups that focus on impactful patient interventions with appropriate expert input.

3.2. Societies developing guidelines must define and document their interpretation of Conflict of Interest (COI). At a minimum, Societies should follow the principles set out in the CMSS Code. These focus principally on financial relationships with Companies at the individual and Society levels. In addition, Societies should be cognizant of the existence of indirect and non-financial interests (e.g., research bias, institutional mission, practice bias) and their potential impact on the process.

Definitions should include:

3.2.1. Criteria for determining relevance if and when a relationship is material or pertinent to the topic of the writing panel or Guideline Development Group.

3.2.2. Criteria may include determining the level if and when a relationship is modest or significant.

3.2.3. A process, including options, for the resolution of all significantly relevant financial and non-financial COI, such as not voting or participating in evidence based reviews.

3.2.4. Societies will require that at least a majority, including the chair, of the Guideline Development Group and/or Writing Panel members are free of relevant conflicts of interest pertinent to the subject matter during and for one year after their work on guidelines or their revisions.

Annotation: Processes should be in place to achieve balance, not only when the group or panel is commissioned but also reviewed periodically during the writing process. Processes should include the ability to add non-conflicted members or remove conflicted members to achieve balance. Transparency is critical if changes to the writing panel occur because of a relationship with a Company. Processes can involve management of COI per the Society's policies and need not exclude participation on a panel or other development group. .

Panel members should decline offers from industry to speak about guidelines related to their products as outlined in the CMSS Code. Similarly, panel members should not discuss a guideline under development with industry employees or representatives (CMSS Code).

A process should be in place to document disclosure of relationships, and management of conflicts of interest. The guideline document or material publicly available online should have a clear description of the management that was employed. Annotation: Disclosure should occur in writing, prior to the selection of the Guideline Development Group, and updated at every meeting as necessary.

3.2.5. Societies will create processes for collecting, managing, and disclosing COI information for Guideline Development Groups and/or Writing Panel members as well as any person with direct influence as defined by the Society, over the review or approval of guideline content. This includes any external consultants, methodologists and boards.

Annotation: Systems should be established to help ensure compliance with these processes.

3.2.6. Societies should pursue fair and consistent interpretation and application of the policy across guideline type and with partner/collaborator organizations.

Annotation: Routine review of COI management outcomes is suggested in order to ensure appropriate decisions. The review may result in policy or process changes.

3.2.7. Societies should have a process in place to make sure that the members of a guideline development group understand the COI policy and importance of disclosing all relevant relationships and interests.

3.3. Transparency

3.3.1. Societies will ensure that any relevant relationships are publicly disclosed, along with relevant COI management strategies. This includes relationships that the Society determines a reasonable user of a guideline would like to know.

Annotation: All Societies developing guidelines should have a published COI disclosure policy to include relevant COI and management policies.

3.3.2. All relationships relevant to the topic must be disclosed and reaffirmed periodically during the development process per Society policy on COI (see 3.1).

Annotation: This information should be readily available to the public for inspection and review and can be accessible via the internet, print or both. Disclosures should be actively updated during the development process and available publically upon guideline release. This can include referring the reader to the electronic or print media containing the policies.

3.3.3. Societies should require disclosure and release of all relationships that are considered to give rise to potential conflicts of interest.

Annotation: See CMSS Code section2.1. Societies may also disclose related COI procedures. This material can be disclosed on the Society's web site.

3.3.4. COI disclosure should conform to Societies policies with the understanding that relevant relationships will be managed as potential COI and publically available.

4. DEVELOPER QUALIFICATIONS: Ancillary Members

Annotation: Guideline Development Groups should be, as appropriate, multispecialty, multidisciplinary and include individuals with the proper expertise to develop a high-quality guideline.

4.1. All personnel directly and substantively involved in the development process should be subject to the same COI disclosure policies and management procedures as the rest of the Guideline Development Group.

4.2. Systematic Review Authors:

4.2.1. Systematic review authors under the direction of the Society should be subject to the same COI policies and procedures as the guideline development group.

4.2.2. Independent systematic reviewer developers contracted by the Society should have published COI policies and procedures that are consistent with or acceptable to the Society.

4.3. Multispecialty/disciplinary panel composition:

4.3.1. Specialty Societies should incorporate relevant stakeholders in both the development and review of their guidelines. The development panel should be multidisciplinary and balanced, comprising a variety of methodologic experts and clinicians.

4.3.2. Participants and their area of expertise should be published.

4.4. Methodologists or evidence-based medicine expert:

4.4.1. Societies should incorporate a methodologist with expertise and/or training in evidence-based medicine and guidelines development methodology into guideline development.

4.5. Librarian:

4.5.1. The systematic research group should have a librarian or a person with similar knowledge and experience as determined by the Society involved in the guideline process.

4.5.2. The librarian should be experienced in guideline methodology, systematic search strategies, and database content.
Annotation: All search strategies should be saved, and when possible electronic copies of retrieved literature should be archived. Every effort should be made to ensure a consistent, reproducible and comprehensive search strategy.

4.6. Statistician:

4.6.1. If statistical analyses are warranted and performed, they should be done by qualified personnel as determined by the Society, and the appropriate application of statistics should be utilized.

4.7. Patients:

4.7.1. Patients or patient advocate groups' involvement may be considered in guideline development, review, or formulation of clinical questions. Any patient or patient advocacy group must comply with the COI disclosure requirements set forth elsewhere in this document.

4.7.2. Patient preferences and feedback should be addressed in the guideline as appropriate. The role of patient preferences in the development of guidelines should be defined in the methodology.

4.8. Panel Training:

4.8.1. When necessary and depending on their prior knowledge, Societies should incorporate methodology training into guideline development panels.

Annotation: Ideally, Societies can establish a core group of members with sufficient expertise in guideline development to assure future guideline groups' access to experts within their Society. When possible, training should be a requisite for membership on the guideline development group.

5. GUIDELINE DEVELOPMENT PROCESS

5.1. The intent of the guideline must be clearly stated.

5.2. The rationale for the guideline must be elucidated.

5.3. The scope of the guideline should be described and include:

5.3.1. A clear description of the intended guideline audience and the setting(s) in which the guideline is to be used.

5.3.2. A concise statement of guideline objective(s)

5.3.3. A clear description of the patient population(s) covered by the guideline (e.g., age groups, gender, clinical conditions, co-morbidities, exclusions).

5.3.4. A clear and concise statement of guideline questions to be answered. When possible, use of the PICO format is recommended.

Annotation: PICO refers to the framing of the clinical question in terms of the Population, Intervention, Comparison, and Outcome. Limit recommendations to key questions that are relevant to the goals and objectives of the guideline.

5.4. Provide clear descriptions of what the guideline covers related to diagnosis, prognosis and treatment(s) for diseases/conditions, and what is excluded.

Annotation: It is preferable to acknowledge and, when possible, refer to other evidence-based resources for related information for areas that are outside the guideline scope and acknowledge clinical overlap as well as gaps.

5.5. The methods should:

5.5.1. Include addenda for search strategies, and literature selection rules for each question answered. These can be referenced to electronic media and do not necessarily need to be part of the printed manuscript.

5.5.2. Disclose the system used to grade the evidence.

5.5.3. Document the process for reconciling low quality evidence.

5.5.4. Include time period of the searched literature, including secondary searches and updates.

5.5.5. Specify the method of data extraction.

5.6. In systematic review-based guidelines, systematic evidence reviews should be utilized to develop reliable and valid guidelines.

Annotation: Best use of systematic review resources has not been established.

5.6.1. Evidence reviews should include documentation on handling systematic gaps in the literature. Gaps in the literature occur when there is insufficient or non-existent evidence but a strong clinical need for a recommendation.

5.6.2. Evidence reviews should evaluate potential benefits and harms of an intervention, when feasible.

5.6.3. Whenever possible and appropriate, cost effectiveness and comparative effectiveness information should be incorporated into guidelines.

5.6.4. Each citation identified as affecting the evidence review must be evaluated for its quality and its limitations.

5.7. Evidence tables must be provided with information summarizing the relevant articles and standardized quality ratings, and should be available electronically.

5.8. A process for reconciling differences in agreement on the strength of evidence grades should be established.

6. RECOMMENDATIONS

6.1. Recommendations should classify the strength of evidence as well as the strength of the recommendation itself; these strengths should be determined by consideration of the spectrum of evidence and the assessment of benefits and harms, not just be a restatement of the evidence.

Annotation: It should be a rare instance where the recommendation strength exceeds the evidence strength. When this occurs, detailed supporting documentation should accompany the recommendation. It is recognized that there are times when the need for recommendations exceeds the available evidence.

6.2. Recommendations should be based on unbiased systematic review of the highest quality peer-reviewed evidence available.

6.3. Recommendations should be linked with evidence tables and with specific citations when relevant.

6.4. Recommendations supported by expert opinion, consensus, or the lack of quality evidence must be clearly stated as such.

Annotations: Developers should consider the impact of recommendations that are based on low-level evidence. There are occasions when expert opinion is the only available information on a topic with a high need for a recommendation, low risk and clear potential benefit. There

should rarely be "strong recommendations" based on low-level evidence; this might happen when high-level studies would be impossible or unethical to perform.

6.5. Results of development panel votes on recommendations, including abstentions, should be summarized and publically available.

Annotation: This is a transparency issue. Readers may infer that strong recommendations are the result of nearly unanimous votes, while less strong recommendations may be associated with majority votes. Documenting variations from such presumed voting patterns is acceptable if the voting system is clearly documented.

6.6. All recommendations should be linked to an evidence profile that transparently document reasoning behind the recommendation.

Annotations: Knowing what actions are harmful or unsubstantiated useful to clinicians, policy makers, and patients. Suggested elements (From AAO-HNS Guideline Development Manual: http://www.entnet.org/Practice/upload/Rosenfeld-and-Shiffman-2009-6.pdf, Table 13) could include:

- Aggregate Evidence Quality
- Benefits/harms/risks/costs: As appropriate for each key action
- Benefit-harms assessment: Is there a preponderance of benefit over harm or harm over benefit, or are they balanced?
- Value judgments: Considerations the committee members included when deciding to make this recommendation.
- Role of patient preferences: When there is a discrepancy between patient preferences and published evidence, a weighting system should be employed to resolve this discrepancy.
- Exclusions: Does this recommendation exclude any patient groups not already excluded by the scope.
- Intentional vagueness: Answered as "none" or specified why some type of AVUL (ambiguous, vague, and under specified language) which was used in the action statement.
- Strength of Recommendation: Determined by consideration of level of evidence and benefits-harms assessment.
- When supported by the literature, negative recommendations should be part of the guideline.

6.7. Recommendation statement formats should be consistent and actionable:

Annotations:
• Recommendations should be explicit about WHO ought to Do WHAT, WHEN (under what circumstances), To WHOM, HOW, and WHY
• Should be actionable and not a statement of fact
• Recommendations should avoid AVUL (ambiguous, vague, and under specified language) whenever possible - sometimes there are reasons for being intentionally vague, such as the case with insufficient evidence or inability to reach consensus.
• When recommendations are ambiguous or vague, transparency may include disclosing results of voting and/or contrary opinions.
• Recommendations should not be in a passive voice, use an active verb wherever possible (i.e. the clinician should prescribe amoxicillin rather than amoxicillin should be prescribed).
• Unless options are clearly specified, recommendations should avoid use of the term "consider."
• Every recommendation should be described clearly, so that reasonable practitioners would agree when the recommendation should be applied.
• Recommendations should be clearly identified - either summarized in a box, typed in bold, underlined, presented in an algorithm, etc.
• There should be a limited number of recommendations based on the scope of the guideline.

6.8. Appropriate, related guidelines as determined by the guideline development group should be acknowledged:

6.8.1. Recommendations should consider related guidelines from other high-quality development groups.

6.8.2. Harmonization with related guidelines is strongly encouraged and efforts should be made to include relevant specialty societies in new guideline development.

6.8.3. When significant differences with existing guidelines cannot be harmonized, there should be a rationale and explanation citing all relevant literature.

6.9. Identify all contributing guideline organizations, work group-panel, writers, consultants, and staff as per publishing journal requirements.

7. GUIDELINE EFFECTIVENESS

7.1. Where possible, guidelines should contain measurable objectives, which can be assessed by users of the guideline.

7.2. Societies should consider processes for reviewing the effectiveness of their guidelines.

7.3. Whenever possible, the guidelines should contain or give rise to an implementation tool kit that can assist users in measuring guideline-related outcomes.

8. GUIDELINE REVIEW

8.1. Internal Review may include:

8.1.1. Vetting draft recommendations should occur through relevant internal committees, sections, and councils as defined by the Society.

Annotation: Incorporating appropriate comments from these internal groups is recommended, when supported by the evidence.

8.1.2. As stated in the CMSS Code, Societies will require that guideline recommendations be subject to multiple levels of review, including rigorous peer-review by a range of experts. Societies will not select individuals employed by or engaged to represent a Company as reviewers. (CMSS Code 7.9)

Annotation: As part of their published guideline development processes, Societies will seek critical feedback on draft guidelines from independent reviewers. These may include subject matter experts, healthcare practitioners, biostatisticians, and patient representatives. (CMSS Code 7.9)

8.1.3. The Society's guideline recommendations will be reviewed and approved before submission for publication by at least one internal body beyond the Guideline development panel, such as a committee or the Board of Directors.(CMSS Code 7.9)

8.1.4. A final acknowledgement of or approval by the Society after all internal, external and peer reviews.

8.2. External and Peer Review should include:

8.2.1. External reviews should incorporate relevant stakeholders comprising a variety of experts and clinicians.

8.2.2. Guideline manuscripts should be subject to independent editorial review by the journal or other source where they are first published (CMSS Code 7.11)

8.2.3. Comments from other stakeholders and feedback from affected groups for provide general appropriateness should be obtained.

Annotation: Disposition of the comments and suggestions should be documented in responses forwarded to the external reviewers. When possible and if applicable, patients and patient advocacy groups should be invited to comment on proposed guidelines.

Annotation: If a Society decides to seek broad external or public comment, the fact that Company representatives might access the review draft and comment should not conflict with CMSS Code 7.9 or 7.15 as long as a reasonable procedure is in place to assure that Company comments are incidental and minimize the potential for abuse.

9. TIMELINES

Annotation: These Principles will be reviewed at least every 5 years per CMSS policy and updated as warranted.

9.1. An expiration date or date of anticipated review or revision should be disclosed within the published guideline.

Annotation: Within guideline text, clearly state when a guideline is expected to be considered for review and update. In lieu of periodic review, indicate the guideline will be considered maximally valid for five years.

9.2. Specialty Societies should implement a process for maintaining the currency of guidelines.

9.2.1. Following publication, guidelines should be assessed regularly for relevant additions to the literature.

9.2.2. A process should be in place to determine if a guideline requires a partial or full update.

9.2.3. A process should be in place for identifying and managing guidelines that are no longer current.

10. DISTRIBUTION AND IMPLEMENTATION

10.1. Society guidelines should be publically available on an organizational website.

10.2. If appropriate, guidelines should be submitted to the National Guidelines Clearinghouse and Guidelines International Network for guideline dissemination.

10.3. Societies should consider guidelines derivatives for physicians, patients, caregivers and other lay audiences to facilitate provider-patient interactions and to incorporate recommendations at the point of care. Publicize all products related to a guideline to relevant audiences.

Annotation: The quality or trustworthiness of a guideline is not necessarily related to the success of its implementation or presence/absence of derivative products.

11. FINANCE AND FUNDING

11.1. Societies will not permit direct external company support of the development of Clinical Practice Guidelines or Guideline Updates (CMSS Code 7.3).

Annotation: Societies will not accept Corporate Sponsorship, Educational Grants, Charitable Contributions, Research Grants, or any other direct industry support of Guideline development activities. Company support of the overall mission based activities of a Society is not considered direct support of Guideline development. Societies will not permit direct company support for the first printing, publication, and distribution of Clinical Practice Guidelines or Guideline Updates. After initial development, printing, publication and distribution are complete, it is permissible for Societies to accept company support for the Society's further distribution of the Guideline or Guideline Update, translation of the Guideline or Guideline Update, or re-purposing of the Guideline content. (CMSS Code 7.4) Sponsorship should be consistent with the rest of these guidelines.

11.1.1. In developing a guideline, a Society should anticipate resources needed for dissemination and updates over the lifetime of the guideline.

11.1.2. Regardless of source, all funding must be transparent and documented.

11.2. Honoraria, travel reimbursement and compensation for developers, should occur transparently, at customary rates for the effort and activities involved.

11.3. Societies developing trustworthy guidelines will likely have several distribution, publication and revenue models, including free or minimal cost availability. It is unlikely that end user prices correlate with the quality or trustworthiness of a given guideline.

11.4. Travel reimbursement from Companies is not permitted.

11.5.
Societies preferably should insure intellectual property ownership of their guidelines by obtaining written copyright assignments for all contributions. Full copyright ownership of a guideline permits the creation of derivative works based on it. If a guideline is developed by more than one society, it is simpler for one society to own the copyright and to license to the other society, thus avoiding the legal burdens of joint copyright ownership. The license could include terms that give the licensee society the ability to create derivative works. Neither society should be able to unilaterally modify the guideline without written agreement from the other society.

11.6. Development of derivative products is an important distribution challenge for guideline developers both from funding and compensation perspectives. It is suggested that:

11.6.1. Individual guideline panelists involved in derivative products are never compensated beyond their time at standard rates.

11.6.2. Derivative product development should be independent of guideline development.

Using these Principles

These Principles were developed by CMSS as a resource for its members and others who develop systematic review-based clinical practice guidelines. Following these Principles is voluntary and is not a condition of continued membership in CMSS. Societies that choose to follow these Principles do so in the spirit of supporting awareness of sound practices in guideline development. Societies will interpret and implement these Principles in the context of their organizational structure, their policies and procedures, their resources, and their member needs.

Any comments received by CMSS relating to a Society's adherence to these Principles will be referred to the Society.

Questions about these Principles may be addressed to CMSS. CMSS will not interpret these Principles on an individual basis. However, CMSS may periodically gather its members' views and update the Annotations, or publish answers to "frequently asked questions."

References

Rosenfeld RM, Shiffman RN. Clinical practice guideline development manual: a quality-driven approach for translating evidence into action. Otolaryngol Head Neck Surg 2009; 140(Suppl): S1-S43.

Qaseem A, Forland F, Macbeth F, Ollenschlager G, Pillips S, va der Wees P. Guidelines International Network: Toward International Standards for Clinical Practice Guidelines. Ann Internal Med. 2012; 156:525-531.
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Special thanks go to the CPG Component Group Chairs and Planning Committee for their work on these Principles.

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CMSS Principles for the Development of Specialty Society Clinical Guidelines

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Referral Updates

ASMNOV1212.B
Management of Sensitive Information within Health Information Exchanges (HIEs)

What has been done on the referral?

- This area has been evolving quickly over the past 18 months, so the committee has waited for some new technical capabilities to be piloted and shown to be acceptable. CMHIT believes that now that this technology for improving the confidentiality of sensitive information has been proven, a useful position statement can be crafted.
- CMHIT members, along with Glenn Martin, are preparing a draft paper for review and comment by Council on Healthcare Systems & Financing, Council on Advocacy & Government Relations, and Council on Psychiatry & the Law. A final draft is expected in July.

ASMNOV1312.D
Protecting Privacy and Confidentiality in the Age of the Electronic Medical Records

What has been done on the referral?

- CMHIT has discussed this and thinks some minor changes in wording of the position statement would be appropriate in terms of the security of the record. A discussion with the Council on Psychiatry and the Law and with Council on Healthcare Systems & Financing will occur in June, and final language will be developed and forwarded to JRC on completion.

Item JRC #8.L
Joint Reference Committee
May 31, 2014

Action Item

Will the Joint Reference Committee approve updated language to item number five of the APA's *Choosing Wisely*® *campaign* list, which identifies targeted, evidence-based recommendations that can prompt conversations between patients and physicians about what care is really necessary?

- Explanation for updates and current APA Item #5 Statement, Attachment 1
- Suggested language up for approval, Attachment 2

Will the Joint Reference Committee approve that the APA COI policy be reviewed and aligned with policies for guideline development groups recommended by the Institute of Medicine (IOM) and the Council of Medical Specialty Societies (CMSS) now being adopted by most other medical specialties?

- IOM Conflict of Interest policy, Attachment 3
- CMSS Coflict of Interest policy, Attachment 4 (please view page 6 of the document)

Meeting Minutes

See following pages for the minutes of the joint meeting of the Council on Quality Care.

Council on Quality Care
May 7, 8-11AM
Conference D, Lower Lobby
Sheraton New York
Times Square Hotel
New York, New York

I. Opening/Introductions: Joel Yager, M.D., Chair

A. Conflict of Interest/Disclosure Statements, Attachment #1

Attendees:

Chair: Dr. Yager
Members (CQC): Drs. Dalack, Daviss, Pierce, Pincus, Smith, Wilner, Zima
Fellows: Drs. Acharya, Das
Guests: Drs. Levin, Jabbarpour, Kraus, Martin
Staff: Kroeger, Narrow, Sanders, Shugarman

Meeting participants introduced themselves, summarized their background in Quality Care, and identified any potential conflicts of interest. Dr. Acharya (NIMH grant), Dr. Zima (PCORI. UCLA CTSI. and Illinois Child Healthcare Foundation), Dr. Smith (NY Community Trust and the NYS Department of Health), Dr. Pincus (employed by Columbia University, NYP, and RAND and consulting for Mathematica and Manila)

II. Minutes from last meeting

A. September 20, 2013 Fall Components meeting, Attachment #1A

Minutes approved.

III. Remarks by Dr. Levin (8:45AM-9:15AM)

Dr. Levin identified that Quality is a very important emerging area in health care. He would like to see the APA quality initiative and the National Quality Enterprise advance and be meaningful to APA members. His concerns are related to members who ask why their performance must improve; he explains that it is beneficial for the profession and the safety of patients served.

Further discussion included topics related to access to care include the increased rate of psychiatrists opting out of insurance and the inability of registries to shed light on this topic. Dr. Pincus commented that the issue of access to behavioral health services at a plan level has been brought to CMS attention, but he does not know what they are doing about it.

Dr. Levin enforced the need for the Council on Quality Care to lead the discussion on the APA's role in the development of a registry (more details on this discussion found within the registry discussion).

IV. Reporting Component Updates

A. Steering Committee on Practice Guidelines

Mr. Kunkle reported that the Assembly did not approve new practice guidelines on aspects of psychiatric evaluation. A process to review and re-vote on these guidelines

will be determined by the Assembly leadership in collaboration with members of the Steering Committee for Practice Guidelines. Dr. Martin suggested that the Assembly felt that there was insufficient time to review the guidelines, given their importance. Also, more explanation about the new guideline structure and rating system for strength of evidence and strength of recommendations may be needed. For example, there were concerns that the documents need to be more nuanced or need to be more explicit that the recommendations are not intended to be standards or requirements. Many people were uncomfortable, for example, with the terminology "insufficient evidence." Dr. Yager said the documents represent substantial work by a group that was chaired by Joel Silverman, M.D. The group was charged to develop guidelines that meet new standards of the Institute of Medicine, including use of a systematic process to review and grade evidence. Gradings of high, moderate, low, and insufficient have become the standard terminology used by guideline developers to describe available research evidence, and these terms have standard meanings that are used across medicine. Dr. Daviss agreed that many members of the Assembly did not have adequate time to review the documents. He suggested that a similar process be used as was used for DSM-5. Dr. Narrow said conversations are in process with the Assembly leadership to come up with a process that uses liaisons from each Area to review and address concerns in advance of a re-vote in November.

Mr. Kunkle said the Steering Committee agreed on a specific action for the Council with respect to COI policy: The committee asks the Council to recommend to the JRC and the Board of Trustees that the APA COI policy be reviewed and aligned with policies for guideline development groups recommended by the Institute of Medicine (IOM) and the Council of Medical Specialty Societies (CMSS) and by now adopted by most other medical specialties. Current APA policy, said Mr. Kunkle, requires disclosure but does not set any limits for participation on guideline writing groups by individuals who have COI. IOM and CMSS recommend that whenever possible, groups should be composed of individuals without conflicts. When this is not possible, IOM and CMSS recommend that no more than a minority of the group should include individuals with conflicts, and the chair should be a person without conflicts. Dr. Yager clarified that nobody currently appointed to an APA guideline work group has any relationships with industry. However, the letter of the current APA policy would allow the entire group to have unlimited conflicts. A change in the policy would simply safeguard against this possibility. The Council agreed to suggest to the JRC that the APA Board of Trustees review the current APA policy and consider if it can be aligned it with IOM and CMSS recommendations.

The Council further discussed if the members of the Assembly and Board who approve APA guidelines should also make disclosures and recuse themselves from voting if they have a conflict of interest. Dr. Yager noted that under our new development process, the work group is responsible for determining the content of the guidelines, via a Delphi voting process. It was never our intention to invite the Assembly to wordsmith the guidelines, he said. Rather, the Assembly was to certify that the development process was followed.

B. Committee on Mental Health Information Technology

a. General report from Dr. Daviss, from the meeting on Monday, Attachment #2

Dr. Daviss summarized EHR is focusing on several different areas including SAMHSA trying to coordinate Health IT initiatives. Some current challenges: Maureen Boyle in the Office of the National Coordinator is leaving her post and will likely slow things down. There is focus on data segmentation in privacy—SAMHSA commissioned an IT group on technology to tag data (e.g."mental health" or "substance abuse"). An open source on any EHR exchange could add to software for no cost. Tagging allows patients to provide informed consent on what to release or not. The current Health Information Exchange does not allow the option to choose the information that is shared, this "all or nothing" option leads to distrust of the system. Patients can't audit to review who has viewed their information. The tags allow more control on the patient side. There have been five successful pilots programs implementing this data segmentation. It will likely become the default standard.

There is an opportunity for action on patient access to records. HIPPA allows patients' right to their information, but do not have the right to psychotherapy notes. Committee on Psychiatry and Law is lead on this effort. CMIT will put together a draft for discussion.

Dr. Pierce commented that state laws vary on privacy. She suggested the APA consider drafting a model standard that various states might use as a standard of care for protecting patients. Dr. Daviss suggested a position statement around the idea to develop state law language. He agreed to discuss new state law language with the CMHIT and will share with the Council. He reported that there is a meeting in June with all EHR vendors. He plans to share the dearth of effective functional requirements as a package to vendors. Recommendations were made to include child scales and ADHD scales as well as DSM5 language be included.

b. Discussion of charge and appointments to a new workgroup to recommend APA activities related to Mental Health and Psychiatric Apps, Attachment #3

Dr. Yager explained this important service to members so APA might disseminate information on the multitude of apps in existence. Dr. John Luo, at UCLA, who has written extensively on HIT, has agreed to chair and has list of possible members. Dr. Lori Simon, a member of CMHIT, has also agreed to participate.

Dr. Daviss requested for a motion to approve Charge—approved.

C. Workgroup on Patient Safety, Attachment #4

Dr. Jabbarpour representing. Dr. Jayaram explained the discussion from the meeting of the group that took place on May 5, 2014. Discussion included international patient safety concerns and its role in education. The group supports the idea that best practices is a culture of safety. Among the many patient safety issues considered, the Workgroup has opted to focus on transitions of care that occur when patients are discharged from inpatient care, given that increased rates of suicide occur shortly after discharge from hospitals. Focused on transitions of care, psychiatrists should act as a guide as subject matter experts. Transitions of care: navigating transitions is necessary as increased rates of suicide occur shortly after discharge from inpatient care.

D. Workgroup on Standards and Survey Procedures
Dr. Jabbarpour provided an update for the group. He explained that the The Joint Commission recognizes the importance of physician feedback and welcomes criticisms on improving their survey process.

A symposium was presented at the 2014 APA Annual Meeting: *Violence in Clinical Psychiatry: Overcoming the Barriers to Improving Safety on the Unit*. This topic will help drive discussion on this key quality and safety issue, which is also a concern for APA membership. The symposium allowed the APA to further discuss policy and standards development, including activities with *The Joint Commission*.

E. Workgroup on Gender Dysphoria
Dr. Byne described the history of the group, its development of a position statement, and production of both a task force report and submitted paper under review. He asked Council to extend the Workgroup's commission, with a plan to develop resource documents focusing on treatment. These documents will not be based on a high level of evidence and will not be considered formal practice guidelines.
The Council granted an extension of the group's work.

F. Workgroup on Registries, Attachment :
The group reviewed and approved the Charge for a new Workgroup on Registries . Dr. Dalack has agreed to chair this workgroup. Dr. Levin will participate in the first few calls. A number of members from the Council on Quality Care, Council on Research, and Council on Healthcare Systems and Finance, and several other qualified APA members, have agreed to serve. The purpose of this workgroup is to help the BOT and staff think through where the APA might have role in this burgeoning area of quality. The Council noted that a number of registries are already operating via professional associations, institutions, and academic facilities.
Motion to approve charge was granted.

V. Discussion: Current Status of Quality Improvement and Quality Measurement

A. Update: National Quality Forum (NQF) Activities

a. Moving forward with 3rd stage of Behavioral Health Measure Endorsement.
Ms. Shugarman reported that the APA will support the nomination of three members (Pincus, Zima, Shea) to the NQF Behavioral Health Standing Committee

b. Measures Application Partnership (MAP) recommended behavioral health measures,
Dr. Pincus explained the process by which measures are reviewed and recommended.

c. MAP Medicaid Task Force
Dr. Pincus and Ms. Shugarman explained an effort by NQF that includes identifying ways to revise, strengthen and improve the initial core set of health care quality measures for Medicaid-eligible adults (Medicaid Adult Core Set) for voluntary use by states. The task force will consider states' experience with quality reporting, available measures, and high-priority measure gaps and make recommendations to support the program's goals. The findings of the MAP Medicaid Task Force will be delivered to HHS in August 2014.

B. Update: Current APA Activities

a. Partners with AAN in management of Dementia Measure Set

Ms. Shugarman provided an update to the group on the partnerships with AAN, AACAP, and potential substance abuse specialty groups.

Discussion focused around the benefits of the APA developing measures. Dr. Pincus suggested rather than developing new measures that we cultivate relationships with those groups already in development (e.g. Mathematica).

A question was posed by a group member: because it is an expensive endeavor, will CMS fund measure developments for the APA?
Dr. Zima raised the position that before development of new measures occurs the APA should consider measure validity of the existing measures. Measures are currently being approved by NQF only if they can be shown to be tightly tied to meaningful clinical outcomes.

Dr. Pincus expressed that the APA should not be in the role of stewarding quality measures.

In contrast, Ms. Shugarman expressed the importance of the APA maintaining a lead role in the development and stewardship of performance measures, with the concern being that if APA withdraws from these activities and pulls back we might lose our ability to dictate (or even influence) the way psychiatric clinicians are paid in relation to quality measures, and therefore leave it open to other groups to dictate.

The group questioned how the APA can partner with development and funding groups. Dr. Pincus explained that the groups require Technical Expert Panels and it should be APA's goal to position leaders on these groups. It was suggested that the APA groom health services researchers to work on these projects.

Dr. Pincus explained that CMS might be interested in meeting with APA to talk about these issues. The Joint Commission (TJC), the group that developed the Hospital Based Inpatient Psychiatric Services measure set has a group/committee and staff that developed measure set. TJC has the man power and funding to support validity testing together. The APA doesn't have the man power to do that (right now).

Dr. Yager suggested the possibility of scheduling a retreat or invitation meeting to figure out how we might interact with and what we might want to do with these groups (e.g. TJC, NCQA).

Dr. Pincus stressed the importance of developing measure concepts within the practice guidelines.

Ultimately, the group agreed that the APA should maintain some sort of voice over psychiatric quality measurement. Dr. Yager summed up that we be certain to nominate and get members to participate on technical panels and in other roles with national

quality organizations. As a field, we face the large task of attempting to improve the scientific validity of suggested quality measures.

b. Partners with AACAP in management of Childhood Major Depressive Disorders Measures
Ms. Shugarman is currently working with a representative of AACAP to assume shared responsibility over the Childhood MDD measures orginially developed with PCPI.
c. Potential partners with substance use specialty groups in Substance Use Measures
Ms. Shugarman is accepting suggestions on who to best approach to develop a partnership to share responsibility over the SUD measures originally developed with PCPI.

VI. Discussion: Integrated Care/Health Reform activities at APA: How Council can contribute

A. Report from the Council on Healthcare Systems and Finance re: Tuesday meeting
Dr. Dalack provided an outline of the discussion that occurred at the May 6, 2014 meeting.

The group discussed a number of programs:

1. Some with long history (Bruce Schwartz and Montefiore Pioneer ACO preceded by development of business entity (UBA),

2. Another at the state level (Larry Miller, MD - Arkansas Payment Improvement Initiative, ADHD Episode, and

3. Small project in a particular community, implementing care management for super utilizers/high cost Medicare patients.

4. Spoke about Aetna experience. “Seen one ACO, seen one ACO”. Sees great variety in degree of inclusion of BH in ACO organization structures. They are not really brought into these discussions early on. Re: provider focus, 90% not in any organized practice and have many misunderstandings about HIPAA, fear of competition and measurement and challenges of sharing information among providers and between patients and providers.

5. Discussion about outcome/quality measures and the challenges of doing something we control vs. having others doing it to us.

Agreement that a lot is going, but certain issues still not addressed:

1. Need for payment models for Collaborative care/psychiatric/behavioral health activity which does not include direct patient care.

2. Need to deal with “mortality gap” for SMI- focus on primary care collaborative care has meant that the SMI issues not being focused on.

The group discussed ways to implement ideas and push the APA to identify gaps and suggest a specific action, particularly keyed to the Recommendations from the "Summergrad Report" (Role of Psychiatry in Healthcare Reform: APA BOT Work Group Recommendations)

SUGGESTION and APPROVAL to take Recommendations from Summergrad report and have Councils show what they would do in any/each area. The Council on HSF will make the recommendation to the JRC to ask them to make this integration a topic for the Components meeting in September and have councils, in the meantime, indicate which recommendations from the Summergrad report they are working on.

Dr. Yager explained that Dr. Summergrad will be holding a strategic retreat.

Ms. Kroeger explained that this retreat will not host a large group. Dr. Narrow and Mr. Muszynski will be in attendance. The idea is to have synergy among the groups moving forward. This meeting is happening the weekend after 7/12/14. Dr. Summergrad might want to pull the council chairs together, but it is unclear who else will participate.

VII. Discussion: Choosing Wisely Campaign

A. Discussion: Potential collaborations among Choosing Wisely, the American College of Physicians' High Value Care initiative and PCORI
Dr. Yager proposed that PCORI fund projects to examine the comparative effectiveness of behavioral, psychosocial and pharmacological interventions (including atypical antipsychotic medications) used to manage the large array of child psychiatric disorders that in recent years have been increasingly treated "off label" with antipsychotic medications.

Discussion included whether this should be consulted on with AACAP before moving forward.

Although Dr. Yager commented "I can't imagine it would get push back for research and funding," Ms. Kroeger's consultation will be sought regarding collaboration with other groups on this recommendation.

B. Update: Altered language of the Choosing Wisely Campaign item # 5 around atypical antipsychotics in children and adolescents, Attachment #9
Dr. Yager explained that shortly after releasing the statement in September 2013, several member-experts in the area of child and adolescent psychiatry expressed concerns that the current official statement is too restrictive and might potentially serve as the basis of lawsuits against prescribing clinicians. To that end, the members of the APA Councils on Quality Care and Children, Adolescents, and their Families convened a teleconference with members of the American Academy of Child and Adolescent Psychiatry to revise the current statement to more clearly state the concerns and options to assist clinicians, patient and their families. , and produce Further work, in addition to a vetting process that included approval by the Councils on Quality Care; Children, Adolescents, and their Families; and Research, as well as members of AACAP has resulted in a new statement to be presented to JRC for BOT approval.

Dr. Yager described the request by PCORI for suggestions on research priorities for funding comparative effectiveness treatment research. We agreed to propose that such research focus on issues raised in the APA's child and adolescent statement for the Choosing Wisely campaign.

Dr. Yager reminded the group that the statement is supposed to raise a question about when it is appropriate to prescribe antipsychotics and that entire statement must be considered, not just the initial sentence.

VIII. Update: Council on Research

A. Report from Dr. Yager, who attended Council on Research Tuesday meeting
Dr. Yager reported that the discussion focused on concerns on how the APA will continue to support research training and minority research training. Funding from NIH is ending. Future funding may depend on other Federal agencies (e.g. NIDA, NIAAA) and foundations.

Several APA staff changes are impacting the work of Council. The Council on Research is happy to participate in the registry workgroup. The Council may attempt to establish Workgroups to address TMS and DBS that may be able to develop Task Force Reports.

Dr. Narrow mentioned that the Complementary and Alternative Medicine (CAM) caucus was invited to present to the Council on Research. They were invited to write a resource document on a specific treatment of their choosing, that has an evidence base sufficient to evaluate. This was a productive discussion that illustrates the changes in attitudes toward CAM over the past 10 to 15 years. These are treatments that many people use and we don't know much about efficacy, interactions with the treatments prescribed by psychiatrists, etc.

IX. Update: Recruitment of QIPS Director—
Ms. Kroeger commented that the position has received a lot of interest and candidates are being interviewed.