Item 11.B
Board of Trustees
March 14-15, 2015

SUMMARY

Ad Hoc Work Group on APA Health Care Reform

ACTION 1:
Will the Board of Trustees vote to accept the report of the Ad Hoc Work Group on APA Health Care Reform and its recommendations and commend them to the APA Administration to develop a plan of implementation?

ACTION 2:
Will the Board of Trustees vote to approve the reconvening of the Ad Hoc Work Group on APA Health Care Reform at the 2015 APA September Components Meetings for the purpose of reviewing the APA Administration's implementation plan for each of the recommendations as proffered in this report and request that the Work Group report back to the Board at its October, 11-12, 2015 meeting on this review?

Report of the APA Board of Trustees Work Group on Healthcare Reform

This report is dedicated to the memory of Dr Wayne Katon, friend and colleague, who devoted a substantial part of his extraordinary career to the development of an evidence base that supports the effectiveness and efficacy of integrated and collaborative care. We are greatly indebted to his work, which will inform the advancement of our profession for years to come, and will miss him personally.

Executive Summary:

The APA Is currently actively engaged in multiple healthcare reform initiatives. This work group was appointed to review APA activities and to make recommendations for the ongoing prioritization and direction of the APA so that the APA and American psychiatry are well positioned to strategically promote and influence US healthcare reforms.

The report is organized into six priority areas, and within each area is a recommended strategic priority. Within each of the 6 sections there are also a number of findings and tactical recommendations intended to be readily actionable by the APA over the next several years.

The strategic recommendations from the report are as follows:

Quality: Strategic Recommendation Q1: Prioritize psychiatric leadership in defining the quality measurement of psychiatric services in US healthcare.

Financing: Strategic Recommendation F1: Establish a sustainable advocacy and communications strategy to message the value of psychiatry to all key stakeholder audiences: legislators and regulators, employers as purchasers, and health plans.

Integrated Care: Strategic Recommendation IC1: Design a plan of action to define and advocate for the payment models for integrated care that will support sustainability. Work with CMS around newly announced plans to offer bundled payments and other payment reform based on quality.

Research: Strategic Recommendation R1: Effectively influence the national research agenda for behavioral health services and related sciences.

Health Information Technology: Strategic Recommendation HIT1: Leverage our position as clinical leaders to stimulate advances in technology so that EMR and

app developers work with the APA to create EMRs and apps that better and more efficiently support the unique clinical needs of psychiatric providers.

<u>Workforce and Education: Strategic Recommendation WE1:</u> Develop a national strategy that defines and highlights the relative role of psychiatrists in organized systems of care that include multiple behavioral health and allied professionals.

Report of the APA Board of Trustees Work Group on Healthcare Reform

Introduction

This APA Board of Trustees Work Group (BOT WG), is the third in a series of critical work groups that have examined issues and opportunities for psychiatry in the era of Healthcare Reform that is associated with the passage of the landmark Patient and Protection and Affordable Care Act (ACA) in March 2010. Key elements of this current BOT WG charter are to:

1. Review the specific recommendations of the first (2013) BOT WG report for each content area as well as to review the work products of the second (2014) BOT WG and develop a set of specific recommendations that will guide APA advocacy and member initiatives.
2. Review an inventory of APA activity in six key areas. These are: Healthcare Financing, Workforce, Health Information Technology, Research, Integrated Care, and Quality Measurement.
3. Make recommendations to enable the prioritization of APA activities that include the development of initiatives and resources by components for the purpose of educating federal and state policy makers, regulatory agencies, and payers regarding the role of psychiatrists in organized systems of care.
4. Recommend a structure for the APA to continue these activities without the necessity to empanel future Board Work Groups in this area. (See Attachment 1.)

Background on Prior APA Work Groups on Healthcare Reform

The first of these work groups, chaired by Dr. Paul Summergrad, was appointed by Dr. John Oldham in 2011 and continued through Dr. Dilip Jeste's term. The product of this first work group was an extensive report completed in March 2013. This report recognized numerous opportunities the APA might focus on to increase the knowledge of APA members as well as effectively target APA policy, education, and advocacy activities. Multiple themes and opportunities were identified that focused on opportunities for the APA and APA members to become more knowledgeable about and more engaged with the key policy areas and initiatives embodied in the ACA.

The second work group, appointed by Dr. Jeffrey Lieberman and chaired by Dr. Howard Goldman, included national behavioral healthcare policy experts and was oriented toward product development, culminating in the production of resources related to each of three areas:

- Advocacy documents for the new Medicaid opportunities under the ACA
- Psychiatric quality and outcome measures
- Training and education materials for psychiatrists on integrated care

Each product was specifically designed to advance APA member knowledge and proficiency in advocacy and ACA implementation. There were two products on Medicaid: 1) a toolkit on use of the 1915i waiver created by the ACA to provide a care continuum for special populations (An Advocacy Toolkit—Improving Care for People with Serious Mental Illness: Medicaid's 1915 (i) Option); and 2) a toolkit to enable

contract review for Medicaid managed care arrangements (Managing Managed Care: A Toolkit for Advocates). The product from the Quality Work Group was a white paper, -Measuring Performance in Psychiatry: A Call to Action,‖ discussing the need for and setting forth a blueprint for the development of psychiatric outcome measures (to be published online in *Psychiatric Services* in Advance, May 2015, and in the August 2015 print issue of *Psychiatric Services*) . The APA contracted with the AIMS Center (Advancing Integrated Mental Health Solutions) at the University of Washington to develop CME educational modules that will be available to APA members Spring 2015.

Current BOT WG

Membership

The work group was appointed by Dr. Summergrad with the charge as noted above. Dr. Anita Everett is the chair of the work group and Dr. Lori Raney is vice-chair. Numerous staff from the Administration have also been involved. (See Attachment 2.) In order to support fulfillment of its charge, the composition of this work group was principally comprised of relevant APA council chairs and recognized experts in key topic areas.

Process

The work group held two conference calls prior to an in-person meeting January 8-10, 2015, in Arlington, VA. These two calls were used to clarify the charge, review the recommendations from the 2013 BOT WG report, review an inventory of activities of the APA Administration, and to achieve consensus on the agenda for the in-person meeting.

The in-person meeting began with a review of the charge and general orienting comments as members introduced themselves. The working dinner speaker, Dr. Harold Pincus, Professor and Vice Chair Columbia University Medical Center Department of Psychiatry, Director of Quality and Outcomes Research, New York-Presbyterian Hospital, and Co-Director, Irving Institute for Clinical and Translational Research, provided a concise accounting of the current state of quality measurement in behavioral health services in the US and the many implications for psychiatry going forward. The first full day covered an agenda that included time in the morning and afternoon for breakout groups into each of the six focus areas that were carried forward from the original Task Force report (see below). Plenary discussion was facilitated on each of the areas as the breakout groups reported back to the whole group. The final day's session culminated with a summary review of the key points from each of the six topic areas and the shaping of these conversations into discrete recommendations. Each area and recommendation is accounted for in the following section of this report.

Scope of Recommendations

The conclusions of the group included in this report are consensus-based and were the culmination of expertise from the viewpoint of each individual BOT WG member as well as the emergent discussion points from extensive deliberation on each of the six priority areas. The implications of health reform for psychiatric practice are quite broad, and it

is recognized that they will impact APA members differently depending on their primary practice settings and choices regarding participation in emerging models of care and payment. Thus, this report and recommendations are not made with the intention of impeding other ongoing APA activities or initiatives that are minimally related to these broad healthcare reform initiatives.

APA Staff preparation work: Primary to the work group's charge was to review the recommendations of the 2013 BOT WG report. To facilitate this, APA staff were directed to prepare an inventory of the recommendations for each of the six areas discussed in the report and to note where substantive activities have been initiated by the APA respecting these. (See Attachments 3a-3f.) It is notable that there has been and continues to be considerable activity within the APA directed toward fulfilling the recommendations of the first BOT WG 2013 report. It is the current BOT WG's view that at a basic level all the recommendations are essential, inasmuch as key healthcare reform initiatives invariably have many overlapping or interconnected pieces; e.g., integrated care models that operate successfully have essential components that draw on quality measures, HIT, and payment methodology among others. Given this interconnectedness, prioritization among them would be difficult and possibly counterproductive. The demands on the APA flowing from the current complex and fast-changing environment are dense and dynamic, and there really is no way around this reality.

SIX KEY HEALTH REFORM TOPICS

Quality and Performance Monitoring (Q)

General statement: Quality and performance monitoring is critical to current healthcare policy priorities. Contributing factors include: increasing attention to value-based, population-based healthcare; advancement of electronic health systems; new payer regulations; and public demand for accountable, safe, and effective health systems.

Strategic Finding: It is critical that the quality of psychiatric services be able to be measured. Multiple forces are rapidly defining quality throughout healthcare. If the APA and psychiatry are not actively engaged in this process, quality will be defined for our profession by others.

Strategic Recommendation Q1: Prioritize psychiatric leadership in defining the quality measurement of psychiatric services in US healthcare.

Finding: Currently the APA does not have an identified plan for the promotion of psychiatric engagement and leadership in the area of quality and performance measurement/monitoring for psychiatric services and/or behavioral health systems of care.

Recommendation Q2: APA should fill the vacant leadership position for quality and performance measurement.

Recommendation Q3: Establish a specific plan of action to ensure representation of the APA on the boards or advisory councils of the national stakeholders that are involved with nationally significant quality measures such as the NCQA, etc. used for payment or other quality monitoring purposes in behavioral health treatment.

Recommendation Q4: Create a stakeholders coalition across advocacy groups and with representation from federal agencies such as the VA, SAMHSA, AHRQ, NASMHPD, and others to create recommendations for standardization of behavioral health population (denominator) characterization so that outcomes/quality and performance can more reliably and fairly be reported on.

Finding: The APA Council on Quality Care has a very broad charge with multiple responsibilities. There is no standing committee on quality and performance measurement that specifically includes members with expertise in clinical systems performance measurement.

Recommendation Q5: Create a standing committee within the Council on Quality Care that includes members with expertise in both: 1) care systems, services, and settings; and 2) quality and performance measurement. This committee would report to the council and be an immediate resource for APA Quality staff for various quality policy initiatives and regulations. This committee should be chartered so that it is not dependent on semi-annual council meetings to be able to render expertise regarding quality proposals proposed to be adopted nationally. The longstanding APA Committee on RBRVS, Codes, and Reimbursements provides an example of how this could be structured and operated.

Finding: Psychiatrists often do not receive sufficient training in performance and quality measurement.

Recommendation Q6: Create a CME activity that is designed for members on quality measurement in practice so that as members can receive enhanced expert teaching in quality and performance measurement both at the practice and broader service levels. Develop this so that it qualifies as an ABPN PIP for MOC.

Financing (F)

General statement: Health reform has ushered in a variety of payment innovations largely designed to incentivize value over volume. The innovations range from fee-for-service based approaches, modified positively or negatively by performance metrics, to prospective methodologies with case-mix adjustment features and global budgets. Some payment innovations are driven by new care delivery developments; e.g. medical/health homes, collaborative care. The suitability of these emerging payment approaches for psychiatric care delivery and varied population subgroups; e.g. the SMI, is not always evident. Their actual impact on shaping clinical care at the practitioner level is not well understood either. The need to monitor payment developments that harmonize with the performance demands of emerging payment strategies for psychiatric care delivery is essential.

Strategic Finding: The value that psychiatry brings to health systems' objectives concerning quality and cost is not generally understood by public and private payer policy audiences. Recognition must be achieved so that multiple activities that include direct face-to-face service as well as care coordination and team supervision events will be covered and paid equitably. This cannot occur without a solid foundation based on understanding psychiatry's added value.

Strategic Recommendation F1: The APA should establish a sustainable advocacy and communications strategy to message the value of psychiatry to all key stakeholder audiences: legislators and regulators, employers as purchasers and health plans.

Finding: The plethora of payment innovations and demonstrations ongoing in the public and private payer spheres is considerable. How these will impact psychiatric clinical care and patients (including patient subgroups) needs to be better understood and optimal payment methods need to be identified.

Recommendation F2: The APA should develop an inventory of and monitoring system for established and emerging alternative (to fee for service) psychiatric payment approaches. Several initiatives should be developed within the APA that provide useful information to APA members on opportunities for psychiatry as they emerge in new accountable payment models. This includes big systems models such as bundling, global payment, and shared savings models as well as models more related to individual practices such as case rates, care coordination coding, and participation in treatment planning.

Finding: Successful population health strategies require advanced integrated care approaches that must have essential behavioral healthcare components. Facilitating essential psychiatric functions cannot occur without appropriate payment for them. At present, there is no coherent private or public payer policy that enables reimbursement sustainability for these new and promising population care delivery approaches.

Recommendation F3: Design a plan of action to define and advocate for the payment issues around integrated care that is sustainable. Work with CMS around recently announced plans to offer bundled and global health style payments that support the incorporation of behavioral health within healthcare. See recommendation IC1 in the integrated care section.

Recommendation F4: The APA should create a forum for psychiatrists who are actively engaged with population health leadership in Accountable Care Organizations and other population based activities so that shared experiences and successful initiatives can be exchanged and disseminated to APA members.

Integrated Care (IC)

General statement: The integration of psychiatry and other areas of medicine is a key driver of outcome-changing care that leverages psychiatric expertise across larger

populations of patients. Utilizing evidence-based models of team-based care that include psychiatrists as key members can add significant value to the overall healthcare system and make better use of finite resources during a time of psychiatric workforce shortage. It is important for psychiatrists to be prepared to work in these models, which require different skill sets. More widespread utilization of psychiatrists has been hampered by a lack of payment mechanisms for the indirect care components of these models. An important product of the second BOT WG is the educational resource contracted for with the University of Washington that will be released in the spring of 2015. This includes six modules that will be available to APA members:

- Module 1: Introduction to Integrated/Collaborative Care
- Module 2: Leadership Essentials
- Module 3: Developing a Collaborative Care Team and Workflow
- Module 4: Working with a Collaborative Care Team
- Module 5: Assessment of Common Mental Health Conditions in Primary Care
- Module 6: Treatment of Common Mental Health Conditions in Primary Care

Strategic Finding: There are inconsistent funding mechanisms to compensate psychiatrists for the non-face-to-face functions that are essential to their participation in evidence-based, collaborative, team-based clinical care delivery.

Strategic Recommendation IC1: Design a plan of action to define and advocate for the payment issues around integrated care that will support sustainability. Work with CMS around newly announced plans to offer bundled payments and other payment reform based on quality.

Finding**:** APA membership requires resources to quickly locate information on models of integrated care that currently exist nationally and internationally. This is not now available to members and not part of the existing section on Integrated Care on the APA website.

Recommendation IC2: Develop an inventory of the aggregate evidence for models of integrated care to provide a resource to members wishing to design and implement programs. Support for the Council on Psychosomatic Medicine-Association of Psychosomatic Medicine project currently underway to catalog national models is requested.

Finding: There is often confusion about confidentiality in the context of integrated care, which may inhibit the participation of psychiatrists in these models. The rules vary among states, with some states having stricter regulations than the federal HIPAA regulations, which allow coordination of care between providers without a signed release.

Recommendation IC3: Develop a position statement on confidentiality that is no stricter than federal law and disseminate accurate information to psychiatrists about the limits. Work to dismantle stricter confidentiality standards in states to allow relevant communication between psychiatrists, non-physician behavioral health providers, and

other medical providers. Educate members on the facts contained in the federal privacy statues to dispel misunderstandings that currently exist.

Finding: The APA Work Group on Integrated Care has created a resource document on liability associated with integrated care.

Recommendation IC4: Promote the resource on liability associated with integrated care so that APA members are aware of it.

Research (R)

General statement: A fundamental underpinning to health reform initiatives is achieving increased value for patient health outcomes per dollar spent. This is facilitated through deployment of evidence-based clinical and care delivery strategies. Clinical and healthcare services research is essential to inform decision makers in this endeavor. There are many questions spanning numerous relevant categories that remain to be answered at the individual and system levels respecting psychiatric and substance abuse care.

- What is the effectiveness of integrated care for persons with severe mental illness? What models will work best and improve access to treatment for medical comorbidities?
- What are the implications of emerging payment methodologies for clinical care and patient outcomes? What are valid risk adjustment models for psychiatric patients in prospective/bundled payment schemes?
- What are viable patient outcome measures? How should they drive reimbursement? Or not?
- What implementation/dissemination models are effective in improving adoption of performance metrics at the practice level?
- What EHR applications actually improve care and outcomes?

There are numerous governmental and non-governmental entities involved in research and evaluation of healthcare reform initiatives. With the need to hire a new director for its research office, the APA has an opportunity to develop a broad strategic plan that increases its capacity to influence research agendas that advance knowledge regarding the value of psychiatric practice in healthcare reform initiatives.

Strategic Finding: The APA has variable and fluctuating influence on the national psychiatric and neuroscience research agenda.

Strategic Recommendation R1: The APA should be involved in effectively influencing the national research agenda for behavioral health services and related sciences.

Finding: Provider accountability is increasing rapidly and practice guidelines have taken on increasing significance with insurance coverage determinations, reimbursement, and accreditation/standard setting to name a few. Payers adopt clinical practice guidelines for the provision of preventive, acute, and chronic psychiatric services. Evidence-based

guidelines from professional organizations are designed to guide practitioner decisions about appropriate healthcare for specific clinical circumstances and are regarded as authoritative. There are concerns with respect to how current APA guidelines are, and there are emerging needs for new guidelines that address, for example, team-based collaborative care and the role of psychiatry. It is critical that the APA adapt its guidelines processes and publication formats to address the IOM mandated development process while simultaneously meeting the demands of payers and policy makers to timely guide emerging care and service delivery developments.

Recommendation R2: Update the practice guidelines more regularly and frequently. Any knowledge gap identified in the practice guideline update process will inform a research advocacy agenda for the APA.

Finding: Knowledge is often delayed in being received by practicing psychiatrists. And while the prominent journals provide highly influential information regarding leading edge science, they often do not provide information that can be implemented clinically.

Recommendation R3: APA should develop a strategy to communicate significant research findings in a format that is timely and useful to practicing psychiatrists.

Finding: The APA office of research has undergone significant staffing changes in the last year.

Recommendation R4: Hire a research director and develop a strategic plan for the APA Office on Research that includes reorienting the Practice Research Network (PRN) so that we take full advantage of the unique role it has and can have in understanding the US psychiatric workforce practice, experience, opinions, and day-to-day practical challenges.

Health Information Technology (HIT)

General statement: Health Information Technology (HIT) is the electronic framework that provides for the comprehensive management and secure exchange of health information among providers, insurers, governments, patients, and other entities. It is the matrix out of which the electronic health record (EHR) evolves and it also includes telemedicine, e-mail, websites, databases, electronic prescribing, and patient-controlled personal health records and patient registries. HIT is essential to almost all care delivery innovations, yet adoption has been slow and most experts think we are years away from universal use. HIT is fundamental to the array of emerging alternative care delivery models. Any entity that coordinates care and promotes accountability among a group of providers for a given patient population will require various capabilities that will be extremely difficult to achieve without the use of HIT.

Strategic Finding: APA members have a wide variation in skills and experience with technology at this point in time. Among other things practice setting (large systems vs. private practice), practitioner age, level of comfort with increasing use of technology within medicine and psychiatry in particular influence the

receptivity to and adoption of technology. Potential APA tasks include developing tools that support a core knowledge and minimal skill set for all psychiatrists, while also being able to stimulate knowledge advancement so that psychiatric practices can participate in contemporary practice. The electronic medical record (EMR) is one of many important components of healthcare reform. However, the broader area of technology-facilitated treatment also includes telepsychiatry, population outcomes data management, electronic outreach, and communication and quality improvement.

Strategic Recommendation HIT1: Psychiatrists should leverage their position as clinical leaders to stimulate advances in technology so that EMR and app developers will work with APA to create EMRs and apps that better and more efficiently support the unique clinical needs of psychiatric providers.

Finding: The word *technology* and the potential it represents for psychiatric clinicians is often too narrowly used to only connote the use of an EMR for the purposes of recording a clinical intervention. Currently the APA does not have a uniform approach to or working definition/glossary of clinical technology.

Recommendation HIT2: Develop a communications initiative that targets APA membership knowledge regarding technology as a catalyst for improving treatment. This would include EMR, registry and population management, telepsychiatry, and other apps that support enhanced treatment and outreach. This could include a series in *Psychiatric News* and articles in the *American Journal of Psychiatry* and *Psychiatric Services*.

Finding: Electronic medical records are increasingly mandated. Large numbers of psychiatrists are currently involved with making decisions about the purchase and updating of EMRs.

Recommendation HIT3: APA should develop guidelines that psychiatrists can refer to with regard to influencing the purchase of EMRs. This would not be specific brand recommendation; but would rather include a collection of factors to consider. Examples of the categories of information that the guidelines would address include how the EMR protects the privacy of mental health and substance abuse services, how treatment plans are documented, how patient contact for care coordination is documented, and the access patients have to staff and to their own recorded information.

Finding: There are ongoing problems with the privacy of substance abuse treatment records that create barriers to care coordination. It is not known what the current consensus of APA members is regarding the risks and benefits in advocating for a change in the current federal privacy regulations so that substance abuse treatment records can be protected under the same rules as other medical and psychiatric treatment records.

Recommendation HIT4: APA should develop a position statement on the privacy of substance abuse treatment records. This position statement would serve as a foundation for advocacy.

Workforce/Education (WE)

General statement: Health reform trends have numerous implications for the current and future education and training of the psychiatry workforce. The insurance coverage expansion programs under the ACA will generate considerable demand for psychiatric services and psychiatry, and there is already a workforce shortage. New healthcare delivery models and population-based health strategies will place new and important demands on the skill sets psychiatrists need to be successful, and this requires curriculum redesign for medical education and training. As these healthcare delivery system shifts occur, there is an increased need for education about new models of care in the medical education continuum – undergraduate, graduate, and continuing medical education.

Strategic Finding: Increased awareness of the need for behavioral health as well as increasing numbers of insured Americans brings to light the gap between need and the numbers of psychiatrists and behavioral health providers.

Strategic Recommendation WE1: Develop a national strategy that defines and highlights the relative role of psychiatrists in organized systems of care that include multiple behavioral health and allied professionals.

Finding: As new care delivery models emerge, psychiatrists' roles will likely develop and change. Education of psychiatrists regarding new integrated care models is essential to improving access, and psychiatrists will serve patients who often present with complex needs in physical health, mental health, and substance use. The APA must take on the challenge of preparing current and future psychiatrists and their primary care colleagues, including physician assistants and nurse practitioners, to deliver this sort of patient-centered, team-based, measurement-monitored, and population-oriented care.

Recommendation WE2: The APA should 1) develop a certification program, possibly online, for members trained in integrated care; 2) recognize model psychiatric training programs that are teaching integrated care and develop a communications approach to assure widespread dissemination; and 3) provide training programs with learning modules to assist in educating them about changes in healthcare delivery.

Finding: Medical students get little exposure to psychiatry and may choose another residency rather than psychiatry due to influences from medical and surgical faculty during those rotations. Current psychiatry residents and faculty are the best individuals to highlight the experiences and activities psychiatric residents receive in training.

Recommendation WE3: The APA should focus its energy on efforts to provide medical students with a more positive and complete impression of psychiatric training and practice. For example, the APA is considering creating a contest among psychiatry residency programs to create a presentation that most effectively demonstrates what it is like to be a psychiatric trainee. Finalists will be posted on the website and on YouTube for voting by members and medical students.

Finding: Psychiatrists, nurse practitioners (NPs), physician assistants (PAs), psychologists, social workers, and professional counselors practicing together is a necessary model for delivering high quality, cost-effective, patient-centered psychiatric care. This model is ideal for improving access problems, particularly to patients in underserved communities and populations.

Recommendation WE4: Collaborate with national NP and PA organizations on the development of best practice models of care between psychiatrists and NP/PAs, and explore the feasibility of practice guidelines for this.

Discussion and Summary

This report presents the culmination of expert opinion and experience, discussion through multiple phone calls and an intensive in-person meeting of involved APA leadership. It presents recommendations at a point in time, and while it is intended to transcend day-to-day shifts in initiatives associated with the broad implementation of healthcare reforms associated with the ACA, there continue to be frequent attempts to modify this highly politicized and provocative legislation. Already, since the original draft was completed, there are threats within multiple state budgets to reduce health and behavioral health benefits due to the relatively high expense that Medicaid and other public funded programs represent in state budgets. Thus, while the report has attempted to include recommendations that are enduring, fluctuation is inherent in areas as politically charged as the ACA has been.

The request to the BOT-WG to recommend a formal structure to enable focused activity in the health reform arena without creating a new WG was not completely resolved and was suggested by some to be unrealistic given the sweeping significance of healthcare reform. That being said, it is clear that components and the assembly are managing many, many initiatives associated with the ACA throughout the APA. This BOTWG is a unique group of APA all-stars with a keen commitment to the process. These individuals volunteered much time to assure that a clear report with useful findings and recommendations was proffered to the APA BOT.

Board of Trustees Ad Hoc Work Group on Healthcare Reform

Background: The original BOT WG met numerous times over the 2012-2013 period. Its activities culminated in a Work Group report to the BOT March 2013 (later reissued as part of the April 4, 2014 event) and an econometric analysis prepared under Workgroup direction by Milliman. The report had a broad conceptualization of health reform with a particular focus on the role of psychiatrists and integrated care. It set forth a number of general principles and specific recommendations.

The specific recommendations covered the following areas:

- Integrated Care
- Financing
- Quality and Performance Measurement
- Health Information Technology
- Psychiatric Workforce
- Research
- Organizations Implications for APA

The report explicitly recognized that APA is involved in many of the areas that the report covered but that there is no:

- Defined set of priorities for health reform activities
- Identification of key policy/advocacy objectives and rationale for same
- Plan of action based on the foregoing
- Governance and staffing structure that assumes coordination timelines and accountability for execution of activities that cut across numerous areas of content and expertise.

The second BOT WG was intended to expand the work of the prior work group and augment APA staff's capability to develop and optimal strategy to guide the APA and influence the health care reform process, as it will impact psychiatric medicine and mental health care. The elements of this strategy were to, draw explicitly on the work of the APA Board Work Group on the Role of Psychiatry in Healthcare Reform, including the following:

- Review the findings of the former Work Group on the Role of Psychiatry in Healthcare Reform and refine:
    - models of psychiatric services, mental health/substance use and behavioral health systems in the context of both specialty/public sector settings and integrated general medical systems;
    - roles and services provided by psychiatrists, other physicians and other medical and behavioral providers in the context of both specialty/public sector settings and integrated general medical systems;
    - financing schemes for psychiatric services within both specialty/public settings and integrated general medical systems.

- Develop both a political strategy and a communications strategy to ensure that health care policy development optimally represents the interests of psychiatric medicine, behavioral health care and the general medical systems.

The second WG produced several products; e.g. Medicaid Advocacy documents, a background paper on future directions for outcome measures, and a contract to produce training materials and integrated care for members.

Charge: The current BOT WG on Healthcare Reform is established to review current APA resources and efforts to assist members in new and evolving healthcare delivery systems. To that extent the charge will be to:

- Review the specific recommendations of the 2013 BOT WG report for each content area and the work products of the 2014 BOT WG
- Develop a set of specific health reform priority activity recommendations and objectives (with rationale), which will serve as benchmarks as APA advocacy and member initiatives.
- Develop a plan of action for each priority/objective which will serve as basis for reporting and monitoring by governance (including components), in conjunction with APA staff.
- Look at issues related to reimbursement, access, new delivery models, quality measures and prevention efforts with the end of recommending to leadership changes that APA should advocate for within the private and public systems.
- Recommend the development of specific additional materials by components for purposed of educating federal and state policy makers, regulatory agencies, and payors regarding the importance and appropriate utilization of psychiatrists within newly developed organized systems of care.
- Coordinate with appropriate committees to review key issues regarding the state of EMR/HER, quality measures, telepsychiatry and where appropriate recommend APA action and the development of additional practice level tools.
- Work with appropriate APA departments to develop a clearing house of information for APA members in states to use for a advocacy at the state legislative level as well as with national accreditation bodies (NCQA, URAC etc.).
- Recommend a formal structure for the APA to continue these activities without continued requirement to empanel future BOT WG's in this area.

Proposed Members: 10-12 members with leadership experience, representing a broad range of psychiatric practice and who are involved in advocating for or the implementation of innovative

delivery systems in their local community or state. Leadership from HCSF, Psychosomatic Medicine, CAGR and Quality, should be included.

Proposed Process: The workgroup will conduct a review virtually through tele or web conferencing, with at least one in person initial meeting, and a second if required. The APA staff from related departments will prepare and provide to the committee all relevant information and materials requested or deemed necessary for the review and will prepare minutes and an initial draft report. The review will be completed in time for a report to be made to APA BOT at its March 2015 meeting in Arlington, Virginia.

Resources Provided: Administrative support for scheduling conference calls and obtaining conference line will be provided along with support for minutes and report drafting. Funds will be made available for one and possibly two in person meetings.

PRIMARY APA ADMINSTRATION TO WORK GROUP

Chair	**Anita Everett, MD** 3563 Cattail Creek Dr Glenwood, MD 21738-9607 **Tel:** (410) 550-8806 **Fax:** (410) 550-1748 **Email:** aeveret4@jhmi.edu
Vice Chair	**Lori Raney, MD** 30110 Road S Dolores, CO 81323-9383 **Tel:** (970) 759-9461 **Email:** lraney@pcbhconsulting.net
Member **Chair HSF**	**Harsh Trivedi, MD** Vanderbilt Behavioral Health 1601 23rd Ave S Suite 3059 Vice Chair for Clinical Affair, Department of Psychiatry Nashville, TN 37212-3196 **Tel:** (615) 327-7024 **Fax:** (615) 343-4007 **Email:** harsh.k.trivedi@vanderbilt.edu **Assistant:** Nancy Lancaster **Email:** nancy.d.lancaster@vanderbilt.Edu
Member **Chair CAGR**	**Barry Perlman, MD** Dept of Psych 127 S Broadway Yonkers, NY 10701-4006 **Tel:** (914) 378-7342 **Fax:** (914) 378-7727 **Email:** barry.perlman@mssm.edu
Member **Chair Psychosomatics**	**David Gitlin, MD** Brigham & Womens Hospital 75 Francis St Boston, MA 02115-6110 **Tel:** (617) 732-6727 **Fax:** (617) 738-1275 **Email:** dgitlin@partners.org
Member Speaker-elect, Assembly	**Glenn Martin, MD** 10933 71st Rd Suite 1G Forest Hills, NY 11375-4800 **Tel:** (718) 268-2044 **Email:** apf@glennmartinmd.com
Member	**Howard Goldman, MD** 10600 Trotters Trl Potomac, MD 20854-4241 **Tel:** (301) 983-1671 **Email:** hh.goldman@verizon.net

Member	**Jay H. Shore, MD, MPH** University of Colorado Depression Center Mail Stop F800 13055 East 17th Avenue Aurora, Colorado 80045 **Tel:** 303.724.1465 **Fax:** 303.724.1474 **Email:** jay.shore@ucdenver.edu
Member	**Herbert Pardes, MD** New York Presbyterian Hospital 177 Fort Washington Ave Room 142 New York, NY 10032-3733 **Tel:** (212) 305-8000 **Fax:** (212) 305-8012 **Email:** pardesh@nyp.org **Assistant:** Patty Schaus **Email:** pas9095@nyp.org
Member	**Jürgen Unützer, MA, MD, MPH** University of Washington PO Box 356560 Seattle, WA 98195-6560 **Tel:** (206) 543-3752 **Email:** unutzer@uw.edu **Assistant:** Molly Jones **Email:** mojo@uw.edu
Member	**Barry Sarvet, MD** 3300 Main St Floor 4 Baystate Health, Division of Child Psychiatry Springfield, MA 01199-1002 **Tel:** (413) 794-5552 **Email:** bdsarvet@gmail.com
Member	**Rhonda Robinson-Beale, MD** 505 N Brand Blvd Suite 1200 Glendale, CA 91203-3328 **Tel:** (818) 484-9200 **Fax:** (818) 484-9208 **Email:** r.robinsonbeale@gmail.com
Member	**Roger Kathol, MD** 3004 Foxpoint Rd Burnsville, MN 55337-1072 **Tel:** (952) 426-1626 **Fax:** (952) 426-1200 **Email:** roger-kathol@cartesiansolutions.com
Member	**John Wernert, MD** Professional Development Associates, LLC 1776 Summerlakes Ct Carmel, IN 46032-9679 **Tel:** (888) 822-9732 **Fax:** (888) 822-9732 **Email:** dr.john.wernert@gmail.com

Office of the CEO & Medical Director:	**Saul Levin, MD, MPH** **Chief Executive Officer & Medical Director** **Email:** slevin@psych.org
	Kristin Kroeger **Chief of Policy, Programs & Partnerships** **Email:** kkroeger@psych.org
Healthcare Systems & Finance:	**Irvin (Sam) L Muszynski, JD** **Director, Office of Healthcare Systems & Financing** **Email:** imus@psych.org
	Rebecca (Becky) Yowell **Deputy Director** **Email:** byowell@psych.org
	Karen Sanders **Associate Director, Publicly Funded Services** **Email:** ksanders@psych.org
	Melissa Staats **Associate Director** **Email:** mstaats@psych.org
Department of Government Relations:	**Deana McRae** **Associate Director, Research and Policy** **Email:** dmcrae@psych.org
	Matt Sturm **Deputy Director, House Affairs** **Email:** msturm@psych.org
	Jeff Regan **Deputy Director, Senate Affairs** **Email:** jregan@psych.org
Education & Training:	**Ann Thomas** **Editorial Manager** **Email:** athomas@psych.org
Quality Improvement & Psychiatric Services:	**Samantha Shugarman** **Deputy Director** **Email:** sshugarman@psych.org
Research:	**Joyce West, PhD, MPP** **Senior Research Scientist, PRN** **Email:** jwest@psych.org

HIV Psychiatry

Ian Hedges
Associate Director
Email: ihedges@psych.org

Staff Observers:

Rodger Currie
Chief Department of Government Relations
Email: rcurrie@psych.org

Glenn O'Neal
Director, Corporate Communications & Public Affairs
Email: goneal@psych.org

Ranna Parekh
Director, Division of Diversity & Health Equity
Email: rparekh@psych.org

Jason Young
Chief Communications Officer
Email: jyoung@psych.org

QUALITY AND PERFORMANCE MEASUREMENT
Key Findings and Recommendations
From the 2013 Board Workgroup of Healthcare Reform
(With Primary Current APA Activities Noted)

Background

Healthcare reform has greatly accelerated the development and use of performance indicators, and these measures will increasingly be applied to psychiatric and other mental health/substance use disorder care.

Key Findings

- **Necessity for consensus** - There must be consensus among psychiatrists about what quality domains are most important to measure. Not all measures are equal.
- **Quality of current performance measures** - Few performance measures in behavioral health are fully validated and reliable, nor are they robustly included in existing measure sets.
- **Range of quality measures** - It is important to develop and measure indicators not only for individual medical and behavioral health conditions but also for the key processes associated with integrated care delivery.
- **Accreditation and certification** - Current programs have not benefited from robust psychiatric input and lack adequate mental health and substance use measures and measures that cover coordination with general healthcare and medical comorbidity.
- **Health information technology (HIT)** - The use of HIT, including electronic health records, is necessary to facilitate quality improvement.
- **Risk adjustment** - Many measures do not adequately account for variations in patient panels nor do they necessarily account for more severely psychiatrically ill patients or patients with multiple comorbidities (i.e., they fail to make the necessary risk adjustments to determine actual quality of care).
- **Awareness of APA members** - There are some psychiatric quality measures in place, albeit a very limited number, but it is not clear that psychiatrists are sufficiently informed or use measures frequently.
- **Adoption** - Given the greater prevalence of solo or small group practices for psychiatry, and the expense of HIT, the adoption of performance measures may be more difficult for psychiatrists.

Recommendations and Current APA Activities

- **The APA must clarify and articulate its vision for mental health quality measures that are integrated with those for other medical care.**
  Current activities:
  - The APA recently acquired 4 measure sets previously stewarded by the AMA-Physician's Consortium for Performance Improvement (PCPI): Child and Adolescent Major Depressive Disorder Measure Set, Adult Major Depressive Disorder Measure Set, Substance Use Disorder Measure Set, and Dementia Measure Set. The dementia measure set, jointly stewarded by the APA and the American Academy of Neurology, will begin to undergo a maintenance phase in 2015.
- **The APA must 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.**
  Current activities:

  - The APA website, www.psychiatry.org , currently hosts a webpage that has an Excel spreadsheet providing the measures appropriate for psychiatric clinicians to complete for the purposes of internal quality improvement and/or payment programs.
- **The APA must work to broaden the range of quality measures to include outcome measures and measures of integrated care for individuals with multiple comorbidities.**
  Current activities:
  - The second Board Workgroup developed a paper entitled "Measuring Performance in Psychiatry: A Call to Action," which largely argued that the scope of measurement in behavioral health needs to be expanded to include functional outcome measures.
- **The APA and its members must engage where appropriate in research activity on quality in psychiatric practice.**
  Current activities:
  - The Workgroup on Registries is focused on determining a way to develop an APA-sponsored registry focused on improving care quality and will report to the BOT in March 2015.
  - Ongoing development of practice guidelines for psychiatric disorders, which include quality measures.
- **The APA should consider a leadership role in the development of EHR and relevant registry quality reporting capacity.**
  Current activities:
  - The APA has developed and executed a webinar for vendors as an effort to take on a leadership role in working with vendors to identify what works for psychiatry.
  - Dr. Steve Daviss has represented the APA as an organizational member of HL7, the international standards development organization for health IT that establishes EHR, HIE, and registry standards.
- **The APA should disseminate psychiatric outcome measures that are meaningful and actionable.**
  Current activities: None currently
- **The APA should expand educational outreach on performance measurement to its members.**
  Current activities:
  - Administration attendance at various Council meetings to present the current state of measure development and management at the APA.
  - Updating the APA website with the latest public reporting information.
  - Fielding phone calls and emails from members about performance measurement and quality reporting.
- **The APA should expand its participation in national initiatives on quality measures at all levels (federal, state, private insurance, etc.).**
  Current activities:
  - Several APA members are seated on the National Quality Forum's (NQF) Behavioral Health Standing Committee. While none of these members officially represents the APA in this effort, this does give the APA the opportunity to communicate the perspective of the Council on Quality Care and have its views and opinions made known.
  - APA members and Administration are participating on Technical Expert Committees during the performance measure development by commercial developers (e.g., NCQA Psychiatric In-Patient Hospital Measure Set).
  - APA Administration monitors and meets with CMS regarding quality measure activities.
- **The APA should expand its efforts in monitoring and participation in health plan certification/accreditation.**

Current activities:

- The APA Workgroup on Standards and Survey Procedures has active involvement with certification and accreditation organizations via formal representation on The Joint Commission's Professional and Technical Advisory Councils (PTACs) for both hospital accreditation and behavioral health care accreditation.
- The APA also has representation with URAC, including involvement at leadership levels.
- The APA Workgroup on Patient Safety has focused on participating in standards development associated with patient safety, as exemplified by present work on transition of care, which is a Joint Commission National Patient Safety Goal in development.

- **The APA needs to assume a leadership role on quality metrics for psychiatric care and their consistent adoption across payers and regulatory entities.**

  Current activities:

  - Dr. Harold Pincus currently participates on the Coordination Committee of the NQF MAP (Measures Applications Partnership), a multi-stakeholder partnership that guides the Department of Health and Human Services (HHS) on the selection of performance measures for federal health programs. Similar to other NQF projects, although Dr. Pincus does not officially represent the APA in this role, he does identify the need to align and support measures that are related to the improvement of quality care for psychiatrists.
  - APA has filed objections to CMS's Medicare PQRS quality measure configuration as it is presently codified. This is due to a lack of sufficient body of meaningful measures for psychiatry. Administration staff will be meeting with CMS to discuss changes for the 2016 Medicare Physician Fee Schedule.

The Financing of Psychiatric Care: Structure, Payment, and Administration
Key Findings and Recommendations
from the 2013 Board Workgroup of Healthcare Reform
(With Primary Current APA Activities Noted)

Background

The financing of and payment for psychiatric care is a complex topic, and no discussion of it in the context of health reform is complete without due consideration of its sources, structure, and management, and the inequities relative to general healthcare. While the ACA offers the potential to expand coverage and access and enable new care delivery models, this will be unrealized if fundamental payment issues are not addressed.

Key Findings

- **A report by Milliman was commissioned to estimate the economic impact of integrated medical-behavioral health care for commercially insured, Medicare, and Medicaid populations.** In all market segments, medical costs for persons with a treated psychiatric or substance use disorder typically cost 2-3 times more on average than costs for persons without a MH/SUD condition. The difference between the two was defined as the "value opportunity," or what could theoretically be saved through providing integrated care. Based on its review of integrated care studies, Milliman rendered a conservative estimate of projected savings of $26-49 billion if integrated care were provided to patients with MH/SUD.
- **Financial sustainability for integrated care initiatives is essential.** The ability to provide appropriate MH/SUD services in primary care settings (and vice-versa) is impeded by a number of reimbursement barriers. The sustainability of desired integrated care initiatives is dependent on permanent solutions, including payment for infrastructure, care management, and currently non-reimbursed consultative services.
- **CPT Coding Changes may be needed.** Codes that describe essential services and functions provided by psychiatrists in integrated care systems may be needed.
- **Medicaid is the largest payer of mental health services overall.** Medicaid payment policy is complex and is becoming increasingly decentralized with respect to decision-making regarding coverage and payment policy through the "waiver" process and multiple state demonstration projects.
- **Current fee for service (FFS) payment methodologies are projected to shift toward global payment and value purchasing.** Pay for Performance will be increasingly prevalent. It is highly likely that payment levels/fee schedules for all physicians will be, in part, dependent on performance metrics.
- **Fee for Service (FFS) still has a future.** Most proposed payment approaches, such as medical homes and shared savings for accountable care organizations, maintain fee-for-service components. Fee schedule codes and prices are the building blocks for other proposed approaches. Bundled payments for episodes of care and global payments also depend on FFS pricing.
- **Payment to psychiatrists for work valued similarly for other physicians is generally not at par when measured on an RVU basis.** This pattern has persisted despite enactment of the parity law.

- **Structure and management of payment:** carved out v. integrated. There are some advantages (protection of MH/SU dollars) and many disadvantages to the carve-out models and the legacy issues they bring that are barriers to the quest for integrated care. These must be resolved if they are to remain a management option, especially for public sector populations.
- **Mental Health Parity creates a different milieu for coverage, payment and management issues.** The Parity law has created a new legal framework for achieving appropriate coverage and access to MH/SUD services. Maintaining this leverage for patients and physicians is a priority.

Recommendations and Current APA Activities

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

Current Activities

  - APA has supported the development of and reimbursement for non-face-to-face care management services through regulatory comments and meetings with CMS officials.
  - APA member representatives and OHSF staff continue collaborative efforts with other medical specialty societies to improve payments for care coordination and to develop a CPT coding mechanism that will capture work that is not currently included in existing CPT codes.
  - OHSF is exploring development of a white paper on financing that would include integrated care and the role of psychiatry.

- **In a system that integrates care, the value of psychiatry must be acknowledged in improving total healthcare quality and achieving costs savings. Proper attribution is needed to ensure that the psychiatric care system, our patients, and psychiatrists can benefit from improvement in total costs.**

Current Activities

  - OHSF worked with the Toward Accountable Care Association to explore merit based shared savings distribution model. This is not a final resolution to this issue.

- **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.**

Current Activities

  - APA is part of the Cognitive Specialty Coalition, which advocates for improved payments for E/M services through legislation, regulation, and meetings with key decision makers (MedPac)
  - The APA delegation has lobbied the AMA to advocate on behalf of psychiatry for increased payments for primary care services (E/M services).

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

Current Activities

  - OHSF prepared a 116-page curriculum and presented a Health Reform train-the-trainer event.

- OHSF monitors and reports policy initiatives related to overall health care payment reform, transitions to global payments systems as well as any initiatives or reform on MH payment transactions.
- OHSF is working to establish an ongoing education outreach effort for APA members on health reform topics. OHSF has developed a series of webinars for CME credit.

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

Current Activities

- OHSF monitors state Medicaid initiatives, CMMI, and commercial payer activities with varying models of integration of medical and behavioral health services that can include IC treatment models.
- OHSF maintains relationships with CMS, CMMI, the Federally Coordinated Health Care Office, and the Center for Clinical Standards and Quality.
- The second BOT Workgroup commissioned the development of two 'toolkits' on Medicaid for state advocates – Managing Managed Care: A Toolkit for Advocates http://www.psychiatry.org/File%20Library/Practice/APA-PR-ManagedCaretoolkitforAdvocates20140924.pdf and An Advocacy Toolkit—Improving Care for People with Serious Mental Illness: Medicaid's 1915 (i) Option http://www.psychiatry.org/File%20Library/Practice/APA-PR-1915iAdvocacyToolkit20140924.pdf

- **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.**

Current Activities

- See next recommendation

- **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.**

Current Activities

- The Council on Healthcare Systems and Financing has discussed with Administration staff the need to explore how clinical, administrative, and fiscal benchmarks can be established to ensure access and payment for all services regardless of structures or medical settings.

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

Current Activities

- OHSF will survey several states that have moved to Medicaid integrated care to determine how quality and budget issues were addressed.

- **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.**

Current Activities Non-applicable currently

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

Current Activities

- OHSF works with the Partnership on Workplace Mental Health to advocate MHPAEA to employers.
- OHSF, in conjunction with the APA General Counsel, is involved in a wide variety of compliance and enforcement activities regarding the Parity Act.
- OHSF, in conjunction with the Parity Implementation Coalition, continues to maintain the website that provides information about and advocacy for the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008.

INTEGRATED CARE
Key Findings and Recommendations
From the 2013 Board Workgroup of Healthcare Reform
(With Primary Current APA Activities Noted)

Background

Integrated care is an integral part of health care reform. Collaborative care through integration is essential for improving patient care, health, and outcomes.

Key Findings

- **Evidence Base** - There is a significant body of evidence for the collaborative care model. The evidence for the other models of care continues to be developed.
- **Sustainability for models** - The current fee-for-service payment structure is a barrier to integrated care.
- **APA leadership is needed to ensure success of integrated care** - Despite the healthcare imperative for integrated care, there is no central or organized leadership or overarching strategy within the APA to support this agenda.
- **There is a need to increase understanding of the financial and quality consequences of integrated care** - Given the prevalence of psychiatric and substance use disorders in primary care and specialty settings and their high total healthcare cost, integrated care is essential to improving the quality of care for patients with multiple co-morbidities while decreasing costs.
- **There is a need for an agreed-upon vocabulary to describe integrated care.**
- **There are currently five models of integrated care in the public and private sectors** - These are: collaborative care; care management; co-location (e.g., patient-centered primary care based homes with psychiatric or other mental health provider presence) and reverse co-location (e.g., community mental health centers with psychiatric leadership and primary medical care services) or as more recently identified, bi-directional models; medical homes; patient-centered medical homes (PCMHs) and patient-centered behavioral health homes (PCBHHs) with a broad range of medical and psychiatric/behavioral care; and accountable care organizations (ACOs).
- **Substance use disorders must be addressed** - Substance use disorders are prevalent in all care settings, impacting cost and quality. The role for psychiatry needs to be better defined and articulated, and more research on effective care models in integrated settings is required.
- **The APA needs an increased presence with key stakeholders** - There are many stakeholders with a vested interest in integrated care—e.g., numerous federal agencies, commercial payers, accrediting entities, medical associations, patient groups, non-physician healthcare professionals, collaborative organizations, and so on.
- **Standards, quality measures, performance metrics, and payment methods for these core integrated care models are still in development and/or evolving** - Accountability standards and payment initiatives are beginning to be implemented. These shape patient care and psychiatric practice. Psychiatry should be leading the mental health standards, measures, and payment agendas.
- **Psychiatrists require core competencies to participate in integrated care models** - Integrated care models require psychiatrists to perform different clinical and management functions than are otherwise required in psychiatric practices. Psychiatrists need training and education at all points in their careers to effectively perform these functions.
- **Data on current psychiatric practice is lacking.** There is limited information on the number of psychiatrists currently involved with alternative care arrangements and on the training and education psychiatrists receive.

Recommendations and Current APA Activities

- **APA should develop a vision statement.**
  Current activities:
  - The Integrated Care Workgroup under the Council for Healthcare Systems and Financing developed the following mission and vision statement in 2013: "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."
- **The APA should develop specific communications strategies to promote the value of integrated care and psychiatric physician leadership with key stakeholder audiences. This strategy should include internal and external audiences.**
  Current activities:
  - The APA hosted a press conference *Integrated Primary & Mental Health Care: Reconnecting Brain & Body* on April 4, 2014. This was conducted in collaboration with a number of physician organizations, patient groups and federal agencies to highlight the release of the Milliman Report - *Economic Impact of Integrated Medical- Behavioral Healthcare: Implications for Psychiatry*.
- **The APA should support the value of integrated medical and psychiatric care for patients with psychiatric illness in all treatment settings**.
  Current activities:
  - The APA's Division of Policy and Program Development, through OHSF, has a number of activities underway; e.g., a formal working structure to interact with the Patient Centered Primary Care Collaborative, outreach to primary care and allied health organizations, among others, and there is cross-over with education and training.
- **The APA should establish an ongoing inventory of current models of integrated care for all populations and promulgate that information to psychiatrists, other physicians, healthcare leaders, and policy makers. This should include data on best evidence for integrated care and its implementation.**
  Current activities:
  - The Council on Psychosomatic Medicine is in the process of conducting an inventory of extant models of care.
  - OHSF prepared a Healthcare Reform document that includes an inventory of current models.
- **The APA should provide integrated care training and education to psychiatrists at every point in their professional careers.**
  Current activities:
  - The APA's online Learning Management System is used as a distribution channel for integrated care content. The AIMS Center at the University of Washington is developing integrated care educational modules for the APA for Spring 2015 (details in education and training section).
  - OHSF produces Integrated Care News Notes, a bi-weekly integration policy newsletter. Additional distribution channels outside of APA membership are being explored.

  - APA publications include *Psychiatric Services* with column on integrated care and numerous studies on the topic; the *American Journal of Psychiatry*, which publishes studies; and textbooks – Dr. Lori Raney (*Integrated Care Working at the Interface of Primary Care and Behavioral Health*) and Dr. Robert McCarron (*Preventive Medical Care in Psychiatry: A Practical Guide for Clinicians*)
  - Integrated care tracks at the Annual Meeting and Institute for Psychiatric Services.
- **The APA should take a lead role with accreditation and federal agencies in developing quality metrics for integrated care and the patient registries needed to implement these.**
  Current activities:
  - QIPS monitors the advancement of mental health measures and standards developed by NQF and federal agencies. Accrediting entities are monitored tangentially but plans are underway to assign responsibility.
- **The APA needs to 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.**
  Current activities:
  - OHSF and QIPs work to ensure APA input on developing standards; e.g. The Joint Commission's Behavioral Health Home, and URAC's Clinically Integrated Network (CLIN) standards.
- **The APA needs to define the role of psychiatry in integrated care.**
  Current activities:
  - The contracted educational modules from the AIMs Center will define and explain the role of psychiatry in integrated care.
- **The APA must take the lead in the development, implementation, and propagation of evidence based integrated care.**
  Current activities:
  - Numerous members are leaders in the field of IC program development, implementation, and research, but these do not constitute official APA representation.
  - The APA has submitted a proposal for a federal grant to create a Support and Alignment Network in collaboration with the AIMs Center.
- **The APA should maintain working relationships with a wide variety of key stakeholders, including the AMA, major primary care medical associations, and specialty collaboratives; numerous federal agencies; commercial payers; accrediting entities; medical associations; patient groups; non-physician healthcare professionals; and collaborative organizations.** Current activities:
  - The APA's Division of Policy and Program Development, which includes OHSF and Quality, is working with a number of medical and allied organizations, federal agencies, patient groups, and collaborative care organizations.
  - The Partnership for Workplace Mental Health is working with employers to advocate for integration and quality care.

RESEARCH AND MENTAL HEALTH EVIDENCE BASE
Key Findings and Recommendations
from the 2013 Board Workgroup of Healthcare Reform
(With Primary Current APA Activities Noted)

Background

The ACA contemplates a transformation of care delivery and payment reform and has also set into motion a plethora of research and evaluation efforts to inform policy and clinical care. Its repeated emphasis on quality of care measures and on evidence-based treatment increases the need for proven approaches in mental healthcare delivery.

The Workgroup identified many of what it considered important research questions and recommendations. These 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. A sampling of the questions and recommendations follows.

Research Questions Topical Areas Involved in Health Reform

- **Integrated Care**
  - What is the effectiveness of integrated care in general medical and related psychiatric practice settings?
  - What is the effectiveness of integrated care for those with severe mental illness? What models will work best in this population and help with the medical disorders found in them?
  - What models could ensure sustainability?
- **Financing of Psychiatric Care**
  - What are the best models for financing integrated care models?
  - What models of financing will ensure appropriate care under healthcare reform for those within the current public mental health system?
  - What models of payment by Medicaid/Medicare are best for those with mental illness?
  - What mental health and substance use disorder interventions shold be part of a basic package of insurance coverage (this becomes especially relevant with health exchanges and expansion of Medicaid)?
- **Quality and Performance Measurement**
  - What are the viable pay for performance models for MH/SUD, including integrated models?
  - How can the development of patient-centered outcome measures be increased?
  - What are the best risk adjustment models? (also relevant to Financing)
- **Health Information Technology (HIT)**
  - What EHR applications actually improve care and outcomes?
  - What EHR data related to those with mental health/substance use disorders are critical for improved treatment outcomes?
- **Workforce, Training, and Education**
  - What is the projected demand for services given the increase in coverage under the ACA?
  - What range of mental health disorders will primary care physicians, non-physician primary care medical caregivers, and specialists treat? What are the existing and expected skill sets and training they will need?

- What skill sets are needed now for psychiatrists to practice in future models of healthcare?

Current Policy-Relevant Research Initiatives

Current APA policy research efforts are focused on analyzing and reporting findings from the *National Study of Psychiatric Practice under Health Care Reform* and the *Medicaid Psychiatric Treatment Access Study.*

- The *National Study of Psychiatric Practice under Health Care Reform* will provide the APA with up-to-date information on psychiatrists': 1) settings and sources of payment; 2) current and anticipated future use of new payment methods and electronic health records (EHRs); and 3) receptivity to working in new roles and services delivery models such as integrated care.
- The *Medicaid Psychiatric Treatment Access Study* will document patients' problems in accessing evidence-based psychosocial and pharmacologic treatments, including psychotherapy, alcohol or other substance abuse treatment, assertive community treatment, case management, supported employment, and housing.
- Both studies will provide the APA with important pre-ACA baseline information on the status and readiness of psychiatrists as health services move into new models of care, and on treatments gaps and access issues facing psychiatrists and their patients. The APA and its members will have important tools to support advocacy efforts for access to clinically indicated medications and psychosocial treatment for Medicaid psychiatric patients.

ELECTRONIC HEALTH RECORDS (EHR) AND RELATED TECHNOLOGY
Key Findings and Recommendations
From the 2013 Board Workgroup of Healthcare Reform
(With Primary Current APA Activities Noted)

Key Findings

- **Technology acquisition** – Psychiatrists, who are disproportionately solo and small-group practitioners, have lagged behind other specialties in adopting EHR, in part due to cost and the necessity of adapting available EHR to psychiatric care needs. It is essential that psychiatrists adopt EHR if they are to participate in the new healthcare world. Reporting on performance measures is a vital element for participating in healthcare reform, and this is best accomplished through the use of EHRs. There are currently a limited number of EHR products suitable for psychiatric practices.
- **Medical record confidentiality** – Psychiatric and substance use disorder medical records present numerous problems in the emerging era of health information exchange that must be overcome especially with regard to integrated care initiatives.
- **Federal policy issues** – The law that regulates the confidentiality of alcohol and drug abuse records, 42 CFR Part 2, poses a major barrier to the effective use of EHR by mental health clinicians. The fact that Medicare payment policy will be penalizing physicians who fail to use EHR regardless of the size of their practices, and that quality measure reporting, which is tied to new pay-for-performance policies, is largely dependent on the use of EHR, make it clear that there is no avoiding the need to begin using EHR.
- **Patient registries and integrated care models** – Success under emerging integrated care models depends upon the use of EHR and patient registries. Registries are essential for tracking patients, developing data that will contribute to evidence-based care, and for reporting on quality measures that will be tied to reimbursement.
- **Health information exchange (HIE)** - HIEs provide services that enable the electronic sharing of health-related information across statewide, regional, and local initiatives. Due to the complexity and variation in policies and laws, as well as to concerns about the sensitivity of information pertaining to mental health and substance abuse disorder (MH/SUD) treatment, there are many challenges in deciding how information pertaining to MH/SUD treatment will be shared over health information exchanges. The two most common approaches (sharing MH/SUD information without any additional protection and withholding MH/SUD information from any form of exchange) are both problematic for patients with mental health or substance abuse disorders.
- **Key organizations** - Several organizations are key to funding and setting policy for developing HIT: CMS; the Health Resources and Services Administration (HRSA); the Office of the National Coordinator for HIT (ONC); and the Nationwide Health Information Network Exchange.

Recommendations and Current APA Activities

- **The APA should develop resources that help members select, implement, maintain, and use EHRs and other forms of HIT.**
  Current Activities:
  - The APA's Committee on Mental Health Information Technology (CMHIT) has developed lists of features that EHRs should include in order to meet the needs of psychiatrists. These lists will support many activities, including educating APA members and communicating with software vendors about psychiatrists' needs. They are posted on the APA website.

- The APA has partnered with the American Medical Association, the American College of Physicians, and a broad range of other professional associations to support the American EHR Project, which consolidates information from practicing physicians about EHR products. The American EHR Project established a website that serves as a resource for physicians, (as well as state and federal agencies, vendors, and funding organizations across the US) to access physician-rated reviews of EHR vendors. It provides the necessary tools to identify, implement, and effectively use EHRs and other healthcare technologies. Individuals who wish to fully access the ability to use the filters for psychiatry and to compare EHR vendors should open a free account.
- The APA will be hiring a Health Information Technology Specialist in 2015 to provide dedicated member services around evaluation and selection of EHRs.

- **The APA should continue/expand activities pertaining to HIT privacy.**
  Current Activities:
  - Information related to privacy and security is posted on the APA website.
  - A position statement on "Management of Sensitive Information within Health Information Exchanges (HIEs)" has been completed by CMHIT in response to an Assembly Action Paper.
  - CMHIT is currently discussing guidance on advising patients regarding the sharing of their psychiatric records along with their medical records (for example, in Epic's "Care Everywhere" EHR/HIE).
  - The APA Administration has provided input to and is monitoring SAMHSA's current decision about whether to revise 42 CFR Part 2.
- **The appropriateness and feasibility of the APA developing patient registries for psychiatric patients should be explored.**
  Current Activities:
  - A work group, formed under the Council on Quality Care and also reporting to the Councils on Research and Healthcare Systems and Financing, has been meeting on these issues for the past 6 months. Their report is expected to be submitted to the BOT in March. It should be noted that the American Psychological Association has recently developed a registry for mental health providers.
- **The APA should explore developing an RFP 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.**
  Current Activities:
  - A two-hour webinar, "Behavioral Health EHRs: What Vendors Need to Know," was held on June 27, 2014. The webinar was attended by 39 EHR vendors. CMHIT intends to develop continuing dialog between the APA/CMHIT, AACAP, SAMHSA, ONC, HL7, and the EHR vendors.
  - An Action Paper was approved by the Assembly in November 2014 that asks the APA to assist the CMHIT in exploring the feasibility of sending out an RFP to EHR vendors for "psychiatry friendly" EHRs.
  - In 2010 and 2011, the Committee on Electronic Health Records and the Council on Research and Quality Care (as these committees were then named) explored the pros and cons of the APA developing an EHR or endorsing an EHR from a vendor. The components detailed the many relevant issues, including the significant allocation of APA resources involved; identifying a vendor willing to partner with us and meet our needs; the large variation of our members' needs, preferences, settings, and workflows; the immaturity of the EHR market; the risk of a chosen vendor going out of business; interoperability concerns; potential conflicts of interest in developing a commercial relationship with a vendor; the problem of

organizational accountability for inevitable software problems; and other aspects of such an undertaking. A presentation was made to the Board of Trustees in March 2011, and a full discussion resulted in the BOT concluding that selecting a specific EHR was not appropriate at that time. However, the BOT did agree on partnering with the American EHR Project (see above) to provide a platform where members can share their experiences with particular EHR products in a manner that permits potential purchasers to learn what aspects to consider and to become aware of other's experiences. CEHR subsequently developed a detailed list of EHR functionalities that psychiatrists should consider when evaluating an EHR (also noted above).

- Administration staff are exploring convening a users groups at the Annual Meeting in Toronto to collect member experience.

- **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.**
  Current Activities: Non-applicable currently
- **The APA should develop policy and provide educational training on EHRs and privacy/confidentiality.**
  Current Activities: Non-applicable currently
- **The APA should engage with Health Information Exchange (HIE) efforts.**
  Current Activities:
  - Currently, HIEs are forming at the local level, and each locale is handling psychiatric health information differently. In order to realize the potential of HIEs to facilitate integrated care, APA could participate in oversight bodies at the national level and develop educational material for APA member.
- **The APA should expand efforts to develop resources to help members select, implement, maintain, and use Electric Health Records and other forms of HIT.**
  Current Activities:
  This topic is addressed above under, “APA should develop resources that help members select, implement, maintain, and use EHRs and other forms of HIT.”
- **The APA should continue its efforts to advocate for the expansion of HIT to all aspects of the mental healthcare system.**
  Current Activities: Non-applicable currently

WORKFORCE, WORK ENVIRONMENT, MEDICAL EDUCATION AND TRAINING
Key Findings and Recommendations
from the 2013 Board Workgroup of Healthcare Reform
(With Primary Current APA Activities Noted)

Background

It is clear that key health reform trends underway have important implications for the demand for, types of, and provision of psychiatric services. The exact shape of these changes, the skills that will be required, and who in the general medical, psychiatric, and broader mental health communities will provide this care are all unknown at this point.

Key Findings

- **Federal health manpower policy** – Federal medical workforce policy places premium emphasis on primary care over specialty physicians. There are no foreseeable changes that will radically alter numbers in the near future. There is a disconnect between the likely need and demand for specialty psychiatric physician services as part of behavioral healthcare delivery and current federal behavioral health manpower development policy.
- **Healthcare reform initiatives** – New initiatives are predicated on an expanded non-medical workforce. ACA workforce provisions and initiatives for the behavioral health workforce are focused on training and developing non-MD practitioners.
- **Supply and distribution of psychiatric workforce** – There are known shortage area designations (distribution issues) for both psychiatric and non-MD behavioral health practitioners. These shortage designations have a high degree of correlation with sites of service delivery that will likely be points of access for many of the newly insured.
- **Coverage expansion, increased demand, the non-medical workforce and scope of practice** – The composition (education and training) of the current workforce in most shortage areas/settings and the general non-availability of physicians will likely contribute to increased scope-of-practice debates across all of medicine, not just on the scope of practice for non-medical mental health and substance use disorder practitioners.
- **Provider payment rates under ACA coverage expansion health plans** – Expansion schemes may not offer payment rates that make participation attractive.
- **Psychiatry's role and responsibility in integrated care (IC) models and core competencies required** – While integrated care models employ a wide range of medical and non-medical practitioners in both primary care and behavioral health care, psychiatry has medical skill sets that are essential to successful IC delivery models.
- **Core competencies** – There is a gap between the current typical competencies of psychiatric physicians and those needed to function appropriately in integrated care models. These core competencies are not fully developed in most medical education and training programs.

  While the need and demand for psychiatry to be appropriately embedded in IC delivery models is relatively self-evident, it is not clear that there are sufficient numbers of trained individuals within the current manpower supply who can meet the demand, or even that a significant number of currently practicing psychiatrists are interested in these roles.
- **Current physician training initiatives re integrated healthcare** – There are a number of training curriculum/course opportunities for practicing psychiatrists currently available through the APA, the AIMS Academy, and the National Council.

Recommendations and Current APA Activities

- **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.**
  Current Activities:
  - The Council on Medical Education and Lifelong Learning (CMELL) is collaborating with the Council on Psychosomatic Medicine to evaluate existing educational materials including
    - The Gitlin curriculum for general psychiatry residents;
    - Undergraduate and graduate medical education recommendations from the CMELL whitepaper "Training Psychiatrists for Integrated Behavioral Health Care," which has been approved by the JRC as an APA Resource Document. The paper includes: 1) a review of literature to define the new skills and responsibilities for psychiatrists; 2) scans of the undergraduate, graduate, and CME environments to determine the extent and methods used for integrated care education; 3) a discussion of the challenges and solutions for promoting integrated care training; and 4) recommendations to the APA and to outside educational programs.
  - The Council on Psychosomatic Medicine had an article, "Recommendations for Training Psychiatry Resident in Psychosomatic Medicine," published in the September-October 2014 issue of the journal *Psychosomatics.*

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

- **The APA should develop practice management education 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.**
  Current Activities:
  - The APA contracted with the AIMS Center at the University of Washington to development educational modules that will be available to APA members in 2015.
    - Module 1: Introduction to Integrated / Collaborative Care
    - Module 2: Leadership Essentials
    - Module 3: Developing a Collaborative Care Team and Workflow
    - Module 4: Working with a collaborative Care Team
    - Module 5: Assessment of Common Mental Health Conditions in Primary Care
    - Module 6: Treatment of Common Mental Health Conditions in Primary Care

- CMELL member Dr. Deborah Crowley will lead a symposium at the 2015 Annual Meeting entitled "Educating Psychiatrists for Work in Integrated Care: Focus on Interdisciplinary Collaboration."
- The APA has had dedicated CME course tracks at both the Annual Meeting and the Institute on Psychiatric Services on integrated care and there has been an issue of FOCUS dedicated to integrated care.
- Online integrated care CME courses are in development through the APA's Learning Management System.

- **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).**
  Current Activities:
  - APA convened a meeting with Education directors of various primary care associations to find ways to collaborate. CMELL will work with the Council on Psychosomatic Medicine and the Office of Healthcare Systems and Financing to develop presentations that are planned for primary care association meetings.