American Psychiatric Association
Joint Reference Committee
October 17, 2015

MATERIALS INCLUDED IN THE PACKET

NB: The action items in the JRC Agenda, not the council reports, are the final actions for the JRC

Click on the Item Number to view

2. Draft Summary of Actions from the July 2015 Joint Reference Committee Meeting

3. Report of the CEO and Medical Director

4. Request: Caucus of Korean American Psychiatrists

5. Awards
   - 5.A 2015 Jacob Javits Award
   - 5.B 2016 George Tarjan Award
   - 5.C 2016 Jack Weinberg Award
   - 5.D 2015 Psychiatric Services Achievement Awards
   - 5.E 2016 Bruno Lima Award

7. Council Assessments
   - 7.A Council on Advocacy and Government Relations
   - 7.B Council on Healthcare Systems and Financing

8. Council Reports
   - 8.A Council on Addiction Psychiatry
   - 8.B Council on Advocacy and Government Relations
   - 8.C Council on Children, Adolescents, and Their Families
   - 8.D Council on Communications
   - 8.E Council on Geriatric Psychiatry
   - 8.F Council on Healthcare Systems and Financing
   - 8.G Council on International Psychiatry
   - 8.H Council on Medical Educations and Lifelong Learning
   - 8.I Council on Minority Mental Health and Health Disparities
   - 8.J Council on Psychiatry and Law
   - 8.K Council on Psychosomatic Medicine
   - 8.L Council on Quality Care
   - 8.M Council on Research

Joint Reference Committee
July 10, 2015
DRAFT SUMMARY OF ACTIONS
As of September 2015

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

JRC Members Present:
Maria Oquendo, MD: JRC Chairperson; APA President-Elect (stipend); Salaried at Columbia and NYSPI; royalties from suicide severity rating scale; NIMH; Neuropsychology ; Suicide Research;
Daniel Anzia, MD: JRC Vice Chairperson; APA Speaker-Elect (stipend); 80% employed at Advocate Lutheran Health and Hospitals Corporation; Spouse and father of Advanced Practice Nurses.
Jenny Boyer, MD: Department of Veterans Affairs – salaried; small private practice; State Medical Board of Oklahoma;
Saul Levin, MD, MPA: CEO/Medical Director – APA salary; Chair of the APAF Board of Directors
Theresa Miskimen, MD: Robert Wood Johnson School of Medicine – salaried; Consultant for involuntary medical panels;
Gail Robinson, MD: Professor of Psychiatry – University of Toronto; Expert witness; Member – Ministry of Health Task Force on Sexual Abuse of Patients; GAP Board; Vice President of ACP.
Paul Summergrad, MD: excused

JRC Administration:
Margaret Cawley Dewar – Director, Association Governance
Laurie McQueen, MSSW – Associate Director, Association Governance

APA Administration:
Rodger Currie, JD – Chief of Government Affairs
Yoshie Davison, MSW – Chief of Staff
Tristan Gorrindo, MD – Director, Division of Education
Kristin Kroeger – Chief, Policy, Programs, & Partnerships
Ranna Parekh, MD, MPH – Director, Division of Diversity and Health Equity
Jason Young – Chief of Communications

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
2	Review and Approval of the Summary of Actions from the January 2015 Joint Reference Committee Meeting **Will the Joint Reference Committee approve the draft summary of actions from the January 2015 meeting?**	The Joint Reference Committee approved the draft summary of actions from the January 2015 meeting.	Shaun Snyder, JD Margaret Dewar Laurie McQueen, MSSW	Association Governance
3	CEO/Medical Director's Office Report **Updates on Referrals**			
3.1	Position Statement: Bill of Rights: Principles for the Provision of Mental and Substance Abuse Treatment Services [JRCOCT148.G.17] The position statement remains important when advocating on behalf of mental and substance use treatment services. The principles are applicable to implementation as they were to the enactment of passage. The Division of Government Relations is working with the Council on Advocacy and Government Relations to revise the statement. The Council on Advocacy and Government Relations is establishing a work group comprised of members from appropriate APA components, to include CAGR and the Council on Healthcare Systems and Financing (CHSF), in developing a revised position statement that best represents the organization in addressing treatment services. The Council has volunteered to lead the participants in the development of the position statement and to engage the other endorsing organizations	The Joint Reference Committee thanked the CEO/Medical Director for the update and requested that the JRC receive a revised position statement or an update at its October 2015 meeting.	Rodger Currie, JD Deana McRae	Council on Advocacy and Government Relations Report to JRC: October 2015 (Due 10/2/2015)

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3.2	Current Health Services Literature on Integrated Care Models [JRCOCT148.G.22] See also Item 8.4 Division of Research Administration met with Healthcare Systems and Financing Administration to discuss and clarify the areas of focus that would be most helpful for this literature review. From these discussions, an outline was developed to guide the literature searches, which will now commence.	The Joint Reference Committee thanked the CEO/Medical Director for the update and requested a report to the JRC in October 2015 on the discussions and literature review.	Kristin Kroeger Eve Moscicki, ScD, MPH	Programs, Policy & Partnerships Division of Research Report to JRC: October 2015 (Due 10/2/2015)
4	JRC Discussion Topics	The Joint Reference Committee reviewed its charge. All council chairpersons were encouraged to hold regular conference calls of their councils and to facilitate the communication between the councils and the Assembly utilizing the Assembly member on the council. The JRC revised the schedule for assessing Councils. **October 2015** Council on Advocacy and Government Relations Council on Healthcare Systems and Financing **January 2016** Council on Quality Care Council on Psychiatry and Law		Association Governance
6	Assembly Report			

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6.1	New Position Statement on Firearm Access, Acts of Violence, and the Relationship to Mental Disorders and Mental Health Services (ASMMAY1512.B) The Assembly voted to refer action paper 2015A1 12.B to the Council on Psychiatry and Law. **Will the Joint Reference Committee refer action paper *2015A1 12.B: New Position Statement on Firearm Access, Acts of Violence, and the Relationship to Mental Disorders and Mental Health Services* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the position statement to the Council on Psychiatry and Law requesting the Council's feedback on revising the current position statement at this time.	Rodger Currie, JD Lori Klinedinst Whitaker	Council on Psychiatry and Law Report to JRC: October 2015 (Due 10/2/2015)
6.2	Developing an Access to Care Toolkit (ASMMAY1512.C) The action paper asks: 1. That an Access to Care Tool Kit be developed and maintained by the Council on Healthcare Systems and Financing to include relevant Action Papers, Position Statements, Guidelines, model or sample state legislation, survey instruments and a repository of related legal actions from states. The Tool Kit should include links to the Parity Tool Kit and other related resources and to be easily downloadable to members. 2. The availability of the Tool Kit and its components should be publicized in APA News, and to District Branches and State Organizations through the Federal Legislative Representative Network and the Office of Ethics and District Branch/State Association Relations. **Will the Joint Reference Committee refer action paper *2015A1 12.C: Developing an Access to Care Toolkit* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing Report to JRC: January 2016

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6.3	Compendium of Access to Care Action Papers and Position Statements (ASMMAY1512.D) The action paper asks that a compendium of Action Papers and Position Statements relating to access to care be included in an easily downloadable Access to Care Tool Kit to be developed and maintained by the Office of Health Care Systems and Financing. **Will the Joint Reference Committee refer action paper *2015A1 12.D: Compendium of Access to Care Action Papers and Position Statements* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing Report to JRC: January 2016
6.4	Access to Care Survey (ASMMAY1512.E) The action paper asks that one or more patient centered Access to Care Surveys, such as the Area 6 Access to Care Survey, be included in an Access to Care Toolkit, to be developed and maintained by the Council on Health Care Systems and Financing. **Will the Joint Reference Committee refer action paper *2015A1 12.E: Access to Care Survey* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing Report to JRC: January 2016

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6.5	Level of Service Intensity Instrument (ASMMAY1512.F) The action paper asks: 1. Within six months the APA Administration will research what level of care/intensity of service tools are available and used by insurance companies and other organizations for determination of appropriate psychiatric and substance abuse care for adults. 2. This data will be presented to the Councils on Quality Care and Healthcare Systems and Financing to determine whether APA should: a. Endorse a specific tool or set of criteria, or; b. Propose development of such a tool by APA 3. That the Councils will report their recommendations to the Joint Reference Committee the following year. **Will the Joint Reference Committee refer action paper *2015A1 12.F: Level of Service Intensity Instrument* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred items #1 and #2 to the Office of Healthcare Systems and Financing and items #2 and #3 to the Council on Healthcare Systems and Financing.	Kristin Kroeger Sam Muszynski, JD Becky Yowell	Office of Healthcare Systems and Financing Council on Healthcare Systems and Financing Report to JRC: October 2015 (Due 10/2/2015)

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6.6	Timely Reimbursement for Psychiatric Treatment (ASMMAY1512.G) The action paper asks: That the Council on Healthcare Systems and Financing and the Division of Government Affairs will encourage state and national governments to enact enabling legislation and grants to psychiatrists to voluntarily use effective systems of immediate payment to insurance - paneled psychiatrists (and patients of psychiatrists who have opted out of third party payors excluding Medicare), using secure card or mobile technology for web-based patient identification, registration, and payment; and That the APA/AMA Delegation will work with the American Medical Association to promote the adoption of a national voluntary system of immediate electronic medical claims filing, adjudication, and payment. **Will the Joint Reference Committee refer action paper *2015A1 12.G: Timely Reimbursement for Psychiatric Treatment* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Quality Care [LEAD], and the Council on Healthcare Systems and Financing and requested a report in October 2015. The councils are asked to determine what the appropriate scope or universe would be to implement this paper and if legislation might be needed. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Kristin Kroeger Samantha Shugarman Becky Yowell	Council on Quality Care [LEAD] Council on Healthcare Systems and Financing Report to JRC: October 2015 (Due 10/2/2015)

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6.7	<u>Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault</u> (ASMMAY1512.H) The action paper asks that: 1. The APA develop a Position Statement and a Resource Document regarding the psychiatric morbidity associated with sexual assault, including the psychological difficulties attendant to sexual assault evidence procurement and the failure of acting upon such evidence; 2. The relevant component of the APA work with the American Association for Emergency Psychiatry to ascertain that the emergency treatment of sexual assault victims, including that the administration of sexual assault evidence assessment kits, be coupled with provision of information about access to mental health treatment resources; 3. The relevant component of the APA liaise with the entities responsible for analyzing sexual assault victim evidence kits and acting upon their results in order to educate those entities to the psychiatric morbidity of their failing to do so, and to be available to assist those entities in their efforts to obtain adequate funding by providing them with information about the psychiatric morbidity associated with sexual assault; 4. The APA Council on Healthcare Systems and Financing advocate for the adequate provision of psychiatric treatment benefits to assure the provision of needed psychiatric services to victims of sexual assault. **Will the Joint Reference Committee refer action paper 2015A1 12.H: *Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Minority Mental Health and Health Disparities (LEAD), Council on Quality Care, Council on Healthcare Systems and Financing and the Council on Psychiatry and Law. The councils were asked to provide feedback and comment on the feasibility of the action paper and to whom the APA would advocate. The JRC noted that the Council on Minority Mental Health and Health Disparities is currently developing a position statement on rape and human trafficking. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Kristin Kroeger Ranna Parekh, MD, MPH Alison Bondurant Samantha Shugarman Becky Yowell Rodger Currie, JD Lori Klinedinst Whitaker	Council on Minority Mental Health and Health Disparities [LEAD] Council on Quality Care Council on Healthcare Systems and Financing Council on Psychiatry and Law Report to JRC: January 2016

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6.8	<u>Fostering the Next Generation of Leaders within the APA</u> (ASMMAY1512.J) The action paper asks: That the APA develop a comprehensive and coordinated set of leadership, team building and enrichment activities aimed at fostering leadership and promoting positive relationships between the young leaders* of the APA and established APA leadership. That the APA look to consolidate and coordinate current offerings to prevent duplication of efforts and to ensure the best use of resources That these activities occur at the APA Annual Meeting in May. That these activities be coordinated by the Chief RFM-ECP Officer, the Director of the Division Diversity and Health Equity, and the Director of Education. **Will the Joint Reference Committee refer action paper 2015A1 12.J: *Fostering the Next Generation of Leaders within the APA* to the appropriate Component(s) for inpu or follow-up?**	The Joint Reference Committee referred the action paper to the Office of the Chief Executive Officer/Medical Director for refinement and a cost estimate.	Saul Levin, MD Jon Fanning Tristan Gorrindo, MD Ranna Parekh, MD, MPH	Office of the CEO & Medical Director Report to JRC: January 2016

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6.9	<u>The Impact of Global Climate Change on Mental Health</u> (ASMMAY1512.L) The action paper asks: 1. That the Assembly recommends the American Psychiatric Association adopt a Position Statement addressing the mental health impact of extreme weather events and natural disasters resulting from global climate change. 2. Should the Assembly approve this action paper, it will be referred to the Committee on Psychiatric Dimensions of Disasters to study and produce a position statement. **Will the Joint Reference Committee refer action paper *2015A1 12.L: The Impact of Global Climate Change on Mental Health* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Minority Mental Health and Health Disparities (LEAD), the Council on International Psychiatry, the Committee on Psychiatric Dimensions of Disasters and the Council on Communication. A report to the JRC was requested for January 2016. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Kristin Kroeger Ranna Parekh, MD, MPH Alison Bondurant Jon Fanning Ricardo Juarez Jason Young	Council on Minority Mental Health and Health Disparities (LEAD) Council on International Psychiatry Committee on Psychiatric Dimensions of Disasters Council on Communication Report to the JRC: January 2016

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6.10	Promoting Military Cultural Knowledge among Psychiatrist (ASMMAY1512.M) The action paper asks: 1. That the APA support as a core professional practice that psychiatrists consider asking the question: "Have you or someone close to you served in the military?" as part of the clinical evaluation. 2. That the APA support psychiatrists' attaining a basic level of military cultural knowledge through the completion of Module I of the free, accredited, online DoD/VA course at http://deploymentpsych.org/military-culture 3. Through the APA Department of Education's website and educational activities, the APA promote the availability of resources for attaining military cultural knowledge. 4. That the APA, through its educational liaisons to other medical education organizations, promote education about military cultural knowledge among clinicians. 5. That the APA consider drafting a position paper on the importance of promoting military cultural knowledge among psychiatrists. **Will the Joint Reference Committee refer action paper *2015A1 12.M: Promoting Military Cultural Knowledge among Psychiatrists* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Medical Education and Lifelong Learning [LEAD]. Council on Advocacy and Government Relations, Council on Quality Care and the Caucus of VA Psychiatrists and report to the JRC on the ways to implement this and the potential to develop a position statement at the October 2015 meeting. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Tristan Gorrindo, MD Rodger Currie, JD Deana McRae Kristin Kroeger Samantha Shugarman	Council on Medical Education and Lifelong Learning [LEAD] Council on Advocacy and Government Relations Council on Quality Care Caucus of VA Psychiatrists Report to JRC: October 2015 (Due 10/2/2015)

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6.11	Changing ECP Status to 8 Years Following Completion of Training (ASMMAY1512.N) The action paper asks that the APA adopt a similar position to the AMA in defining the ECP period as eight years following the completion of residency/fellowship training. **Will the Joint Reference Committee refer action paper *2015A1 12.N: Changing ECP Status to 8 Years Following Completion of Training* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Membership Committee and then to the Finance and Budget Committee. It was requested that both committees look into the feasibility of implementing the action paper including a cost/benefit analysis.	Jon Fanning, MS, CAE Susan Kuper Shaun Snyder, JD Margaret Hunte	Membership Committee Finance and Budget Committee Report to the JRC: January 2016
6.12	Improving APA Support of Mental Health of African American Males (ASMMAY1512.O) The action paper asks that the Council on Medical Education and Lifelong Learning and the Office of Education investigate, in collaboration with experts, how to provide training opportunities for psychiatrists to provide community-based, culturally competent therapeutic interventions for traumatized African American communities. **Will the Joint Reference Committee refer action paper *2015A1 12.O: Improving APA Support of Mental Health of African American Males* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Division of Education, the Division of Diversity and Health Equity and the Council on Minority Mental Health and Health Disparities for implementation. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Kristin Kroeger Tristan Gorrindo, MD Ranna Parekh, MD, MPH Ranna Parekh, MD Alison Bondurant	Division of Education [LEAD} Division of Diversity and Health Equity Council on Minority Mental Health and Health Disparities Report to JRC: October 2015 (Due October 2, 2015)

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6.13	<u>Emergency Department Boarding of Individuals with Psychiatric Disorders</u> (ASMMAY1512.S) The action paper asks: That the Council on Psychosomatic Medicine and the Council on Healthcare Systems and Financing jointly develop a position statement for the elimination of the conditions contributing to emergency department boarding of individuals with psychiatric disorders; and That the Council on Advocacy and Government Relations explore mechanisms towards expanding all community resources, including the increasing the availability of staffed State Psychiatric Hospital beds and funding additional psychiatric beds and units in community hospitals, with special attention to establishing high-risk psychiatric units capable of accepting complicated and aggressive patients, so as to end the practice of psychiatric boarding. **Will the Joint Reference Committee refer action paper *2015A1 12.S: Emergency Department Boarding of Individuals with Psychiatric Disorders* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Psychosomatic Medicine (LEAD), the Council on Healthcare Systems and Financing, the Council on Advocacy and Government Relations and the Council on Psychiatry and Law. A progress report was requested for October 2015. The Council on Psychosomatic Medicine is asked to develop a position statement with input from the other councils, and once the input has been received and incorporated into the draft statement, the proposed statement should be forwarded to the JRC.	Kristin Kroeger Ian Hedges Becky Yowell Rodger Currie, JD Deana McRae Lori Klinedinst Whitaker	Council on Psychosomatic Medicine [LEAD] Council on Healthcare Systems and Financing Council on Advocacy and Government Relations Council on Psychiatry and Law Report to JRC: October 2015 (Due October 2, 2015)

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6.14	Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior (ASMMAY1512.T) The action paper asks: That the APA will establish a Work Group comprised of researchers and clinicians knowledgeable in the area of the neuro-developmental and behavioral effects of environmental toxins to advise the Division of Education. That the Assembly of the APA requests that the APA Division of Education develop an educational plan aimed at educating the general membership of the APA on the scientific, clinical and regulatory aspects of the neuro-developmental and behavioral effects of environmental toxins. **Will the Joint Reference Committee refer action paper *2015A1 12.T: Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Division of Education [LEAD], the Council on Children, Adolescents and Their Families and the Council on Medical Education and Lifelong Learning. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Tristan Gorrindo, MD Ranna Parekh, MD, MPH Alison Bondurant Tristan Gorrindo, MD	Division of Education [LEAD] Council on Children, Adolescents and Their Families Council on Medical Education and Lifelong Learning Report to the JRC: January 2016

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.15	<u>Parity in Payment, Parity in Policy Implementation</u> (ASMMAY1512.U) The action paper asks: That the APA request the Council on Advocacy and Government Relations explore and then implement media coverage, and support regulatory, administrative and amicus briefs, against insurance companies, as the insurance companies continue to fail to be in compliance with the Affordable Care Act, and the Mental Health Parity Act. That the APA publically state that in the requiring preapproval directly from Department of Veterans Affairs mental health service providers or any other licensed mental health provider, adversely affects the treatment of patients with psychiatric and psychological problems requiring regularly scheduled appointments, That the APA will advocate at the highest level for comparability of length and procedural review, administrative action and reimbursement for professional services. That a joint Board of Trustees and Assembly Task Force be appointed to coordinate, oversee and guide this process. **Will the Joint Reference Committee refer action paper *2015A1 12.U: Parity in Payment, Parity in Policy Implementation* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing [LEAD], the Division of Government Affairs, the Department of Healthcare Systems and Financing and APA Legal Counsel. All feedback and comments on this referral should be contained within the lead's report to the JRC	Kristin Kroeger Becky Yowell Rodger Currie, JD Sam Muszynski, JD Colleen Coyle, JD	Council on Healthcare Systems and Financing [LEAD] Division of Government Affairs Department of Healthcare Systems and Financing APA General Counsel. Report to the JRC: January 2016

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.16	<u>Location of Civil Commitment Hearings</u> (ASMMAY1512.V) The action paper asks that: 1. The Council on Psychiatry and Law will develop a position statement on best practices for the location of civil commitment hearings and the transportation of detained hospital inpatients to those hearings. 2. In developing the position statement the Council on Psychiatry and Law shall consider the following proposed principles: a. Holding civil commitment hearings at hospitals where psychiatric inpatients are detained should be regarded as a best practice for courts; b. Courts hearing civil commitment cases should exhaust all reasonable alternatives, including working with hospitals to develop appropriate on-site courtroom facilities or telecourt, before transporting detained inpatients to court; c. APA recognizes that exceptional circumstances may sometimes necessitate transporting inpatients to a courthouse for civil commitment hearings; d. Patient preference for a courtroom hearing, when a courtroom hearing is available, constitutes such an exceptional circumstance; e. Convenience of the court and counsel does not constitute an exceptional circumstance; f. When transportation to a courthouse is necessary because of an exceptional circumstance, courts should conduct an individual assessment of each detainee's violence and elopement risks before ordering the use of physical restraints. **Will the Joint Reference Committee refer action paper *2015A1 12.V: Location of Civil Commitment Hearings* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Psychiatry and Law (LEAD) and requested that input be sought from the Council on Advocacy and Government Relations. The Joint Reference Committee noted that civil commitment hearings are held in hospital in Canada.	Rodger Currie, JD Lori Klinedinst Whitaker Deana McRae	Council on Psychiatry and Law [LEAD] Council on Advocacy and Government Relations Report to JRC October 2015 (Due October 2, 2015)

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6.17	<u>Reconfiguring the Health Care Percentage of the GDP</u> (ASMMAY1512.W) The action paper asks: That the APA delegation to the AMA House of Delegates present a motion in that body that calls on the AMA to establish a process for providing the public with separate percentages of the GDP corresponding to actual health care provision and to ancillary, administrative-management-type economic activities that have been linked to health care. **Will the Joint Reference Committee refer action paper *2015A1 12.W: Reconfiguring the Health Care Percentage of the GDP* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing to develop a motion for the APA AMA Delegation to present to the AMA.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing Report to the JRC: January 2016

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6.18	Mental Health Leave in Colleges (ASMMAY1512.Y) The action paper asks: That the APA help to develop mental health guidelines for colleges so that they feel adequately equipped to deal with the challenges of mental health crisis. That the APA produce a position statement in collaboration with the Caucus on College Mental Health, Council on Minority Mental Health and Health Disparities and the Council on Children, Adolescents and Their Families supporting the idea that student mental health should follow guidance from mental health providers who treat these students and that colleges need to invest in more on-campus mental health services in order to be prepared and equipped to better address such problems in a way that protects the future of their students. This should also include a statement that psychiatric problems which arise while students are enrolled are treated on campus adequately and at parity with any other health problems. That the APA affirms its position by advocating that requiring students with mental health problems to take a year off away from campus can further adversely affect students' mental health and self-esteem, and recommends that students' safety prior to returning to college must be determined in collaboration with by a mental health care provider on a case-by-case basis. **Will the Joint Reference Committee refer action paper *2015A1 12.Y: Mental Health Leave in Colleges* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Children, Adolescents and Their Families for incorporation into their rewriting of the position statement on college mental health.	Kristin Kroeger Ranna Parekh, MD, MPH Alison Bondurant	Council on Children, Adolescents and Their Families Report to JRC: October 2015 (Due October 2, 2015)

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.19	Proposed Position Statement: Patient Access to Electronic Mental Health Records (JRCOCT148.J.2; ASMMAY15 4.B.4) The Assembly did not approve the Proposed Position Statement: Patient Access to Electronic Mental Health Records as it was felt the position statement needed additional review. **Will the Joint Reference Committee refer the Proposed Position Statement: *Patient Access to Electronic Mental Health Records* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Psychiatry and Law noting that the original intent of the action paper seemed to differ from the intent of the position statement drafted by the Council. The comments from the Assembly will be forwarded to the Council if possible.	Rodger Currie, JD Lori Klinedinst Whitaker	Council on Psychiatry and Law Report to JRC: January 2016
6.20	Position Statement: Active Treatment (JRCOCT148.G.14; ASMMAY154.B.7) The Assembly did not approve the retirement of the Position Statement: Active Treatment as it was felt this position statement is still current. **Will the Joint Reference Committee refer the Position Statement: *Active Treatment* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee recommended that the Board of Trustees retain the position statement on *Active Treatment*.	Shaun Snyder, JD Margaret Cawley Dewar Ardell Lockerman	Board of Trustees – October 2015
6.21	Revised Position Statement: Role of Psychiatrists in Assessing Driving Ability (JRCJAN158.E.2; ASMMAY154.B.8) The Assembly did not approve the Revised Position Statement: Role of Psychiatrists in Assessing Driving Ability and referred in back to the Council on Geriatric Psychiatry as well as the Council on Psychiatry and Law. **Will the Joint Reference Committee refer the Revised Position Statement: *Role of Psychiatrists in Assessing Driving Ability* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the position statement to the Council on Geriatric Psychiatry to revise with information about chronic issues that affect driving ability. The council was asked to seek input from the Council on Psychiatry and Law.	Ranna Parekh, MD, MPH Sejal Patel Roger Currie, JD Lori Klinedinst Whitaker	Council on Geriatric Psychiatry [LEAD] Council on Psychiatry and Law Report to JRC: October 2015 (Due October 2, 2015)

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.A	Council on Addiction Psychiatry			
8.A.1	Proposed Position Statement: Tobacco Use Disorder **Will the Joint Reference Committee recommend that the Assembly approve the position statement: *Tobacco Use Disorder* and if approved, forward it to the Assembly for consideration?**	The Joint Reference Committee requested that the Council on Addiction Psychiatry revise the position statement. As currently written it places excessive perceived expectations on clinicians.	Tristan Gorrindo, MD Bea Eld	Council on Addiction Psychiatry Report to JRC: September 1, 2015 Assembly – November 2015 (Due 9/13/2015)
8.A.2	Revised Position Statement: Treatment of Substance Use Disorders in the Criminal Justice System **Will the Joint Reference Committee recommend that the Assembly approve the position statement: *Treatment of Substance Use Disorders in the Criminal Justice System*, and if approved, forward it to the Board of Trustees for consideration?** The document was developed in collaboration with members of the Council on Psychiatry and Law. If the revised position statement is approved, the current PS on Treatment of Substance Use Disorders in the Criminal Justice System will be retired.	The Joint Reference Committee referred the revised position statement back to the Council on Addiction Psychiatry and requested that they get input from the Council on Quality Care regarding the feasibility and implementability from a policy standpoint. The position statement could be narrowed and have practical recommendations for this population.	Tristan Gorrindo, MD Bea Eld	Council on Addiction Psychiatry Report to JRC: October 2015 (Due October 2, 2015)
8.A.3	Proposed Position Statement: Opioid Overdose Education and Naloxone Distribution – Joint Statement of the APA/AAAP **Will the Joint Reference Committee recommend that the Assembly approve the proposed Joint APA/AAAP position statement: *Opioid Overdose Education and Naloxone Distribution* and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly approve the proposed Joint APA/AAAP position statement: *Opioid Overdose Education and Naloxone Distribution* and if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Cawley Dewar Allison Moraske	Assembly – November 2015

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.A.4	Information: Strategic Plan for Better Addressing Tobacco Use Disorders The Council's Workgroup on Tobacco Use Disorder is funded by a grant from the Robert Wood Johnson Foundation's Smoking Cessation Leadership Center. The group meets monthly by conference call and has made significant progress in completing the deliverables in the grant: (1) develop a Position Statement on Tobacco Use Disorder, (2) present a workshop at APA's Annual Meeting, (3) conduct a pilot survey of 100 APA members to assess current practice, and (4) develop a strategic plan for the association that guides programmatic initiates to encourage psychiatrists to assess and treatment tobacco use disorder in their patients. **The Council invites the Joint Reference Committee to review a summary of this initiative (pages 2-3 of the minutes) and the draft strategic plan that is appended as Attachment #2.**	The Joint Reference Committee thanked the Council for this information and will forward it to the Board of Trustees for their information.	Shaun Snyder, JD Margaret Cawley Dewar Ardell Lockerman	Board of Trustees – October 2015
8.B	Council on Advocacy and Government Relations			

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.B.1	Reaffirm AMA 2010 Position Statement "Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices **Will the Joint Reference Committee recommend that the Assembly *reaffirm APA's 2010 position statement "Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices"* in lieu of the Action Paper and if approved, forward it to the Board of Trustees for consideration?** Referral Update The Council on Advocacy and Government Relations discussed the JRC referral of Action Paper, "Direct to Consumer Advertising" [ASMNOV1412.A; JRCJAN156.1] to determine political aspects of the Action Paper. The Council addressed APA's previous adoption of AMA's Direct-to-Consumer position in 2010. The Council believes the AMA position supports FDA accountability and physician responsibility. Through unanimous consent, the Council recommends the Action Paper not move forward and to reaffirm current APA policy. The Council has shared their recommendations with the Council on Quality of Care (LEAD).	The Joint Reference Committee recommended that the Assembly retain the current position statement APA's 2010 position statement *Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices,* and if retained, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Cawley Dewar Allison Moraske	Assembly – November 2015 (Due 9/13/15)

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.B.2	Referral Update Endorsement of Principles for the Provision of Mental and Substance Abuse Treatment Services: A Bill of Rights [JRCOCT148.G.17] The Council on Advocacy and Government Relations (CAGR) discussed the JRC referral of the position statement, "Endorsement of Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights." As noted in the JRC summary of actions, the Council agreed the position statement remains important when advocating on behalf of the mental and substance use treatment services. Through unanimous consent, the Council is establishing a work group comprised of members from appropriate APA components, to include CAGR and the Council on Healthcare Systems and Financing (CHSF), in developing a revised position statement that best represents the organization in addressing treatment services. The Council has volunteered to lead the participants in the development of the position statement and to engage the other endorsing organizations.	The Joint Reference Committee requested that the Division of Government Affairs and the Council on Advocacy and Government Relations prepare a timeline for developing the Bill of Rights and convey the timeline to the JRC not later than July 17, 2015. A progress report is requested to the Assembly in November 2015.	Rodger Currie, JD Deana McRae	Division of Government Affairs Council on Advocacy and Government Relations Report to JRC: July 17, 2015

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.B.3	Referral Update Multiple Co-payments Charged for Single Prescriptions [ASMMAY1412.A; JRCMAY146.1; JRCOCT148.G1] The Council on Advocacy and Government Relations discussed the updates received from the Council on Health Care Systems and Financing (LEAD) regarding the Action Paper "Multiple Co-payments Charged for Single Prescription." APA General Counsel Colleen Coyle determined that the issues raised in the Action Paper would not be classified as a MHPAEA concern, if this occurred for all drugs in short supply. Currently, the Office on Healthcare Systems and Financing (OHSF) is finalizing a member survey comprising feedback on PBM practices. As directed by the JRC summary of actions, the Council has been asked to provide input to CHSF in drafting a position statement. The Council agreed, before developing comprehensive policy, they would require additional information from OHSF, including statistical evidence on the issue. The Council will revisit the Action Paper in September, after obtaining additional information from APA Administration.	The Joint Reference Committee thanked the Council for the update.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.B.4	Referral Update Proposed Position Statement: Patient Access to Treatments Prescribed by Their Physicians [JRCOCT148.G.9] The Council on Advocacy and Government Relations was asked by the Council on Healthcare Systems and Financing (CHSF) to review a draft revision of the 2007 APA position statement, "Patient Access to Treatments Prescribed by Their Physicians," which addresses off-label use. The position statement under review is modeled after an AMA statement, since modified. As requested by CHSF, the Council discussed the suggested language affirming a physician's authority to use off-label drug products and medical devices. The Council recommends to the Council on Healthcare Systems and Financing to retain the more detailed 2007 off-label position statement without revisions.	The Joint Reference Committee requested that the Council on Healthcare Systems and Finance to obtain feedback from all councils as originally noted and make a recommendation to the JRC on the disposition of the position statement in October 2015.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing Report to JRC: October 2015 (Due October 2, 2015)
8.C	Council on Children, Adolescents and Their Families			

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.C.1	Revision to Position Statement: Psychiatric Hospitalization of Children and Adolescents (2008) **Will the Joint Reference Committee recommend that the Assembly approve the revision to the 2008 Position Statement on Psychiatric Hospitalization of Children and Adolescents and if approved, forward it to the Board of Trustees for consideration?** Rationale: The Council noted that the Position Statement was revised because it had outdated facts, inaccurate statements, and it did not highlight current concerns of the field. Please note that if the revision to the Position Statement is approved, the 2008 version of the statement will automatically be retired.	The Joint Reference Committee referred the position statement back to the Council on Children, Adolescents and Their Families for additional revision. It was noted that the recommendations, if they are important to the position statement, could perhaps be incorporated into the statement in bold. The JRC asked that the Council reconsider, and if necessary, revise the document.	Ranna Parekh, MD, MPH Alison Bondurant	Council on Children, Adolescents and Their Families Report to JRC: October 2015 (Due 10/2/2015)
8.D	Council on Communications			
8.E	Council on Geriatric Psychiatry			
8.E.1	Position Statement: Substance Use Disorders in Older Adults **Will the Joint Reference Committee recommend that the Assembly approve the Position Statement *Substance Use Disorders in Older Adults* and if approved, forward it to the Board of Trustees for consideration?** The Position Statement was developed collaboratively with the Council on Addiction Psychiatry.	The Joint Reference Committee recommended that the Assembly approve the position statement *Substance Use Disorders in Older Adults* to the Assembly and if approved, to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Cawley Dewar Allison Moraske	Assembly – November 2015 (Due 9/13/15)

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.E.2	Resident Fellow Member on Council on Geriatric Psychiatry **Will the Joint Reference Committee recommend that the Board of Trustee approve designating one member position on the Council to a Resident Fellow?** A Resident Fellow position would parallel the member positions on the council designated for an ECP and an Assembly member. There is no additional cost to this change as the Resident Fellow member position would allocate an existing member position on the council to an RFM. [Please note that this action was not approved by the JRC in May 2014]	The Joint Reference Committee did not approve the action item requesting an RFM member on the Council. The DDHE is enhancing the fellowship program and reworking how fellows are assigned to Councils. It is anticipated that for 2015-2016, two fellows will be assigned to the Council on Geriatric Psychiatry.	Ranna Parekh, MD, MPF Sejal Patel	Council on Geriatric Psychiatry – FYI
8.E.3	Referral Update Revision of Position Statement: Principles of End-of-Life Care for Psychiatry (2001) [JRCJAN158.E.3] The Council is currently working on revising the position statement. Once re-drafted, it will be reviewed by the Council on Psychosomatic Medicine and then the Council on Psychiatry and Law. Among the issues to be addressed are, patient competency and surrogate decision makers. There is a great deal of legislative activity around the country on the topic of "death with dignity"; this often involves consideration of physicians providing the means for patients to end their lives under certain circumstances. Given the level of interest in this aspect of end-of-life care, the Council agreed that a document on end-of-life care must address it	The Joint Reference Committee thanked the Council for the update and requested a re-drafted position statement for its review in October 2015.	Ranna Parekh, MD, MPH Sejal Patel	Council on Geriatric Psychiatry Report to JRC: October 2015 (Due 10/2/2015)
8.F	Council on International Psychiatry			
8.G	Council on Healthcare Systems and Financing			

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.1	Referral Update Adequacy of Health Insurance Provider Networks [ASMNOV1212.A] Proposed Position Statement on Improving Patient Access to Psychiatric Services through MCO Provider Panels (JRCJUNE128.F.2; ASMNOV124.B.5] There have been a number of activities related to the issue of network adequacy that have occurred since our last report to the Assembly. The APA sponsored resolution from the June 2014 Annual Meeting of the American Medical Association resulted in the following AMA policy on Network Adequacy: (More info in the agenda)	The Joint Reference Committee thanked the Council for the update.		
8.G.2	Referral Update Mental Health Parity Act Compliance & Insurance Accreditation Organizations [ASMNOV1212.C] As noted in our draft minutes, OHSF continues to monitor and respond to parity compliance issues and to advocate on behalf of our profession and patients.	The Joint Reference Committee thanked the Council for the update.		
8.G.3	Referral Update Multiple Co-payments Charged for Single Prescriptions [ASMMAY1412.A] OHSF continues to gather additional data. APA is finalizing a survey on pharmacy issues to be sent to a representative sample of APA members	The Joint Reference Committee thanked the Council for the update and requested an updated report in October 2015.	Kristin Kroeger Becky Yowell	Council on Healthcare Systems and Financing Report to JRC: October 2015 (Due 10/2/2015)

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.G.4	Referral Update Critical Psychiatrist Shortages at Federal Medical Centers [ASMNOV1412.D] The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing and the Council on Psychiatry and Law and its Work Group on Mental Illness and Criminal Justice. The Council on Healthcare Systems and Financing was asked to determine if the compensation issues raised in the action paper are covered in other APA documents and to identify current statistics on this question. There are no current APA position statements that speak to the issue of compensation. OHSF has begun to identify preliminary data on salary/income (see the chart within the Council's report) and will share this information with the Council on a future conference call.	The Joint Reference Committee thanked the Council for the update.		
8.H	Council on Medical Education and Lifelong Learning			
8.I	Council on Minority Mental Health and Health Disparities			

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.I.1	Revised Position Statement: Bias-Related Incidents (2007) **Will the Joint Reference Committee recommend that the Assembly approve the revised the 2007 Position Statement on Bias-Related Incidents and if approved, forward it to the Board of Trustees for consideration?** Please note that if the revision to the Position Statement is approved, the 2008 version of the statement will automatically be retired. Rationale: The revision updates key concepts based on the references above. Specifically, the following changes were made: 1. The new position statement includes a more comprehensive list of cultural identity variables in the first sentence consistent with current understanding of cultural identity in DSM-5 (See the DSM-5 revised Outline for Cultural Formulation section "Cultural Identity" p. 749-750). 2. The new position statement expands the description of bias as "both intentional/explicit/conscious and unintentional/ implicit/unconscious" in the second sentence consistent with current understanding of bias. (Blair IV, Steiner JF, Havranek EP. Unconscious (Implicit) Bias and Health Disparities: Where Do We Go from Here? *The Permanente Journal*. 2011;15(2):71-78. Accessed 6/15/15 at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3140753/) 3. The new position statement expands the description of bias-related incidents to include "intimidation" and "micro-aggressions" in addition to "violence" and "harassment" in the third sentence consistent with current understanding of bias-related incidents. (Derald Wing Sue (2010). *Microaggressions in Everyday Life: Race, Gender, and Sexual Orientation*. Wiley. And Sue, Derard Wing (2010). *Microaggressions and Marginality: Manifestation, Dynamics, and Impact*. Wiley.)	The Joint Reference Committee recommended that the Assembly approve the revised position statement *Bias-Related Incidents* and, if approved, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly – November 2015 (Due 9/13/15)
8.J	Council on Psychiatry and Law			

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.J.1	Retire Position Statement: The Right to Privacy (2007) **Will the Joint Reference Committee recommend that the Assembly retire the 2007 Position Statement: *Right to Privacy* and if retired, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly retire the position statement *The Right to Privacy,* and if retired, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly – November 2015 (Due 10/2/2015)
8.J.2	Retire Position Statement: Sexual Harassment (2007) **Will the Joint Reference Committee recommend that the Assembly retire the 2007 Position Statement: *Sexual Harassment* and if retired, forward it to the Board of Trustees for consideration**? Rationale: The Council on Psychiatry and Law reviewed the 2007 Position Paper on Sexual Harassment. After much discussion, the Council felt the paper should be retired as sexual harassment is illegal and there is no need for the paper.	The Joint Reference Committee recommended that the Assembly retire the position statement *Sexual Harassment*, and if retired, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly – November 2015 (Due 10/2/2015)
8.J.3	Referral Update Review of Position Statement on College and University Mental Health The Council on Psychiatry and Law reviewed the revised Position Statement on College and University Mental Health. The Council recommends that the position statement be updated to include topics concerning transitioning youth, privacy of health records, and mandatory withdrawals and mental health leave. Further, there will be updates to the resource document under consideration. A draft will be available for review at the Council meeting in September with hopes to have something to the JRC for their October meeting.	The Joint Reference Committee thanked the Council for the update.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.J.4	Proposed Position Statement on Assisted Outpatient Treatment **Will the Joint Reference Committee recommend that the Assembly approve the proposed position statement on Assisted Outpatient Treatment, and if approved, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee referred the proposed position statement back to the Council on Psychiatry and Law for revision and review by the Ethics Committee.	Rodger Currie, JD Lori Klinedinst Whitaker Shari Graham, JD	Council on Psychiatry and Law Ethics Committee Report to JRC: 9/1/2015 Report to Assembly November 2015 (Due 9/13/2015)
8.J.5	Resource Document: Assisted Outpatient Treatment **Will the Joint Reference Committee approved the Resource Document on Outpatient Treatment?**	The Joint Reference Committee referred the resource document back to the Council on Psychiatry and Law for revision. The JRC noted that clarification was needed regarding why the term AOT had changed. That additional statements and words are needed to contextualize the racial issues and concerns.	Rodger Currie, JD Lori Klinedinst Whitaker Shari Graham, JD	Council on Psychiatry and Law Ethics Committee Report to JRC: 9/1/2015 Report to Assembly November 2015 (Due 9/13/2015)
8.K	Council on Psychosomatic Medicine			

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.K.1	Referral Update: Identify the Roles and Responsibilities of Psychiatrists [JRCOCT148.G.23] This item was referred to the Council on Psychosomatic Medicine after the Council informed the Council on Healthcare Systems and Financing that the Council on Psychosomatic Medicine was creating a joint APA Council on Psychosomatic Medicine and Academy of Psychosomatic Medicine workgroup to meet the objective of this action item. This workgroup will be tasked with performing an environmental scan of high quality, cost-effective integrated care models in which psychiatrists play a predominant role in the practice setting. A report is being prepared by the workgroup for the Council's review in September, and will include a section on the roles and responsibilities of psychiatrists in collaborative care settings.	The Joint Reference Committee thanked the Council for the update.		
8.L	Council on Quality Care			
8.L.1	Request for Committee on Performance Measurement **Will the Joint Reference Committee recommend that the Board of Trustees approve the creation of a Committee on Performance Measurement reporting to the Council on Council on Quality Care? The proposed charge and budget is appended.**	The Joint Reference Committee recommended that the Board of Trustees approve the creation of a Committee on Performance Measurement formed under the Council on Quality Care.	Shaun Snyder Margaret Dewar Laurie McQueen	Board of Trustees – July 2015
8.L.2	Retain Position Statement: High Volume of Psychiatric Practice and Quality Patient Care **Will the Joint Reference Committee recommend that the Assembly retain the position statement: *High Volume of Psychiatric Practice and Quality Patient Care* and if retained, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly retain the position statement *High Volume of Psychiatric Practice and Quality Patient Care* and if retained, forward it to the Board of Trustees for consideration	Shaun Snyder Margaret Dewar Ardell Lockerman	Assembly – November 2015 (Due 9/13/15)

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.L.3	Retain Position Statement: Psychotherapy as an Essential Skill of Psychiatrists **Will the Joint Reference Committee recommend that the Assembly retain the position statement: *Psychotherapy as an Essential Skill of Psychiatrists* and if retained, forward it to the Board of Trustees for consideration?**	The Joint Reference Committee recommended that the Assembly retain the position statement *Psychotherapy as an Essential Skill of Psychiatrists* and if retained, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly – November 2015 (Due 9/13/15)
8.L.4	Referral Update E-prescribing of Controlled Substances [ASMNOV1412.B] The action paper requests the development of a position statement supporting options for electronic prescribing of controlled substances and that the APA AMA Delegation support the option for e-prescribed controlled substances as aligned with federal standards. The Council on Quality Care, in consultation with the Committee on Health Information Technology (CMHIT) recommends that this action paper be withdrawn as it believes the paper no longer necessary. Additionally, the Council is in favor of e-prescribing and the APA should explore the feasibility of EHR vendors creating psychiatry friendly EHR endorsement processes. The CMHIT does not support endorsing EHRs, but agrees is can develop a list of criteria and capabilities that should be included in the development of EHRs for psychiatrists.	The Joint Reference Committee thanked the Council for the update. Given that the APA was already moving forward on the issues contained within the action paper, the Council requested that the action paper be closed. The APA currently has recommendations for e-prescribing and has policy on controlled substances. The Joint Reference Committee considered the action paper completed and closed.		

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.L.5	Referral Update EHR for Psychiatrists [ASMNOV1412.E] The action paper asks the CMHIT to explore the feasibility of a RFP to EHR vendors for psychiatry friendly EHRs with the goal of identifying and/or fostering development of products for consideration by members. The CMHIT recommends that the APA should not attempt to develop its own EHR. The Committee does recommend that the APA identify current EHRs and foster development of future EHRs that meet the needs of APA members.	The Joint Reference Committee thanked the Council for the update.		
8.M	Council on Research			
8.M.1	Retire Position Statement: Interference with Scientific Research and Medical Care Will the Joint Reference Committee recommend that the Assembly retire the position statement: Interference with Scientific Research and Medical Care and if retired, forward it to the Board of Trustees for consideration? Please note that if the revision to the Position Statement is approved, the 2005 version of the statement will automatically be retired. Rationale: The Council is recommending that this statement be retired as it seems to function as an overly generic statement about de-stigmatization rather than provide a specific perspective on psychiatric practice or research designed to enhance and support the profession. Further, given recent advances in the legislature on mental health parity, the statement is less relevant today than when it was developed.	The Joint Reference Committee recommended that the Assembly retire the position statement Interference with Scientific Research and Medical Care and if retired, forward to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly – November 2015 (Due 9/13/15)

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.M.2	Revised Position Statement: Hypnosis Will the Joint Reference Committee recommend that the Assembly approve the revised position statement: Hypnosis and if approved, forward it to the Board of Trustees for consideration? Rationale: The position statement is still relevant, but the Council is recommending that the statement be revised for language and clarity. As per the Joint Reference Committee's request, it also has been reformatted so that it conforms to the latest APA position statement formatting guidelines.	The Joint Reference Committee recommended that the Assembly approve the revised position statement Hypnosis and if approved, forward to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly – November 2015 (Due 9/13/15)
8.M.3	Retain Position Statement: Posttraumatic Stress Disorder and Traumatic Brain Injury Will the Joint Reference Committee recommend that the Assembly retain the position statement: Posttraumatic Stress Disorder and Traumatic Brain Injury and if retained, forward it to the Board of Trustees for consideration? Rationale: The revisions are only for adherence to the latest APA position statement formatting guidelines. The statement is still relevant and useful. No content revisions are warranted at this time.	The Joint Reference Committee recommended that the Assembly retain the position statement Stress Disorder and Traumatic Brain Injury and if retained, forward it to the Board of Trustees for consideration.	Shaun Snyder, JD Margaret Dewar Allison Moraske	Assembly – November 2015 (Due 9/13/15)

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
8.M.4	Referral Update Current Health Services Literature on Integrated Care Models [JRCOCT148.G.22] The Division of Research has undertaken a review of the extensive body of literature on integrated care. The goal is to identify the key elements, or "active ingredients", on which integrated care models are built and to define an overall framework to characterize the spectrum of integrated care for APA. This framework will subsequently provide the context to describe current models of integrated care and will include supporting research for each model. The work is on track, and Division of Research is currently reviewing numerous published studies on collaborative care to identify and compile information about various aspects of methodology, delivery system design, and outcomes reported throughout the literature. It is anticipated that this project will be complete by this Fall, with a report generated and presented to the Joint Reference Committee at their October 2015 meeting.	The JRC thanked the Council for the update.		

CEO Report to the JRC, October 2015

Action	CEO/MDO Response	Staff/Component Responsible	Status
Fostering the Next Generation of Leaders within the APA (ASMMAY1512.J) The action paper asks: That the APA develop a comprehensive and coordinated set of leadership, team building and enrichment activities aimed at fostering leadership and promoting positive relationships between the young leaders of the APA and established APA leadership. That the APA look to consolidate and coordinate current offerings to prevent duplication of efforts and to ensure the best use of resources That these activities occur at the APA Annual Meeting in May. That these activities be coordinated by the Chief RFM-ECP Officer, the Director of the Division Diversity and Health Equity, and the Director of Education. Will the Joint Reference Committee refer action paper 2015A1 12.J: *Fostering the Next Generation of Leaders within the APA* to the appropriate Component(s) for input or follow-up? The Joint Reference Committee referred the action paper to the Office of the Chief Executive Officer/Medical Director for refinement and a cost estimate.	The development of the next generation of leaders within APA is a critical function that will require input and collaboration from across the organization. In the Administration, Membership, Education, and the Division of Diversity and Health Equity are working on addressing this issue. The Administration has also solicited feedback from the Council on Medical Education and Lifelong Learning. We agree with the author's cost estimate as the scope of the paper was narrowed.	Saul Levin, MD, MPA; Jon Fanning, MA, CAE; Tristan Gorrindo, MD; Ranna Parekh, MD, MPH	The Council on Medical Education and Lifelong Learning had a robust discussion of this topic which they deemed important. Focusing on this issue primarily through the lens of GME training, the Council noted that there is already a day-long leadership conference for residents at the Annual Meeting. In future years, this conference will be available to all senior residents and fellows, not just chief residents. Additionally, the scientific program committee is evaluating a number of proposals which would also include leadership forums at the next Annual Meeting in conjunction with potential sponsorship from the Association for Academic Psychiatry. The new online transition to practice curriculum will also focus on basic leadership and managements skills that residents require. The Council will continue to support leadership opportunities of this nature for trainees. The Council is supportive of one-to-one mentorship with APA leadership. The Education Department is exploring ways in which to incorporate a community service activity during the annual meeting that includes leadership opportunities for residents and medical students.

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DEPARTMENT OF PSYCHIATRY & BEHAVIORAL SCIENCES
2230 STOCKTON BOULEVARD
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UNIVERSITY OF CALIFORNIA DAVIS
MEDICAL CENTER, SACRAMENTO
2315 STOCKTON BOULEVARD
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October 5, 2015

Dear APA committee:

We are writing this letter in support for the formation of a Korean American Psychiatrists Caucus in time for APA 2016 in Atlanta. Korean Americans have made up a relatively small proportion of psychiatrists in the United States in part because of the cultural bias against the concept of mental illness in Korean culture. In more recent years, more Korean Americans entering medical school are considering Psychiatry as a career.

A Korean American Psychiatrists Caucus would:
1) Allow a forum for members to discuss how our cultural identity can influence how we treat our patients from various backgrounds.
2) Provide a forum to network with other Korean American psychiatrists.
3) Disseminate ideas on encouraging Korean American medical students in considering psychiatry as a career choice.
4) Provide a forum for the first generation of Korean American psychiatrists to engage with and mentor the new generation of Korean American psychiatrists. As current and active members of the APA we plan to actively participate in the Korean American Psychiatrists Caucus.

Sincerely,

Jaesu Han	84798
Jason Yebin Cho	1117233
Chris Shim	45329
Steve Koh	1013428
Austina Cho	86796
Dongchan Park	1114705
Dr. Tai P. Yoo	30853
Raymond Chong	310655
Jonathan Kistler	1159790
Sue Kim	61446

AWARD REVIEW FORM

APA Board instructions:
Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation to the Joint Reference Committee (lmcqueen@psych.org)

APA Foundation instructions:
If the award will be approved by the American Psychiatric Association Foundation Board, please return this form to Lindsey Fox (lfox@psych.org).

AWARD NAME: Jacob K. Javits Public Service Award

NAME OF AWARD ADMINISTRATIVE COMPONENT: Council on Advocacy and Government Relations

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CHAIRPERSON: Barry B. Perlman, M.D.

STAFF LIAISON: Deana McRae

[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:
The Council on Advocacy and Government Relations presents the Jacob K. Javits Public Service Award annually to a public servant who has made a significant contribution to the mental health community and patients suffering from mentally disorders. This is the highest award conferred upon a public servant by the APA. Presenting the Javits Award gives APA the opportunity to showcase the work honorees provide on behalf of consumers and the fields of health care and mental health care.

Description of Selection Criteria for Award:
The award is given annually, alternately, between a state public servant and a federal public servant.

Award Funding Information: [Please complete the following if applicable]
Cost for Plaque: **$200.00**
Cost of Cash Award:
Cost of Lectureship:
Other (please list):

Award Account Balance: _____ (as reported by APA Online Financials)
Date Balance Determined: _____

Award Nominee(s): U.S. Representative Tim Murphy (R- PA)

(Please attach a biosketch and up to three letters of nomination/support for this individual)

Description of the Committee's Selection Process:

The Committee on Advocacy and Government Relations received one nomination from APA leadership, District Branches, State Associations, and Council members for this award and determined that U.S. Representative Tim Murphy of Pennsylvania would receive the award, by a majority vote. The vote took place during the CAGR meeting at the September Component Meeting on September 11, 2015.

AMERICAN PSYCHIATRIC ASSOCIATION

AWARD REVIEW FORM

Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation on to the Joint Reference Committee.

AWARD NAME: GEORGE TARJAN

NAME OF AWARD ADMINISTRATIVE COMPONENT: Council on Minority Mental Health and Health Disparities

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CHAIRPERSON: Christina Mangurian, MD

STAFF LIAISON: ALISON BONDURANT

[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:

RECOGNIZES AN INDIVIDUAL WHO HAS MADE SIGNIFICANT CONTRIBUTIONS TO THE ENHANCEMENT OF THE INTEGRATION OF INTERNATIONAL MEDICAL GRADUATES INTO AMERICAN PSYCHIATRY.

Description of Selection Criteria for Award:

SEE ABOVE

Award Funding Information: [Please complete the following if applicable]

Cost for Plaque:	<$300
Cost of Cash Award:	$500
Cost of Lectureship:	
Other (please list):	*Travel expenses for non-APA member awardee: @ $1,500 if applicable* *Travel expenses for APA member awardee: $0*

Award Account Balance: $102,114
Date Balance Determined: 10/1/15

Award Nominee(s): Emmanuel Cassimatis, MD

(Please attach a biosketch and any letters of nomination or support for this individual)

Other individuals considered for the award:

Description of the Committee's Selection Process:
Selection is made by a work group specially tasked by the Council on Minority Mental Health & Health Disparities. The work group is composed of council members and other IMG APA members and representatives from the APA IMG Caucus. The work group evaluates nominations and selects a finalist via email or conference call. Nomination sources are work group members, APA members, and the general psychiatric public.

Dr. Emmanuel G. Cassimatis

Emmanuel Cassimatis is President and Chief Executive Officer of the Educational Commission for Foreign Medical Graduates (ECFMG) and Chair of the Foundation for Advancement of International Medical Education and Research (FAIMER), ECFMG's non-profit foundation. He was formerly Vice President for Affiliations and International Affairs at the Uniformed Services University of the Health Sciences (USUHS), Associate Dean for Clinical Affairs and Professor of Psychiatry at the University's F. Edward Hébert School of Medicine. A graduate of the University of Chicago, Harvard Medical School, and the Washington Psychoanalytic Institute, he served on active duty with the U.S. Army for more than 25 years.

In addition to his duties at ECFMG, Dr. Cassimatis continues to serve as Professor of Psychiatry at USUHS; and is a member of the Executive Council of the World Federation for Medical Education (WFME) and the Composite Committee of the U.S. Medical Licensing Examination (USMLE). He is a past Chair of the Accreditation Council for Graduate Medical Education (ACGME) and of the American Medical Association (AMA) Council on Medical Education. Dr. Cassimatis is a member of the Academy of Medicine of Washington, DC, a Life Fellow of the Association of Military Surgeons of the US, a Psychoanalytic Fellow of the American Academy of Psychoanalysis and Dynamic Psychiatry, and a Distinguished Life Fellow of the American Psychiatric Association.

Biography

In January 2015, Congressman Tim Murphy, Ph.D. of Upper St. Clair began serving his seventh term in Congress representing the 18th District of Pennsylvania, encompassing the South Hills of Pittsburgh and portions of Greene, Allegheny, Washington and Westmoreland counties.

Congressman Murphy relies on his three decades as a psychologist to advocate for meaningful reforms in the U.S. healthcare system. As one of only a handful of members of Congress with a background in healthcare, Tim quickly established himself as a leader on the issue. He is Co-chair of the Mental Health Caucus and a founding member of the GOP Doctors Caucus, giving him a platform to educate other members of Congress and the public on ways to make healthcare more affordable and accessible for all families.

Representing Southwestern Pennsylvania, a world leader in the research, development, and transmission of energy, Congressman Murphy holds a senior position on the House Energy and Commerce Committee as Chairman of Oversight and Investigations. Rep. Murphy also sits on two additional subcommittees: Health and Environment & Economy.

As the oldest-standing legislative committee in the U.S. House of Representatives, Energy and Commerce has jurisdiction over telecommunications, consumer protection, food and drug safety, public health research, environmental quality, energy policy, and interstate and foreign commerce. Oversight Chairman Murphy is continuing with a vigorous review of the administration's stimulus spending, implementation of the healthcare law, elimination of government waste, fraud and abuse, and outlining steps to prevent future incidents of food and drug contamination.

In December 2013, following a year-long investigation by his subcommittee into the nation's broken mental health system, Mr. Murphy unveiled his landmark mental health reform legislation, the Helping Families In Mental Health Crisis Act. Praise and support for the Helping Families In Mental Health Crisis Act has poured in across the country from the American Psychiatric Association, National Alliance on Mental Illness, and numerous media outlets such as CNN, the Wall Street Journal, Washington Post, and Pittsburgh Post-Gazette.

Legislative accomplishments include authoring the 'Generic Drug and Biosimilar User Fee Act of 2012' (H.R. 3988), which was signed into law by President Obama in July 2012 as part of a larger Food and Drug Administration (FDA) Reform package. Murphy's innovative legislation closes a major safety gap in the global drug supply chain and establishes the first-ever program bringing life-saving generic medications to market faster. In addition to requiring the FDA to inspect foreign factories with the same rigor and biennial frequency as domestic plants, Murphy's bill will add to the $1,000 in savings each senior citizen receives due to access to safe generic medications.

Murphy also authored the Seniors Access to Mental Health Act, which ended the discriminatory

practice of charging higher co-pays to seniors on Medicare seeking mental healthcare services. The legislation became federal law as part of the Medicare Improvements for Patients and Providers Act on July 15, 2008.

Most recently, Murphy's 'Strengthening Medicare and Repaying Taxpayers Act' (SMART Act, H.R. 1063) was signed into law by President Obama. Murphy's bill eliminates bureaucratic hurdles to the Medicare Secondary Payer program and recoups billions of dollars owed to taxpayers. The new law accelerates the processing of Medicare secondary payer reimbursement from liability and workers' compensation settlements; removes bureaucratic delays at Medicare that can jeopardize seniors' benefits; and collects billions of dollars owed by insurance companies to the Medicare Trust Fund.

He also introduced the Mental Health Security for American Families in Education Act and passed legislation into law to get college students suffering from depression or other mental illnesses the help they need before tragedy strikes.

Before coming to Congress, Congressman Murphy served in the Pennsylvania State Senate from 1997-2002. There he penned the state's historic Patient Bill of Rights and increased funding for medical research, while consistently supporting responsible fiscal management of government to promote job creation and reduce the tax burden on families.

In addition to his work in Congress, Commander Murphy currently serves in the Navy Reserve Medical Service Corps at Walter Reed National Military Medical Center at Bethesda. There he works as a Navy psychologist with service members with traumatic brain injury and post traumatic stress. His ADT has included service with Navy Special Warfare Coronado and on the USS Carl Vinson.

He and his wife Nan now reside in Upper St. Clair and attend St. Thomas More Catholic Church in Bethel Park. They are the parents of Bevin and proud grandparents of one granddaughter.

Congressman Murphy earned a bachelor's degree from Wheeling Jesuit University, a master's degree from Cleveland State University, and his PhD from the University of Pittsburgh.

Additional Articles:

http://murphy.house.gov/latest-news/murphys-mental-health-legislation-gains-100-cosponsors/

http://murphy.house.gov/latest-news/murphy-honored-with-paul-wellstone-mental-health-advocacy-award/

American Psychiatric Association

Jacob K. Javits Public Service Award

NOMINATION FORM

On behalf of the American Psychiatric Association (APA), the Council on Advocacy and Government Relations presents the Jacob K. Javits Public Service Award annually to a public servant who has made a significant contribution to the mentally ill. This is the highest award conferred upon a public servant by the APA, representing 36,000 psychiatric physicians nationwide, and their patients. The Javits Award is given annually, alternately to a state public servant and a federal public servant. Presenting the Javits Award gives APA the opportunity to showcase the work honorees provide on behalf of consumers and the fields of health care and mental health care.

In 1986, the APA established the Jacob K. Javits Public Service Award to honor the legacy of a U.S. Senator from New York, Jacob K. Javits. First elected in 1956, Senator Javits served for 24 years, using his position on the then-Labor and Public Welfare Committee to spearhead health-related legislation, achieving multiple successes on behalf of the mentally ill and on substance abuse issues. In the name of this great statesman, the Council on Advocacy and Government Relations confers this award to federal and state public servants, who have earned recognition for outstanding contributions to the cause of the mentally ill.

Past federal recipients of the Jacob K. Javits Public Service Award include U.S. Senators Al Franken (D-MN) (2014), Sheldon Whitehouse (D-RI) (2012), Olympia Snow (R-ME) (2010), and U.S. Representative Lloyd Doggett (D-TX) (2008).

Your Name: Constance E. Dunlap, MD, President, Washington Psychiatric Society

Address: 550M Ritchie Highway, #271

Telephone/ Email: 202-785-1005/ cdunlap2015@verizon.net

District Branch / State Association: Washington Psychiatric Society

Name of Individual you are nominating: Congressman Tim Murphy, PhD

Position of nominee: U.S. Congressman, 18th District of Pennsylvania

Materials required for a nomination include:

1) **Abbreviated bio of the nominee.**
2) **Nomination or justification letter from you or Distract Branch / State Association.**
3) **Supporting letters from other organizations.** ***(optional)***

If you would like to nominate someone for consideration, please submit these materials to the Department of Government Relations by Friday, August 21, 2015.

Nominations must be received by August 21, 2015

Attn: Deana McRae
American Psychiatric Association
Email: advocacy@psych.org
PH: (703) 907-8643 | Fax: (703) 907-1083

Please email the completed form, and attach the bio and your statement separately.

Washington Psychiatric Society

August 10, 2015

Ms. Deana McRae
American Psychiatric Association
advocacy@psych.org

Dear Ms. McRae,

I am writing to nominate U.S. Congressman Tim Murphy, PhD of the 18th District of Pennsylvania for the 2016 Jacob K. Javits Public Service Award.

As a psychologist for more than three decades he is the leading Congressional advocate for the reform of the nation's broken mental health system and has introduced bipartisan landmark mental health reform legislation entitled "Helping Families in Mental Health Crisis Act" which now has more than 102 members of Congress as cosponsors. He is also Co-Chair of the Mental Health Caucus and sits on subcommittees for Health, Environment & Economy. In addition, he serves as a commander in the Navy Reserve Medical Service Corps as a psychologist treating Wounded Warriors with post-traumatic stress.

Now serving his seventh term in Congress, Congressman Murphy has used this platform to educate politicians and the public on ways to improve the government's approach to mental health's stigmas, treatment, transparency and research. His "Helping Families in Mental Health Crisis Act" expands inpatient and outpatient psychiatric treatment; training for caretakers and first responders; additional Medicare and Medicaid coverage and brings accountability to mental health and substance abuse providers.

As a staunch advocate of immediate mental health reform, especially in the wake of so many recent mass killings in the U.S. by disturbed individuals, Congressman Murphy should be recognized for his unconditional devotion to help patients, families, healthcare providers and communities to provide better quality care for those in need. It is our hope that this honor will show our nation's gratitude for his relentless efforts as well as motivate others in leadership positions to provide more education, professionals and resources for mental health care and reform in an effort to mitigate personal and societal tragedies resulting from mental illness.

In anticipation and appreciation of your interest, I look forward to hearing from you.

Sincerely,

Constance E. Dunlap, MD
President
Washington Psychiatric Society
550M Ritchie Highway, #271
Severna Park, MD 21146

AWARD REVIEW FORM

APA Board instructions:
Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation to the Joint Reference Committee (lmcqueen@psych.org)

APA Foundation instructions:
If the award will be approved by the American Psychiatric Association Foundation Board, please return this form to Lindsey Fox (lfox@psych.org).

AWARD NAME: Jack Weinberg Award in Geriatric Psychiatry

NAME OF AWARD ADMINISTRATIVE COMPONENT:
Council on Geriatric Psychiatry

CHAIRPERSON: ___Robert Paul Roca, MD

STAFF LIAISON: _Sejal Patel

[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:
A psychiatrist who over the course of his or her career has demonstrated special leadership or has done outstanding work in clinical practice, training, or research into geriatric psychiatry.

Description of Selection Criteria for Award:
Clinical Practice
Training
Research

Award Funding Information: [Please complete the following if applicable]
Cost for Plaque: $150
Cost of Cash Award: $500
Cost of Lectureship: No lecture
Other (please list): NA

Award Account Balance: _____$2,386_____ (as reported by APA Online Financials)
Date Balance Determined: __October 2, 2015

Award Nominee(s): Constantine G. Lyketsos, M.D., M.H.S.,
DFAPA, FAPM, FACNP

(Please attach a biosketch and up to three letters of nomination/support for this individual)

Description of the Committee's Selection Process:
The selection committee reviewed the applications and rated those using following criteria: clinical skills, leadership, involvement in community work and academic accomplishments (research and publication). Later, the committee members discussed the nominations in a conference call to decide on the nominee. The selected name was presented to the other council members in the Fall Component Meeting. It was unanimously approved by the Council.

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

July 31, 2015

American Psychiatric Association
c/o Sejal Patel
1000 Wilson Boulevard, #1825
Arlington, VA 22209

Re: Nomination of Constantine G. Lyketsos, M.D., M.H.S., DFAPA, FAPM, FACNP, for the Jack Weinberg Memorial Award for Geriatric Psychiatry

Dear Colleagues:

I am writing to nominate Dr. Constantine Lyketsos for the 2015 APA Jack Weinberg Memorial Award for Geriatric Psychiatry. My nomination documents Dr. Lyketsos' outstanding academic career, his landmark scientific research contributions, his innovative clinical program leadership, his exemplary record of mentoring investigators who are future leaders in the field of Geriatric Psychiatry, and his creative, energetic and ongoing advocacy for our field. In addition, from my perspective at the Department of Veterans Affairs, Dr. Lyketsos' research and his efforts to improve the care and quality of life of persons with dementia provide a clear and compelling roadmap for the optimal care of aging Veterans.

Training and Career Development: Dr. Lyketsos was educated at Northwestern University (B.A. 1984) and went on to receive his medical degree from Washington University in St. Louis (1988). He completed his internship at Francis Scott Key Medical Center (now Johns Hopkins Bayview) and residency in Psychiatry at the Johns Hopkins Hospital, followed by research fellowships in psychiatric epidemiology and neuropsychiatry at Johns Hopkins. After completing his fellowships, Dr. Lyketsos joined the Johns Hopkins faculty in 1993 as an Assistant Professor of Psychiatry, with a joint appointment in the School of Public Health Departments of Epidemiology and Mental Health.

Dr. Lyketsos' academic progress was impressively rapid and sustained allowing him to attain the level of Professor in short order. He now occupies The Elizabeth Plank Althouse Professorship and is Chair of Psychiatry at Johns Hopkins Bayview. His strengths in Psychiatry, Epidemiology, Neuropsychiatry, and Geriatrics as well as his clinical leadership have been recognized by Johns Hopkins in several additional ways by electing him to the Chair of Johns Hopkins Bayview Medical Board and elevating him to Vice-Chair of the Department of Psychiatry in 2006.

Scientific Contributions: Dr. Lyketsos' pioneering contributions in late life memory disorders have altered how the field understands and treats Alzheimer's disease. Since 1983, he has published over 350 peer reviewed articles in leading national and international journals including *JAMA, NEJM, Lancet, JAMA Psychiatry (Archives of General Psychiatry), American Journal of Psychiatry, Neurology, American Journal of Medicine, American Journal of Epidemiology, Journal of Affective Disorders, and the European Journal of Psychiatry.* He has had ongoing funding from the NIH since 1997 having been the principal investigator of several independent investigator (R01/U01) grants, including the seminal Cache County Dementia Progression Study (DPS), as well as a number of multi-center clinical trials. In addition, he has been a co-principal investigator for multiple other NIH research funded projects involving tens of millions of dollars. While Dr. Lyketsos' contributions are comprehensively outlined in his attached curriculum vitae, I summarize a few of the most impressive examples here.

In the DPS, Dr. Lyketsos' team conducted one of the most thorough population-based studies on the naturalistic course of dementia. The team studied an incident population of individuals who were well-characterized before the onset of dementia, followed into the onset of dementia, and then characterized in an ongoing fashion for a number of years until death, with very little loss to follow-up. Findings from this study have demonstrated the great variability in the progression of dementia at the population with as many as 40% of people with Alzheimer's disease having a very slow progression level and often not seeking services. Additionally, the DPS has defined a number of modifiable factors that may slow progression including early delivery of therapeutic activities, closeness between patient and caregiver, early management of neuropsychiatric symptoms, systematic management of medical comorbidities among others. The

identification of these modifiable factors has greatly contributed to the development of the Johns Hopkins Maintaining Independence at Home (MIND) intervention for people with dementia (more fully discussed later in this letter) which is emerging as one of the premier approaches to effectively and successfully managing dementia in home environments.

Dr. Lyketsos' most seminal research contributions have involved work on the neuropsychiatric disturbances of dementia (NPS). Along with other collaborators, Dr. Lyketsos' team has been central in the successful effort to characterize the epidemiology of NPS and confirm the universal presence of NPS during the course of dementia. These findings have led to a recharacterization of how the field thinks about dementia - from a simple disorder of memory to one of a complex cognitive disorder with prominent psychiatric disturbances. Through his research, Dr. Lyketsos has also demonstrated the critical role that these disturbances play in the course of dementia, including quality-of-life, functional impairment, caregiver burden, aggressive behaviors and institutionalization. Further, he has conducted critical nosologic work demonstrating that NPS clusters into predictable syndromes (depression, agitation, psychosis, apathy) and has collaborated with investigators from all over the world to develop syndrome-specific treatments. He was a key contributor to the NIH funded CATIE-AD study and principal investigator of the multicenter DIADS-2 and CitAD studies. These studies have shown the limited efficacy of available psychotropic medications for these disturbances (e.g., limited utility of SSRI antidepressants for depression). At the same time, in the CitAD study which he led, his team has shown the potential value for citalopram in the management of agitation in a subgroup of people with dementia.

The Alzheimer's Association recognized Dr. Lyketsos' work in the NPS field when he was asked to lead a Research Roundtable in 2009 with international participation aimed at redefining the treatment development agenda for neuropsychiatric disturbances. The results of this Roundtable have been impressive. It has led to the development of the NPS-Professional Interest Area (PIA) of the International Society to Advance Alzheimer's Research and Treatment which he chairs and which now has almost 500 members. This organization continues to draw scientists from all over the world interested in NPS and has recently published consensus criteria for "Mild Behavioral Impairment" a non-cognitive prodromal syndrome to dementia. The PIA has played a central role in

reinvigorating the interest of pharmaceutical companies in developing treatments for agitation and other NPS in dementia. Where several years ago there was little treatment development for NPS, as many as six major pharmaceutical companies are actively developing novel therapies for NPS associated with Alzheimer's disease in most case applying study designs and intervention approaches developed by Dr. Lyketsos and his team.

Dr. Lyketsos and his team are now moving forward to better characterize the neurobiology of NPS, especially therapeutically relevant subgroups, by utilizing a variety of brain imaging techniques. In addition, given the demonstration from his team that NPS occurs frequently in cognitively normal older individuals or individuals with mild cognitive impairment and are major predictors of the onset of dementia, Dr. Lyketsos is leading efforts to determine how best to treat these disturbances in early Alzheimer's disease in the hope of providing an avenue for the prevention of the devastation brought about by dementia.

In more recent years, in his role as Clinical Core Director of the NIH-funded Johns Hopkins Alzheimer's Disease Research Center, Dr. Lyketsos has assembled an impressive inter-disciplinary team at Johns Hopkins to develop biomarkers that can accelerate the development of new treatments for Alzheimer's. This group's research includes studies using diffusion tensor imaging, PET imaging with combinations of novel ligands, as well as blood and CSF lipidomics.

This team has played a critical role in the development of blood biomarkers. For example, they were the first to define the utility of blood lipids as predictors of the incidence of Alzheimer's dementia and of the progression of mild cognitive impairment or dementia after onset, and they showed how specific (ceramide) lipid levels in the blood can predict hippocampal deterioration on brain MRI in patients with mild cognitive impairment. Aspects of this work have been replicated by investigators at Georgetown University and elsewhere. Development of blood biomarkers with therapeutic utility in Alzheimer's disease remains a focus of Dr. Lyketsos' group and has expanded further to the study of changes in blood amyloid levels in response to oral glucose loading.

In the area of brain imaging, using brain MRI, his team has shown the early deterioration of fornix in the course of Alzheimer's disease. This has led to the potential for a highly novel therapy, specifically deep brain stimulation targeting the fornix. Applying a technique developed by neurosurgeons at the University of Toronto, Dr. Lyketsos is leading an NIH-funded multicenter clinical trial evaluating the efficacy of deep brain stimulation targeting the fornix for the treatment of very early Alzheimer's dementia. The study recently reported promising results especially for individuals over age 65. If successful in the long term, DBS has great potential as a novel mechanism for the treatment of Alzheimer's disease.

Of enormous importance is Dr. Lyketsos' work on translation of evidence-based treatment advances for persons with dementia into practice. The NIMH-funded Maryland Assisted Living Study (MD-AL), of which he has been the principal investigator, has changed how dementia is treated in that setting. MD-AL characterized the high prevalence and significant impact of dementing disorders on quality of life and the ability to age in place in assisted living environments. This work has led to major changes in how assisted living is regulated and how assisted-living staff is educated in Maryland and nationwide.

Dr. Lyketsos' team has also focused its attention to the delivery of dementia-related services at home. Building upon the work of the Johns Hopkins Memory Center and the work of the DPS, he developed the previously mentioned Maintaining Independence at Home (MIND), a novel needs-based care coordination intervention intended to improve the ability of elders with dementia to age in place. Supported by an impressive grass-roots philanthropic effort, raising $2.25 million, his team recently reported the efficacy of MIND in a randomized clinical trial. Specifically, the study demonstrated an impressive 9 month delay in transition from home into a nursing home, with improved quality of life, as well as with reductions of caregiver objective and subjective burden. Further development and dissemination of MIND is now moving to its next stage with support from NIH ($5.8 million), the Center for Medicare and Medicaid Services ($6.8 million), and the private sector (in development) to target dual Medicare-Medicaid eligibles, retirement community residents, and individuals in urban home environments.

Clinical Care: In addition to his pioneering research scholarship, Dr. Lyketsos has remained a clinician par excellence drawing praise from patient, families and colleagues alike. He has led the Johns Hopkins

clinical care memory programs for almost 2 decades assuming the mantle of Marshall Folstein who departed Hopkins in the early 1990s. Over time Dr. Lyketsos has expanded the programs into what is now the Johns Hopkins Memory and Alzheimer's Treatment Center (MATC), a collaboration between psychiatry, neurology, and geriatric medicine at Johns Hopkins. The Center provides state-of-the-art diagnosis and comprehensive ongoing care for individuals with memory disorders in any setting, especially at home. At present, the Johns Hopkins MATC evaluates approximately 1000 new memory disorder patients annually and supports a team of 12 specialized psychiatrists, neurologists and geriatricians. Dr. Lyketsos himself is a highly sought after clinician with individuals seeking his care and expertise from all over the world. Impressively, has been cited by Castle Connolly as a *Top Doctor in America* for almost a decade and a half.

Over his many years of clinical experience Dr. Lyketsos has had the opportunity to refine his approaches to patient evaluation, care, and treatment- these are summarized in the landmark book, *Practical Dementia Care* (with co-authors Dr. Peter Rabins and Cynthia Steele, R.N.), now in its upcoming 3rd Edition, which has been praised as a leading resource and practical manual for clinicians working with patients who have dementia.

Mentoring and Teaching: Dr. Lyketsos mentorship has led to the development of an impressively accomplished and promising group of funded independent researchers. These include Paul Rosenberg (Associate Professor of Psychiatry at Johns Hopkins, Beeson Award, several R01s, PET amyloid imaging, microglia markers in Alzheimer's); Michelle Mielke (Associate Professor of Psychiatry at Mayo Clinic, several R01s, diffusion tensor imaging, blood biomarkers studies); Quincy Samus (Associate Professor of Psychiatry at Johns Hopkins, K Award, R01,MIND at HOME project); Ben Lee (Associate Professor of Psychiatry at Yale, K Award, R01, depression-dementia relationship); Vani Rao (Associate Professor of Psychiatry at Johns Hopkins, K Award, R01-equivalent from DoD, depression after traumatic brain injury); Adam Rosenblatt (Professor and Director of Geriatric Psychiatry at VCU, R01, assisted living studies). Additionally, a number of emerging leaders in geriatric psychiatry and geriatric medicine are under his current mentorship (Esther Oh, Jeannie Leoutsakos, Christopher Marano, Jin Joo, Milap Nowrangi).

In his role as Professor of Psychiatry at Johns Hopkins, Dr. Lyketsos is one of the main teachers of Geriatric Psychiatry for

medical students, residents, fellows, faculty and allied health professionals. One of his enduring accomplishments in this area is his creation of a course in Research Methods in Psychiatry for Residents and Fellows. His mentees report that he challenges and supports them simultaneously and encourages them to push the academic boundaries of the established current body of knowledge. Dr. Lyketsos was the founder and had been the course director of the widely acclaimed Johns Hopkins annual CME course on dementia care for 20 years, an educational program that attracts approximately 200 attendees. Additionally, he was for over a decade the Academic Director of the Copper Ridge Institute (an affiliate of Johns Hopkins at the time) where he developed a research and teaching program to help providers learn to diagnose and treat patients with complex dementia and behavior problems. Finally, he has overseen the growth and development of one of the premier fellowships in geriatric psychiatry (now directed by his mentee Dr. Marano) funded by a collaborative grant from HRSA.

Dr. Lyketsos is an exceptionally talented educator committed to teaching Geriatric Psychiatry at a national and international level. He is widely sought out by many academic and research institutions worldwide. He has given over 150 invited presentations, including grand rounds at university centers, keynote lectures at conferences, named lectureships, and award lectures throughout the United States and in Europe, South America, Asia, and Australia.

Leadership in Geriatric Psychiatry: Dr. Lyketsos has been an exceptional leader and advocate for geriatric psychiatry over many years and on many levels. He is a previous Board member of the American Association for Geriatric Psychiatry (AAGP) and currently serves on the Board of the International Psychogeriatric Association where he has recently been elected Treasurer and serves as Deputy Editor for North America for the society's journal, *International Psychogeriatrics.* Dr. Lyketsos is a past Editor-in-Chief of the *International Review of Psychiatry* and currently serves on the Editorial Boards of the *American Journal of Psychiatry* and *Alzheimer's and Dementia* (the preeminent journal in his field). In addition, he has been invited to edit/co-edit several journal special issues on topics in geriatric psychiatry. In past years, he has been a member (and frequently a chair) of multiple American Psychiatric Association (APA) Committees where he has recognized for his organizational talents and expertise in geriatric psychiatry. On the local level, he has been active in the Maryland Psychiatric Society CME Committee and previously served as the MPS Chair of the Committee on Residents/Fellows and the

Committee on Public Psychiatry. He has been and continues to be highly valued by the MPS for his expertise and willingness to consult on issues relating to geriatric psychiatry.

The quality and enduring impact of Dr. Lyketsos' work is demonstrated by the numerous honors and awards he has received. Two such awards in the field of geriatric psychiatry are particularly noteworthy. He received the 2006 *William S. Proxmire Award* for "extraordinary leadership in the fight against Alzheimers" and in 2012 he was honored by the AAGP with its highest honor, the *Distinguished Scientist Award.* Other important recognitions of his contributions include his selection as a Distinguished Fellow of the APA, Fellow of the American College of Neuropsychopharmacology, and Member of the American College of Psychiatrists.

In summary, Dr. Lyketsos is an international leader in Geriatric Psychiatry with an unsurpassed record of academic achievement, landmark scientific contributions in the field of dementia, innovative clinical program design benefiting elders with psychiatric morbidities (as well as their families and communities), outstanding mentorship to a new generation of geriatric psychiatrists, and sustained leadership in the field of geriatric psychiatry. He is internationally recognized as a member of the very top tier of clinician-researcher- educators and as an inspirational force for promoting a better quality of life for the elderly. I believe Dr. Lyketsos to be supremely qualified for, and richly deserving of, the Weinberg Memorial Award and it is my deepest privilege to nominate him.

Respectfully,

Marsden McGuire, M.D., M.B.A., DFAPA
Deputy Chief Consultant, Mental Health Standards of Care
Office of Patient Care Services
Department of Veterans Affairs

Clinical Associate Professor
University of Maryland School of Medicine

Assistant Professor
Johns Hopkins University School of Medicine

CURRICULUM VITAE

CONSTANTINE G. LYKETSOS, MD, MHS, DFAPA, FAPM, FACNP[1]

(Signature)  VERSION DATE: 28 June 2015

DEMOGRAPHIC AND PERSONAL INFORMATION

Current Appointments

Johns Hopkins University, Baltimore, Maryland

- The Elizabeth Plank Althouse Professor in Alzheimer's Disease Research, 2007-
- Chair, Department of Psychiatry, Johns Hopkins Bayview Medical Center, 2006-
- Vice-Chair, Department of Psychiatry, Johns Hopkins Medicine, 2006-
- Professor of Psychiatry and Behavioral Sciences (tenured), School of Medicine, 2000-
- Joint Appointment, Department of Mental Health, Bloomberg School of Public Health, 1994-

Johns Hopkins Medicine, Baltimore, Maryland

- Chair, Medical Board, Johns Hopkins Bayview Medical Center, 2013-
- Director, Johns Hopkins Memory and Alzheimer's Treatment Center, 2007-
- Attending Physician, Full-time Medical Staff, The Johns Hopkins Hospital, 1993-
- Attending Physician, Full-time Medical Staff, Johns Hopkins Bayview Medical Center, 2006-

Education and Training (reverse chronological order)

- Johns Hopkins Leadership Development Program, 2006
- Certificate (Business of Medicine), Carey Business School, Johns Hopkins University, 1995
- Master of Health Science (MHS), Epi/Clinical Epi, Johns Hopkins School of Public Health, 1994
- Fellow (Psychiatric Epidemiology), Johns Hopkins Bloomberg School of Public Health, 1992-4
- Senior Clinical Fellow, School of Medicine, Johns Hopkins University, 1992-3,
- Chief Resident in Psychiatry, Johns Hopkins Hospital, Baltimore, Maryland, 1991-92
- Resident in Psychiatry, Johns Hopkins Hospital, Baltimore, Maryland, 1989-91
- Intern in Psychiatry/Medicine, Francis Scott Key Medical Center, Baltimore, Maryland, 1988-89
- Doctor of Medicine (MD), Washington University, School of Medicine, St. Louis, Missouri, 1988
- Bachelor of Arts with Distinction (BA), Northwestern University, Evanston, Illinois 1984
- Apolytirion (High School Diploma), Athens College, Athens, Greece

---

[1] **Contact information**

5300 Alpha Commons Drive, Baltimore, Maryland, 21224
410-550-0062 (tel); 410-550-1407 (fax); kostas@jhmi.edu

Professional Experience (reverse chronological order)

Johns Hopkins University and/or Johns Hopkins Medicine

- Academic Director, Copper Ridge Institute (*affiliated with Johns Hopkins Medicine*), 1999-2008
- CoDirector, Division of Geriatric Psychiatry and Neuropsychiatry, 2002-06
- Founding Director, Neuropsychiatry Service, 1995-2006
- Associate Professor of Psychiatry and Behavioral Sciences, School of Medicine, 1996-0
- Assistant Professor of Psychiatry and Behavioral Sciences, School of Medicine, 1993-6

RESEARCH ACTIVITIES

Publications: **Peer-reviewed Original Science Research**

1. Lyketsos GC, Mouyas AA, **Lyketsos CG**. Changements de l'attitude du public face aux malades mentaux en Grece. Psychologie Medicale 1983:15(14):2351

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CURRENT EXTRAMURAL FUNDING

R01AG042165 (Lyketsos) 09/30/12-05/31/17 0.96 calendar NIA $395,981

Deep Brain Stimulation for Alzheimer's Disease

The project is a phase 2b study of deep brain stimulation of the fornix in early Alzheimer's disease patients, based on promising data from a pilot phase 1 trial. The study focuses on safety, preliminary estimation of efficacy, and response predictors, using clinical and neuroimaging (MR, PET) outcomes.

P50AG005146 (Albert) 04/01/10–03/31/15 1.08 calendar NIA $1,133,337

Johns Hopkins Alzheimer's Disease Research Center (Albert)

Core B (Lyketsos); Core E (Albert)

The major goal of Clinical Core B is to recruit and follow a diverse group of research subjects to support research projects associated with the ADRC. Core B will accomplish this overarching goal by working closely with ADRC leadership and with the other Cores and Projects. The subjects in the Core include: (1) cognitively normal controls, (2) subjects meeting criteria for Mild Cognitive Impairment (MCI), (3) patients with Alzheimer's disease (AD), and (4) patients with other related dementias. The major goals of Education Core E are to train medical professionals in clinical and basic research in age-related neurodegenerative disorders, to communicate progress in clinical and basic science about AD to patients, families and other lay persons, to direct focused outreach efforts to the minority community about age-related health problems, in general, and clinical care and research in AD, in particular, and to augment mechanisms for recruiting and retaining subjects in clinical research in the ADRC.

R01AG038893 (Smith) 09/01/11-05/31/16 0.6 calendar NIA $367,850

PET Studies of Serotonin and Amyloid in MCI and AD

The studies will use PET to evaluate the relationship between amyloid deposition and serotonin transporter availability in MCI.

R01AG041633 (G. Smith) 09/30/11-05/31/16 0.6 calendar NIA $369,437
Longitudinal imaging of neuropsychiatric symptoms in mild cognitive impairment
Longitudinal molecular imaging methods will be used to study the neurobiology of neuropsychiatric symptoms and the relationship to the dementia transition in mild cognitive impairment.

R01AG039384 (Rosenberg) 09/30/11-08/31/16 0.72 calendar NIA $322,719
DIADS-3: An RCT of venlafaxine for depression in AD
Depression in Alzheimer's Disease-3 (DIADS-3)is a proof of concept (Phase II) single-site, double-blind, placebo-controlled RCT of venlafaxine for dAD with a target dose (225 mg/day) sufficient to achieve SNRI effect, and duration (12 weeks) sufficient to detect sustained improvement in mood outcomes. If the efficacy of venlafaxine for dAD is supported in DIADS-3, we will propose a definitive (Phase III), multi-center hypothesis-testing RCT with the group of investigators that successfully carried out DIADS-2. Demonstrating the efficacy of venlafaxine for dAD will have substantial impact on the care of AD patients.

Lyketsos 02/15/12 – 12/31/15 0.12 calendar Functional Neuromodulation, Inc. $76,061
Deep Brain Stimulation for Alzheimer's Disease
This is a prospective, multi-center, double-blind randomized feasibility trial designed to estimate the potential clinical benefit, and associated risks, of deep brain stimulation of the fornix (DBS-f) in patients with mild Alzheimer's disease. The primary objective of this feasibility study is to precisely estimate the treatment effect size in the outcomes of interest at 12 months post-randomization.

Lyketsos 12/01/11-11/30/15 0.12 calendar Avanir Pharmaceuticals $5,882
AVP-923 for Agitation in Alzheimer's Disease
Provide expert consultation and advisory services for the AVP-923 clinical development program.

Gitlin 09/27/12-12/31/15 0.36 calendar NINR/Univ. of Michigan NCE
An Innovative Caregiver Tool to Assess and Manage Behavioral Symptoms of Dementia This study is designed to develop and evaluate an electronic web-based tool to assist families in identifying nonpharmacologic strategies to address problematic behaviors.

R01AG041781 (Gitlin) 09/15/12-05/31/18 0.36 calendar NIA $379,729
Reducing Agitation in Dementia Patients at Home: The Customized Activity Trial
The major goal of this randomized trial is to test the efficacy of an in-home activity program for families caring for patients who have dementia and agitation-type behavioral symptoms.

Samus 09/01/2013-08/31/2018 1.2 calendar NIA $477,040
MIND: An RCT of care coordination for community-living persons with dementia
This Phase III definitive effical study is an 18-month single blind randomized control trial that will test a multidimensional, home-based, care coordination model for community residing people with dementia. The primary outcome is delaying transition out of the home.

Samus 04/01/2014-03/31/20170 0.6 calendar Centers Medicare & Medicaid
$1,918,157
Comprehensive home-based dementia care coordination for Medicare-Medicaid Dual Eligibles in MD
We seek to restructure how dementia care is delivered by equipping community-based health organizations with the workforce and skills necessary to deliver comprehensive AD coordination and by supporting primary care, which faces significant time and resource challenges. We link existing community, medical, and family resources; provide care access to a disadvantaged population; and deploy an interdisciplinary workforce to address dementia care needs.

PREVIOUS EXTRAMURAL FUNDING

Principal Investigator	Citalopram for Agitation in Alzheimer Dementia (CitAD)	NIA R01AG031348	2008-2015
Principal Investigator	Depression in Alzheimer's Disease Study-2 (DIADS-2)	NIMH U01 MH066133	2003-2010
Principal Investigator	Dementia and Psychiatric Disorders in Assisted Living	NIMH R01 MH60626	2003-2009
M-Principal Investigator	Progression of dementia: a Population-based study	NIA MPI: Tschanz	2002-2012
CoPI and Site Director	Alzheimer's Disease Anti-inflammatory Prevention Trial	NIA PI: Breitner	2000-2008
Principal Investigator	A clinical trial of Donepezil in Parkinson's disease	Pfizer-Eisai	2000-2002
Principal Investigator	Validation of the Alkon Test as a Diagnostic Test for Alzheimer	NeuroLogic	2000-2001
Investigator	The Cardiovascular Health Study Cognition Study	NIA/NHLBI PI: Kuller	1998-2001
Investigator	Center for the Study of the Seriously Mentally Ill	NIMH PI: Steinwachs	1998-1999
Investigator	The Evolution of Psychopathology in the Population	NIMH PI: Eaton	1997-2008
Principal Investigator	Treating Depression in Alzheimer's Disease (DIADS)	NIMH R01 MH56511	1997-2003
Investigator	Dementia in the Community: Assessment, Outcomes, Costs	NIMH PI: Rabins	1997-2002
Investigator	Cache County Study of Memory and Aging	NIA PI: Breitner	1994-2007
Principal Investigator	Dementia in the General Hospital	Alzheimer's Association	1998
Principal Investigator	Bright Light Therapy in the Nursing Home Dementia Patient	Helen Bader Foundation	1996-1998
Principal Investigator	Outreach for Baltimore residents with dementia	Cover-White Foundation	1996-1997
Principal Investigator	Depression as AIDS develops	NIMH R03 MH52507	1995

Investigator	Collaborative Atypical Trial of Intervention Effectiveness (CATIE-AD)	NIMH PI: Schneider	1994-2002
Project Director	Development of Research Infrastructure at Copper Ridge	Copper Ridge Inc.	1994-1998
Principal Investigator	Psychiatric Disorders in HIV+ Women Prisoners	Johns Hopkins CRC (NCRR)	1994-1996
Principal Investigator	Apolipoprotein E 4 & psychopathology in Alzheimer's	Johns Hopkins CRC (NCRR)	1994-1996
Investigator	Psychiatric Disorders in STD Clinics	NIMH PI: Erbelding	1992-2002
Investigator	Multicenter AIDS Cohort Study	NIAID PI: Saah	1992-1997
NRSA Trainee	Training in Psychiatric Epidemiology (5T32-14592)	NIMH PI: Eaton	1992-1994

EDUCATIONAL ACTIVITIES

Peer Reviewed Educational Publications

1. Lyketsos GC and **Lyketsos CG**. Transcultural Psychosomatics (in Greek). Psychiatriki (Journal of the Hellenic Psychiatric Society) 1990:1(3):224

2. **Lyketsos CG**, Lyketsos GC, Fishman M, Treisman GJ. Dementia and secondary mood disorders in AIDS. Psychiatriki 1992; 3: 118-124

3. Treisman GJ, **Lyketsos CG**, Fishman M, Hanson A, McHugh PR. Psychiatric care for patients with HIV infection: the varying perspectives. Psychosomatics, 1993;34(5):432-439.

4. Treisman GJ, **Lyketsos CG**, Fishman M. Mental Health Care of HIV Patients: Part I: Managing Psychiatric Disease. AIDS Clinical Care 1994; 6(8):63-66.

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6. Hooten RM, **Lyketsos CG**. Fronto-temporal Dementia: A clinicopathological review of four post-mortem studies. J Neuropsychiatry Clin Neurosciences 1996; 8:10-19

7. **Lyketsos CG**, Treisman GJ, Lipsey JR, Morris PLP, Robinson RG. Does stroke cause depression? J Neuropsychiatry Clin Neurosciences 1998; 10:103-107

8. Treisman G, Fishman M, Schwartz J, Hutton H, **Lyketsos CG**. Mood disorders in HIV infection. Depression and Anxiety 1998; 7:178-187

9. **Lyketsos CG**. Diagnosis, and management of delirium in the elderly. J Clinc Outcomes Management 1998;5(4): 51-62

10. Rao V, **Lyketsos CG**. Delusions in Alzheimer's disease: A Review. J Neuropsychiatry Clin Neurosciences 1998;10:373-382

11. **Lyketsos CG**. The prion dementias. Maryland Medical Journal 1999; 48: 18-22

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13. Taragano FE, **Lyketsos CG**. La depresion en pacientes de mas de 60 anos (in Spanish). Gerontologia Mundial 1998; 2(3): 64-76

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15. **Lyketsos CG**, Treisman GJ. Mood disorders in HIV infection. Psych Annals 2001; 31:45-9

16. **Lyketsos CG**, Rabins PV, Breitner JCS. An evidence-based proposal for the classification of neuropsychiatric disturbance in Alzheimer's disease. Int J Ger Psychiatry 2001; 16(11):1037-1042

17. Blass DM, Steinberg MS, Leroi I, **Lyketsos CG**. Successful multi-modality treatment of severe behavioral disturbance in a patient with advanced Huntington's disease. Am J Psychiatry 2001; 158(12): 1966-1972

18. Lee HB, **Lyketsos CG**. Delayed Post-Hypoxic Leukoencephalopathy. Psychosomatics 2001; 42(6)530-533

19. Olin JT, Schneider LS, Katz IS, Meyers BS, Alexopoulos GS, Breitner JCS, Bruce ML, Caine ED, Cummings JL, Devanand DP, Jeste DV, **Lyketsos CG**, Lyness JM, Rabins PV, Reynolds III CF, Rovner BW, Steffens DS, Tariot PN, Lebowitz BD. National Institute of Mental Health - Provisional Diagnostic Criteria for Depression of Alzheimer Disease. Am J Ger Psychiatry 2002; 10: 125-128

20. **Lyketsos CG**, Olin JT. Depression in Alzheimer's disease: overview and treatment. Biol Psychiatry 2002; 52(3):243-252

21. Charney DS, Reynolds CF, Lewis L, Lebowitz BD, Sunderland T, Alexopoulos GS, Blazer DG, Katz IR, Meyers BS, Arean PA, Borson S, Brown C, Bruce ML, Callahan CL, Charlson ME, Conwell Y, Cuthbert BN, Devanand DP, Gibson MJ, Gottlieb GJ, Krishnan KR, Laden SK, **Lyketsos CG**, Mulsant BH, Niederehe G, Olin JT, Oslin DW, Pearson J, Persky T, Pollock BG, Raetzman S, Reynolds M, Salzman C, Schulz R, Schwenk TL, Scolnick E, Unützer J, Weissman MM, Young RC. Depression and Bipolar Support Alliance Consensus Statement on the Unmet Needs in Diagnosis and Treatment of Mood Disorders in Late Life. Arch Gen Psychiatry 2003;60:664-672

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24. **Lyketsos CG**, Lee HB. Depression and treatment of depression in Alzheimer's disease: A practical update for the clinician. Dementia and Geriatric Cognitive Disorders 2004; 17:55-64

25. Onyike CU, **Lyketsos CG**, Treisman GJ. Mania after interferon treatment. Am J Psychiatry 2004; 161:429-435

26. **Lyketsos CG**, Rosenblatt AR, Rabins PV. Forgotten Frontal lobe Syndrome. Or, Executive Dysfunction Syndrome. Psychosomatics 2004; 45: 247-255

27. Gitlin DF, Levenson JL, **Lyketsos CG**. Psychosomatic Medicine: A New Psychiatric Subspecialty. Academic Psychiatry 2004; 28:4-11.

28. Alzheimer's Association (**CG Lyketsos, Workgroup Chair)**. Consensus Recommendation: Research consent for cognitively impaired adults: Guidelines for Institutional Review Boards and Investigators. Alzheimer Dis Assoc Disord 2004; 18:171-175

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31. Livingston G, Johnston K, Katona C, Paton J, **Lyketsos CG**. Systematic review of psychological approaches to the management of neuropsychiatric symptoms of dementia. Am J Psychiatry 2005; 162:1996-2021

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33. Tschanz JT, Treiber K, Norton MC, Welch-Bohmer K, Toone L, Zandi P, Szekeley CA, **Lyketsos CG**, Breitner, JCS. A population study of Alzheimer disease: Findings from the Cache County Study on Memory Health and Aging. Care Management Journals 2005; 6(2):107-114

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2006;14(7):561-72

35. Mielke MM, **Lyketsos CG**. Lipids and the pathogenesis of Alzheimer's disease: is there a link? Int Rev Psychiatry. 2006 Apr;18(2):173-86

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37. **Lyketsos CG**. Lessons from Neuropsychiatry. J Neuropsychiatry Clin Neurosci 2006; 18(4): 445-449

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41. **Lyketsos CG**, Szekely CA, Mielke MM, Rosenberg PB, Zandi PP. Developing new treatments for Alzheimer's disease: the who, what, when, and how of biomarker-guided therapies. Int Psychogeriatr. 2008 May 23:1-19. [Epub ahead of print] [NIHMS 79471]

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43. **Lyketsos CG**, Chisolm MS. The trap of meaning: a public health tragedy. JAMA Jul 2009 22;302(4):432-3

44. Vaishnavi S, Rosenblatt A, Rabins P, **Lyketsos C**, Rao V. Behavioral neurology and neuropsychiatry fellowship training: the Johns Hopkins model. J Neuropsychiatry Clin Neurosci 2009;21(3):335-41

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51. Spencer L, **Lyketsos** CG, Samstad E, Dokey A, Rostov D, Chisolm MS. A suicidal adult in crisis: an unexpected diagnosis of autism spectrum disorder.Am J Psychiatry. 2011 Sep;168(9):890-2

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59. Steinberg M, **Lyketsos** CG. Atypical antipsychotic use in patients with dementia: managing

safety concerns. Am J Psychiatry. 2012 Sep 1;169(9):900-6.

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68. Kales HC, Gitlin LN, **Lyketsos C** for the Detroit Expert Panel on the Assessment and Management of Neuropsychiatric Symptoms of Dementia. Management of neuropsychiatric symptoms of dementia in clinical settings: Recommendations from a multidisciplinary expert panel. J Am Geriatr Soc. 2014 Mar 17. doi: 10.1111/jgs.12730. [Epub ahead of print].

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review and discussion of recent randomized clinical trial design. Int Psychogeriatr. 2014 Sep 16:1-17. [Epub ahead of print]

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Invited Review Articles and Editorials

1. **Lyketsos CG**, Steele C. The care of patients with dementia. Reviews in Clinical Gerontology 1995; 5:189-207

2. **Lyketsos CG**, Treisman GJ. Epidemiology and drug treatment of psychiatric disorders in HIV-infected patients. CNS Drugs 1995, 4(3): 195-206

3. **Lyketsos CG**, Federman EB. Psychiatric disorders and HIV infection: impacting one another. Epidemiologic Reviews 1995; 17(1): 152-164

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10. **Lyketsos CG**. Research training during psychiatric residency: A personal reflection. Academic Psychiatry 2001; 25(1):31-33

11. **Lyketsos CG**, Breitner JCS. Mental and Behavioral Disturbances in Dementia: Findings from the Cache County Study of Memory in Aging. Research and Practice in Alzheimer's disease (Volume 5), Serdi/Springer: Paris 2001, pp. 144-150

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13. **Lyketsos CG**. Neuropsychiatric and behavioral disturbances in dementia (Chapter 18). Geriatrics Review Syllabus (5th Edition), Blackwell Publishing, 2002, pp. 125-131

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17. Lee H, **Lyketsos CG**. Diagnosis and management of depression in mild cognitive impairment. Psychiatric Annals 2004; 34(4):273-280

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20. **Lyketsos CG**. Commentary on the NIH Cognitive and Emotional Health Project: Report of the Critical Evaluation Study Committee." What would be the effect of raising the retirement age by five years on the cognitive and emotional health of individuals age 65 and older? Alzheimer's and Dementia: The Journal of the Alzheimer's Association 2006; 2(2):86-88

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22. Munro CA, **Lyketsos CG**. Cognitive response to sertraline treatment for depression in Alzheimer's disease: A possible sex effect. Research and Practice in Alzheimer's Disease 2006*,* 11*,* 361-365

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25. **Lyketsos CG**. Neuropsychiatric symptoms (behavioral and psychological symptoms of dementia) and the development of dementia treatments. Int Psychogeriatr 2007 Jun;19(3):409-20

26. **Lyketsos CG**, Kozauer N, Rabins PV. Psychiatric Manifestations of Neurologic Disease: Where are we headed? Dialogues in Clinical Neuroscience 2007; 9(2): 111-124 (NIHMS84634)

27. **Lyketsos CG**. Apathy and agitation: challenges and future directions (Guest Editor Editorial). Am J Geriatr Psychiatry 2007;15(5):361-4

28. Rabins PV, **Lyketsos CG**. The Pharmacotherapy of Neuropsychiatric Symptoms: Opportunities, Challenges, and Current Prospects. Nat Clin Pract Neurol 2007;3(5):239

29. **Lyketsos CG**. Antidepressants improve depression in people with Alzheimer's disease. Evid Based Ment Health 2007 Nov;10(4):115

30. Rosenberg PB, **Lyketsos C.** Mild cognitive impairment: searching for the prodrome of Alzheimer's disease. World Psychiatry 2008 Jun;7(2):72-8

31. **Lyketsos CG**. The interface between depression and dementia: where are we with this important frontier? Am J Geriatr Psychiatry 2010 Feb;18(2):95-7 (PMCID: PMC2813464 NIHMSID: NIHMS161457)

32. Lyketsos CG. Depression and diabetes: more on what the relationship might be. Am J Psychiatry 2010 May; 167(5):496-7

33. Rabins PV, **Lyketsos CG**. A Commentary on the Proposed DSM Revision Regarding the Classification of Cognitive Disorders. Am J Geriatr Psychiatry 2010; DOI: 10.1097/JGP.0b013e3182051ac7

34. **Lyketsos CG**. Commentary on "Recommendations from the National Institute on Aging-Alzheimer's Association workgroups on diagnostic guidelines for Alzheimer's disease." New criteria for a new era. Alzheimers Dement. 2011 May; 7(3):328-9

35. Rosenberg PB, **Lyketsos CG**. Treating agitation in dementia: a systematic pain management protocol may help. BMJ 2011; 343:d3913

36. **Lyketsos CG**. Prevention of unnecessary hospitalization for patients with dementia: the role of ambulatory care. JAMA 2012 Jan 11; 307(2):197-8

37. **Lyketsos CG**, Miller DS; Neuropsychiatric Syndromes Professional Interest Area of the International Society to Advance Alzheimer's Research and Treatment. Addressing the Alzheimer's disease crisis through better understanding, treatment, and eventual prevention of associated neuropsychiatric syndromes. Alzheimers Dement 2012 Jan;8(1):60-4.

38. Geda YE, Schneider LS, Gitlin LN, Miller DS, Smith GS, Bell J, Evans J, Lee M, Porsteinsson A, Lanctôt KL, Rosenberg PB, Sultzer DL, Francis PT, Brodaty H, Padala PP, Onyike CU, Ortiz LA, Ancoli-Israel S, Bliwise DL, Martin JL, Vitiello MV, Yaffe K, Zee PC, Herrmann N, Sweet RA, Ballard C, Kin NA, Alfaro C, Murray PS, Schultz S, **Lyketsos CG**. Neuropsychiatric Syndromes Professional Interest Area of ISTAART. Neuropsychiatric symptoms in Alzheimer's disease: Past progress and anticipation of the future. Alzheimers Dement. 2013 Apr 3. pii: S1552-5260(12)02570-8. doi: 10.1016/j.jalz.2012.12.001. [Epub ahead of print]

39. **Lyketsos CG**. Now Is the Time for True Reform of Mental Health Services. JAMA Intern Med. 2014 Nov 10. doi: 10.1001/jamainternmed.2014.6086. [Epub ahead of print]

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41. Rao V, Koliatsos V, Ahmed F, **Lyketsos** C, Kortte K. Neuropsychiatric disturbances associated with traumatic brain injury: a practical approach to evaluation and

management. Semin Neurol. 2015 Feb;35(1):64-82. doi: 10.1055/s-0035-1544241. Epub 2015 Feb 25.

42. Rosenberg PB, Nowrangi MA, **Lyketsos** CG. Neuropsychiatric symptoms in Alzheimer's disease: what might be associated brain circuits? Mol Aspects Med. 2015 Jun 3. pii: S0098-2997(15)00035-7. doi: 10.1016/j.mam.2015.05.005. [Epub ahead of print]

Case Reports

1. **Lyketsos CG**. Successful treatment of bowel obsessions with nortriptyline. American Journal of Psychiatry, 1992:149(4):573
2. Lee HB, Hanner JA, Yokley JL, Appleby B, Hurowitz L, **Lyketsos CG**. Clozapine for treatment-resistant agitation in dementia. J Geriatr Psychiatry Neurol 2007; 20(3):178-82
3. **Lyketsos CG**, Kraus M. The dementia of Gerstmann-Sträusler-Scheinker syndrome: clinical variability demonstrated by two case reports. J Neuropsychiatry Clin Neurosciences 1995; 7:239-242.
4. McMullen DP, Rosenberg P, Cheng J, Smith GS, **Lyketsos** C, Anderson WS. Bilateral Cortical Encephalomalacia in a Patient Implanted With Bilateral Deep Brain Stimulation for Alzheimer's Disease: Case Report. Alzheimer Dis Assoc Disord. 2015 Apr 3. [Epub ahead of print]

Letters, correspondence

1. Steinberg MS, **Lyketsos CG**. Pharmacological treatment of neuropsychiatric symptoms of dementia [letter]. JAMA 2005; 293(18): 2211-2212

Book Chapters, Monographs

1. Lyketsos GC and **Lyketsos CG**. Evolution des attitudes sociales a l'egard des maladies mentales. In: Chanoit PF and de Verbizier J (editors). Recherches en Psychiatrie Sociale. Paris:Eres, 1986

2. Lyketsos GC and **Lyketsos CG**. Personality characteristics in psychosomatic illness. In: Christodoulou GN (editor). Psychosomatic Medicine: Past and Future. New York:Plenum Press, 1986

3. Lyketsos GC and **Lyketsos CG**. Psychiatric Assessment and Phenomenology (in Greek). In: Arapakis G. Textbook of Medical Phenomenology. Athens:Athens University Press, 1991

4. Treisman GJ, Fishman M, **Lyketsos CG**, McHugh PR. Evaluation and treatment of psychiatric disorders associated with HIV infection. In Price RW, Perry SW (eds) HIV, AIDS and the Brain, ARNMD Volume 72, New York: Raven press, 1993, pp. 239-250.

5. **Lyketsos CG**, Fishman M, Treisman GJ. Patients with HIV infection (Chapter 29, pp. 404-418). In Modern Community Psychiatry, WR Breakey, Editor, New York: Oxford Press, 1996

6. Kraus MF, **Lyketsos CG**. Neuropsychiatric assessment after brain injury. In Physical Medicine and Rehabilitation Secrets (BA O'Young, MA Young, and S Stiens, Editors), Hanley and Belfus: Philadelphia, 1996 pp.111-116.

7. Treisman GJ, Fishman M, **Lyketsos CG**. Mental Health. in Medical Management of HIV Infection (Bartlett, J, Ed), Chicago: Physicians and Scientists Publishing Co., 1996, pp. 195-206. Second Edition, Port City Press: Baltimore, 1997, pp.205-215

8. **Lyketsos CG** and Lyketsos GC. Psychiatric Assessment and Phenomenology (in Greek). In: Arapakis G. Textbook of Medical Phenomenology. Athens:Athens University Press, 3rd Edition 1997

9. Fishman M, **Lyketsos CG**, Schwartz J, Treisman G. Psychiatric disorders in HIV infection. In The Neurology of AIDS. Gendelman, Lipton, Epstein, Swindels (Eds.). Chapman and Hall: New York, 1998

10. **Lyketsos CG**, Steele C, Steinberg M. Behavioral Disturbances in Dementia. Reichel's Care of the Elderly: Clinical Aspects of Aging, Fifth Edition, Gallo JJ, Busby-Whitehead J, Rabins PV, Silliman R, Murphy J (Eds.), Baltimore,Williams & Wilkins, 1999, pp. 214-228

11. **Lyketsos CG**. Desired Characteristics of Instruments to Measure Physical Capacity to Work—Discussion, Wunderlich G (ed), Measuring Functional Capacity to Work: Summary of a Workshop. Institute of Medicine, Washington DC: 1999, pp. 52-55

12. Treisman GJ, Fishman M, Schwartz J, **Lyketsos CG**. Treatment of psychiatric disorders in patients infected with HIV. Psychiatric Treatment of the Medically Ill, Robinson RG and Yates WR (Eds), Marcel and Dekker, 1999

13. **Lyketsos CG**. Aggression. Textbook of Geriatric Neuropsychiatry (Coffey and Cummings, Editors). American Psychiatric Press Inc.: Washington 2000, pp. 477-488

14. Rovner B, Katz I, **Lyketsos CG**. Neuropsychiatry in the Nursing Home. Textbook of Geriatric Neuropsychiatry (Coffey and Cummings, Editors). American Psychiatric Press Inc.: Washington 2000, pp. 891-903

15. **Lyketsos CG**, Steinberg M. Behavioral measures for cognitive disorders. Handbook of Psychiatric Measures. American Psychiatric Association: Washington 2000, pp.393-416

16. Taragano F, **Lyketsos C**. Trastornos de la conducta en la demencia. En Tratado de Neurología Clínica, Federico Michelli et al. Editorial Médica Panamericana, Buenos Aires, 2002. ISBN 950-06-1568-1, pág:753-762 www.medicapanamericana.com .

17. Onyike CU, **Lyketsos CG**. Aggression and violence. Textbook of Psychosomatic Medicine (Levenson et al, Editors). American Psychiatric Press Inc, Washington DC, 2004, pp. 171-191

18. Treisman GJ, Angelino AF, Hutton HE, Hsu J, **Lyketsos CG**. Neuropsychiatric aspects of HIV infection and AIDS. Comprehensive Textbook of Psychiatry 8th Edition, (Sadock and Sadock, Editors), Lippincott, Williams, and Wilkins, Philadelphia 2004, pp. 426-451

19. Leroi I, **Lyketsos CG**. Neuropsychiatric aspects of dementia. Dementia (Edited by Burns, O'Brien, and Ames) Cambridge Press, Cambridge 2005, Chapter 6, pp. 55-63

20. Rosenberg P, **Lyketsos CG**. Depression in Alzheimer's disease. The Physician's Guide to Depression and Bipolar Disorders (Edited by Evans, Charney, Lewis) McGraw Hill, Chapter 12, pp. 303-332

21. Rosenberg P, **Lyketsos CG**. Depression in Alzheimer's disease. Depression and Brain Dysfunction (Edited by Gilliam, Kanner, Sheline) Taylor and Francis, Chapter 10, pp. 239-262

22. Galik E, Rabins PV, **Lyketsos CG**. Dementia. Psychosomatic Medicine (Edited by Blumenfield and Strain) Lippincott, Williams and Wilkins, Chapter 29, pp. 513-535

23. Ferrando SJ, **Lyketsos CG**. Psychiatric Co-morbidities in Medically Ill Patients with HIV/AIDS. Psychiatric Aspects of HIV/AIDS (Edited by Fernandez and Ruiz), Lippincott, Williams and Wilkins, Chapter 19, pp. 198-211

24. Steinberg MS, **Lyketsos CG**. Psychiatric disorders in people with dementia. Textbook of Alzheimer's Disease and Other Dementias (Edited by Weiner and Lipton), APPI, 2009, Chapter 15, pp. 263-281

25. **Lyketsos CG**. Dementia and Milder Cognitive Syndromes. Textbook of Geriatric Psychiatry (Edited by Blazer and Steffens), APPI, 2009, Chapter 13, pp. 243-260

26. Leroi I, **Lyketsos CG**. Neuropsychiatric aspects of dementia. Dementia (Edited by Ames, Burns, and O'Brien) Hodder Arnold, London 2010, Chapter 8, pp. 70-74

27. Salami O, **Lyketsos CG**. Clinical features of Alzheimer's disease: cognitive and non-cognitive. Principles and Practice of Geriatric Psychiatry 3rd Edition (Edited by Abou Saleh, Katona, Kumar), Wiley-Blackwell, 2011, Chapter 41, pp. 226-231

28. Oh E, **Lyketsos CG**, Wong P. Mouse models of Alzheimer's disease. Principles and Practice of Geriatric Psychiatry 3rd Edition (Edited by Abou Saleh, Katona, Kumar), Wiley-Blackwell, 2011, Chapter 44, pp. 252-256

29. Steinberg M, **Lyketsos CG**. Pharmacologic therapies in Alzheimer's disease. Principles and Practice of Geriatric Psychiatry 3rd Edition (Edited by Abou Saleh, Katona, Kumar), Wiley-Blackwell, 2011, Chapter 52, pp. 304-311

30. Oishi K, Mielke MM, Albert M, **Lyketsos CG**, Mori S. DTI analyses and clinical applications in Alzheimer's Disease. Handbook of Alzheimer's Disease (Editors: M. Smith, G. Perry, J. W. Ashford, A. Rosen, M. Adamson, O. Sabri, S. Black, G. B. Frisoni, C. R. Jack and M. W. Weiner), Series: Imaging the Alzheimer's Disease Brain, Volume 2, Chapter 7, 2011.

31. Marano C, Rabins PV, **Lyketsos CG**. Neurocognitive disorder due to Alzheimer's disease. Gabbard's Treatments of Psychiatric Disorders, APPI Press, 2014, Chapter 64, pp. 957-966

Books, Textbooks, Journal Special Issues

1. **Lyketsos CG** (Guest Editor). The Psychiatry of HIV Infection. International Review of Psychiatry Volume 8 (2/3) 1996

2. Rabins PV, **Lyketsos CG**, Steele C. Practical Dementia Care, Oxford University Press Inc.: New York, 1999. Second edition, 2006.

3. **Lyketsos CG** (Guest Editor). Neuropsychiatry. Psychosomatics (special issue), American Psychiatric Press, Inc., January-February 2000

4. Levenson J, **Lyketsos CG**, Trzepacz PT (Editors). Psychiatry in the Medically Ill. Psychiatric Clinics of North America, Saunders, Philadelphia, March 2002, Volume 25:1

5. Panel to Review Risk and Prevalence of Elder Abuse and Neglect (Bonnie R, **Lyketsos CG** et al). Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America. The National Academies Press: Washington DC, January 2003

6. Rao V, and **Lyketsos CG** (Guest Editors)**.** Neuropsychiatric Aspects of Traumatic Brain Injury. International Review of Psychiatry Volume 15 (4) 2003

7. Levenson JL (Editor), (**Lyketsos CG:** Editorial Board). Textbook of Psychosomatic Medicine. American Psychiatric Press Inc, Washington DC, 2004

8. **Lyketsos CG**, Rabins PV, Lipsey J, Slavney PR (Editors). Psychiatric aspects of neurological diseases. Oxford University Press, New York, 2008

9. Ballenger JF, Whitehouse PJ, **Lyketsos CG**, Rabins PV, Karlawish JHT. Treating dementia: do we have a pill for it? Johns Hopkins University Press, Baltimore, 2009

10. Chisolm MC, **Lyketsos CG**. Systematic Psychiatric Evaluation. Johns Hopkins University Press, Baltimore, 2012

11. De Waal H, **Lyketsos C**, Ames D, O'Brien J. Designing and Delivering Dementia Services. Wiley Blackwell, London, 2013

Other media (films, videos, CD-ROMS, slide sets, etc)

1. Steele CD, Brandt J, Baker A, Vozella S, Hovanec L, **Lyketsos CG**. The Copper Ridge Institute Dementia Care Certification Course (electronic media). Lippincott Williams and Wilkins Press, Philadelphia, 2004

Teaching

Classroom Instruction

Johns Hopkins School of Medicine,

First and Second Year Psychiatry Instructor and Tutor, 1995-04
First Year Epidemiology Tutor, School of Medicine, 1994-7
First Year Neuroscience Tutor, School of Medicine, 1994-6

Bloomberg School of Public Health

Introduction to Mental Hygiene, 1996

Neuropsychiatry Conference (weekly), Course Director, 1994-99

Psychiatry Residency, Weekly Journal Club Faculty Advisor and Discussion Leader, 1997-2011

Clinical Investigation in Psychiatry: The ABCs for Residents, Fellows, and Junior Faculty (26 hours), 2000-6

Clinical Instruction

Psychiatry Clerkship Lecturer and Preceptor, 1994-06
Second Year Clinical Skills Tutor, 1994-7
Psychiatric Emergency Conference, 1991-2
HIV Neuropsychiatry Conference, Course Director, 1990-4

CME Instruction

Program Chair, 2002-2003: 50th Anniversary Meeting of the Academy of Psychosomatic Medicine: Celebrating the New Medical Subspecialty of Psychosomatic Medicine. San Diego, California, November 19th to 23rd, 2003 (International Conference, 381 attendees)

Johns Hopkins CME Instruction

Course Director, April 12, 2014	20th Annual Update on Alzheimer's Disease and Other Dementias	Regional Conference (124 attendees)
Course Director, April 13, 2013	19th Annual Update on Alzheimer's Disease and Other Dementias	Regional Conference (97 attendees)
Course Director, March 31, 2012	18th Annual Update on Alzheimer's Disease and Other Dementias	Regional Conference (165 attendees)
Course Director, April 2, 2011	17th Annual Update on Alzheimer's Disease and Other Dementias	Regional Conference (174 attendees)
Course Director, April 12th, 2010	16th Annual Update on Alzheimer's Disease and Other Dementias	Regional Conference (215 attendees)
Course Director, April 4th, 2009	15th Annual Update on Alzheimer's Disease and Other Dementias:	Regional Conference (182 attendees)
Course Director, April 12th, 2008	14th Annual Update on Alzheimer's Disease and Other Dementias:	Regional Conference (228 attendees)
Course Director, March 24th, 2007	13th Annual Update on Alzheimer's Disease and Other Dementias:	Regional Conference (275 attendees)
Course Director, March 25th, 2006	12th Annual Update on Alzheimer's Disease and Other Dementias	Regional Conference (267 attendees)
Course Director, March 26th, 2005	11th Annual Update on Alzheimer's Disease and Other Dementias	Regional Conference (246 attendees)

Course Director, March 19-20th, 2004	10th Annual Update on Alzheimer's Disease and Other Dementias[2]	National Conference (185 attendees)
Course Director, March 22nd, 2003	9th Annual Update on Alzheimer's Disease and Other Dementias	Regional Conference (240 attendees)
Course Director, April 6th, 2002	8th Annual Update on Alzheimer's Disease and Other Dementias	Regional Conference (228 attendees)
Course Director, April 21st, 2001	7th Annual Update on Alzheimer's Disease and Other Dementias	Regional Conference (105 attendees)
Course Director, April 15h, 2000	6th Annual Update on Alzheimer's Disease and Other Dementias	Regional Conference (208 attendees)
Course Director, April 24th, 1999	5th Annual Update on Alzheimer's Disease and Other Dementias	Regional Conference (235 attendees)
Course Director, October 2-3RD, 1998	Psychopharmacologic Treatments for mood disorders, dementia, and Alzheimer	Regional Conference (95 attendees)
Course Director, April 4th, 1998	Update on Alzheimer's Disease and Other Dementias	Regional Conference (228 attendees)
Course Director, October 20th, 1997	Care of the Aging Adult with Mental Retardation	Regional Conference (210 attendees)
Course Director, October 6-10, 1997	Basic Dementia Care (5-day Course)	Athens, Greece (100 attendees from Greece)
Course Director, April 12th, 1997	Update on Alzheimer's Disease and Other Dementias	Regional Conference (198 attendees)
Course Director, April 27th, 1996	The Practical Management of Alzheimer's Disease and Other Dementias	Regional Conference (210 attendees)
Course Director, April 1st, 1995	Update on Alzheimer's Disease and Other Dementias	Regional Conference (265 attendees)

Mentoring: Current mentees in primary or other central role
Christopher Marano, MD, Assistant Professor of Psychiatry at Johns Hopkins
K-23 Recipient (Sponsor: Lyketsos)

Matthew Peters, MD, Neuropsychiatry Fellow at Johns Hopkins
Formerly Goldman Family Summer Scholar 2008
Formerly Medical Student, Resident, and Chief resident in Psychiatry at Johns Hopkins

Milap Nowrangi, MD, Assistant Professor of Psychiatry at Johns Hopkins
Formerly postdoctoral Fellow in Neuropsychiatry at Johns Hopkins

Esther Oh, MD, Assistant Professor of Medicine at Johns Hopkins (Geriatric Medicine)
KL2 and then K23 Recipient (Sponsor: Lyketsos)

[2] *Covered on front page of the New York Times*

Paul Rosenberg, MD, Associate Professor of Psychiatry at Johns Hopkins
Paul B. Beeson Career Development Award in Aging (K23) recipient (Sponsor: Lyketsos)

Vani Rao, MBBS, Associate Professor of Psychiatry at Johns Hopkins
Previously K-23 Recipient (Sponsor: Lyketsos); Former Neuropsychiatry Fellow

Martin Steinberg, MD, Assistant Professor of Psychiatry at Johns Hopkins
Former Dementia Research Fellow

Quincy Miles-Samues, PhD, Associate Professor of Psychiatry at Johns Hopkins
Formerly K02 recipient (Sponsor: Rabins, Co-sponsor: Lyketsos)

Antonios Politis, MD, Assistant Professor in Psychiatry at Johns Hopkins (Part Time)
Assistant Professor of Psychiatry at the University of Athens, Greece

Mentoring: former junior faculty mentees, fellows, and pre-doctoral students in primary role
Sarah Tighe, MD, Assistant Professor of Psychiatry, Carver School of Medicine, Univ. of Iowa
Former Postdoctoral Fellow in Neuropsychiatry at Johns Hopkins
Formerly Medical Student Advisor, Resident Advisor, AFAR Summer Scholar 2004

Hochang (Ben) Lee, MD, Associate Professor of Psychiatry, Yale University
Formerly Assistant and then Associate Professor of Psychiatry at Johns Hopkins
Formerly K-23 Recipient (Sponsor: Lyketsos)
Former Fellow in Neuropsychiatry and Psychiatric Epidemiology

Michelle Mielke, MA, PhD, Associate Professor of Epidemiology, Mayo Medical School
Formerly Assistant Professor, Post-doctoral fellow, Dissertation Committee at Johns Hopkins

Oludamilola (Dami) Salami, MBBS, Director Neuropsychiatry, Medical College of Wisconsin
Formerly Postdoctoral Fellow in Geriatric Psychiatry/Neuropsychiatry

Cynthia Fields, MD, Attending Psychiatrist, Good Samaritan
Formerly Postdoctoral Fellow in Geriatric Psychiatry/Neuropsychiatry

Adam Rosenblatt, MD, Professor of Psychiatry, Virginia Commonwealth University
Formerly, Assistant and then Associate Professor of Psychiatry at Johns Hopkins

Adam Kaplin, MD, PhD, Assistant Professor of Psychiatry at Johns Hopkins
Formerly K-23 recipient (Sponsor: Rabins; Co-sponsor: Lyketsos)

Sherita Golden, MD, Professor of Medicine at Johns Hopkins
Formerly K-23 Recipient (Sponsor: Brancatti; Co-sponsor: Lyketsos)

Chiadikaobi Onyike, MD, Assistant Professor of Psychiatry at Johns Hopkins
Former Neuropsychiatry and Psychiatric Epidemiology Fellow

Elizabeth Galik, RN, MS, CRNP, PhD, Associate Professor of Nursing, University of Maryland
Formerly Hartford Foundation Scholar in Nursing (one of 10 nationally)

Ariel Green, BA, MA, MD, Instructor of Geriatric Medicine at Johns Hopkins
Formerly Capstone Fellow, Johns Hopkins Bloomberg School of Public Health

Kathleen Hayden, MA, PhD, Associate Professor, Wake Forest University
Formerly Doctoral Student in Mental Hygiene, Dissertation Committee

Ara Khatchaturian, BA, PhD, Managing Editor, Alzheimer's and Dementia
Formerly Doctoral Student in Mental Hygiene, Dissertation Committee and advisor

Laura Podewils, MSc, PhD, Assistant Professor of Epidemiology, University of Arizona
Formerly Doctoral Student in Epidemiology, Dissertation Committee Chair, advisor

William Groves, MD (deceased)
Formerly Dementia Research Fellow (T32)

Iracema Leroi, MBBS, Clinical Senior Lecturer in Old Age Psychiatry, University of Manchester, UK
Formerly Neuropsychiatry Fellow and then Assistant Professor of Psychiatry at Johns Hopkins
2001 Research Award Recipient by ANPA

Heidi Hutton, PhD, Associate Professor of Psychiatry, Johns Hopkins University
Research Study: "HIV Risk Behaviors in Women Prisoners," 1995-8

Joyce West, MPP, PhD, Staff Scientist, American Psychiatric Association
Dissertation Committee as Doctoral Candidate in the Johns Hopkins School of Public Health

Susan Patania, RN, MSW
Chair Dissertation Committee as Doctoral Candidate in the Johns Hopkins School of Public Health

Jennifer Payne, MD, Assistant Professor of Psychiatry Johns Hopkins
Chief Resident and Resident in Psychiatry and Johns Hopkins
Senior Medical Student at Washington University (Elective in Neuropsychiatry)

Other students/trainees

Mark Bickett, MD, AFAR Summer Scholar 2007
Johns Hopkins second year medical student

Melissa Morgan, MD, Goldman Scholar 2005
Johns Hopkins rising second year medical student

Edmond Nelson, DO, AFAR Scholar, 2005
1st Year South Alabama Osteopathic Student

Donovan Maust, MD, Goldman Scholar, 2004
Johns Hopkins \ second year medical student

Daniel Burdick, MD, AFAR Scholar, 2003
Johns Hopkins second year medical student

Lourdes Del Campo, MD, Elective, 2001
Senior Resident in Psychiatry, Pamplona, Spain

Pamella Rollings, MD, Elective, 2000
PGY-V Resident University of New Foundland

Eric Kagaruki, DO, AFAR Summer Scholar, 2000
1st Year Student Ohio Osteopathic Medicine

Argyro Voulgari, Dr. Md. Sci., 1999, Visiting Scientist
Greek Center for Mental Health

Robert McLay, PhD, 1999
Senior Medical Student at Tulane University

Medhat Bassiony, MBBS, Humphrey, 1998-9
Associate Professor at the Zagazig University, Egypt

Mark Broadhurst, Clerkship, 1995
Medical Student at University of Manchester

Theresa Salvador, MD, Visiting Scientist, 1998
Academic Psychiatrist from Pamplona Spain

E. Scott Kopetz, MD, AFAR Summer Scholar, 1998
Second Year Medical Student at JHU

Diane Klein, MD, Elective, 1998
Medical Student/Psychiatry Resident at JHU

Angela Kim, MD, Elective, 2000
Senior Resident in Psychiatry at JHH

William Belfar, MD, Elective, 1997
Senior Resident in Psychiatry at JHH

Gregory Creager, MD, Elective, 1997
Senior Resident in Psychiatry

Alexandra Soldatou, MB, BCh, Clerkship, 1997
Medical Student at the University of Athens Greece

Susan Hobbs, MD, APA Minority Research, 1996-7
Senior Resident in Psychiatry

Peter Steinmetz, MD, PhD, Elective, 1996
Senior Medical Student at JHU

Tom Brashers-Krug, PhD, MD, Elective, 1995
Senior Medical Student from Loyola University (Ch

Michael Hooten, MD, Elective, 1994-5
Resident in Psychiatry at JHH

Argye Hillis, MD, Elective, AFAR Scholar, 1994
Senior Medical Student at JHU
(*now* Professor of Neurology at Johns Hopkins)

NIH Training Grants Core Faculty

Age Related Neuropsychiatric Disorders (PI: Marilyn Albert, PhD; Co-PI: Lyketsos)
Psychiatric Epidemiology Training Grant (PI: Peter Zandi, PhD)

CLINICAL ACTIVITIES

Certification

National Board of Medical Examiners: Diplomate, 1989 (#352931)
State of Maryland: Physician and Surgeon, 1989 (#D38790); Psychiatrist, 1992
American Board of Psychiatry and Neurology:
Board Certified in Psychiatry, 1994 (Certificate #38903)
Additional Qualification in Geriatric Psychiatry, 1995-2004 (Certificate #1474)
Additional Qualification in Psychosomatic Medicine, 2005-2015 (Certificate #16)

Service Responsibilities

Chair, Department of Psychiatry, Johns Hopkins Bayview
Oversee the clinical, research and teaching activities of a hospital based academic department of psychiatry with internationally known academic programs in dementia, geriatric psychiatry, medical psychology, neuropsychiatry, chronic mental illness, and addictions (including addictions in pregnancy), c.60 full time faculty, 20 inpatient psychiatry beds, 28 chronic hospital beds (collaboration with geriatric medicine), 12 domiciliary beds, partial hospitalization, outreach, and over 210,000 outpatient visits per year. In FY 2015 Bayview Psychiatry was home to $20+ M ($17+ NIH) in research grants and a clinical operations budget of $54+M.

ORGANIZATIONAL ACTIVITIES

Institutional Administrative Appointments at Johns Hopkins

Faculty Compensation Committee, Johns Hopkins School of Medicine, 2015-

Search Committee for Chair of Physical Medicine and Rehabilitation, 2015

Member, Advisory Board of the Medical Faculty, Johns Hopkins School of Medicine, 2013-

Chair and *ex officio* Trustee (elected), Medical Board, Johns Hopkins Bayview Medical Center, 2013-

Board of Governors (elected), Clinical Practice Association, 2009-2012

Search Committee for Chair of Geriatric Medicine, 2008-09

Search Committee for Chair of Neurology, 2006-07

Executive Committee, Department of Psychiatry and Behavioral Sciences, 2006-

Appointment/Promotions Committee, Department of Psychiatry and Behavioral Sciences, 2006-

E-Commerce Workgroup, 1999

Geriatrics Network Steering Committee, 1999-2002

Co-Chair, Meyer 5 Performance Improvement Team, Department of Psychiatry, 1998

The Paul R. McHugh Chair Committee, Department of Psychiatry, 1997-8

Member/CoChair, Joint Committee on Clinical Investigation/ IRB 3, 1996-2004

Physician Leader, Critical Path for Dementia, Department of Psychiatry, 1996 and 2000

Faculty Advisor, Hubert H. Humphrey Fellowship Program, 1996-1999

Member, Development Committee Department of Psychiatry, 1996-2001

Faculty, SCAN Training Center, WHO/Johns Hopkins Collaborative Center 1994-1999

Member, Protocol Review Sub-Committee, Outpatient General Clinical Research Center 1994-9

Editorial Activities

Editorial Advisory Board, Alzheimer's and Dementia: Journal of the Alzheimer's Association, 2014-

Associate Editor, American Journal of Psychiatry, 2013-2017

Deputy Editor, International Psychogeriatrics, 2011-

Associate Editor, Principles & Practice Geriatric Psychiatry 3rd Edition (Editors: Abu Saleh, Katona, Kumar)

Contributing Editor for *Section 2: Psychosomatic Medicine*, Comprehensive Textbook of Psychiatry 9th Edition (Editors: Kaplan, Sadock, Ruiz)

Joint Editor-in-Chief, International Review of Psychiatry, 2004-

Editorial Board, European Journal of Psychiatry, 2004-

Editorial Board, Alzheimer's Disease and Related Disorders, 2004-

Editorial Committee, Cuadernos de Medicina Psicosomática y Psiquitría de Enlace, 2000-
(Quarterly of Psychosomatic Medicine and Liaison Psychiatry, published in Spain)

Editorial Board, Associate Editor for Reviews, Psychosomatics, 1999-

Reviewer (over the years)

Academic Psychiatry	Alzheimer Disease and	American Journal of
AIDS Care	Associated Disorders	Epidemiology

American Journal of Geriatric Psychiatry
American Journal of Psychiatry
Archives of General Psychiatry
Archives of Internal Medicine
Archives of Neurology
Biological Psychiatry
Bulletin of the World Health Organization
Clinical Drug Investigation
International Journal of Epidemiology
International Journal of Geriatric Psychiatry
International Journal of Methods in Psychiatric Research
International Journal of Psychiatry in Medicine
International Psychogeriatrics
JAMA
Journal of General Internal Medicine
Journal of Geriatric Psychiatry and Neurology
Journal of Neuropsychiatry and Clinical Neuroscience
Journal of Psychiatric Research
Journal of the American Geriatrics Society
Journal of the International Neuropsychological Society
Lancet
Lancet Neurology
Molecular Psychiatry
Neurology
Neuropsychopharmacology
Psychiatry Research
Psychosomatic Medicine
Psychosomatics
Schizophrenia Bulletin
Social Psychiatry and Psychiatric Epidemiology

Professional Societies

International Society to Advance Alzheimer's Research and Treatment
Chair, Neuropsychiatric Syndromes Professional Interest Area, 2011-

International Psychogeriatric Association
Trustee (elected), 2012-2015

American College of Psychiatrists
Member, 2005-

American Board of Psychiatry and Neurology
Exam Writing Group for "Psychosomatic Medicine" 2003-9

American College of Neuropsychopharmacology (ACNP)
Fellow, 2012
Chair, Education Committee, 2009-11
Vice-Chair, Education Committee, 2006-2009
Member, 2003

American Association for Geriatric Psychiatry
Board of Directors, 2009-2012
Education Committee Member, 2004-6
Steering Committee for the Fall Clinician Institute, 2001-2

Hellenic American Psychiatric Association
President-Elect, 1999-02
President, 2002-04

American Psychiatric Association
Vice Chair, Council on Psychosomatic Medicine, 2006-07
Member, Council on Psychosomatic Medicine, 2004-07
Chair, Corresponding Committee on Research in Psychosomatic Medicine, 2004-07
Chair, Committee on Consultation-Liaison Psychiatry, 2002-05
Assembly Executive Committee, 1999-2001
Member, Committee on Consultation-Liaison Psychiatry, 1999-2002
Assembly Liaison, Council on Quality Improvement, 1999-2000
Assembly Representative (Member in Training), 1992-4
Steering Committee on Practice Guidelines, 1992-4
APA Research Network Liaison for Maryland, 1994-6
Chair, Assembly Committee of Allied Psychiatric Organization Liaisons, 1996-01
Member, Work Group on Governance, 1998
Member, Committee on Consultation-Liaison Psychiatry, 1999-2002

Academy of Psychosomatic Medicine

Past-President, 2008-2010
President, 2007-8
President Elect, 2006-7
Vice President, 2005-6
Secretary, 2003-05
Executive Council, 2000-10
Chair, Search Committee for the Editor of Psychosomatics, 2006
Chair, Subspecialty Task Force for "Psychosomatic Medicine", 1999-03
Membership Committee Chair, 1998-2000
Constitutional Committee, Member 1993-5, Chair 1995-6
Representative to American Psychiatric Association, 1994-2003

Maryland Psychiatric Society
Member, CME Committee 1992-4
Chairperson, Committee on Residents/Fellows, 1992-3
Member, Committee on Residents/Fellows, 1991-3
Member, Committee on Public Psychiatry, 1989-92

Advisory Committees and Review Groups
Reviewer, Wellcome Trust Grants Program, 2013

College of CSR Reviewers, Center for Scientific Review, National Institutes of Health, 2010-2012

Chair, Organizing Committee, Alzheimer's Association Research Roundtable: *Neuropsychiatric Symptoms in Alzheimer's Disease*, April 29-30, 2010, Washington DC

Scientific Board, 12th Annual Meeting of the European Association for Consultation Liaison Psychiatry and Psychosomatics (EACLPP), Noordvijkerhout, Holland, June 25-29, 2009

Advisor, Novartis RIV Patch meeting: Protocol Development, Washington DC, March 8th, 2008

Advisor, Management of Behavioral Symptoms in Alzheimer's Disease: Roundtable Meeting, Lundbeck-Merz-Forest, Hong Kong, February 27, 2008

Advisor, Global Neuroscience Steering Committee, Wyeth Research, Philadelphia, PA, October 29-30, 2007

Advisor, International Psychogeriatric Association Consensus Conference: "Defining and measuring treatment benefits in dementia," Canterbury, England, October 31-November 1, 2006

Advisor, National Institute on Aging "Conference of Alzheimer's Disease: Setting the Research Agenda a Century After Auguste D," Bethesda, Maryland, October 26-27, 2006

Member, National Institutes of Health, Center for Scientific Review, Neurological, Aging, and Musculoskeletal Epidemiology Study Section (NAME), 2005-2009

Advisor, National Institutes of Health, National Institute on Aging: "Leadership Summit on Alzheimer's disease research in the next decade," Bethesda, Maryland, December 1st, 2005

Member, Data Safety and Monitoring Board, "Geriatric Depression: Getting Better, Getting Well"(R01-MH 37869-22; C.F. Reynolds PI), 2005-2008

National Institutes of Health, Center for Scientific Review, Special Emphasis Panel (ZAG1 SRC[99]), July 8, 2005

American Association for Geriatric Psychiatry, Task Force Chair, Development of Position Statement on the "Standard of Care in the Treatment of Dementia," 2005

American Geriatrics Society, Panel to the review the implementation of Dementia Care Guidelines, Member, 2005

Medical Research Council of Great Britain, Ad Hoc Reviewer, 2004

National Institutes of Health, Center for Scientific Review, Special Emphasis Panel (ZRG1 SSS-S[11]), July 21, 2004

National Institute of Mental Health, Intervention Studies Review Panel (ITV), October 13-14, 2004

International Scientific Committee, 5th International Congress of Neuropsychiatry Joint with 1st Mediterranean Regional Congress of the World Federation of Societies for Biological Psychiatry, Athens, Greece, 14-18 October, 2004

Chair, Data Safety and Monitoring Board, "Treatment of Depression Associated with Parkinson's Disease with S-Adenosyl-Methionine" (NccAM-R01 At00941, PI: Di Rocco), 2003-2005

Speaker and participant, "Perspectives on Depression and Mild Cognitive Impairment," National Institute of Mental Health, Aging Research Consortium, Bethesda, Maryland, November 2-3, 2003

National Institute of Mental Health, Intervention Studies Review Panel (ITV), October 14-15, 2003

National Institutes of Health, Center for Scientific Review, Special Emphasis Panel (ZRG1 SSS-S[11]), July 7-8, 2003

National Institute on Mental Health, Special Emphasis Review Panel (ZMH1 NRB-G[12]), February 21, 2003

National DBSA Panel on Depression in Co-Morbid Medical Illness, November 12-13, 2002
Washington, DC

Chair, National Institute of Mental Health, Special Emphasis Review Panel (ZMH1 NRB-Q (CA)), Bethesda, Maryland, August 16th, 2002

Co-Chair and Speaker, “Advancing mood disorders research in late life”, National Institute of Mental Health, Aging Research Consortium, Bethesda, Maryland, July 10-11, 2002

Participant and Speaker, “Proxy and surrogate consent in geriatric neuropsychiatric research: advancing the debate,” National Institute of Mental Health, Aging Research Consortium, Bethesda, Maryland, July 1, 2002

National DMDA Panel on Late Life Depression, October 9-10, 2001
Washington, DC

National Institute on Aging Special Emphasis Review Panel (ZAG1 FAS-7), June 12, 2001

Panel on Risk and Prevalence of Elder Abuse and Neglect, National Research Council, The National Academies, May 2001-April 2002

Advisory Committee, 6th Hellenic Biomedical Diaspora Congress, 1999-2000

Task Force Chair, Subspecialization Application, Academy of Psychosomatic Medicine, 1999-2003

Bridge Day Program Committee for Alzheimer 2000 Conference, Alzheimer Association, 1999

Advisor, Workshop on Functional Capacity and Work Requirements, Committee to Review SSA’s Disability Decision Process Research, Institute of Medicine, Washington DC, June 4th, 1998

Work Group Member "Practice Guideline for Patients with HIV Infection and AIDS"
American Psychiatric Association, 1998-2000

Advisor, Social Security Administration, Employee Benefits Program, 1996

Editorial Review Panel, Educational Video Series on Alzheimer's Disease, Time-Life Medical, Inc.1995-6

Alzheimer's Association, Central Maryland Chapter, Inc.
Board of Directors, 1995-9
Medical and Scientific Advisory Board, Member 1996-9, Chair 1999-

Committee Member, Maryland Attorney General's Research Working Group, 1995-9

Advisory Board, 3rd World Conference Hellenic Bio-Medical Diaspora, 1994

Greek Orthodox Counseling and Social Services of Baltimore, Inc.
Vice-President, 1991-1992
Board of Directors, 1989-1992

Consultantships
Consultant Orion Pharma, 2013-
Drug development in Alzheimer's disease

Consultant BMS, 2013-
Drug development in Alzheimer's disease

Consultant Avanir, 2011-
Drug development in Alzheimer's disease

Consultant Takeda/Zinfandel, 2011-12
Drug development in Alzheimer's disease

Member Mackey White TBI Committee, NFL Players Association, 2010-
Chair of Longterm Outcomes Subcommittee

Consultant, Pfizer, 2010-2011, 2012-
Drug development in Alzheimer's disease
DMSB Chair for a drug in development for Alzheimer's disease

Consultant, Elan, 2010-
Drug development in Alzheimer's disease

Consultant, 2009
Chicago Health and Aging Project (CHAP) (Denis Evans, PI)

Consultant, Eli Lilly, 2008-
Drug development in Alzheimer's disease

Consultant, Wyeth, 2007-8
Drug development in Alzheimer's disease

Consultant, Takeda, 2007
Treating sleep disorders in dementia

Advisor, Adlyfe Inc., 2007
Biomarker development in Alzheimer's disease

Advisor, Supernus, 2006
Treatment development for CNS drugs

Advisor, Glaxo Smith Kline, 2004-6
Treatment development for Alzheimer disease

Advisor, Novartis, 2004
Treatment development for Alzheimer disease

Consultant, Eisai Pharmaceuticals, 2003-4
Treatment development for Alzheimer disease

Consultant, Janssen Research Foundation, 2000
Risperidone and Galantamine Development Program

Consultant, 2000
Effects of novel HIV-antiretroviral therapies on mood
DuPont Pharamceuticals

Consultant, 1998-9
TBIA v. Hogan Lawsuit
Connecticut Attorney General's Office

Consultant, Eli Lilly and Company, 1998
Olanzapine Development Program

Consultant, Task Force on Geriatric Psychiatry, Argentine Association of Psychiatrists (AAP), 1996

Consultant, 1995-7
Williams v. Wasserman Lawsuit
Maryland Attorney General's Office

Consultant, 1995
Vietnam Era Study 25 Year Follow-up (NIMH funded)
Washington University, St. Louis

RECOGNITION

Honors and Awards

Visiting Professor, University of Hawaii at Manoa, Honolulu, Hawaii, April 3-5, 2013

Visiting Professor, Brazilian Geropsychiatric Association, Sao Paulo, Brazil, March 23-24, 2012

Visiting Professor, Stetson University, DeLand Florida, February 22, 2012

Distinguished Scientist Award, American Association for Geriatric Psychiatry, 2012

Distinguished Physician, Hellenic Medical Society of New York, December 5, 2009

Guest Lecturer (national lecture tour), Alzheimer's Australia, September 14-24, 2009

Keynote speaker, Royal Australian and New Zealand College of Psychiatrists, Faculty of Psychiatry of Old Age, Annual Scientific Meeting, Adelaide, Australia, October 4-5 2007

Named one of America's Best Doctors in 2007, by Best Doctors, Inc

Named to "America's Top Doctors" by Castle Connolly Medical Ltd., 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015

William S. Proxmire Award "for extraordinary leadership in the fight against Alzheimer's disease," 2006

Included in "Guide to America's Top Psychiatrists" by the Consumers' Research Council of America, 2004

Member, American College of Psychiatrists, 2005

Distinguished Fellow, American Psychiatric Association, 2004

Visiting Professor, Creighton University/University of Nebraska, Omaha, Nebraska, April 21-22, 2004

Dorfman Journal Paper Award for best paper in Psychosomatics in 2003 (Borowicz L, Royall R, Grega M, Selnes O, Lyketsos CG, McKhann G. Depression and Cardiac Morbidity 5 years after Coronary Artery Bypass Surgery)

Member, American College of Neuropsychopharmacology, 2003

Research Award, Academy of Psychosomatic Medicine, 2002

Advising, Mentoring and Teaching Award, Johns Hopkins Bloomberg School of Public Health 2002

Bayer Education Fund Scholar, Wake-Forest University, Winston-Salem, May 17th-18th, 2001

Visiting Professor, The University of Iowa Medical Center, Iowa City, October 2-3, 2000

Chair, Medical and Scientific Advisory Board, Maryland Alzheimer Association, 1999-2004

Visiting Professor, National and Kapodistrian University of Athens, Academy of Psychosomatic Medicine Visiting Professor Award, October 25-27, 1999

Fellow, Academy of Psychosomatic Medicine, 1996

Dlin/Fisher Award (Excellence in Clinical Research), Academy of Psychosomatic Medicine, 1995

William Sorum Award, American Psychiatric Association, 1993

Lilly Research Fellowship (Honorable Mention), American Psychiatric Association, 1992

Ginsburg Fellow, Group for the Advancement of Psychiatry, 1991-92

Outstanding Resident Award, National Institute of Mental Health, 1990

Washington University School of Medicine, 1988
Alpha Omega Alpha
Medical Fund Prize in Surgery
Merck Award

Northwestern University College of Arts and Sciences, 1984
Phi Beta Kappa
University Service Award
Departmental Honors in Psychology

Invited Talks and Panels

2. **Lyketsos CG**. Mood disorders in temporal lobe epilepsy (Plenary Presentation). 4th Annual Conference of the American Neuropsychiatric Association, Washington D.C., May, 1992

3. **Lyketsos CG**, Lyketsos GC, Fishman M, Treisman GJ. Dementia and secondary mood disorders in AIDS (Plenary Presentation). Xth Southeastern European Neuropsychiatric Congress, Thessaloniki, Greece, September 1992.

4. **Lyketsos CG**. Depression does not affect medical outcomes in HIV infection. 5th B. Frank Polk Symposium, Center for AIDS Research, Johns Hopkins School of Hygiene and Public Health, Baltimore, Maryland, April, 1993

5. **Lyketsos CG**, Treisman GJ, Fishman M. The Impact of HIV Infection on Psychiatric Services. All day session at the 45th Institute on Hospital and Community Psychiatry, Baltimore, Maryland, October, 1993.

6. **Lyketsos CG**. HIV, AIDS and Mania. The AIDS Dementia Conference, Institute of Pennsylvania Hospital, Philadelphia, Pennsylvania, January 26th, 1994.

7. **Lyketsos CG**. Depression in HIV infection: recognition, assessment, and management. AIDS 94: Healthcare Professionals' Conference, Medical University of South Carolina, Charleston, South Carolina, February 4th, 1994.

8. **Lyketsos CG**. Depression in head trauma and dementia. Grand Rounds, Montebello Rehabilitation Hospital, Baltimore, Maryland, April 15th, 1994.

9. **Lyketsos CG**. Depression in HIV: recent research and future directions. Keynote address, American Society for Psychiatric Oncology and AIDS, Philadelphia, Pennsylvania, May 22nd, 1994.

10. **Lyketsos CG**. Dementia: evaluation and medication management. Conference on "Practical Interventions in Geriatric Mental Health", Baltimore, Maryland, June 10th, 1994.

11. **Lyketsos CG**. Dementia Research: on the Cutting Edge. Second Annual Alzheimer Association Conference, Western Maryland Chapter, Cumberland, Maryland, June 18th, 1994.

12. **Lyketsos CG**. Dementia: assessment and treatment. Grand Rounds, Springfield Hospital Center, Sykesville, Maryland, June 18th, 1994.

13. **Lyketsos CG.** Alzheimer's Research Update. Board of Directors, Central Maryland Chapter-Alzheimer's Association, September 27th, 1994.

14. **Lyketsos CG.** Pharmacologic management of behavioral problems in patients with Alzheimer's. Conference on "The Management of Behavioral Problems in Alzheimer's Patients", Sponsored by the Hagerstown Junior College, Hagerstown Maryland, November 11th, 1994.

15. **Lyketsos CG**. Depressive symptoms as predictors of medical outcomes in HIV infection. Invited lecture at the PsychoNeuroImmunology Research Society's Annual Meeting, Key Biscayne, Florida, November 18th, 1994.

16. **Lyketsos CG**. Depression after traumatic brain injury. Grand Rounds, Springfield Hospital Center, Sykesville, Maryland, December 16th, 1994.

17. **Lyketsos CG**. Pharmacologic treatment of Alzheimer's disease. Psychiatry Grand Rounds at The Johns Hopkins Hospital, March 20th, 1995.

18. **Lyketsos CG**. Alzheimer's Disease: Current Issues. Keynote lecture, Conference on Update on Alzheimer's Disease and Other Dementias, Baltimore, Maryland, April 1st, 1995.

19. **Lyketsos CG**. Dementia and HIV Infection. BETAK Conference on HIV and Dementia, Philadelphia, Pennsylvania, April 21st, 1995.

20. **Lyketsos CG**. When is a mental disorder due to a general medical condition? Psychiatry Grand Rounds at the University of New Mexico, Albuquerque, New Mexico, May 12th, 1995.

21. **Lyketsos CG**. The Life Chart Interview method: A standardized interview to describe the course of psychopathology in epidemiologic studies. Research methods and data analysis seminar, Psychiatric Epidemiology Training Program, the University of Pittsburgh, Pittsburgh, Pennsylvania, October 13th, 1995.

22. **Lyketsos CG**. Psychiatric disorders in old age. 9th English Memorial Lecture Series. Eastern Shore Hospital Center, Cambridge, Maryland, October 25th, 1995.

23. **Lyketsos CG.** Depression and dementia in old age. Annual Conference on the Interface of Psychiatry and Medicine. St. Joseph's Hospital Center, Baltimore, Maryland, November 4th, 1995.

24. **Lyketsos CG.** Changes in depression as AIDS develops. DLIN/FISHER Award Presentation. Annual Meeting of the Academy of Psychosomatic Medicine, Palm Springs, California, November 12th, 1995.

25. **Lyketsos CG**. Alzheimer's Disease: Current Issues. Keynote Address, Annual Caregiver Conference, Central Maryland Chapter of the Alzheimer's Association, Timonium, Maryland, November 18th, 1995.

26. **Lyketsos CG**. Psychiatric disorders in patients with substance use and HIV. Lecture at the 6th Annual Meeting of the American Academy of Psychiatrists in Alcoholism and the Addictions, Amelia Island, Florida, December 2nd, 1995.

27. **Lyketsos CG.** Depression in Alzheimer's disease. Grand Rounds at the Springfield Hospital Center, Sykesville, Maryland, February 16th, 1996.

28. **Lyketsos CG.** The treatment of depression in Alzheimer's disease. Grand Rounds at the Johns Hopkins Hospital, Baltimore, Maryland, April 22nd, 1996.

29. **Lyketsos CG.** The care of dementia outpatients. Conference on the Practical Management of Alzheimer's Disease and Other Dementias, Baltimore, Maryland, April 27th, 1996.

30. **Lyketsos CG.** New research on secondary mood disorders. Keynote Lecture: 10th Anniversary Meeting of APPAC, Athens Greece, May 13th, 1996.

31. **Lyketsos CG**. The pharmacologic treatment of the dementia patient. Lecture at "New Frontiers in the Management of Dementia", sponsored by the University of Maryland, Cumberland Maryland, June 19th, 1996.

32. **Lyketsos CG.** Depression in Alzheimer's disease. Grand Rounds, the Mogano Psychiatric Hospital, Buenos Aires, Argentina, September 5th, 1996.

33. **Lyketsos CG.** Depression in old age. Keynote Lecture: Argentine Academy of Medical Sciences, Buenos Aires, Argentina, September 6th, 1996.

34. **Lyketsos CG**. Alzheimer's disease: Assessment and treatment. Grand Rounds, Harford Memorial Hospital, Havre-de-Grace, Maryland, October 1st, 1996.

35. **Lyketsos CG.** Neuropsychiatry: Concepts and principles. Grand Rounds, Union Memorial Hospital Department of Psychiatry, Baltimore, Maryland, November 26th, 1996.

36. **Lyketsos CG**. Alzheimer's disease: Current Issues in Diagnosis and Treatment. Continuing Education Series Lecture, Maryland Association of Nurse Practitioners, Baltimore, Maryland, February 12th, 1997.

37. **Lyketsos CG**. Alzheimer's disease: Current Issues in Diagnosis and Treatment. Grand Rounds, Mercy Hospital Department of Internal Medicine, Baltimore, Maryland, March 12th, 1997

38. **Lyketsos CG**. The Prion Dementias. Grand Rounds, The Johns Hopkins Hospital Department of Psychiatry, Baltimore, Maryland, March 17th, 1997

39. **Lyketsos CG**. Alzheimer's disease: Current Issues in Diagnosis and Treatment. Grand Rounds, Springfield Hospital Center, Sykesville, Maryland, March 21st, 1997

40. **Lyketsos CG**. Alzheimer's disease: Current Issues in Diagnosis and Treatment. Grand Rounds, Nazareth Hospital, Philadelphia, Pennsylvania, March 26th, 1997

41. **Lyketsos CG**. Current Issues in Geriatric Care: Alzheimer's Disease and Depression. Continuing Education Series Lecture, Maryland Association of Consultant Pharmacists, Baltimore, Maryland, April 17th, 1997.

42. **Lyketsos CG**. Cognitive and behavioral problems in the developmentally disabled. Conference on New Pharmacological Options and Treatment Strategies for the Care of the Developmentally Disabled, Miami, Florida, June 1st, 1997

43. **Lyketsos CG**. Depression in Alzheimer's disease, Biennial Meeting of the Johns Hopkins Medical and Surgical Association, Baltimore, Maryland, June 6th, 1997

44. **Lyketsos CG**. What's new in Alzheimer's disease? Grand Rounds at Church Home and Hospital, Baltimore, Maryland, June 12th, 1997

45. **Lyketsos CG**. Current Issues in Alzheimer's Disease, NIA/RAND Summer Institute, Santa Monica, California, July 13th, 1997

46. **Lyketsos CG**. Aggression in Dementia, Annual Update in Neuroscience, Virginia Beach, Virginia, July 17th, 1997

47. **Lyketsos CG**. Depression in Alzheimer's disease, Weekly Conference on "Clinical, Social, and Scientific Foundations of Geriatric Medicine" sponsored by NIA/Johns Hopkins Division on Gerontology, Baltimore, Maryland, July 29th, 1997

48. **Lyketsos CG**. The Evaluation and Treatment of Psychiatric Disorders in Long Term Care Residents, Southeast Medicaid Commissioners Annual Pharmacy Meeting, Orange Beach, Alabama, August 2nd, 1997.

49. **Lyketsos CG**. Alzheimer's disease. Grand Rounds, Hannover Hospital, Hannover Pennsylvania, October 24th, 1997

50. **Lyketsos CG**. Dementia. Conference entitled: "Geriatric Psychiatry Update: New Knowledge, New Roles", Johns Hopkins Bayview Medical Center, March 27th, 1998

51. **Lyketsos CG**. Dementia Care at Copper Ridge. Psychiatry Grand Rounds at the Johns Hopkins Hospital, Baltimore, Maryland, March 30th, 1998

52. **Lyketsos CG**. New Medications for Alzheimer's disease: when and how to use them. Annual Update on Dementia and Alzheimer's Disease (Johns Hopkins University Conference), Baltimore, Maryland, April 4th, 1998

53. **Lyketsos CG.** New Options in Bipolar Disorders. Meeting on New Frontiers in Social Phobia and Bipolar Disorders, CME Inc., San Francisco, California, August 8th, 1998

54. **Lyketsos CG.** New Options in Bipolar Disorders. Meeting on New Frontiers in Social Phobia and Bipolar Disorders, CME Inc., San Diego, California, October 10th, 1998

55. **Lyketsos CG.** New Options in Bipolar Disorders. Meeting on New Frontiers in Social Phobia and Bipolar Disorders, CME Inc., Charlotte, N. Carolina, October 11th, 1998

56. **Lyketsos CG**. Depression in Alzheimer disease. Joint Psychiatry and Neurology Conference, University of Bern, Bern Switzerland, October 29th, 1998.

57. **Lyketsos CG**. Current Issues in Dementia and Alzheimer disease. Annual Meeting, Department of Psychiatry, Innova/Fairfax Hospital, November 11th, 1998

58. **Lyketsos CG (Program Director)**. Detecting, evaluating, and managing memory impairment in primary care: The Primary Care Initiative, Copper Ridge Institute, Ellicott City, Maryland, November 17th, 1998

59. **Lyketsos CG**. Medication treatments in Alzheimer disease. Continuing Education Conference: "Forget Me Not: Caring for Patients with Dementia". Perry Point Veterans Administration Medical Center, November 20th, 1998

60. **Lyketsos CG**. Coping with AIDS dementia. Symposium of Coping with HIV and AIDS, Annual Meeting of the Academy of Psychosomatic Medicine, Orlando, Florida, November 21st, 1998

61. **Lyketsos CG**. Psychiatric disorders after traumatic brain injury. Psychiatry Grand Rounds at the Johns Hopkins Hospital, Baltimore, Maryland, November 30th, 1998

62. **Lyketsos CG**. Anticonvulsants in psychiatry: New Options and Therapeutic Directions. Psychiatry Grand Rounds at SUNY Buffalo, NY, December 11th, 1998

63. **Lyketsos CG (Program Director)**. Detecting, evaluating, and managing memory impairment in primary care: The Primary Care Initiative, Copper Ridge Institute, Columbia, Maryland, February 23rd, 1999

64. **Lyketsos CG.** New Options in Bipolar Disorders. Meeting on New Frontiers in Social Phobia and Bipolar Disorders, CME Inc., Minneapolis, MN, March 7th, 1999

65. **Lyketsos CG.** New Options in Bipolar Disorders. Meeting on New Frontiers in Social Phobia and Bipolar Disorders, CME Inc., Long-Island, NY, April 17th, 1999

66. **Lyketsos CG**. Anticonvulsants in psychiatry: New Options and Therapeutic Directions. Psychiatry Grand Rounds at the University of Virginia, Charlottesville, VA, April 27th, 1999

67. **Lyketsos CG (Workshop Co-Chair).** Common Psychiatric disorders in the elderly. Workshop 313: Psychotropic Drug Use in Older Adults: Management Strategies, School of Social Work, The University of Maryland, Baltimore, Maryland, May 4th, 1999

68. **Lyketsos CG.** Update on the care of the patient with dementia (3 hour course). First Argentine Congress of Geriatric Neuropsychiatry. Buenos Aires, Argentina, June 17-19, 1999

69. **Lyketsos CG**. Memory and aging (1 hour lecture broadcast live on the Internet by Intellihealth). A Women's Journey (Johns Hopkins National Conference), Baltimore, Maryland, October 23rd, 1999

70. **Lyketsos CG**. Mood disorders in HIV infection. Psychiatry Grand Rounds at the University of Alabama-Birmingham, Birmingham, Alabama, November 30th, 1999

71. **Lyketsos CG.** Management of behavior disturbances in patients with dementia. Grand Rounds at Cooper Hospital (University of Medicine and Dentistry of New Jersey), Camden, New Jersey, March 7th, 2000

72. **Lyketsos CG**, Rabins PV, Breitner JCS. Behavioral disturbances in dementia. Invited presentation before the Food and Drug Administration Psychopharmacology Advisory Committee, Gaithersburg, Maryland, March 9th, 2000.

73. **Lyketsos CG**. Dementia Care 2000: A Comprehensive Approach. Keynote Address at the 7th Annual Celebration of Caregiving Conference, Friends of Alzheimer Caregivers, Long Beach, California, March 17th, 2000

74. **Lyketsos CG**. Management of depression in the nursing home resident. Symposium "Depression and Chronic Medical Illness in the Nursing Home: Recognition and Management", during the Annual Meeting of the American Medical Directors Association, San Francisco, California, March 18th, 2000.

75. **Lyketsos CG.** Evaluation and treatment of early signs of dementia in men. Men's Health 2000 (Johns Hopkins CME Course), Baltimore, Maryland, March 31st ,2000

76. **Lyketsos CG**. Telemedicine. Symposium on Technology and the Elderly. Maryland Association of Counties 50th Annual Summer Conference, Ocean City, Maryland, August 18th, 2000

77. **Lyketsos CG.** Advances in the Management of Alzheimer's disease (Keynote Lecture). CME Conference sponsored by UMDNJ and Genesis Eldercare, Morristown, NJ, September 19th, 2000.

78. **Lyketsos CG**. Cognitive Decline in the Population: Findings from the Baltimore ECA. Research Conference, Department of Psychiatry, University of Iowa, Iowa City, October 2nd, 2000

79. **Lyketsos CG.** Depression in Alzheimer's Disease: Epidemiology, Impact, Treatment. Grand Rounds, Department of Psychiatry, University of Iowa, Iowa City, October 3rd, 2000

80. **Lyketsos CG**. Psychotic and Mood disorders in Alzheimer's disease: epidemiology, classification, treatment. Presented as part of Symposium 26, 6th Hellenic Biomedical Diaspora Congress, Athens, Greece, October 13th, 2000

81. **Lyketsos** CG**.** Management of agitation in the elderly. 14th Annual Interface: Medicine-Psychiatry, St. Joseph's Medical Center, Baltimore, Maryland, Novemebr 4th, 2000.

82. **Lyketsos CG.** Management of depression and other psychiatric disorders in the medically ill. CME Course: Topics in Psychiatry, Johns Hopkins School of Medicine, Baltimore, Maryland, November 10th, 2000

83. **Lyketsos CG.** Memory and Aging. 7th Annual Johns Hopkins Woman's Journey Conference, Baltimore, Maryland, November 11th, 2000

84. **Lyketsos CG**. Dementia Care 2000: Emphasis on Alzheimer's Disease. Department of Medicine Grand Rounds at Sinai Hospital, Baltimore, Maryland, November 7th, 2000

85. **Lyketsos CG**. The Epidemiology of Psychosis and Agitation in Dementia. Presented as part of Symposium: The NIMH CATIE Program: Understanding psychosis and anti-psychotic effectiveness. 14th AAGP Annual Meeting, San Francisco, CA February 24th, 2001

86. **Lyketsos CG**. Mood disorders in HIV infection . Psychiatry Grand Rounds, University of Texas Health Science Center in San Antonio, San Antonio, Texas, March 20th, 2001

87. **Lyketsos CG**. Agitation in the elderly: Evaluation and management. Geriatric Medicine Grand Rounds. Medical College of Virginia-Hunter Holmes McGuire Veterans Affairs Medical Center, Richmond, Virginia, March 23rd, 2001

88. **Lyketsos CG**. Dementia Care 2001: Emphasis on Alzheimer's Disease. Psychiatry Grand Rounds, State University of New York at Stony Brook, Stony Brook, New York, April 24th, 2001

89. **Lyketsos CG**. Effects of other psychotherapeutic medications. Presented as part of Industry Sponsored Symposium "Psychosis in Alzheimer's disease" Ira Katz, MD (Chair). American Psychiatric Association, 154th Annual Meeting, New Orleans, LA, May 2001

90. **Lyketsos CG**. Depression in Alzheimer's disease: Epidemiology, impact, treatment. Psychiatry Grand Rounds, Wake Forrest University, Winston-Salem, North Carolina, May 18th, 2001

91. **Lyketsos CG**. Treatment of depression in dementia. Presentation at National DMDA Panel Meeting on Late Life Depression, Washington DC, October 9th, 2001

92. **Lyketsos CG**. Keynote Lecture: Management of Agitation in Dementia. Presentation at Annual Conference of the Italian Interdisciplinary Network on Alzheimer's Disease (ITINAD), Modena, Italy, October 20th, 2001.

93. **Lyketsos CG**. Keynote Lectures: Dementia in Old Age: Evaluation and Management. Presentation at the Annual Seminar on Dementia of the Hellenic Psychiatric Association and the Hellenic American Psychiatric Association, Athens, Greece, October 24th, 2001.

94. **Lyketsos CG**. Dementia in the Medically Ill. Review Course on Psychiatry of the Medically Ill, presented at the Annual Meeting of the Academy of Psychosomatic Medicine, San Antonio, Texas, November 16th, 2001

95. **Lyketsos CG**. Dementia. CME course: 12th Annual Neurology for the Primary Practitioner, Johns Hopkins School of Medicine, Baltimore, Maryland, December 8th, 2001

96. **Lyketsos CG**. Is the prevention of Alzheimer's disease possible? 2nd Panhellenic Interdisciplinary Conference on Alzheimer's Disease and Related Disorders. Thessaloniki, Greece, January 18th, 2002

97. **Lyketsos CG**. Epidemiology and classification of psychiatric disturbances in dementia. 2nd Panhellenic Interdisciplinary Conference on Alzheimer's Disease and Related Disorders. Thessaloniki, Greece, January 20th, 2002

98. **Lyketsos CG**. Treatment of depression in Alzheimer's disease. NIMH Symposium on the new criteria for "Depression of Alzheimer's disease" (**Error! Contact not defined.** and Jason Olin, CoChairs), 15th Annual Meeting of the American Association for Geriatric Psychiatry, Orlando, Florida, February 26th, 2002

99. **Lyketsos CG**. The American application for subspecialization in C-L psychiatry: Foundations, process, and present state. Special Address as part of a Symposium. 37st Annual Meeting of the Spanish Society of Psychosomatic Medicine. Madrid, Spain, April 12th, 2002

100. **Lyketsos CG**. Depression and dementia. The Master Class in Dementia. St. John's College, Cambridge, England, September 13-15, 2002

101. **Lyketsos CG**. Behavioral disturbances in dementia. Dementia Mini Fellowship, Iselin, NJ, October 11-12, 2002

102. **Lyketsos CG** (Meeting Chair and Keynote Speaker). Dementia Syndromes: Theory and Practice. 3rd Annual Meeting on the Dementias, Hellenic Psychiatric Association, National Research Institute, Athens, Greece, October 22-23, 2002.

103. **Lyketsos CG** Lieff S (Symposium Chair). Evaluation and differential diagnosis of dementia. Symposium as part of "Clinician's Institute," American Association of Geriatric Psychiatry, Orlando, Florida, November 9th, 2002.

104. **Lyketsos CG**. Depression in Alzheimer's disease: Prevalence, impact, recognition, treatment. Presentation at National DBSA Panel Meeting on Depression in Co-Morbid Medical Illness, Washington DC, November 12h, 2002

105. **Lyketsos CG**. Neuropsychiatric disturbance in Alzheimer's disease: where are we now and where are we headed? Psychiatry Grand Rounds, Westchester Division, Weill Cornell Medical College, White Plains, New York, January 7th, 2003

106. **Lyketsos CG**. Neuropsychiatric disturbance in Alzheimer's disease: where are we now and where are we headed? Psychiatry Grand Rounds, Payne Whitney Clinic, Weill Cornell Medical College, New York, New York, January 8th, 2003

107. **Lyketsos CG.** Cognitive Impairment, Dementia, and Parkinson's Disease. Industry Sponsored Symposium (M. Menza, Chair), 16th Annual Meeting of the American Association of Geriatric Psychiatry, Honolulu, Hawaii, March 2nd, 2003

108. **Lyketsos CG.** Aging and HIV Disease. Symposium (S. Schultz, Chair), 16th Annual Meeting of the American Association of Geriatric Psychiatry, Honolulu, Hawaii, March 2nd, 2003

109. **Lyketsos CG**. The impact of depression on Alzheimer patients and other medically ill populations: New challenges for the field of Psychosomatic Medicine. Keynote address during the Awarding of the 2003 Dutch "Lundbeck Pris," Amsterdam, Holland, April 1st, 2003

110. **Lyketsos CG**. Neuropsychiatric disturbance in Alzheimer's disease: where are we now and where are we headed? Neurology Seminar, Vrei Universiteit Medical Center, Amsterdam, Holland, April 2nd, 2003

111. **Lyketsos CG**. Psychosomatic Medicine: a new psychiatric subspecialty. Invited lecture during Symposium 19 of the Annual Meeting of the Dutch Psychiatric Association (NVVP), Amsterdam, Holland, April 4th, 2003

112. **Lyketsos CG**. Advances in Alzheimer's research. Research Update for the Clinician. 156th Annual Meeting of the American Psychiatric Association, San Francisco, California, May 19th, 2003

113. **Lyketsos CG.** Cognitive Impairment, Dementia, and Parkinson's Disease. Symposium (M. Menza, Chair), 156th Annual Meeting of the American Psychiatric Association, San Francisco, California, May 20th, 2003

114. **Lyketsos CG**. Treatment of depression and apathy in dementia. Course 91 (W. Reichman, Chair), 156th Annual Meeting of the American Psychiatric Association, San Francisco, California, May 21st, 2003

115. **Lyketsos CG**. Efforts toward the prevention of Alzheimer's disease (Plenary Presentation). 13th Alzheimer Europe Conference/ 3rd Hellenic National Alzheimer Disease and Related Disorders Conference, June 13th, Thessaloniki, Greece

116. **Lyketsos CG** (Speaker and Session Chair). Management of neuropsychiatric disturbances in dementia (Plenary Presentation). 13th Alzheimer Europe Conference/ 3rd Hellenic National Alzheimer Disease and Related Disorders Conference, June 14th, Thessaloniki, Greece

117. **Lyketsos CG** (Speaker and Session Chair). Models of dementia care in the USA (Seminar). 13th Alzheimer Europe Conference/ 3rd Hellenic National Alzheimer Disease and Related Disorders Conference, June 14th, Thessaloniki, Greece

118. **Lyketsos CG**. Evaluation and management of depression in dementia (Symposium). 13th Alzheimer Europe Conference/ 3rd Hellenic National Alzheimer Disease and Related Disorders Conference, June 15th, Thessaloniki, Greece

119. **Lyketsos CG**. Cognitive disorders and Mental Health. Plenary Address at the National Institutes of Health Conference on "Physical Disabilities through the Lifespan," Natcher Conference Center, National Institutes of Health, Washington DC, July 21st, 2003

120. **Lyketsos CG**. Depression associated with cognitive impairment. Plenary Presentation as part of a Satellite Symposium on "Management of depression in Late Life: Emerging Concepts," 11th Annual International Psychogeriatric Association Meeting, Chicago, Illinois, August 20th, 2003

121. Lyketsos CG. Evaluation and management of depression in Alzheimer's disease. Psychiatry Grand Rounds, Rush University, Chicago, Illinois, October 8th, 2003

122. **Lyketsos CG (Symposium Chair).** Introduction to Dementia Care, Monotherapy Strategies. Presentations at "Emerging Management Strategies in Alzheimer's Disease: A CME Satellite Symposium" at Pri-Med East Conference & Exhibition, Boston, Massachussetts, November 6, 2003

123. **Lyketsos CG.** Case studies in Dementia Care. Workshop as part of 4th Annual Topics In Psychiatry, Johns Hopkins CME, Baltimore, Maryland, November 13th, 2003

124. **Lyketsos CG.** Cognitive Impairment, Dementia, and Parkinson's Disease. Industry Sponsored Symposium (M. Menza, Chair), 17th Annual Meeting of the American Association of Geriatric Psychiatry, Baltimore. Maryland, February 24th, 2004

125. **Lyketsos CG** (Symposium Chair)**.** Aging, cognitive impairment, and coronary bypass surgery. 17th Annual Meeting of the American Association of Geriatric Psychiatry, Baltimore. Maryland, February 24th, 2004

126. **Lyketsos CG**. Depression in Alzheimer's disease: a practical update for the clinician. Grand Rounds, Logan Regional Hospital, Logan, Utah, March 2nd, 2004

127. **Lyketsos CG**. Executive Dysfunction in Clinical Practice. Grand Rounds, Creighton University School of Medicine, Omaha, Nebraska, April 21st, 2004

128. **Lyketsos CG**. Is Alzheimer's Disease Preventable? Alzheimer Disease and Related Disorders Educational Series, sponsored by University of Nebraska Medical Center,

Creighton University Medical Center, and the Alzheimer's Association. Omaha Nebraska, April 22, 2004

129. **Lyketsos CG**. Dementia in the Assisted Living Setting. Alzheimer Disease and Related Disorders Educational Series, sponsored by University of Nebraska Medical Center, Creighton University Medical Center, and the Alzheimer's Association. Omaha Nebraska, April 22, 2004

130. **Lyketsos CG**. Treatment of depressive disorders in dementia. Alzheimer Disease and Related Disorders Educational Series, sponsored by University of Nebraska Medical Center, Creighton University Medical Center, and the Alzheimer's Association. Omaha Nebraska, April 22, 2004

131. **Lyketsos CG (**Discussion Group Leader). Depression in Alzheimer's disease and other neurologic conditions: evaluation and treatment. Meet the Experts. American Psychiatric Association, 157th Annual Meeting, New York, New York, May 3rd, 2004

132. **Lyketsos CG**. The impact of psychiatric morbidity on medical illness: Challenges for the "new" field of psychosomatic medicine. Plenary address, Hellenic Psychiatric Association, 18th Annual Meeting, Kos, Greece, May 15th, 2004

133. **Lyketsos CG**. Is prevention of late life cognitive decline possible? Distinguished Lecture Series, Athenian Club, Athens, Greece, May 18th, 2004

134. **Lyketsos CG**. Depression in Alzheimer's disease: Brief update. Plenary lecture, PADRECC/MIRECC Symposium on Neurodegenerative Diseases: the Interface of Psychiatry and Neurology. University of Pennsylvania, Philadelphia, Pennsylvania , May 24th, 2004

135. **Lyketsos CG**. Neuropsychiatric symptoms of dementia: Nature and treatment. Plenary Lecture, 9th International Conference on Alzheimer's Disease and Related Disorders. Philadelphia Convention Center, Philadelphia, Pennsylvania, July 20th, 2004

136. **Lyketsos CG**. Depression in Alzheimer's disease: where are we now and where are we headed? Psychiatry Grand Rounds, Mayo Medical School and Clinic, Rochester, Minnesota, September 28th, 2004

137. **Lyketsos CG**. Etiology and epidemiology of dementia in the long-term care setting. Symposium lecture in "Optimizing Outcomes in Dementia: the increasing role of cholinesterase inhibitors" Satellite to Senior Care Pharmacy '04, ASCP 35th Annual Meeting, San Francisco, California, November 6th, 2004

138. **Lyketsos CG**, Lee HB, Golden, S, Szcklo M. Depression and cardiovascular disease: Research Advances. Advances in Psychiatry: Regional and Intersectional Congress, World Psychiatric Association, Athens, Greece, March 15th, 2005

139. **Lyketsos CG**, Lee HB, Golden, S, Szcklo M. Depression and cardiovascular disease: Research Advances. Invited Lecture as part of Advances in Psychiatry: Regional and Intersectional Congress, World Psychiatric Association, Athens, Greece, March 15th, 2005

140. **Lyketsos CG**. The future of psychiatry: strengthening our medical roots. Invited presentation, Symposium on the Future of Psychiatry, Advances in Psychiatry: Regional and Intersectional Congress, World Psychiatric Association, Athens, Greece, March 15th, 2005

141. **Lyketsos CG, Wong D**. Effective biomarker strategies in Alzheimer disease. BDNP Group, Novartis Pharmaceuticals, Basel, Switzerland, March 17th, 2005

142. **Lyketsos CG**. Depression in Alzheimer disease: Prevalence, diagnosis, treatment. Psychiatry Grand Rounds, University of Maryland Medical School and Hospital, Baltimore, Maryland, March 24th, 2005

143. **Lyketsos CG**. The impact of psychiatric morbidity on medical illness: challenges for the "new" psychiatric subspecialty of Psychosomatic Medicine. Psychiatry Grand Rounds, University of Michigan Medical School and Hospital, Ann Arbor, Michigan, April 6th, 2005

144. **Lyketsos CG**. Weighing the Evidence for the Treatment of Neuropsychiatric Symptoms of Mild-to-Moderate Dementia: What Do We Really Know? Symposium as part of the American Geriatrics Society Annual Meeting, Orlando, Florida, May 13th, 2005

145. **Lyketsos CG**. Recent advances in depression and cardiovascular disease research. Presidential Symposium 1: "Advances in Psychosomatic Medicine," organized by the International College of Psychosomatic Medicine with the National Institute for Mental Health, 158th Annual Meeting of the American Psychiatric Association, Atlanta, Georgia, May 23rd, 2005

146. **Lyketsos CG**. Psychiatric aspects of dementia. Presidential Symposium 5: "The Interface of Psychiatry and Medicine: disorders of affect, behavior, and cognition," organized by the Academy of Psychosomatic Medicine, 158th Annual Meeting of the American Psychiatric Association, Atlanta, Georgia, May 25th, 2005

147. **Lyketsos CG**. Developing new medications for Alzheimer's disease. Departmental Academic Program. Biennial Meeting and Reunion Weekend, The Johns Hopkins Medical and Surgical Association, Baltimore, Maryland, June 3rd, 2005

148. **Lyketsos CG**. Treatment of depression in Alzheimer's and Parkinson's disease. Plenary lecture, PADRECC/MIRECC Symposium on Neurodegenerative Diseases: the Interface of Psychiatry and Neurology. University of Pennsylvania, Philadelphia, Pennsylvania, September 15th, 2005

149. **Lyketsos CG**. Developing new medication treatments for Alzheimer disease: What will it take? Plenary presentation during "Topics in Geropsychiatry," a Conference of the

Psychogeriatric and Biological Psychiatry Branches of the Hellenic Psychiatric Association, Athens, Greece, September 30th, 2005

150. **Lyketsos CG.** Relationship of self reported high cholesterol, diabetes, and other cardiovascular diseases to incidence of Alzheimer dementia (DAT): Findings from the Cache County Study of Memory Health and Aging. Panel Presentation at 5th Annual Meeting of the International College of Geriatric Psychoneuropharmacology, Pittsburgh, November 4, 2005

151. **Lyketsos CG.** Detection of dementia in Assisted Living Facilities: the Maryland Assisted Living Study. Panel Presentation at 5th Annual Meeting of the International College of Geriatric Psychoneuropharmacology, Pittsburgh, November 4, 2005

152. **Lyketsos CG.** Best care practices for Alzheimer and dementia: What patients and families should know. Annual Educational Seminar hosted by Morningside House Assisted Living, Columbia, Maryland, November 9th, 2005

153. **Lyketsos CG**. Alzheimer and dementia: What can be done? A Women's Journey, Baltimore, Maryland, November 12th, 2005

154. **Lyketsos CG.** Best care practices for Alzheimer and dementia: What patients and families should know. Annual Educational Seminar hosted by Morningside House Assisted Living, Columbia, Maryland, February 8th, 2006

155. **Lyketsos CG**. Biomarker guided treatment trials in dementias: the who, what, when, where, and why of translational treatment studies. 96th Annual Meeting of the APPA, New York City, March 2, 2006

156. **Lyketsos CG**. The management of neuropsychiatric symptoms in dementia: how can the clinician succeed? Pre Conference Symposium "Psychiatry for the Internist" at the American College of Physicians Annual Meeting, Philadelphia, Pennsylvania, April 5, 2006

157. **Lyketsos** CG. Individualizing Alzheimer's disease therapy over the disease course. Industry Sponsored Symposium: "Alzheimer's disease: Challenging the Practice Paradigm" at the American Psychiatric Association 159th Annual Meeting, Toronto, Canada, May 21st, 2006

158. **Lyketsos CG.** Alzheimer and dementia: Where are we and where are we headed? Howard County Hospital Board of Trustee's, Annual Retreat, Columbia, Maryland, June 1st, 2006

159. **Lyketsos CG**. What the community know about memory loss. Community Health Forum, Heritage United Church of Christ, Baltimore, Maryland, June 10th, 2006

160. **Lyketsos CG**. The importance of neuropsychiatric symptoms (aka, BPSD) as outcomes. International Psychogeriatric Association Consensus Conference: "Defining and measuring treatment benefits in dementia," Canterbury, England, October 31st, 2006

161. **Lyketsos CG**. The New Landscape of Dementia Care: 2007. **The Beeson Lecture**, 34th Annual Current Topics in Geriatrics, Baltimore, Maryland, February 15th, 2007

162. **Lyketsos CG**. Depression in Alzheimer's disease: prevention, evaluation, and management. Industry Sponsored Symposium "Treating Depression and Comorbid Illness in Late Life" at the Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, Louisiana, March 2nd, 2007

163. **Lyketsos CG**. Treatment effects on daily function, quality of life, caregiver burden, and health services. Industry Sponsored Symposium "Results of the NIMH CATIE-AD Trial" at the Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, Louisiana, March 2nd, 2007

164. **Lyketsos CG**. Comprehensive multi-disciplinary care. Industry Sponsored Symposium "Expert Dialogue on Alzheimer's disease" at the Annual Meeting of the American Association for Geriatric Psychiatry, New Orleans, Louisiana, March 3rd, 2007

165. **Lyketsos CG.** Empirically based pharmacology for depression, psychosis, and agitation. 11th Annual Symposium "The Comprehensive Approach to Dementia: a Practical Update for Practitioners in Mental Health, Primary Care, and Longterm Care Settings," New York, New York, March 8th, 2007

166. **Lyketsos CG**. Alzheimer's disease: the who, what, when and how of biomarker guided treatment development. Food and Drug Administration, CDEAR Clinical Reviewers Education Program. White Oak CSU, Maryland, May 18th, 2007

167. **Lyketsos CG**. Care for patients with Alzheimer's disease and other dementias. Panel on Health and Services Linkages. The Maryland Summit on Health and Aging. Columbia Maryland, July 10th, 2007

168. **Lyketsos CG.** Cognitive impairment, dementia, and Alzheimer's disease AND Overview of dementia care and pharmacologic treatments AND Case Studies. CME Course on: Identifying, evaluating, and managing memory impairment in the primary care setting, sponsored by the Copper Ridge Institute. Easton, Maryland, July 24th, 2007

169. **Lyketsos CG.** Dementia Care 2007: A New Landscape, Royal Australian and New Zealand College of Psychiatrists, Faculty of Psychiatry of Old Age, Annual Scientific Meeting, Adelaide, Australia, October 4, 2007

170. **Lyketsos CG**, Steinberg MS, Norton M, Tschanz JT. The Natural history of Alzheimer's dementia: findings from the Cache County Dementia Progression Study, Royal Australian and New Zealand College of Psychiatrists, Faculty of Psychiatry of Old Age, Annual Scientific Meeting, Adelaide, Australia, October 5 2007

171. **Lyketsos CG**. Brain circuits and symptom development in Alzheimer's disease, Annual Caregivers Meeting of the Maryland Chapter of the Alzheimer's Association, December 6, 2007

172. **Lyketsos CG**. Management of neuropsychiatric symptoms (aka BPSD) in patients with dementia. Grand Rounds, Drexel Medical College—Friends Hospital, Philadelphia, Pennsylvania, March 22, 2008

173. **Lyketsos CG**. Alzheimer's disease Current Issues and Case Studies. Grand Rounds, Bon Secours Hospital, Baltimore, Maryland, April 10, 2008

174. **Lyketsos CG**. Developing new treatments for Alzheimer's disease: what needs to be done. Grand Rounds, Beth Israel Hospital, New York, New York, April 24, 2008

175. **Lyketsos CG**. Scales for the measurement of neuropsychiatric symptoms in dementia. Alzheimer's Research Roundtable, Alzheimer's Association, Washington DC, April 30, 2008

176. **Lyketsos CG**. Management of neuropsychiatric symptoms of dementia. Seminar, Delaware Department of Substance Abuse and Mental Health, Wilmington, Delaware, May 6, 2008

177. **Lyketsos CG**. Developing new treatments for Alzheimer's disease: what needs to be done. Dementia Care Grand Rounds, The Copper Ridge Institute, Sykesville, Maryland, May 7, 2008

178. **Lyketsos CG**. Biomarker guided treatment development for Alzheimer's disease. Mini-Course on Translational Treatment Development, American Academy of Neurology, Park City, Utah, August 7, 2008

179. **Lyketsos CG**. Biomarker guided treatment development for Alzheimer's disease. Keynote Lecture, Aeginition Hospital, University of Athens, Athens, Greece, October 13, 2008

180. **Lyketsos CG**. Dementia and Depression in the Elderly. Keynote Lecture, Baltimore County Office on Aging Annual Caregivers Conference, Towson, Maryland, November 8th, 2008

181. **Lyketsos CG**. Depression in dementia. Special Lecture, Glen Retirement Systems, Sherveport, Louisiana, November 10th, 2008

182. **Lyketsos CG**. Preserving your memory. Invited Lecture, A Woman's Journey, Baltimore, Maryland, November 15th, 2008

183. **Lyketsos CG**. Preserving your memory as you age. Invited Public Education Lecture. Goucher College, Towson, Maryland, March 18th, 2009

184. **Lyketsos CG**. Neuropsychiatric symptoms and the proposal for revision of the criteria for Alzheimer's disease. Alzheimer's Research Roundtable, Alzheimer's Association, Washington DC, April 1, 2009

185. **Lyketsos CG**. Developing new treatments for Alzheimer's disease: what needs to be done. Spring Meeting of the Hellenic Psychogeriatric Association, National Hellenic Research Foundation, Athens, Greece, April 11, 2009

186. **Lyketsos CG**. Management of neuropsychiatric symptoms in dementia. Grand Rounds, University of North Carolina, Chapel Hill, April 22, 2009

187. **Lyketsos CG**. Treatment of Alzheimer's and dementia in 2009. Hadassah of Greater Baltimore, Morton Reiser Center for the Performing Arts, Beth Tfiloh School, May 5, 2009

188. **Lyketsos CG**. Dementia Care guidelines in the USA. World Federation of Societies of Biological Psychiatry Guidelines Series-Psychogeriatrics (Session TG-01). 9th World Congress of Biological Psychiatry, Paris, June 28, 2009

189. **Lyketsos CG**. Neuropsychiatric symptoms in Alzheimer's disease: occurrence and treatment. The Kobe Conference of the International Neuropsychiatric Association, Kobe, Japan, September 12, 2009.

190. **Lyketsos CG**. Dementia Awareness Week: Facing the epidemic. Conference sponsored by Alzheimer's Australia (WA), Alexander Library, Perth, Australia, September 15, 2009.

191. **Lyketsos CG**. Dementia Awareness Week: Facing the epidemic. Conference sponsored by Alzheimer's Australia (SA), Alzheimer's SA, Adelaide, Australia, September 16, 2009.

192. **Lyketsos CG**. Dementia Awareness Week: Facing the epidemic. Conference sponsored by Alzheimer's Australia (VIC), Sunderland Theater, University of Melbourne, Melbourne, Australia, September 17, 2009.

193. **Lyketsos CG**. Dementia Awareness Week: Facing the epidemic. Conference sponsored by Alzheimer's Australia (TAS), Baha'i Center for Learning, Hobart, Australia, September 18, 2009.

194. **Lyketsos CG**. Dementia Awareness Week: Facing the epidemic. Conference sponsored by Alzheimer's Australia (QLD), State Library of Queensland, Brisbane, Australia, September 21, 2009.

195. **Lyketsos CG**. Dementia Awareness Week: Facing the epidemic. Conference sponsored by Alzheimer's Australia (NSW), Parliament House, Sydney, Australia, September 22, 2009.

196. **Lyketsos CG**. Dementia Awareness Week: Facing the epidemic (nationally televised live by the Australian Broadcast Company). Australian National Press Club, Canberra, Australia, September 23, 2009.

197. **Lyketsos CG**. Providing dementia care in the community an evidence-based approach. National Dementia Research Forum, Sydney, Australia, September 24, 2009.

198. **Lyketsos CG**. Treating depression in dementia. National Dementia Research Forum, Sydney, Australia, September 24, 2009

199. **Lyketsos CG**. Neuropsychiatric symptoms in dementia. Psychiatry Grand Rounds, Columbia University-Presbyterian Hospital, New York, New York, December 4, 2009

200. **Lyketsos CG**. Clinical Neuropsychiatry. Panel on Aging and Autism organized by University of North Carolina to set the national research agenda for the field, Chapel Hill, NC, March 18-19, 2010

201. **Lyketsos CG.** Risk reduction factors for Alzheimer's disease and cognitive decline in older adults: Depression and related neuropsychiatric disturbances. NIH State of the Science Conference: Preventing Alzheimer's disease and cognitive decline, National Institutes of Health, Natcher Conference Center, Washington DC, April 26-28, 2010

202. **Lyketsos CG**. Epidemiology of Neuropsychiatric Disorders in Dementia Keynote Presentation, Alzheimer's Association Research Roundtable: Neuropsychiatric Symptoms in Alzheimer's Disease, April 29-30, 2010, Washington DC

203. **Lyketsos CG.** Executive Dysfunction. Plenary Presentation, Alzheimer's Association Research Roundtable: Neuropsychiatric Symptoms in Alzheimer's Disease, April 29-30, 2010, Washington DC

204. **Lyketsos CG.** How to diagnose and treat "Mild Cognitive Impairment" AND "How to manage co-morbid depression in cognitively impaired patients" [In Greek]. Invited workshop: 10th Annual Meeting of the International College of Geriatric Psychoneuropharmacology, September 15, 2010, Athens, Greece

205. **Lyketsos CG**. Current issues in the diagnosis and treatment of dementia. Keynote Address: Caring for the patient with dementia through the health care continuum [Holy Cross Hospital], October 2 2010, Silver Spring, Maryland

206. **Lyketsos CG**. Providing dementia care in the community on a large scale. Invited lecture: Institute for Psychiatric Services-American Psychiatric Association, October 15 2010, Boston, Massachusetts

207. **Lyketsos CG.** Depression and psychosis in dementia: therapeutic perspectives. Invited lecture: 15th Annual Comprehensive Approach to Dementia, March 10 2011, New York, New York

208. **Lyketsos CG**. Neuropsychiatric Syndromes in Dementia and MCI: Where are we heading? Plenary Presentation: Alzheimer's Association International Conference (AAIC 2011), July 18 2011, Porte de Versailles, Paris, France

209. **Lyketsos CG**. Neuropsychiatric Syndromes in Dementia and MCI: Where are we heading? Invited Lecture, Douglas Research Institute, McGill University, Montreal, Canada, January 26 2012

210. **Lyketsos CG**. Managing the cure versus care conundrum in dementia. Distinguished Scientist Award Lecture, American Association for Geriatric Psychiatry, Washington, DC, March 18 2012

211. **Lyketsos CG**. Neuropsychiatric symptoms in dementia: where are we headed? Invited Plenary, 17th Annual Meeting, Brazilian Psychogeriatric Association, Sao Paulo, Brazil, March 23, 2012

212. **Lyketsos CG**. Using antipsychotics in patients with dementia. Invited Plenary, 17th Annual Meeting, Brazilian Psychogeriatric Association, Sao Paulo, Brazil, March 24, 2012

213. **Lyketsos CG**. Who are responders to treatment with ELND0005 treatment? Plenary Panel presentation, 12th International Stockholm/Springfield meeting, Stockholm, Sweden, May 12, 2012.

214. **Lyketsos CG**. Discussant: Session IV: Drug Repurposing and Combinatorial Therapy. Alzheimer's Disease Research Summit 2012: Path to Treatment and Prevention, Washington DC, May 15, 2012.

215. **Lyketsos CG**. Chair and Speaker: Tackling overlap of neuropsychiatric symptoms in Alzheimer's and other dementias: Toward a unified approach to evaluation and treatment. Alzheimer's Association International Conference, Vancouver, BC, Canada, July 15, 2012.

216. **Lyketsos CG**. Balancing care with cure in Alzheimer's disease. Plenary Symposium: Butler Conference of Leaders. Baltimore, Maryland, September 6, 2012.

217. **Lyketsos CG**. Care for People with Alzheimer's and Related Dementia and their Families: State of the Art 2012. Grand Rounds. Center for Medicare and Medicaid (CMS). Baltimore, Maryland, November 27, 2012.

218. **Lyketsos CG**. Care for People with Alzheimer's and Related Dementia and their Families: State of the Art 2013. Keynote Lecture: Leadership Summit, Survey and Certification Group, Center for Medicare and Medicaid. Annapolis, Maryland, April 9, 2013.

219. **Lyketsos CG**. Agitation definition in AD citalopram trials. 2013 International Psychogeriatric Association Agitation Definition Expert Consensus Meeting. Boston, Massachusetts, July 12, 2013

220. **Lyketsos CG**. Treatment development for Alzheimer's Disease: how are we doing? Special Lecture on the occasion of the presentation of the Greek translation of *Psychiatric Aspects of Neurological Diseases* (Lyketsos, Rabins, Lipsey, Slavney). Aiginition Hospital, University of Athens, Athens, Greece, October 8, 2013

221. **Lyketsos CG**. Neuropsychiatric Symptoms in Dementia: Where are we headed? Fall 2013 Lecture Series, Alzheimer's Disease Center, Boston University, Boston, Massachusetts, November 6, 2013

222. **Lyketsos CG**. Dementia Care at Home: State of the Art in 2013. 2013 Simons Lecture, Massachusetts and New Hampshire Alzheimer's Association, Boston, Waltham, November 6, 2013

223. **Lyketsos CG**. Agitation as a target for treatment development. Plenary Lecture as Part of Symposium 3, Clinical Trials in Alzheimer's Disease 2013, San Diego, California, November 15, 2013

224. **Lyketsos CG**. All things remembered. Plenary Lecture, A Woman's Journey, West Palm Beach, Florida, January 23, 2014

225. **Lyketsos CG**. Progress in treatment development for Alzheimer's disease: where are we in 2014? Plenary lecture, 3rd National Conference of the Hellenic Society for Clinical Psychopharmacology, Sani, Halkidiki, Greece, April 26, 2014

226. **Lyketsos CG**. Dementia Care: background, evidence, and practice. Keynote lecture, Semi-Annual joint meeting of Baltimore City and County Medical Associations, Towson, Maryland, May 14, 2014

227. **Lyketsos CG**. Overview and measurement of neuropsychiatric symptoms in Alzheimer's dementia. Plenary presentation for the E.U./U.S. Task Force on Alzheimer's Trials (pre-conference to the CTAD meeting), Philadelphia, Pennsylvania, November 19, 2014

228. **Lyketsos CG**. Dementia Care: State of the Art in 2015. Keynote presentation at the 4th Annual Alzheimer's Education Workshop, Leading the Way in Dementia Care: A Person-Centered Approach, James Madison University, Harrisonburg, Virginia, June 11, 2015

229. **Lyketsos CG**. Neuropsychiatric syndromes of later life: Implications for the study and treatment of major psychiatric diseases. Plenary presentation at the 12th World Congress of Biological Psychiatry, Athens, Greece, June 17, 2015

STANFORD UNIVERSITY SCHOOL OF MEDICINE
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

LAURA ROBERTS, M.D., M.A.
CHAIRMAN AND KATHARINE DEXTER MCCORMICK AND STANLEY MCCORMICK MEMORIAL PROFESSOR

July 27, 2015

American Psychiatric Association
c/o Sejal Patel
1000 Wilson Boulevard, #1825
Arlington, VA 22209

Re: Endorsement of Constantine G. Lyketsos, M.D., M.H.S., DFAPA, FAPM, FACNP, for the Jack Weinberg Memorial Award for Geriatric Psychiatry

To Whom It May Concern:

It is with the great enthusiasm that I offer my endorsement of Constantine G. Lyketsos, M.D., M.H.S., DFAPA, FAPM, FACNP, for the Jack Weinberg Memorial Award for Geriatric Psychiatry. I know Dr. Lyketsos well from psychiatric leadership and education "circles", and I have followed his stellar career with great interest since we were honored to serve GAP Fellows together many years ago. I am delighted to share my thoughts about his distinctive contributions to research, education, and clinical practice in the field of geriatric psychiatry. Dr. Lyketsos is, without a doubt, an eminent leader in his field who has substantially advanced our understanding of late-life mental disorders, their underlying neurobiology, and the treatment algorithms used in the care of elderly individuals.

Rather than duplicating any of Dr. McGuire's discussion of Dr. Lyketsos' tremendous career accomplishments as summarized in her primary letter of nomination, I would like to take this opportunity to highlight some of Dr. Lyketsos' work that I have found most impressive.

First, I would like to underscore the impact that Dr. Lyketsos' Maryland Assisted Living Study, funded by the National Institute of Mental Health, has had on the practice and regulation of assisting living facilities in the United States. This seminal investigation demonstrated the substantial under-recognition and under-treatment of dementia and other psychiatric disorders among elderly individuals in assisted living, finding that approximately half of affected residents were not being treated. The fact that dementia was being addressed in such a suboptimal fashion suggested that it likely contributed to morbidity and reduced overall quality of life. As a result of this investigation, and others that followed, the United States saw a significant revamping of assisted living facilities across the country, in conjunction with legislators, to create more dementia-friendly environments that incorporated processes and guidelines for dementia recognition and management that were embraced staff and clinicians. Many other important findings emerged from this study, such as the finding that caregivers were less aware of dementia in residents without severe cognitive impairment or obvious behavioral and functional problems, and that such unawareness predicted failure to treat dementia. In addition, Dr. Lyketsos and his team identified executive dysfunction as the strongest predictor of functional impairment within assisted living facilities, found that greater levels of activity participation appeared to delay functional decline, and demonstrated significant effects of agitation, depression, apathy and

irritability, but not facility size or homelike environment, on quality of life in residents. Taken together, this work helped to greatly advance the ability of assisted living facilities to address dementia and ensure that residents get the care that they need.

Further, I wish to note the extensive advancements in evidence-based treatments of Alzheimer's disease that Dr. Lyketsos has made while factoring in the critical importance of neuropsychiatric disturbances that may alter the course of dementia and/or affect response to treatment. For example, he and his colleagues have demonstrated that cholinesterase inhibitors and memantine slow the progression of cognitive decline in Alzheimer's disease, particularly among women and those with an APOE ε4 allele. These data are important, given the low percentage of affected individuals who are being treated with these medications. Further investigations by Dr. Lyketsos and his team have demonstrated the relative ineffectiveness of many types of antidepressant medications for depression and other neuropsychiatric symptoms in Alzheimer's disease, findings that have had a direct impact on prescribing practices in geropsychiatry. A promising exception to this is the recent finding by Dr. Lyketsos and his team that citalopram may significantly reduce agitation and caregiver distress. Currently, he is investigating the use of deep brain stimulation as a novel strategy for the treatment of Alzheimer's dementia, specifically targeting the hippocampal fornix, in which Dr. Lyketsos and his colleagues have demonstrated early deterioration in the disease. Given the many failures of emergent medications for the treatment of Alzheimer's disease, this exciting work holds great promise for treatment of this debilitating illness.

Aside from his extensive scholarly contributions and clinical advancements, Dr. Lyketsos has proven himself to be an international leader in geriatric psychiatry and an invaluable teacher and mentor. His extensive service to his field has been recognized with numerous awards, including the Distinguished Scientist Award by the American Association for Geriatric Psychiatry, among many others. Dr. Lyketsos has also clearly shaped a new generation of clinician scientists, many of whom have developed their own highly successful independent research laboratories. His educational leadership at Johns Hopkins has been integral to its fantastic success in attracting the very best trainees and staking its claim as one of the premier educational institutes in geriatric psychiatry in the country, and the world.

In summary, Dr. Lyketsos is a truly inspirational scholar, clinician, teacher, and leader in the field of geriatric psychiatry who carries himself with an amazing sense of humanity, grace, and dedication. He has established an impeccable reputation of excellence at the international, national, and local levels. I believe that he is highly deserving of recognition with the Jack Weinberg Memorial Award for Geriatric Psychiatry. Please let me know if I can provide additional information or commentary.

Sincerely,

Laura Roberts, M.D., M.A.
Chairman and Katharine Dexter McCormick and Stanley McCormick Memorial Professor
Department of Psychiatry and Behavioral Sciences
Stanford University School of Medicine

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August 3, 2015

Dear Colleagues:

I am delighted to support the nomination of Constantine Lyketsos, MD, for the 2015 APA Jack Weinberg Award for Geriatric Psychiatry. He is The Elizabeth Plank Althouse Professor and Chair of Psychiatry at Johns Hopkins Bayview. He is also Vice-Chair of the Department of Psychiatry. I have had the pleasure of knowing and interacting with Dr. Lyketsos for two decades.

Dr. Lyketsos has been a major leader and advocate of Geriatric Psychiatry for years. He has been a Board member of the American Association for Geriatric Psychiatry (AAGP), and International Psychogeriatric Association. He has also served on several APA Committees. He is the Editor of International Review of Psychiatry. He received the AAGP Distinguished Scientist Award, as well as the William S. Proxmire Award for "extraordinary leadership in the fight against Alzheimers". He is a Distinguished Fellow of the APA, Fellow of the American College of Neuropsychopharmacology, and a member of the American College of Psychiatrists.

Dr. Lyketsos has published over 350 peer reviewed articles in leading national and international journals including JAMA, NEJM, Lancet, JAMA Psychiatry, American Journal of Psychiatry and American Journal of Geriatric Psychiatry. He is the principal investigator of several independent investigator (R01/U01) grants, including the Cache County Dementia Progression Study, as well as a number of multi-center clinical trials. His main area of work relates to neuropsychiatric disturbances in dementia. He was central to the NIH-funded CATIE-AD study, and principal investigator of the multi-center DIADS-2 and CitAD studies. Dr. Lyketsos is now focusing on better characterizing the neurobiology of Neuropsychiatric disturbances in dementia, especially therapeutically relevant subgroups, by introducing brain imaging in their studies. In more recent years, in his role as Clinical Core Director of the NIH-funded Johns Hopkins Alzheimer's Disease Research Center, Dr. Lyketsos has played a critical role in the development of blood biomarkers such as blood lipids and blood amyloid levels in response to oral glucose loading.

Of considerable importance is Dr. Lyketsos' work on translation of evidence-based treatment advances for persons with dementia into practice. He has characterized the high prevalence, and significant impact on aging in place and quality of life, of dementing disorders in assisted living environments. More recently, his team has shifted attention to the delivery of services at home.

Dr. Lyketsos has been cited by Castle Connolly as a Top Doctor in America for the past 14 years.

Dr. Lyketsos' mentorship has led to the development of a number of funded independent investigators. He is an outstanding educator committed to teaching Geriatric Psychiatry at a national and international level. He has had over 150 invited presentations, including grand rounds at university centers, keynote lectures at conferences, named lectureships, and award lectures throughout the world.

Dr. Lyketsos is one of the main teachers of Geriatric Psychiatry for medical students, residents, fellows, faculty and allied health professionals. He has also served as the Academic Director of the Copper Ridge Institute, responsible for teaching physicians and allied health professionals how to care for patients with memory disorders and dementia. Dr. Lyketsos has overseen the growth and development a premier fellowship in geriatric psychiatry funded by a collaborative grant from HRSA.

In summary, I strongly support the nomination of Dr. Lyketsos without any reservation for the 2015 APA Jack Weinberg Award for Geriatric Psychiatry. Please do not hesitate to contact me if you have any questions or desire further information.

Sincerely,

Dilip V. Jeste, M.D.
Senior Associate Dean for Healthy Aging and Senior Care
Estelle and Edgar Levi Chair in Aging
Distinguished Professor of Psychiatry and Neurosciences
Director, Sam and Rose Stein Institute for Research on Aging
University of California, San Diego

AMERICAN PSYCHIATRIC ASSOCIATION/FOUNDATION

AWARD REVIEW FORM

APA Board instructions:
Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation to the Joint Reference Committee (lmcqueen@psych.org) by COB September 24th.

Foundation instructions:
If the award will be approved by the Foundation Board, please return this form to Linda Bueno (lbueno@psych.org) by COB September 24th.

AWARD NAME: **Psychiatric Services Achievement Awards**

NAME OF AWARD ADMINISTRATIVE COMPONENT: Psychiatric Services Achievement Awards Selection Committee

---

CHAIRPERSON: **Christina Arredondo, MD**

STAFF LIAISON: **Samantha Hawkins**

[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:

Any hospital, clinic, school, or community program is eligible if it has been in full operation for at least two years.

Description of Selection Criteria for Award:

These awards recognize outstanding programs that deliver services to the mentally ill or disabled, have overcome obstacles, and can serve as models for other programs, from both academically or institutionally sponsored programs as well as community-based programs.

Award Funding Information: [Please complete the following if applicable]
Cost for 4 Plaques:$1270.00
Cost of Cash Award: Total of 10,000 (3500 to each gold award; 2000 for silver; 1000 for bronze; no money is given if the committee chooses programs for a Certificate of Significant Achievement).
Cost of Lectureship: none
Other (please list): IPS expenses

Award Account Balance: _____ (as reported by APA Online Financials)
Date Balance Determined: _____

Award Nominee(s):

Gold award for academically- or institutionally affiliated programs
Sexual Behaviours Clinic, Integrated Forensic Program
Royal Ottawa Mental Health Centre, Canada
Gold award for community-based programs
Missouri Community Mental Health Center Health Home Program
Missouri Department of Mental Health and MO HealthNet,
Silver
Integrating School Based Outreach: Mental Health 101 & Typical or Troubled?® Programs

Mental Health Association of East Tennessee

Bronze

SUSTAIN (SUpporting Seniors receiving Treatment And INtervention) Department of Psychiatry, Perelman School of Medicine, University of Pennsylvania; Department of Aging, Commonwealth of Pennsylvania,

Certificate of significant achievement (2)

- Heartland Clinic/CHARG Resource Center, Denver, Colorado
- St Luke's Behavioral Health Clinic – Twin Falls Campus, part of St. Luke's Healthcare System, Boise, ID

(Please attach a biosketch and any letters of nomination or support for this individual)

The application packet and site review is attached for each of the programs.

Description of the Committee's Selection Process:

Online e-application form, program description, and supporting materials. The Committee reviews all applications, then ranks and selects semifinalist programs to receive site visits. Appropriate district branches are asked to help identify APA members to perform site visits to these semifinalist programs and to submit an evaluation to the Awards Committee, which aids in the Committee's selection of finalists. The Committee convenes by phone to review site evaluations and choses awardees. The committee has no in person meetings over the course of the selection process.

AMERICAN PSYCHIATRIC ASSOCIATION/FOUNDATION

AWARD REVIEW FORM

APA Board instructions:
Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation to the Joint Reference Committee (lmcqueen@psych.org) by COB September 24th.

Foundation instructions:
If the award will be approved by the Foundation Board, please return this form to Linda Bueno (lbueno@psych.org) by COB September 24th.

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NAME OF AWARD ADMINISTRATIVE COMPONENT: Psychiatric Services Achievement Awards Selection Committee

---

CHAIRPERSON: **Christina Arredondo, MD**

STAFF LIAISON: **Samantha Hawkins**

[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:

Any hospital, clinic, school, or community program is eligible if it has been in full operation for at least two years.

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Cost of Lectureship: none
Other (please list): IPS expenses

Award Account Balance: _____ (as reported by APA Online Financials)
Date Balance Determined: _____

Award Nominee(s):

Gold award for academically- or institutionally affiliated programs
Sexual Behaviours Clinic, Integrated Forensic Program
Royal Ottawa Mental Health Centre, Canada
Gold award for community-based programs
Missouri Community Mental Health Center Health Home Program
Missouri Department of Mental Health and MO HealthNet,
Silver
Integrating School Based Outreach: Mental Health 101 & Typical or Troubled?® Programs

Mental Health Association of East Tennessee

Bronze

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Certificate of significant achievement (2)

- Heartland Clinic/CHARG Resource Center, Denver, Colorado
- St Luke's Behavioral Health Clinic – Twin Falls Campus, part of St. Luke's Healthcare System, Boise, ID

(Please attach a biosketch and any letters of nomination or support for this individual)

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Application year 2015 ▼

		Customer ID	Contact Name	Apply Program Name	Status
Select	152	000000071218	Erik J Roskes M.D.	Community Forensic Aftercare Program, Office of Forensic Services, Maryland Department of Health and Mental Hygiene	Completed
Select	162	000001011245	Robert J McHale, MD	Monarch's Open Access	Completed
Select	153	000001015897	Samuel J Pullen, DO	St Luke's Behavioral Health Clinic part of the St. Luke's Health System based out of Boise, Idaho.	Completed
Select	159	000000310351	Benjamin I Goldstein MD PhD	Centre for Youth Bipolar Disorder	Completed
Select	161	000000033666	Reid Finlayson, MD	Vanderbilt Comprehensive Assessment Program, for professionals	Completed
Select	163	000001341580	Kristin Spykerman, MSW	Cherry Health, Sage Behavioral Health Care Home at the Heart of the City location.	Completed
Select	164	000001339161	Paul Alexander Mabe III, PhD	Project GREAT (Georgia Recovery-Based Educational Approach to Treatment)	Completed
Select	167	000000311859	Tony W Thrasher, DO	The program that I am respectfully submitting is the: CRISIS SERVICES BRANCH (Milwaukee County Behavioral Health Division) The Crisis Services branch provides a myriad of intervention services for all adults and children in Milwaukee County experiencing a psychiatric emergency, either of voluntary or involuntary legal status. The eleven components of the Crisis Services branch are described in more detail throughout the application.	Completed
Select	173	000001341771	Benjamin T Harrington	Integrating School Based Outreach: Mental Health 101 & Typical or Troubled? Programs	Completed
Select	160	000001338272	Lisa Murphy, MA	Sexual Behaviours Clinic, Integrated Forensic Program, The Royal	Completed
Select	158	000001079910	David Dyer Burgess	Heartland Clinic	Completed
Select	165	000001342510	Erin O'Neill Zerth, PhD	U.S. Department of Veterans Affairs Edward Hines Jr. VA Hospital Primary Care Behavioral Health (PCBH) Program	Completed
Select	166	000001343238	Christian Shriqui, MD, MSc	CHU de Québec-IUSMQ Mieux-Être Wellness Program	Completed
Select	171	000000059342	Joseph John Parks, MD	Missouri Community Mental Health Center Health Home Program Missouri Department of Mental Health and MO HealthNet Division of Missouri Department of Social Services	Completed
Select	169	000001343737	Julie M. Shaw, LCSW	JeffCare, a program of Jefferson Parish Human Services Authority	Completed
Select	172	000001344433	Susan Callahan, MSW	Lowcountry Autism Foundation	Completed
Select	170	000000042919	Joel E Streim M.D.	SUpporting Seniors receiving Treatment And INtervention (SUSTAIN)	Completed
Select	174	000001344997	Abraham Goldring, MA	The program we would like to present to you for this respected award is called "Thinking for Living", also known as Cognitive Remediation Therapy	Completed
Select	175	000001345024	Michael Bloomquist, PhD	Evidence-based Intensive Outpatient Psychotherapeutic Programs for Youth with Behavior and Depression Disorders: The Behavior Development and Healthy Emotions Programs	Completed

Stay Connected:

AWARD REVIEW FORM

APA Board instructions:
Please complete this form in its entirety and forward the form to the Council to which the award administrative component reports along with the nomination of the award recipient. The Council will then forward this documentation to the Joint Reference Committee (lmcqueen@psych.org)

APA Foundation instructions:
If the award will be approved by the American Psychiatric Association Foundation Board, please return this form to Lindsey Fox (lfox@psych.org).

AWARD NAME: Bruno Lima Award in Disaster Psychiatry

NAME OF AWARD ADMINISTRATIVE COMPONENT: Committee on Psychiatric Dimensions of Disaster

---

CHAIRPERSON: Robert Ursano, M.D.

STAFF LIAISON: Ricardo A. Juarez

[Please note if any of the information listed below revises what is currently listed in the APA Operations Manual or if this award needs to be added to the Operations Manual.]

Description of Eligibility for Award:

APA Member in APA District Branch or State Association. The Bruno Lima Award in Disaster Psychiatry recognizes outstanding contributions of APA members in the care and understanding of the victims of disaster.

Description of Selection Criteria for Award:

A member of APA District Branches and State Associations who epitomizes the APA's highest ethical, clinical, and professional standards, while engaged in one or more of the following activities:

- Providing consultation, education, training and awareness on mental health and disaster issues
- Providing direct service delivery as part of a disaster response team
- Designing disaster response plans

Award Funding Information: [Please complete the following if applicable]
Cost for Plaque: None
Cost of Cash Award: None
Cost of Lectureship: None
Other (please list): None

Award Account Balance: _____ (as reported by APA Online Financials)
Date Balance Determined: _____

Award Nominee(s): Kathleen Clegg, M.D.

Dr. Clegg is the Associate Professor of Psychiatry at Case Western Reserve University, the Director of Public and Community Psychiatry at University Hospitals Case Medical Center, and the Medical Director at Recovery Resources, a community-based public mental health center. She is currently the co-chair of the Group for the Advancement of Psychiatry's Committee on Disasters and the World and is a former co-chair of OPPA's Disaster Committee.

Dr. Clegg has extensive local, national and international experience with teaching mental health disaster response and preparedness including providing training on disaster management in complex humanitarian emergencies, focusing on the mental health recovery of children and families. She has taught at international medical schools and medical societies in Thailand (2001), Nicaragua (2003), Haiti

(2011) and India (2012) on the topics of volunteer self-care, cross-cultural communication, compassion fatigue and vicarious trauma. From 2003 to 2007, Dr. Clegg participated in planning and teaching local disaster preparedness in Ohio with a focus on children and adolescents. In 2011, she participated in the training of primary care nurses in St. Vincent and the Grenadines through a global mental health collaboration with Mt. Sinai Medical School to strengthen their mental health systems in preparation for future disasters. In 2013, during continued earthquake recovery efforts in Peru, Dr. Clegg participated in a university outreach program by teaching topics on disaster and mental health to Peruvian medical students while providing psychiatric care to the community. Most recently, Dr. Clegg lectured on PTSD in children and adolescents at a national pediatric conference in Mexico.

Description of the Committee's Selection Process:

The Committee discussed several nominations during their annual in-person meeting at the 2015 APA Annual Meeting in Toronto. Staff coordinated follow up with the nominees' respective District Branches and State Association Presidents in order to solicit additional nominees and to receive support from the DB/SA President of the nominee. A review of the final letters of support from the DB/SA Presidents who responded finalized the individual to be awarded the 2016 Bruno Lima Award in Disaster Psychiatry.

OHIO PSYCHIATRIC PHYSICIANS ASSOCIATION

A District Branch of the American Psychiatric Association

Dedicated to promoting the highest quality care for people with mental disorders and to serving the professional needs of Ohio's psychiatric physicians.

October 2, 2015

Ricardo A. Juarez:
American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, Va. 22209-3901

Dear Mr. Juarez:

As president of the Ohio Psychiatric Physicians Association (OPPA), I am proud to be able nominate one of our members, Dr. Kathleen Clegg, for the American Psychiatric Association's Bruno Lima Award in Disaster Psychiatry.

Dr. Clegg is an Associate Professor of Psychiatry at Case Western Reserve University, the Director of Public and Community Psychiatry at University Hospitals Case Medical Center, and the Medical Director at Recovery Resources, a community-based public mental health center. She is currently the co-chair of the Group for the Advancement of Psychiatry's Committee on Disasters and the World and is a former co-chair of OPPA's Disaster Committee.

Dr. Clegg's qualifications justifying receipt of this award are many. In fact, she has extensive local, national and international experience with teaching mental health disaster response and preparedness, providing training on disaster management in complex humanitarian emergencies, focusing on the mental health recovery of children and families, including the following:

- She has taught at international medical schools and medical societies in Thailand (2001), Nicaragua (2003), Haiti (2011) and India (2012) on the topics of volunteer self-care, cross-cultural communication, compassion fatigue and vicarious trauma.
- From 2003 to 2007, Dr. Clegg participated in planning and teaching local disaster preparedness in Ohio with a focus on children and adolescents.
- In 2011, she participated in the training of primary care nurses in St. Vincent and the Grenadines through a global mental health collaboration with Mt. Sinai Medical School to strengthen their mental health systems in preparation for future disasters.
- In 2013, during continued earthquake recovery efforts in Peru, Dr. Clegg participated in a university outreach program by teaching topics on disaster and mental health to Peruvian medical students while providing psychiatric care to the community.
- Most recently, Dr. Clegg lectured on PTSD in children and adolescents at a national pediatric conference in Mexico.

Given the above impressive credentials and qualifications, as well as my personal knowledge of Dr. Clegg's work in community psychiatry in Ohio, I am pleased to be able to offer her name in nomination for this prestigious and well-deserved award.

Sincerely,

Steve W. Jewell, MD
President

cc: Frederick Stoddard, MD

3510 Snouffer Road
Suite 101
Columbus, Ohio 43235-4217
(614) 763-0040
(614) 481-7559 Fax

E-mail:
oppa@ohiopsychiatry.org

Website:
www.ohiopsychiatry.org

JOINT REFERENCE COMMITTEE
February 2012

Criteria for Evaluating Councils

1) How many times did the Council meet? [in person, by conference call]
    a. Please provide the attendance (including those not present) at each meeting.
2) Education
    a. What workshops/symposia, etc. have been submitted for presentation at APA Annual Meetings,
    b. What was the attendance at these events and what was the feedback on these events?
3) What are the council's current activities and what activities are planned for the coming years? [please use the work plan template]
4) Has work product been sent to the Assembly and the Board of Trustees?
5) What is the Council doing for RFM and ECP members?
6) Evaluate the staff support to the Council and its components
   (N.B. the staff will be asked to evaluate what the Council does and the work of the participants)

Outcome:

- ☐ Continue the component in its current form
- ☐ Recommend changes to the component
- ☐ Discontinue the component

JRC Assessment of the Council on Advocacy and Government Relations – 2015

Criteria for Evaluating Councils

1. **How many times did the Council meet? [in-person, via conference call]**
    a. Please provide the attendance—including those not present— at each meeting

September Component Meeting (September 2015)

Members in Attendance:

Barry B. Perlman, M.D., Chair
John T. Bailey, D.O., Vice-Chair
Bem Atim, M.D.
Cassandra Newkirk, M.D
Charles Price, M.D.
David Lowenthal, M.D.
David Pickar, M.D.
Debora Koss, M.D.
Jacob Michael Izenberg, M.D.
Jenny Boyer, M.D.
Joshua Berezin, M.D.
Katherine G. Kennedy, M.D.
Michael Christopher Hann, M.D.
Morgan Medlock, M.D.
Napolean Higgins, M.D.
Nicole Wimberger, M.D.
Steve Koh, M.D.
Wilsa Charles Malveaux, M.D.

Conference Call (July 2015)

Members in Attendance:

Barry Perlman
John Bailey
Altha Stewart
David Pickar
Deb Koss
Dave Lowethanal
Steve Koh
Jenny Boyer
Cassandra Newkirk
Napoleon Higgins

Annual Meeting 2015 (May 2015)

Members in Attendance:

Barry Perlman, M.D., Chair
John T. Bailey, D.O., Vice-Chair
Altha Stewart, M.D.
Cassandra Newkirk, M.D
Charles Price, M.D.
Craig Zarling, M.D
Jerry Halverson, M.D.
Matthew Erlich, M.D.
Napolean Higgins, M.D.
Steve Koh, M.D.
Robert Cabaj, M.D.
David Lowenthal, M.D.

Members Absent:

Jerome H. Rogoff, M.D.
Ronald Burd, M.D.

Conference Call (April 2015)

Members in Attendance:

Barry Perlman
Craig Zarling
Jerry Halverson
Steve Koh
Brenda Jensen
John Bailey
David Lowenthal
Cassandra Newkirk
Robert Cabaj
Altha Stewart

Conference Call (December 2014)

Members in Attendance:

Barry Perlman
John Bailey
Robert Cabaj

September Component Meeting (September 2014)

Members in Attendance:

Barry Perlman, M.D.
John T. Bailey, D.O.
Matthew Erlich, M.D.
Jerry Halverson, M.D.
Napolean Higgins, M.D.
Brenda Jensen, M.D.

Steve Koh, M.D.
David Lowenthal, M.D.
Cassandra Newkirk, M.D.
Charles Price, M.D.
Altha Stewart, M.D.
Jerome Rogoff, M.D.
Robert Cabaj, M.D.

Members Absent:
Craig Zarling, M.D.
Ronald Burd, M.D.

Conference Call (July 2014)
Members in Attendance:
Robert Cabaj
Barry Perlman
Altha Stewart
Steve Koh
Ronald Burd

Annual Meeting (May 2014)
Members in Attendance:
Bob Cabaj, M.D., Chair
Barry Perlman, M.D., Vice-Chair
Ade Adelakun, M.D.
Cassandra Newkirk, M.D.
Charles Price, M.D.
Craig Zarling, M.D.
David Lowenthal, M.D.
Jerry Halverson, M.D.
John Bailey, D.O.
Yvonne Yang, M.D.

September Component Meeting (September 2013)
Members in Attendance:
Bob Cabaj, M.D., Chair
Ade Adelakun, M.D.
Ara Anspikian, M.D.
Brenda Jensen, M.D.
David Lowenthal, M.D.
Esther Lee, M.D.
Jamie Ng, M.D.
Jerry Halverson, M.D.
Obi Obianuju, M.D.
Steve Koh, M.D.
Yvonne Yang, M.D.

Annual Meeting (May 2013)
Members in Attendance:
Bob Cabaj, M.D., Chair
Barry Perlman, M.D., Vice Chair
Ara Anspikian, M.D.
Cassandra Newkirk, M.D.
Charles Price, M.D.
Gary Tsai, M.D.
John Bailey, M.D.
Marcia Goin, M.D.
Mary Helen Davis, M.D.
Melinda Young, M.D.
Michelle Durham, M.D.
Peter Martin, M.D.
Yvonne Yang, M.D.

Conference Call (January 2013)
Members in Attendance:
Mindy Young
Gary Tsai
Robert Cabaj
Charles Price
Jerry Halverson
Steve Koh
Marcia Goin
Ara Anspikian

September Component Meeting (September 2012)
Members in Attendance:
Barry Perlman
Charles Price
Jerry Halverson
John Bailey
Marcia Goin
Mary Helen Davis
Melinda Young
Peter Martin

Conference Call (July 2012)
Members in Attendance:
Bob Cabaj
Barry Perlman
Cassandra Newkirk
Charles Price
Gary Weinstein
Jerry Halverson
Marcia Goin

Annual Meeting 2012 (May 2012)
Members in Attendance:
Robert Cabaj, M.D., Chair
Barry Perlman, M.D., Vice Chair
Ara Anspikian, M.D
Charles Price, M.D.
Dale Walker, M.D.
Gary Tsai, M.D.
Jeffrey Metzner, M.D.
Jerry Halverson, M.D.
Marcia Goin, M.D., Ph.D.
Michelle Durham, M.D.
Mindy Young, M.D.
Patrick Runnels, M.D

2. Education

a. What workshops/symposia, etc. have been submitted for presentation at the APA Annual Meetings
b. What was the attendance at these events and what was the feedback on these events?

Annual Meeting 2010
Psychiatric Practice in an Era of Health Care Reform
APA Council on Advocacy & Government Relations
Co-Chairs:
Javeed Sukhera, M.D.
Sarah Vinson, M.D.
Presenters:
Catherine E. Krasnik, M.D., Ph.D.
Margaret Balfour, M.D., Ph.D.
Peter S. Martin, M.D., M.P.H.
Robin Reed, M.D.
(Attendance: 99 people)

Annual Meeting 2011
Promoting Improved Integration: An Examination of Collaborative Health Care Models
APA Council on Advocacy and Government Relations
Chair:
Peter S. Martin, M.D., M.P.H.
Presenter(s):
Marilyn Griffin, M.D.
Peter S. Martin, M.D., M.P.H.
Christina V. Mangurian, M.D.
(Attendance: 65 people)

Annual Meeting 2012
Advocating for Your Patients in an Era of Health Care Reform
APA Council on Advocacy and Government Relations
Chair:
Jerry L. Halverson, M.D.
Presenter(s):
Jerry L. Halverson, M.D.
Ara Anspikian, M.D.
Nicholas M. Meyers
Robert P Cabaj, M.D.

(Attendance: 14 people)

The Future of Psychiatry: The Recovery Model and Severe Mental Illness
APA Council on Advocacy and Government Relations
Chair:
Robert P Cabaj, M.D.
Presenter(s):
Gary Tsai, M.D.
Michelle Durham, M.D.
Elena F. Garcia-Aracena, M.D.
(Attendance: 52 people)

Annual Meeting 2013
Amplifying the Voice of Your Profession and Your Patients: Advocating for Your Patients in an Era of Health Care Reform
APA Council on Advocacy and Government Relations
Chair:
Jerry Halverson, M.D.
Speakers:
Nicholas M. Meyers, B.Sc.
Robert Cabaj, M.D.
Ara Anspikian, M.D.
Jerry Halverson, M.D.
(Attendance: 9 people)

Annual Meeting 2015
Advocacy 101: How to Successfully Advocate for Your Patients and Your Practice
APA Council on Advocacy and Government Relations
Chair:
Jerry Halverson, M.D.
Speakers:
Robert P. Cabaj, M.D.
Jerry Halverson, M.D.
Christina J. Arredondo, M.D.
(Attendance: 7 people)

3. **What are the Council's current activities and what activities are planned for the coming years?**
[Reference council work plan template]

4. **Has work product been sent to the Assembly and the Board of Trustees?**
Over the years, the Council has continuously submitted work products:
    - The Jacob K. Javits Public Service Award presented annually to a public servant who has made a significant contribution to the mental health community and patients suffering from mentally disorders. This is the highest award conferred upon a public servant by the APA. The Council recently recommended U.S. Representative Tim Murphy, PhD (R-PA) for the 2016 Javits Award for his work on comprehensive mental health reform. (2015)
    - Having identified the issue, the Council—through a unanimous vote—proposed a resolution to the APA Board of Trustees (July 14) recommending the APA assess and advocate accordingly regarding the health insurance mergers. The Assembly Executive Committee then voted to support the Council's motion (July 25), and the Executive Committee agreed (August 4) that the APA Administration should prepare a letter to the antitrust regulators focusing on appropriate access to psychiatric care. In September, the APA submitted a formal letter expressing concern to the antitrust regulators at the Department of Justice. (2015)

- The Council, working with the Department of Government Relations, developed recommendations concerning HR. 3717, "The Helping Families in Mental Health Crisis Act." The Board of Trustees reviewed and discussed the recommended changes and additions to bill, as suggested by the Council on Advocacy and Government Relations. The Board agreed the Council's suggestions would align with the association's priorities for the field of psychiatry. (2014)
- Each year, the Council reviews a substantial number of action papers from the Assembly. As Assembly members develop action papers, the authors frequently ask for feedback from Council.
- The Council provides detailed reports to both the Assembly and the Joint reference Committee, summarizing: component activity; cross collaboration with the Assembly in the review of action papers; and when requested, Council members volunteer to assist with reference committee deliberations.

5. **What is the Council doing for RFM and ECP members?**
   The Council has regularly involved the RFMs and ECPs in every level of component activity: conference calls; email solicitations on federal legislative or regulatory issues; participation in the component's bi-annual meetings; and component educational workshops during the annual meeting.

   Unfortunately, response from RFMs has not always met general participatory expectations. The Council will be expanding efforts through CAGR member outreach to RFMs through their respective state associations or district branches. The Council will work with the Division of Diversity and Health Equity in order to provide feedback with the hope that the fellows will be held more accountable, and thus participate with a greater degree.

   The Council will collaborate with the Department of Government Affairs staff to incorporate former Spurlock Congressional fellows as consultants/guest to the Council.

6. **Evaluate the staff support to the Council and its component**
   The staff support has been excellent. Since Mr. Currie has joined the APA, the level of engagement between the Council Chair and Mr. Currie and his staff has been continuously active and mutually supportive. The Council believes the district branches and state associations will also find that the new State Affairs infrastructure introduced by Mr. Currie—with the hiring of Mr. Brain Smith, as Director of State Government Affairs and expansion of his staff—will greatly enhance APA's advocacy strength.

COUNCIL WORK PLAN TEMPLATE – Council on Advocacy & Government Relations

Complete the Template for Current and Future Tasks

	TASK/ACTION	Priority #	Start Date	Completion Date	Responsible Person/Entity
I	**TASK:**				
	Continue to work with the Department of Government Affairs in helping to set advocacy priorities, based on importance for the association, the field of psychiatry and mental health community.	**1**		Continuous	Council
II	**TASK:**				
	Proactively review federal and state regulatory and legislative initiatives.	**2**		Continuous	Council
	To the extent possible, appoint Council members as a lead review liaison on specific issues of interest				Chair
	Assemble members for focus specific conference calls.				Chair
III	**TASK:**				
	Assess and collaborate with APA leadership and the Department of Government Affairs in formulating APA policies and planning strategies related to legislation and regulation.	**3**		Continuous	Council
IV	**TASK:**				
	Collaborate with the Department of Government Affairs on political strategies and tactics.	**4**		Continuous	Council
V	**TASK:**				
	Assist in coordinating advocacy priorities for district branches and state associations with the Department's State Affairs infrastructure.	**5**		Continuous	Council

COUNCIL WORK PLAN TEMPLATE – Council on Advocacy & Government Relations

Complete the Template for Current and Future Tasks

VI	**TASK:**				
	Engage with other APA Councils and Committees in helping to translate their goals into state or federal legislative and regulatory vehicles.	**6**		Continuous	Council
VII	**TASK:**				
	Enhance collaboration with APA's Council on Communication with the goal of overall improvement of APA's advocacy efforts.	**7**		Continuous	Council
VIII	**TASK:**				
	Work with the Division of Diversity and Health Equity in order to mentor and engage RFMs and ECPs in understanding and participating in advocacy efforts.	**8**		Continuous	Council
IX	**TASK:**				
	At the request of the JRC, the Council will continue to comment on action items from other councils.	**9**		Continuous	Council
X	**TASK:**				
	Continue to submit workshops for the Annual Meeting to educate and engage with APA membership on advocacy.	**10**		Continuous	Council

Draft Council on Healthcare Systems and Financing (CHSF)
Workplan

In formulating its workplan for the next 12-18 months the Council considered it essential to fully consider the Strategic Initiatives of the Board issued in March 2015 and the recommendations of the current Board of Trustees Workgroup on Healthcare Reform in its most recent, March 2015, report. The council also requested input from staff as to pertinent developments that fall within the foregoing.

Throughout its discussions CHSF acknowledged that it is essential that any component workplan that is to be meaningful should contain: 1) a clear statement of the issue and rationale for a given work product and its strategic utility; 2) the work product(s) defined for the given issue/topic; e.g., a position statement, educational resource document, specific recommendations for a given public/private policy, etc.; 3) identification of the key resources needed to develop/implement the product; e.g., key governance components and administration expertise; 4) a specific plan for development and implementation of the work product (i.e., the tasks to be performed), assignment of responsibility for each task and coordination thereof with a defined timeline for completion; and 5) a plan to execute and monitor/evaluate.

It is obvious that resources, especially time, are limited and that there must be prioritization. The scope of work referred to the CHSF is large and often highly variable. Sometimes the work requested does not relate to what the council has defined as its priorities. CHSF thinks it is essential that, in the important and rapidly changing healthcare environment, the council must remain focused on the issues within its purview that have significant implications for the future place of psychiatry. We will accept whatever guidance is provided by the JRC as to priority items, with the obvious reality that these will still have to be sequenced based on the manpower resources of the council and the Office of Healthcare Systems and Financing (OHSF). The council recognizes that OSHF has many important work functions that are essential and beyond the workplan of the council.

With the foregoing in mind, CHSF has identified the following as key categories for product development and implementation over the next 12- 24 months. Each of these will necessitate collaboration and priority alignment with various other APA councils and will draw on staff expertise and skills from various departments:

1) Integrated/Collaborative care

a) Development of an APA position statement

Background: It is a given that integrated care delivery policy initiatives are fundamental to help both public and private payers in pursuing better quality care and desired cost efficiencies. The APA has been in the forefront of placing emphasis on the essential role the treatment of behavioral conditions has in respect to these objectives. However, the APA does not have a current position statement that sets forth the principles it thinks should guide payor initiatives. The Council will undertake a lead role in the development of a position statement to be processed through appropriate APA channels.

Key Persons Involved: The key actors involved include the members of CHSF and the Council on Psychosomatic Medicine, and input will be requested from other councils as well. Key administrative personnel are within OHSF.

Key Tasks:

1. To immediately begin drafting a position statement that articulates APA principles with input from other key stakeholders within the APA.
2. Secure JRC approval to begin to process this through governance quickly for eventual final approval of an APA Position Statement.

Timeline: As we understand the standard timeline, between the JRC, the Assembly, and the Board, this statement cannot properly go through channels and be fully considered until the May 2016 meeting of the Assembly. In our view, there is an urgency to expedite the review and approval of this position statement inasmuch as APA is now fully engaged with CMS and the AMA CPT and RUC to develop new codes, value them, and secure Medicare coverage for collaborative care. A defined APA position would be extremely useful in this negotiating process (as there are many many competing interests—e.g., psychology—that are seeking coverage for "collaborative care" in a manner that we feel would be inconsistent with APA principles).

We respectfully ask that consideration be given to how to expedite this process, and would reference remarks made by various Board Health Reform Work Groups that have noted that the APA governance structure may need to develop a rapid response mechanism for certain APA actions. In our opinion, the need for this position statement falls within this category of rapid response.

b) Development of specific coding and valuation amounts for the evidence based collaborative care model for persons with behavioral conditions in primary care settings to enable sustainable reimbursement

Background: The problem of access to psychiatric services in primary care settings has been well documented. Care models to improve access in primary care settings have been developed and tested over time. The most prominent evidence-based collaborative care model is the one that the AIMS Center at the University of Washington has stewarded over time. The key barrier to the proliferation of the model has been payment for the essential functions of the model. CMS announced in July 2015 that it intends to move to coverage of, or further demonstration of, this evidence based model, and specifically intends to address how to appropriately reimburse for it. The Council will work to develop and advocate for a specific coding proposal with CMS. This will be done primarily through the Committee on RBRVS, Codes, and Reimbursement.

Key Persons Involved: A subset of the Council has been designated to work with the Committee on RBRVS and OHSF staff to shepherd this through. We anticipate that the Councils on Psychosomatic Medicine, Quality and the Council on Geriatric Psychiatry will be key contributors, along with their respective staff, as will other APA member experts and consultants we have already engaged for this. We will also be working extensively with other medical associations who either support or have a direct interest in facilitating payment for this type of care delivery model. CMS, AMA CPT and AMA RUC will primary throughout the entire process.

Key Tasks: There are many, many decision points in the following tasks that cannot be specified at this time.

1. Key CPT and RUC representatives will be assessing our options for playing this through given the many stakeholders involved.
2. Designation of a workgroup to begin to draft the required specifications for code development for CPT.

3. Convening a teleconference with APA experts for other medical specialties to explain the model and its requirements.
4. Convening meetings with CMS to provide additional information to the comments APA submitted Sept 2015 on CMS request for information.
5. Developing the content and strategy for when a proposal is submitted to CPT and/or the development of a G code by CMS. This may require two concurrent paths of actions with CPT and CMS.
6. Key tasks that follow from point 5 can only be delineated once we have a more defined pathway which should emerge by December 2015.

Timeline: The foregoing will occur over the next 18 to 24 months. The timelines that the AMA CPT and RUC work on and that of CMS are complex with respect to completion dates for codes to be considered for Medicare rule-making. However, CMS's announced target for coverage is January 2017. It should be noted that target does not mean that we will not be involved with CPT and RUC after that deadline for refinements in evaluation of the eventual codes.

c) Convening an expert workgroup of psychiatrists involved in new care models, e.g. ACOs and health homes (and working with public and private payers around issues for psychiatry in the new care models)

Background: Accountable Care Organizations (ACOs), medical and health homes, and efforts by CMHCs to secure better access for physical health services for the SMI population permeate the landscape. There are stellar examples of achievement--e.g., the Montefiore Pioneer ACO--where the successful integration of treating individuals with behavioral conditions has led to overall success. There are also examples in the health home world where sophisticated approaches to treating behavioral conditions in primary care settings have been successful. There are also a number of CMHC efforts that have been successful. However, the overall penetration of psychiatry in these models has been highly variable as documented in the literature. There is a need to draw on the experience of psychiatrists who have been involved to understand the elements necessary for success and barriers to successful integration. There is also a need to better understand the payer perspective on barriers to the implementation of better care models for behavioral conditions.

Key Persons Involved: The key persons involved will be a designated group of the Council who have had experience with these models, OHSF staff, and experts from the Council on Psychosomatic Medicine.

Key Tasks:

1. Develop an outreach plan throughout the existing APA structure, including the Assembly, to identify psychiatrists who are involved in these alternative arrangements.
2. Establish an outreach effort with commercial and public payers to begin discussions. Note that a meeting has already been had with Aetna.
3. Identify existing APA meetings (e.g., area council meetings, the annual meeting and IPS) to convene forums on these issues.

Timeline: The plan to identify individuals involved and/or interested parties should be developed by December 2015. It should be noted that the APA has received notice that it is the recipient of a major Support Availability Network (SAN) grant from CMS. The general purpose of this grant is to provide education for psychiatrists working in collaborative care situations as well as to bring training opportunities to primary care practices. We think this will be a major vehicle to identify and coalesce the

community of psychiatrists involved or interested in these models and to conduct important outreach with the primary care and payer communities.. The timeline for a potential working group summit for psychiatrists and payers would be spring 2016.

2) Coding and Payment Issues (separate from those for the CoCM model)

a)Working to enable payment for the interprofessional consultation codes and/or the possible development of new EM add-on codes for cognitive work, new or revised care coordination codes for all physician specialties and improvement in coverage for telepsychiatry.

Background: Independent of a specific coding proposal for the CoCM model noted above , there are a number of coding issues that are relevant for all physician specialties in the new healthcare delivery environment. Psychiatry has specific interest in the development of any of these new codes as well as payment for existing codes. We think there are special issues that need to be addressed to expand coverage and payment for telepsychiatry. CHSF, through the Committee on RBRVS, Codes and Reimbursement and with input from the BOT Workgroup on Telepsychiatry, will be actively working on each of these as agenda items.
Key Persons Involved: A designated subgroup of the Council and its Committee on RBRVS will be the primary responsible parties. We anticipate close collaboration with the Council on Psychosomatic Medicine and the Council on Geriatric Psychiatry and working with the BOT Workgroup on Telepsychiatry. Obviously, the key stakeholders of interest include the AMA CPT and RUC and CMS. Other than specific advocacy around telepsychiatry, we anticipate that most of the key work will be done conjointly with relevant coalitions. That is, no one party will carry the day on these issues with CPT, RUC, or CMS.

Tasks:

1. To monitor strategies along with other medical groups to persuade CMS to pay for the existing interprofessional consultation codes (CPT XXXXX to XXXXX).
2. To continue and ensure psychiatry's participation with key coalition groups that have emerged to expand recognition for essential cognitive work and care collaboration and potential new add on codes to the EM CPT codes.
3. Work with the BOT workgroup on telepsychiatry to identify key coverage and payment issues for telepsychiatry and develop an advocacy agenda based on them.

Timeline: Activities around this have already commenced and given prior experience we expect that they will continue actively throughout the next 12 to 18 months.

b) Production of a background paper on the feasibility of alternative payment models for psychiatric/SUD care across all levels of care and payers

Background: Numerous proposals (e.g., value-based payment, bundled payment, episodes of care, and so on) are emerging from both public and private payers as alternatives to fee for service. The feasibility of these alternatives for psychiatric care has not been systematically reviewed. There are many technical issues involved in alternative payment methods (e.g., the cost basis for the unit of payment, however defined; how it is risk adjusted for case mix; how to define the beginning and end points for what triggers an end to an episode and payment for same; and so on). The long-standing APA experience with prospective payment for inpatient care under Medicare, for instance, bears out that this is an extremely complex task. There are also distinct subset issue with other specialty APMs with respect to

how psychiatry should be included for essential consultation functions. Before proceeding to specific proposals the Council thinks it is essential that the APA fully analyze the issues. Even if a way to design an alternative payment model(s) (APM) for psychiatry cannot be found, this effort will assist in defining why these approaches are not appropriate, which may prove to be important in itself in advocating with payers as to how to appropriately deal with psychiatric care. Note that the development of APMs under Medicare is in some respects a special case because of to be stipulated CMS criteria and will be included in the initial work.

Key Persons Involved: The Council will designate a subgroup to work with OHSF staff to identify additional expertise needed to work with APA that does not reside within the Council. This may include outside help from economists, academicians in the services research area, and potential APA member experts who have experience with this issue. We will explore with the APA's Offices of Research and Quality several important roles for them to play in this process.

Key Tasks:

1. Assemble a group with the requisite expertise to begin to develop the necessary background paper/resource document.
2. Convene the group to begin to identify the essential review and analysis tasks that need to be undertaken to produce a definitive paper/resource document
3. Implement and coordinate the development of the document.
4. Ongoing collaboration with other medical associations regarding Medicare APMs.

Timeline: W**e** will begin exploring establishment of this group in October and develop an appropriate timetable to produce the needed resource document. At a minimum, in order to be timely with Medicare's objectives, we believe we need a resource paper/document by spring of 2016.

c) Optimizing payment for psychiatry under the new MIPS formula for Medicare (which cuts across quality, education, and HIT especially) including establishing appropriate exemption thresholds for practicing psychiatrists.

Background: SGR reform (i.e., MACRA) has reconfigured how much physicians will be paid or not paid depending upon how they interact with the various programs and alternative options established under the reform legislation. There are four potential paths that psychiatrists can occupy under MACRA, with each having different physician reporting, risk taking, and bonus/penalty implications. Psychiatrists can choose to:

1. Opt out of Medicare entirely;
2. Participate through the to-be-established MIPS payment formula;
3. Participate and be part of an alternative payment method and potentially be exempt from the MIPS payment formula; or
4. They can participate and be exempt from the MIPS payment formula if they fall under yet-to-be-established low-volume thresholds that exempt physicians from MIPS.

Key Persons Involved: The key persons involved will be the Councils on HSF and Quality. Internally, key administration will include OHSF, the Office of Quality, and potentially the Office of Research

Tasks:

1. Develop materials that fully explain options and implications for APA members;

2. Develop proposals that make it feasible for psychiatrists to meaningfully participate in the MIPS formula (this includes quality measures, meaningful use, and recognized clinical practice improvement activities and appropriate patient attribution methodology) and advocate for same with CMS;
3. Develop a background paper and work with other appropriate medical professional societies to explore the feasibility of an APM for psychiatry consistent with the yet to be developed criteria from CMS; and
4. Develop a specific low-volume threshold exemption for psychiatrist participating in Medicare.

Timeline: A timeline for this will be more fully mapped out once CMS has provided more clarity about its own timeline for development of essential regulations in this arena.

3) Mental health /SUD parity

MHPAEA took more than a decade to come to fruition. It is a complex and not well understood statute and regulations. Currently all individual DBs and State Associations are dealing with MHPAEA issues on their own. APA deals with member issues directly with insurance plans and with the federal government and brings in DBs when possible. It is a patchwork approach that is not strategic.
To successfully implement MHPAEA and obtain payment parity for psychiatrists, which is essential before healthcare reform payment models take hold, APA needs a coordinated and multipronged strategy that continues to demonstrate its strength in the area and mobilizes district branches to work together. APA's credibility and ability to succeed, particularly with the more recalcitrant insurance companies, depends on its ability to join forces in a coordinated fashion nationwide. Key elements of where we are headed are described below.

a) Continuation of current plan of action to secure network adequacy and reimbursement equity for psychiatry

Background: Under MHPAEA network adequacy and reimbursement parity are closely related non-quantitative treatment limitations (NQTLs). It is critical for the APA to successfully engage employers as purchaser and regulators as enforcers to move on the issue of network adequacy for psychiatrists, which is a well-documented problem. There have been many ongoing activities by OHSF staff in conjunction with the APA's General Counsel to pursue this, and there are indications that there is a beginning understanding by purchasers and regulators that network inadequacy is a parity violation. Moreover payment equity is fundamental to this. [Mention Parity and Medicaid Managed Care and Exchange Plans]

Key Persons Involved: CHSF has a working subgroup, and OHSF staff work closely with the APA's General Counsel, the Partnership for Workplace Mental Health, and DGR.

Key Tasks:

1. Building on the current workplan, we need to finalize a letter, which has been prepared, that will go from the New England Business Group on Health to numerous major insurers requesting specific data and documentation about the status of their psychiatric networks.
2. District Branches need to be educated on the issues and provided with the tools needed to address network adequacy at the state level with legislators and regulators. A series of materials are being finalized to be presented at the state legislative conference in October in Florida. A plan for follow-up with the District Branches will be executed at this meeting.

3. Other outreach efforts on network the adequacy issue as a parity problem need to be made to state insurance commissioners, attorney generals, and others.
4. Develop an appropriate internal and external communications plan around thes issues.

Timeline: these efforts have been ongoing and will continue aggressively over the next twelve months.

b) Development of education/action materials for APA state affiliates to identify and act on parity issues under health plans

Background: Many district branches have indicated a desire to move forward on mental health parity issues, but some do not understand the intricacies of the statutes, the enforcement scheme, or the insurance industry. There is need for a coordinated strategy between the APA and its DBs regarding dealing with all relevant stakeholders around the parity issue. The enforcement authorities and the insurance industry do not distinguish the APA from its district branches and our credibility is tied together.

Key Persons Involved: CHSF, OHSF staff, APA General Counsel, and Division of Government Relations staff.

Key Tasks:

1. Work with DBs to identify and define the educational materials most needed to proceed on a local basis regarding parity issues. Some of the needed materials have already been identified, e.g., understanding the enforcement scheme under MHPAEA, and will be disseminated at the October state conference.
2. To prepare other materials needed by the DBs
3. To develop educational opportunities for DBs or other state entities such as in-person meetings or webinar/go-to-meeting events
4. Develop a communications strategy to engage and sustain DB activities on parity with the central office.

Timeline: These activities have been ongoing and there will be scheduled events prior to the May 2016 Annual Meeting. The October 2016 state conference will feature much of these materials.

d) Release of resource document on disclosure and transparency re MHPAEA compliance with model recommendations for state advocates

Background: A fundamental issue regarding MHPAEA compliance and enforcement is the virtual total lack of disclosure by health plans and insurers on details that would permit evaluation of compliance with the statute. Disclosure is essential to transparency, and without real transparency there can be no assurances that plans have a legitimate basis for their assertions of parity compliance. An extensive resource document on disclosure under MHPAEA has been prepared and will be reviewed by the Council. A series of recommendations with model disclosure requests will be prepared for advocates at the state or individual level (should we link or attach the paper?).

Key Persons Involved: The CHSF and OHSF staff and legal consultant.

Key Tasks:

1. Review by Counsel and discussion with staff
2. Approval of recommendations and disclosure templates to be distributed
3. Develop and launch an implementation plan to engage APA affiliates on this important issue.

Timeline: The bulk of the work has already been done and we will target a launch for winter 2016.

4) <u>Development of communications/marketing materials that illustrate psychiatry's value proposition for healthcare reform care delivery and payment initiatives</u>

Background: APA has asserted that psychiatry has a direct value proposition of health reform and the many health systems and payers involved. For example, it has produced the Milliman report (title) which illustrates the extent of the behavioral health problem, its total impact, and psychiatry's potential contribution to ameliorate it. The relevance of psychiatry's value proposition varies from audience to audience. However, we have not effectively communicated this. CHSF will work with the councils on communications and psychosomatic medicine to develop a set of communications/marketing materials and a dissemination strategy.

Key Persons Involved: A subset the OHSF Council has been designated to work with staff and input from the communications, research, and psychosomatic councils will be required.

Key Tasks:

1. CHSF and staff will first survey and inventory the research literature relevant to this as well as materials that have already been developed (such as those from the Academy of Psychosomatic Medicine)
2. Convene a conference call with all necessary parties to develop an appropriate message platform and identify materials for internal and external audiences. This would include materials that would be available to members for use on a local basis.
3. Request that the Council on Communications draft and finalize, with review by CHSF, the needed communications materials
4. Request that the Council on Communications develop a distribution plan for the materials and execute it

Timeline: The target deadline for these materials would be the 2016 Annual Meeting. Consultation with the Division of Communications will commence as soon as practicable and will include specifics of a workplan timeline to achieve the May target deadline.

5) Pharmacy Benefit Management issues

a) Execute a survey of APA members on current PBM issues, produce a background document on current issues and options for APA advocacy

Background: The presence of PBMs is not new but the tremendous increase in micromanagement of pharmacy requests and the associated time burden is. There are many variations in the types of barriers or hurdles PBMs put in place, from securing approval for on or off-label use, to demanding justifications for why step therapy protocols are not in order or why patients who switch plans should be grandfathered on their effective drugs. The volume of complaints coming from members has increased as has the number of action papers from the Assembly on various aspects of this issue. This problem is

not limited to psychiatry. We are aware of many other physician specialties that have voiced similar concerns. The council will explore and potentially recommend a plan of action for resolving this managed care problem.

Key Persons Involved: the Council and OHSF staff.

Key Tasks:

1. Execution of a member survey on a wide variety of PBM issues to enable better definition and identification of what should be considered priority areas. This will also enable better identification of what if any parity issues may be embedded in current practices.
2. Due diligence with other medical associations and the PBM industry to identify potential collaboration and potential points of intervention.
3. The development of a draft action plan for APA for review and consideration by relevant components and governance.
4. Pending consensus on and action plan, implementation of same.

Timeline: We expect to complete tasks 1 and 2 shortly. The survey instrument has been finalized and mechanisms for distribution have been worked out. Explorations with other medical societies and key players in the PBM world will begin this fall.

6) Continued processing of action items referred to the Council with priority attention given to those which fall within the above mentioned categories

CHSF continually receives requests to act on Action Papers and/or Position Statements and other documents. This is an ongoing process and function of the Council. We would note that material triaged to CHSF and timelines assigned should fully consider where a particular matter fits in terms of the APA's priorities.

The Council reviewed several Action Papers referred to it concerning the development of an Access to Care Toolkit. The Council agreed with these Action Papers that such a toolkit would be useful and will begin to develop it with a target date of May 2016. The toolkit will include a compendium of access to care Action Papers and Position Statements as well as an Access to Care Survey, based on one utilized by Area 6, that can be employed by other state associations.

We enthusiastically welcome comment and feedback on all the material submitted here.

Criteria for Evaluating Councils – Council on Healthcare Systems and Financing

1) How many times did the Council meet?
    - 2015: 2 in person; 5 conference calls
    - 2014: 2 in person; 7 conference calls
    - 2013: 2 in person; 4 conference calls

    a) Please provide the attendance at each meeting (data for past year only)
    Sept 2014 (face-to-face); 8 members, 1 consultant 5 absences
    Oct 2014 (call); 7 attendees
    Dec 2014(call); 7 attendees
    Jan 2015 (call); 10 attendees
    Feb 2015 (call); 4 attendees
    April 2015 (call); 13 attendees
    May 2015 (face-to-face); 9 members, 3 fellows attended; 8 absences
    Aug 2015 (call); 11 attendees
    Sept 2015 (face-to-face); 9 members, 2 consultants, 5 fellows and 4 absences

2) Education
    a) What workshops/symposia, etc. have been submitted for presentation at APA Annual Meetings?

        - The CHSF has not presented at the either of the APA meetings for the last several years.

        - The Committee on RBRVS holds a CPT coding and documentation seminar and workshop at every APA Annual Meeting and intermittently at the IPS.

        - Members of the Workgroup on Integrated Care present a large number of workshops and other CME related activities at the APA Annual Meeting and IPS.

    b) What was the attendance at these events and what was the feedback on these events?

        - RBRVS: Both sessions are well attended (seminar fills to capacity each year)

        - Workgroup on Integrated Care: All are well attended (rooms are full)

3) What are the council's current activities and what activities are planned for the coming years?
[See attached workplan]

4) Has work product been sent to the Assembly and the Board of Trustees?
Yes. We have submitted new and revised position statements and reported on issues such as mental health parity, CPT coding and documentation, network adequacy, health reform, reimbursement, collaborative care and so on.

5) What is the Council doing for RFM and ECP members?
As defined by our charge - we are working to foster MH parity, advocating for adequate funding and reimbursement; monitoring and evaluating emerging trends and disseminating information to the membership on developments relating to healthcare systems and financing in an effort to provide a positive and sustainable work environment for the field. We encourage

all Fellows assigned to the Council to participate fully and have tasked individuals to lead specific projects (e.g., liability resource document, workforce document)

6) Evaluate the staff support to the Council and its components
OHSF is a group of high-skilled, outcomes-oriented, and detail-oriented professionals who manage some of the most complex issues that our organization deals with. In light of healthcare reform, passage of mental health parity, new payment models, and a myriad of other significant developments - the number of active work products as well as the complexity of the knowledge-base to successfully maneuver our association and its member has increased multiple-fold. While the sheer volume of work has grown with an increase in the need for more immediate churning of projects to completion - there has not been any increase in staff to support the Council and its components.

Outcome:

- ☐ Continue the component in its current form
- ☐ Recommend changes to the component
- ☐ Discontinue the component

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Workplan

In formulating its workplan for the next 12-18 months the Council considered it essential to fully consider the Strategic Initiatives of the Board issued in March 2015 and the recommendations of the current Board of Trustees Workgroup on Healthcare Reform in its most recent, March 2015, report. The council also requested input from staff as to pertinent developments that fall within the foregoing.

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Key Persons Involved: The key actors involved include the members of CHSF and the Council on Psychosomatic Medicine, and input will be requested from other councils as well. Key administrative personnel are within OHSF.

Key Tasks:

1. To immediately begin drafting a position statement that articulates APA principles with input from other key stakeholders within the APA.
2. Secure JRC approval to begin to process this through governance quickly for eventual final approval of an APA Position Statement.

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We respectfully ask that consideration be given to how to expedite this process, and would reference remarks made by various Board Health Reform Work Groups that have noted that the APA governance structure may need to develop a rapid response mechanism for certain APA actions. In our opinion, the need for this position statement falls within this category of rapid response.

b) Development of specific coding and valuation amounts for the evidence based collaborative care model for persons with behavioral conditions in primary care settings to enable sustainable reimbursement

Background: The problem of access to psychiatric services in primary care settings has been well documented. Care models to improve access in primary care settings have been developed and tested over time. The most prominent evidence-based collaborative care model is the one that the AIMS Center at the University of Washington has stewarded over time. The key barrier to the proliferation of the model has been payment for the essential functions of the model. CMS announced in July 2015 that it intends to move to coverage of, or further demonstration of, this evidence based model, and specifically intends to address how to appropriately reimburse for it. The Council will work to develop and advocate for a specific coding proposal with CMS. This will be done primarily through the Committee on RBRVS, Codes, and Reimbursement.

Key Persons Involved: A subset of the Council has been designated to work with the Committee on RBRVS and OHSF staff to shepherd this through. We anticipate that the Councils on Psychosomatic Medicine, Quality and the Council on Geriatric Psychiatry will be key contributors, along with their respective staff, as will other APA member experts and consultants we have already engaged for this. We will also be working extensively with other medical associations who either support or have a direct interest in facilitating payment for this type of care delivery model. CMS, AMA CPT and AMA RUC will primary throughout the entire process.

Key Tasks: There are many, many decision points in the following tasks that cannot be specified at this time.

1. Key CPT and RUC representatives will be assessing our options for playing this through given the many stakeholders involved.
2. Designation of a workgroup to begin to draft the required specifications for code development for CPT.

3. Convening a teleconference with APA experts for other medical specialties to explain the model and its requirements.
4. Convening meetings with CMS to provide additional information to the comments APA submitted Sept 2015 on CMS request for information.
5. Developing the content and strategy for when a proposal is submitted to CPT and/or the development of a G code by CMS. This may require two concurrent paths of actions with CPT and CMS.
6. Key tasks that follow from point 5 can only be delineated once we have a more defined pathway which should emerge by December 2015.

Timeline: The foregoing will occur over the next 18 to 24 months. The timelines that the AMA CPT and RUC work on and that of CMS are complex with respect to completion dates for codes to be considered for Medicare rule-making. However, CMS's announced target for coverage is January 2017. It should be noted that target does not mean that we will not be involved with CPT and RUC after that deadline for refinements in evaluation of the eventual codes.

c) Convening an expert workgroup of psychiatrists involved in new care models, e.g. ACOs and health homes (and working with public and private payers around issues for psychiatry in the new care models)

Background: Accountable Care Organizations (ACOs), medical and health homes, and efforts by CMHCs to secure better access for physical health services for the SMI population permeate the landscape. There are stellar examples of achievement--e.g., the Montefiore Pioneer ACO--where the successful integration of treating individuals with behavioral conditions has led to overall success. There are also examples in the health home world where sophisticated approaches to treating behavioral conditions in primary care settings have been successful. There are also a number of CMHC efforts that have been successful. However, the overall penetration of psychiatry in these models has been highly variable as documented in the literature. There is a need to draw on the experience of psychiatrists who have been involved to understand the elements necessary for success and barriers to successful integration. There is also a need to better understand the payer perspective on barriers to the implementation of better care models for behavioral conditions.

Key Persons Involved: The key persons involved will be a designated group of the Council who have had experience with these models, OHSF staff, and experts from the Council on Psychosomatic Medicine.

Key Tasks:

1. Develop an outreach plan throughout the existing APA structure, including the Assembly, to identify psychiatrists who are involved in these alternative arrangements.
2. Establish an outreach effort with commercial and public payers to begin discussions. Note that a meeting has already been had with Aetna.
3. Identify existing APA meetings (e.g., area council meetings, the annual meeting and IPS) to convene forums on these issues.

Timeline: The plan to identify individuals involved and/or interested parties should be developed by December 2015. It should be noted that the APA has received notice that it is the recipient of a major Support Availability Network (SAN) grant from CMS. The general purpose of this grant is to provide education for psychiatrists working in collaborative care situations as well as to bring training opportunities to primary care practices. We think this will be a major vehicle to identify and coalesce the

community of psychiatrists involved or interested in these models and to conduct important outreach with the primary care and payer communities.. The timeline for a potential working group summit for psychiatrists and payers would be spring 2016.

2) Coding and Payment Issues (separate from those for the CoCM model)

a)Working to enable payment for the interprofessional consultation codes and/or the possible development of new EM add-on codes for cognitive work, new or revised care coordination codes for all physician specialties and improvement in coverage for telepsychiatry.

Background: Independent of a specific coding proposal for the CoCM model noted above , there are a number of coding issues that are relevant for all physician specialties in the new healthcare delivery environment. Psychiatry has specific interest in the development of any of these new codes as well as payment for existing codes. We think there are special issues that need to be addressed to expand coverage and payment for telepsychiatry. CHSF, through the Committee on RBRVS, Codes and Reimbursement and with input from the BOT Workgroup on Telepsychiatry, will be actively working on each of these as agenda items.
Key Persons Involved: A designated subgroup of the Council and its Committee on RBRVS will be the primary responsible parties. We anticipate close collaboration with the Council on Psychosomatic Medicine and the Council on Geriatric Psychiatry and working with the BOT Workgroup on Telepsychiatry. Obviously, the key stakeholders of interest include the AMA CPT and RUC and CMS. Other than specific advocacy around telepsychiatry, we anticipate that most of the key work will be done conjointly with relevant coalitions. That is, no one party will carry the day on these issues with CPT, RUC, or CMS.

Tasks:

1. To monitor strategies along with other medical groups to persuade CMS to pay for the existing interprofessional consultation codes (CPT XXXXX to XXXXX).
2. To continue and ensure psychiatry's participation with key coalition groups that have emerged to expand recognition for essential cognitive work and care collaboration and potential new add on codes to the EM CPT codes.
3. Work with the BOT workgroup on telepsychiatry to identify key coverage and payment issues for telepsychiatry and develop an advocacy agenda based on them.

Timeline: Activities around this have already commenced and given prior experience we expect that they will continue actively throughout the next 12 to 18 months.

b) Production of a background paper on the feasibility of alternative payment models for psychiatric/SUD care across all levels of care and payers

Background: Numerous proposals (e.g., value-based payment, bundled payment, episodes of care, and so on) are emerging from both public and private payers as alternatives to fee for service. The feasibility of these alternatives for psychiatric care has not been systematically reviewed. There are many technical issues involved in alternative payment methods (e.g., the cost basis for the unit of payment, however defined; how it is risk adjusted for case mix; how to define the beginning and end points for what triggers an end to an episode and payment for same; and so on). The long-standing APA experience with prospective payment for inpatient care under Medicare, for instance, bears out that this is an extremely complex task. There are also distinct subset issue with other specialty APMs with respect to

how psychiatry should be included for essential consultation functions. Before proceeding to specific proposals the Council thinks it is essential that the APA fully analyze the issues. Even if a way to design an alternative payment model(s) (APM) for psychiatry cannot be found, this effort will assist in defining why these approaches are not appropriate, which may prove to be important in itself in advocating with payers as to how to appropriately deal with psychiatric care. Note that the development of APMs under Medicare is in some respects a special case because of to be stipulated CMS criteria and will be included in the initial work.

Key Persons Involved: The Council will designate a subgroup to work with OHSF staff to identify additional expertise needed to work with APA that does not reside within the Council. This may include outside help from economists, academicians in the services research area, and potential APA member experts who have experience with this issue. We will explore with the APA's Offices of Research and Quality several important roles for them to play in this process.

Key Tasks:

1. Assemble a group with the requisite expertise to begin to develop the necessary background paper/resource document.
2. Convene the group to begin to identify the essential review and analysis tasks that need to be undertaken to produce a definitive paper/resource document
3. Implement and coordinate the development of the document.
4. Ongoing collaboration with other medical associations regarding Medicare APMs.

Timeline: W**e** will begin exploring establishment of this group in October and develop an appropriate timetable to produce the needed resource document. At a minimum, in order to be timely with Medicare's objectives, we believe we need a resource paper/document by spring of 2016.

c) Optimizing payment for psychiatry under the new MIPS formula for Medicare (which cuts across quality, education, and HIT especially) including establishing appropriate exemption thresholds for practicing psychiatrists.

Background: SGR reform (i.e., MACRA) has reconfigured how much physicians will be paid or not paid depending upon how they interact with the various programs and alternative options established under the reform legislation. There are four potential paths that psychiatrists can occupy under MACRA, with each having different physician reporting, risk taking, and bonus/penalty implications. Psychiatrists can choose to:

1. Opt out of Medicare entirely;
2. Participate through the to-be-established MIPS payment formula;
3. Participate and be part of an alternative payment method and potentially be exempt from the MIPS payment formula; or
4. They can participate and be exempt from the MIPS payment formula if they fall under yet-to-be-established low-volume thresholds that exempt physicians from MIPS.

Key Persons Involved: The key persons involved will be the Councils on HSF and Quality. Internally, key administration will include OHSF, the Office of Quality, and potentially the Office of Research

Tasks:

1. Develop materials that fully explain options and implications for APA members;

2. Develop proposals that make it feasible for psychiatrists to meaningfully participate in the MIPS formula (this includes quality measures, meaningful use, and recognized clinical practice improvement activities and appropriate patient attribution methodology) and advocate for same with CMS;
3. Develop a background paper and work with other appropriate medical professional societies to explore the feasibility of an APM for psychiatry consistent with the yet to be developed criteria from CMS; and
4. Develop a specific low-volume threshold exemption for psychiatrist participating in Medicare.

Timeline: A timeline for this will be more fully mapped out once CMS has provided more clarity about its own timeline for development of essential regulations in this arena.

3) Mental health /SUD parity

MHPAEA took more than a decade to come to fruition. It is a complex and not well understood statute and regulations. Currently all individual DBs and State Associations are dealing with MHPAEA issues on their own. APA deals with member issues directly with insurance plans and with the federal government and brings in DBs when possible. It is a patchwork approach that is not strategic.
To successfully implement MHPAEA and obtain payment parity for psychiatrists, which is essential before healthcare reform payment models take hold, APA needs a coordinated and multipronged strategy that continues to demonstrate its strength in the area and mobilizes district branches to work together. APA's credibility and ability to succeed, particularly with the more recalcitrant insurance companies, depends on its ability to join forces in a coordinated fashion nationwide. Key elements of where we are headed are described below.

a) Continuation of current plan of action to secure network adequacy and reimbursement equity for psychiatry

Background: Under MHPAEA network adequacy and reimbursement parity are closely related non-quantitative treatment limitations (NQTLs). It is critical for the APA to successfully engage employers as purchaser and regulators as enforcers to move on the issue of network adequacy for psychiatrists, which is a well-documented problem. There have been many ongoing activities by OHSF staff in conjunction with the APA's General Counsel to pursue this, and there are indications that there is a beginning understanding by purchasers and regulators that network inadequacy is a parity violation. Moreover payment equity is fundamental to this. [Mention Parity and Medicaid Managed Care and Exchange Plans]

Key Persons Involved: CHSF has a working subgroup, and OHSF staff work closely with the APA's General Counsel, the Partnership for Workplace Mental Health, and DGR.

Key Tasks:

1. Building on the current workplan, we need to finalize a letter, which has been prepared, that will go from the New England Business Group on Health to numerous major insurers requesting specific data and documentation about the status of their psychiatric networks.
2. District Branches need to be educated on the issues and provided with the tools needed to address network adequacy at the state level with legislators and regulators. A series of materials are being finalized to be presented at the state legislative conference in October in Florida. A plan for follow-up with the District Branches will be executed at this meeting.

3. Other outreach efforts on network the adequacy issue as a parity problem need to be made to state insurance commissioners, attorney generals, and others.
4. Develop an appropriate internal and external communications plan around thes issues.

Timeline: these efforts have been ongoing and will continue aggressively over the next twelve months.

b) Development of education/action materials for APA state affiliates to identify and act on parity issues under health plans

Background: Many district branches have indicated a desire to move forward on mental health parity issues, but some do not understand the intricacies of the statutes, the enforcement scheme, or the insurance industry. There is need for a coordinated strategy between the APA and its DBs regarding dealing with all relevant stakeholders around the parity issue. The enforcement authorities and the insurance industry do not distinguish the APA from its district branches and our credibility is tied together.

Key Persons Involved: CHSF, OHSF staff, APA General Counsel, and Division of Government Relations staff.

Key Tasks:

1. Work with DBs to identify and define the educational materials most needed to proceed on a local basis regarding parity issues. Some of the needed materials have already been identified, e.g., understanding the enforcement scheme under MHPAEA, and will be disseminated at the October state conference.
2. To prepare other materials needed by the DBs
3. To develop educational opportunities for DBs or other state entities such as in-person meetings or webinar/go-to-meeting events
4. Develop a communications strategy to engage and sustain DB activities on parity with the central office.

Timeline: These activities have been ongoing and there will be scheduled events prior to the May 2016 Annual Meeting. The October 2016 state conference will feature much of these materials.

d) Release of resource document on disclosure and transparency re MHPAEA compliance with model recommendations for state advocates

Background: A fundamental issue regarding MHPAEA compliance and enforcement is the virtual total lack of disclosure by health plans and insurers on details that would permit evaluation of compliance with the statute. Disclosure is essential to transparency, and without real transparency there can be no assurances that plans have a legitimate basis for their assertions of parity compliance. An extensive resource document on disclosure under MHPAEA has been prepared and will be reviewed by the Council. A series of recommendations with model disclosure requests will be prepared for advocates at the state or individual level (should we link or attach the paper?).

Key Persons Involved: The CHSF and OHSF staff and legal consultant.

Key Tasks:

1. Review by Counsel and discussion with staff
2. Approval of recommendations and disclosure templates to be distributed
3. Develop and launch an implementation plan to engage APA affiliates on this important issue.

Timeline: The bulk of the work has already been done and we will target a launch for winter 2016.

4) <u>Development of communications/marketing materials that illustrate psychiatry's value proposition for healthcare reform care delivery and payment initiatives</u>

Background: APA has asserted that psychiatry has a direct value proposition of health reform and the many health systems and payers involved. For example, it has produced the Milliman report (title) which illustrates the extent of the behavioral health problem, its total impact, and psychiatry's potential contribution to ameliorate it. The relevance of psychiatry's value proposition varies from audience to audience. However, we have not effectively communicated this. CHSF will work with the councils on communications and psychosomatic medicine to develop a set of communications/marketing materials and a dissemination strategy.

Key Persons Involved: A subset the OHSF Council has been designated to work with staff and input from the communications, research, and psychosomatic councils will be required.

Key Tasks:

1. CHSF and staff will first survey and inventory the research literature relevant to this as well as materials that have already been developed (such as those from the Academy of Psychosomatic Medicine)
2. Convene a conference call with all necessary parties to develop an appropriate message platform and identify materials for internal and external audiences. This would include materials that would be available to members for use on a local basis.
3. Request that the Council on Communications draft and finalize, with review by CHSF, the needed communications materials
4. Request that the Council on Communications develop a distribution plan for the materials and execute it

Timeline: The target deadline for these materials would be the 2016 Annual Meeting. Consultation with the Division of Communications will commence as soon as practicable and will include specifics of a workplan timeline to achieve the May target deadline.

5) Pharmacy Benefit Management issues

a) Execute a survey of APA members on current PBM issues, produce a background document on current issues and options for APA advocacy

Background: The presence of PBMs is not new but the tremendous increase in micromanagement of pharmacy requests and the associated time burden is. There are many variations in the types of barriers or hurdles PBMs put in place, from securing approval for on or off-label use, to demanding justifications for why step therapy protocols are not in order or why patients who switch plans should be grandfathered on their effective drugs. The volume of complaints coming from members has increased

as has the number of action papers from the Assembly on various aspects of this issue. This problem is not limited to psychiatry. We are aware of many other physician specialties that have voiced similar concerns. The council will explore and potentially recommend a plan of action for resolving this managed care problem.

Key Persons Involved: the Council and OHSF staff.

Key Tasks:

1. Execution of a member survey on a wide variety of PBM issues to enable better definition and identification of what should be considered priority areas. This will also enable better identification of what if any parity issues may be embedded in current practices.
2. Due diligence with other medical associations and the PBM industry to identify potential collaboration and potential points of intervention.
3. The development of a draft action plan for APA for review and consideration by relevant components and governance.
4. Pending consensus on and action plan, implementation of same.

Timeline: We expect to complete tasks 1 and 2 shortly. The survey instrument has been finalized and mechanisms for distribution have been worked out. Explorations with other medical societies and key players in the PBM world will begin this fall.

6) Continued processing of action items referred to the Council with priority attention given to those which fall within the above mentioned categories

CHSF continually receives requests to act on Action Papers and/or Position Statements and other documents. This is an ongoing process and function of the Council. We would note that material triaged to CHSF and timelines assigned should fully consider where a particular matter fits in terms of the APA's priorities.

The Council reviewed several Action Papers referred to it concerning the development of an Access to Care Toolkit. The Council agreed with these Action Papers that such a toolkit would be useful and will begin to develop it with a target date of May 2016. The toolkit will include a compendium of access to care Action Papers and Position Statements as well as an Access to Care Survey, based on one utilized by Area 6, that can be employed by other state associations.

We enthusiastically welcome comment and feedback on all the material submitted here.

Item #8.A
Joint Reference Committee
October 17, 2015

Executive Summary
Council on Addiction Psychiatry

Action Items:

- Will the Joint Reference Committee recommend that the Assembly and Board of Trustees approve **The Position Statement on Integrating Opioid Use Disorders Treatment With Buprenorphine And Naltrexone With That Of Co-Occurring Mental Illnesses? - Attachment #1**

- Will the Joint Reference Committee recommend that the Assembly and Board of Trustees approve **The Position Statement on Assuring the Appropriate Care of Pregnant and Newly Delivered Women with Substance Use Disorder – Attachment #2**

- Will the Joint Reference Committee recommend that the Assembly and Board of Trustees approve **The Position Statement on Equitable Access to Quality Medical Care for Persons with Substance Related Disorders – Attachment #3**

Information Item:

- NIDA has provided APA a contract to identify and assess the scope and quality of existing open-source SUD curriculum; design and implement mechanisms to make the curriculum available to all residency training programs; execute a communications plan aimed toward chairs of departments of psychiatry and residency training directors; identify gaps in the existing curriculum; with the goal of developing curriculum to address them in a future initiative; and develop and implement mechanisms to evaluate the project. This project will be undertaken collaboratively by the Council on Addiction Psychiatry and the Council on Medical Education and Lifelong Learning, with representation from other organizations (e.g., ACGME, RRC, AADPRT, AAAP).

Referral Updates

- The Council revised the Position Statement on Tobacco Use Disorder as suggested by the JRC in July. It was resubmitted to the JRC for referral to the Assembly on September 1.

- As suggested by the JRC, the Council provided the proposed Position Statement on Treatment of Substance Use Disorders in the Criminal Justice System to the Council on Quality Care for its review and input. The CQC recommendations were incorporated into the statement and it was resubmitted to the JRC on September 1.

Minutes
Council on Addiction Psychiatry
September 11, 2015
9 a.m. – 5 p.m.
Hilton Crystal City Hotel
Arlington, VA

Attendance: Drs. Frances Levin, (chair), John Renner, (vice chair), Oscar Bukstein, Smita Das, Jeffrey DeVido, Karen Drexler, Robert Feder, Shelly Greenfield, Kevin Hill, Annette Matthews, Jill Williams, Petros Levounis, Andrew Saxon, Leslie Marino, Hector Colon-Rivera, Peolia Fonsworth, Patrice Malone, Elie Aoun, and Marek Hirsch
Absent: Edward Nunes, MD
Guests: Renee Binder, MD; Mitra Ahadpour, MD (SAMHSA/CSAT); Wilson Compton, MD (NIDA); Saul Levin, MD; Raye Litten, PhD (NIAAA); Robert Lubran (SAMHSA/CSAT); and Jay Shore, MD
Staff: Beatrice Eld

1. Meeting with Renee Binder, APA President

Dr. Binder complemented the Council on its impressive record of producing excellent and useful products, tackling difficult issues, and obtaining outside funding. She encouraged the group to continue its productivity and also encouraged the Resident Fellow Members assigned to the council to fully engage in the group's initiatives and take full advantage of the mentorship that is offered. Dr. Binder also reviewed the process of reviewing and providing input on Assembly Action Papers.

2. Role of Resident Fellows on the Council

Dr. Levin asked each fellow to describe their interests and what they hope to gain from their participation. She encouraged them to become fully integrated in the Council's work and seek the mentorship of Council members. The goal is that each resident will have an identified project to work on in the coming months.

3. Position Statements

Several position statements were reviewed and approved by the Council.

On motion, the Council on Addiction Psychiatry approved and forwarded for JRC, Assembly, and Board of Trustees approval the following:

- Will the Joint Reference Committee recommend that the Assembly and Board of Trustees approve **The Position Statement on Integrating Opioid Use Disorders Treatment With Buprenorphine And Naltrexone With That Of Co-Occurring Mental Illnesses?**

- Will the Joint Reference Committee recommend that the Assembly and Board of Trustees approve **The Position Statement on Assuring the Appropriate Care of Pregnant and Newly Delivered Women with Substance Use Disorder**

- Will the Joint Reference Committee recommend that the Assembly and Board of Trustees approve **The Position Statement on Equitable Access to Quality Medical Care for Persons with Substance Related Disorders**

Work on the Position on Adolescent Substance Abuse continues. Following insertion of several Council-recommended edits, the statement will be shared with the Council on Children, Adolescents, and Their Facilities for review and comment.

4. Substance Abuse Curriculum for General Psychiatry Programs

NIDA has provided APA a contract to identify and assess the scope and quality of existing open-source SUD curriculum; design and implement mechanisms to make the curriculum available to all residency training programs; execute a communications plan aimed toward chairs of departments of psychiatry and residency training directors; identify gaps in the existing curriculum; with the goal of developing curriculum to address them in a future initiative; and develop and implement mechanisms to evaluate the project.

This project will be undertaken collaboratively by the Council on Addiction Psychiatry and the Council on Medical Education and Lifelong Learning, with representation from other organizations (e.g., ACGME, RRC, AADPRT, AAAP).

Dr. Levin consulted with Drs. Melissa Arbuckle about her work to develop the national neuroscience curriculum. One of the topics was the possible development of a network of champions of senior residents and early career psychiatrists who would be scholars and develop training modules, meet frequently as a group, attend meetings of pertinent associations, etc. Champions facilitate positive change. Council members mentioned that the Alcohol Medical Scholars Program is an example of that approach. They also suggested that it may be worth considering looking at the PRITE results to inform this project.

Resident Fellow Members who expressed interest in participating in this effort include Elie Aoun, Leslie Marino, and Patrice Malone.

5. Developing an Advocacy Agenda

The Council was asked to have a wide-ranging discussion of policies that inhibit quality SUD care, as well as policies that may facilitate it. Members suggested the APA focus greater attention on the following:

- Reducing the barriers to people accessing evidence-based treatment for substance use disorders, including the full range of medication assisted treatment
- Adequate reimbursement for substance abuse treatment
- Expanding access to SUD treatment, particularly opioid use disorder
- Address the excessive preauthorization requirements for buprenorphine, which is oftentimes every 3 months
- Increase interactions with policymakers and others who are considering changes to the prescribing limits in DATA 2000.

- Prescription Drug Monitoring Programs – encouraging systems (or preferably one national system) that are efficient and fully integrated in electronic records and populate the medication list. In some states, there is a $50 surcharge to physicians to use the PDMP. The charge is connected to licensure.
- Increase workforce, including loan repayment for research, addiction training, and practice in areas of greatest need
- Confidentiality regulations – 42CFR-Part 2
- Public relations initiatives focused on topics such as "Treatment Works", including the effectiveness of buprenorphine and methadone treatment. It is too common to see people advocate for abstinence-only treatment, but very few, if any, who speak about the effectiveness of medication assisted treatment.
- Cannabis and how it will play out on the State and National levels. There is a great deal of misinformation in the country about the risks of marijuana use, particularly by adolescents
- Funding for inpatient treatment (There are no inpatient treatment programs in New Hampshire because insurance no longer covers it. We need to make the strong case that it is absolutely necessary in some cases.)
- Needle Exchange Programs
- Advocating that VA campuses be smoke free (current law stipulates that smoking shelters must be made available)
- Collaborate with Community Anti-Drug Coalitions of America (CADCA)
- Collaborate with the National Association of Drug Court Professionals and the Veterans Justice Outreach

6. Meeting with Saul Levin, MD - CEO and Medical Director

Dr. Levin addressed the opioid epidemic and thanked the Council for its work in addressing it.

- Physician Health Programs

Dr. Levin asked the Council to undertake work related to Physicians Health Programs. APA members have expressed concern that physicians are not receiving due process and asked APA to undertake a review of the programs. Allegations were made that the procedures in many of these programs are of inferior quality.

Since so many of the physicians referred to these programs have a substance use disorder, Dr. Levin asked the Council to develop a white paper on this, in collaboration with the Council on Psychiatry and Law. Some of the issues that might be addressed include lack of due process, very long stays in residential care, variations in State policies that provide or restrict access to buprenorphine, etc.

Jeff DeVido and Marek Hirsh volunteered to work on this project. Shelly Greenfield and others will send them names of addiction psychiatrists who run physician health programs.

- Advising Presidential Campaigns

Council members were encouraged to help APA engage with the various Presidential campaigns to advise them on SUD issues. An example of this is the issue paper released by Hilary Clinton's campaign

that addressed expanding access to medication assisted treatment and recommended lifting the patient limits on buprenorphine treatment. Dr. Levin believes that addiction issues will be very prominent in the upcoming elections and it would benefit all of us if the major addiction organizations can speak with one voice.

It was suggested that the Presidents of the organizations meet routinely to discuss current and emerging issues and attempt to reach a consensus on them. Dr. Saul Levin will pursue that suggestion.

- Philip Wang, MD – Director, Division of Research

Dr. Wang recently joined the APA and spoke with the Council about his plans and expectations for future work and collaborations.

7. AMA Task Force to Reduce Opioid Abuse

John Renner reported on his APA representation on AMA's Task Force. The group is comprised of more than 25 state, specialty and other health care associations participate in an effort to address the inappropriate prescribing of opioids, and the growing crisis of heroin overdose and death. The Task Force is chaired by AMA Chair-elect, Patrice A. Harris, MD, a prominent APA member and a former member of the APA Board of Trustees.

The goals of the Task Force are:

- Increase physicians' use of effective Prescription Drug Monitoring Programs (PDMPs).
- Enhance physicians' education on effective, evidence-based prescribing.
- Reduce the stigma of pain and promote comprehensive assessment and treatment.
- Reduce the stigma of substance use disorder and enhance access to treatment.
- Expand access to naloxone in the community and through co-prescribing.

A series of public messages are being developed which will be widely distributed by each of the member organizations.

8. Action Paper Review: Strengthening the Role of Residency Training to Improve Access to Buprenorphine

Elie Aoun, MD discussed the paper, which is a revision of a previous one that focused on expanding access to buprenorphine treatment. The background section has been updated and narrowed to one actionable item. It asks that the APA liaise with ACGME/Residency Review Committee to integrate buprenorphine training during general adult psychiatric residency training.

Dr. Renner believes that the timing for this paper is better now than it was last year. There is a national epidemic and psychiatry has a responsibility to determine its role in addressing it. There is also great interest in Congress in expanding access.

The PCSS-MAT's free resident buprenorphine training program has been integrated in many training programs and it should be in all programs. It would be useful to develop a comprehensive description of the variety of ways the training can be incorporated in residency training and distribute it to all accredited programs, as well as at the meeting of the American Association of Directors of Psychiatry Residency Training (AADPRT). Dr. Renner suggested that the Council's RFMs take this on as a project

9. Workgroup on Tobacco Use Disorder

Andy Saxon, MD, vice chair of the workgroup, provided a comprehensive overview of the initiative and its progress to date. The initial phase of the work was funded by a grant from the Robert Wood Johnson Foundation's Smoking Cessation Leadership Center. An in-person meeting was convened in May at which great progress was made in developing a strategic plan for the Association. Additionally, the group (1) developed a position statement on Tobacco Use Disorder, (2) presented a workshop at the APA Annual Meeting, (3) organized and presented a webinar, Update on Treatment of Tobacco Use Disorder, and (4) fielded a pilot survey of APA members to assess current practice.
The strategic plan includes the following goals:

- Improve education and training of psychiatrists
- Improve and expand current clinical practices in treating TUD
- Enhance the APA's leadership and sustained commitment to this topic

The group intends to develop a champions program which will identify a network of respected peers in local areas to encourage a new approach to practice. Dr. Saxon asked each Council member to recruit a champion and also encourage their District Branch and/or State Association to include Tobacco Use Disorder sessions in their training programs. The Workgroup will also submit one or more session proposals for the 2016 APA Annual Meeting.

The Position Statement on Tobacco Use Disorder was developed and forwarded to the Joint Reference Committee in July 2015. The JRC asked for minor wording changes to be incorporated. The edited statement was subsequently submitted for review and action by the Assembly at their November 2015 meeting. Dr. Annette Mathews, representative of the Assembly on the Council, volunteered to be fully involved in the Assembly's consideration of the Position Statement and advocate for its approval.
If approved, the Board of Trustees will take final action to approve the statement at their December 2015 meeting.

Members discussed reimbursement of TUD treatment services and endorsed the tactics included in the strategic plan, among them to encourage increased utilization of existing reimbursement mechanisms for TUD counseling, explore mechanisms for reimbursement for biomarker assessment and monitoring (e.g. CO meters), and identify and work to resolve barriers to reimbursement. Dr. Feder suggested the addition of another bullet under Strategy 2.1 to address improving the reimbursement rate for pharmacological treatment. He observed that private insurance companies do not cover pharmacologic treatment. Dr. Jill Williams noted that the Affordable Care Act requires coverage, but noted that Medicaid coverage is very poor. She also noted that SAMHSA excludes coverage of TUD in block grants.

The pilot survey was distributed to about 100 members and the response rate was disappointing, even with an incentive being offered.

10. National Institute on Drug Abuse – Wilson Compton, MD

NIDA's Deputy Director. Wilson Compton, MD, provided an update on major Institute activities, including:

- Legislation is pending in the Senate regarding neonatal abstinence syndrome. It asks AHQR to develop new approaches to evaluating and treating opioid issues for pregnant women and their offspring. It has already passed in the House and is likely to pass the Senate.
- New household survey data was recently released showing a dramatic increase in heroin use in the past year.
- Marijuana rates increased in the past year from 7.2% to 8.4% in the age 12 and up population. The increase is driven by adults.
- NIDA is in the process of launching a large scale longitudinal study of substance use in adolescents, The Adolescent Behavioral and Cognitive Development (ABCD) study. Notices of award will be sent shortly. This is a collaborative effort by seven Institutes. It will study 10,000 youth (ages 9 and 10) prior to exposure to substances. The goal is to do neuroimaging and thorough biopsychosocial evaluation at baseline and periodically across adolescence to look at single and conjoint influences of alcohol, tobacco, and illicit substances on brain development.
- NIDA will sponsor the research track at the 2016 APA Annual Meeting. Sessions will include topics on tobacco use, comorbidity, chronic pain, adolescents, prescription drugs, biologics, treatment and overdose interventions, marijuana, and the opioid epidemic.

11. National Institute on Alcohol Abuse and Alcoholism (NIAAA) – Raye Litten, Ph.D.

Dr. Litten provided the Council a comprehensive overview of medication development initiatives at the Institute, including the launch of a new Division of Medication Development on October 1. He also discussed efforts regarding implementation science.

12. Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment – Robert Luban and Mitra Ahadpour, MD

Mr. Lubran introduced Dr. Ahadpour who recently joined CSAT as a medical director.

In March, the Secretary of HHS announced the Administration's opioid initiative, which has two major goals: reducing deaths from opioid overdose and decreasing the prevalence of opioid use disorders. Three priority areas are prescribing practices and prescriber behavior, overdose prevention, and expansion of medication assisted treatment to reduce OUD and overdose. SAMHSA has a role in all three areas, but is most prominently involved in the expansion of MAT.

Mr. Lubran discussed:

- Development of practice guidelines by the Center for Disease Control, which will be released in March 2016.

- Teaching medical professionals how/when to prescribe opioids by working with lawmakers on bi-partisan legislation requiring specific training for opioid prescribing using the CDC guidelines. There has been ongoing discussion of linking DEA registration to ongoing physician training.
- Prescription Drug Monitoring Programs (PDMPs) – supporting data sharing across and within states through EHRs. SAMHSA has funded a number of states to develop new techniques, e.g., Kroeger Pharmacies have integrated PDMP data in their EHRs.
- There is support for development of new Naloxone products. At least two companies have submitted applications to the FDA that are likely to be approved in coming months.
- The President's budget has a $12 million grant program for States to expand the use of Naloxone. HRSA also has a grant program for rural areas
- SAMHSA received additional funding to expand MAT in states that have high rates of OUD. Eleven states received awards. A total of $25 million will be available.
- Exploring bipartisan policy changes to increase use of buprenorphine. Researchers at Portland State University have developed predictive models of various possible policy approaches. The Secretary of HHS has the authority to make changes in the prescriber limits.
- A demonstration project that would permit physician extenders to prescribe buprenorphine is under consideration.
- SAMHSA is working closely with HHS Assistant Secretary of Planning and Evaluation on these issues. He has created a very specific action plan.
- ONDCP will sponsor a symposium aimed at increasing addiction medicine fellowships

13. Report of the Veterans' Healthcare Administration

Karen Drexler, MD provided a comprehensive overview of VHA initiatives and metrics. Timely appointments continue to be an area for additional improvement. The Veterans Choice Program allows veterans who live more than 40 miles from a VA facility or have to wait more than 30 days to be treated can access care in their local community. Vendors who manage it are Healthnet and TriWest. Psychiatrists interested in providing care through this program can access information at http://www.va.gov/opa/choiceact/for_providers.asp

Dr. Drexler also discussed prevalence rates of opioid use disorder and cannabis use disorder in the veteran patients, and announced that VA's Practice Guideline on SUD will be released for comment soon. They are working with State Prescription Drug Monitoring Programs. VA providers are asked to report to the programs, though it is not mandatory. They have distributed over 7,000 naloxone rescue kits to patients with Opioid Use Disorder and those who are chronic pain patients.

14. Subspecialty Certification

Council discussed correspondence from Dr. Larry Faulkner, which reviewed the current ABPN policy that psychiatrists with certification in a subspecialty (other than child and adolescent) must also maintain certification in their specialty, in order to maintain their subspecialty certification.

It was the consensus of the Council that general psychiatry is the underpinning of the subspecialty and addiction psychiatrists should continue to take the general psychiatry exam. Further they agreed that those who are not grandfathered should be given the option of taking a combination exam and it should apply to child psychiatry, as well as the other subspecialties.

15. Telemedicine – Jay Shore, MD

Dr. Shore visited with the Council and provided an overview of the Workgroup on Telepsychiatry. Council is very interested in the initiative and discussed its potential in expanding access to buprenorphine treatment. Issues of prescribing controlled substances via telepsychiatry were also discussed.

Attachment #1

Position Statement
American Psychiatric Association

TITLE: Integrating Opioid Use Disorders treatment with Buprenorphine and naltrexone with that of co-occurring mental illnesses

Issue: The prevalence of Opioid Use Disorders (OUD) and the mortality from opioid overdoses continue to increase significantly in the United States. Buprenorphine is an approved and effective treatments for OUD with special licensing requirements for the provider that is considering prescribing it. Regional disparities in the supply of credentialing to providers may impede access to care for many patients with OUD. Patients with substance use disorders are twice as likely to suffer from a co-occurring mental illness as those without it and opioid use disorders are nine times more prevalent among patients with psychiatric comorbidities. While mental health comorbidities are associated with poorer outcomes, integrated treatment models have demonstrated improved quality of life, reduce illicit opioid use, notable improvements in comorbidities, crime, and health cost. Recent and continuing changes in the healthcare policy and cost prioritize the integration of evidence-based substance use disorders treatments into general medical settings.

For patients, access to treatment with buprenorphine is complicated due to the scarcity of buprenorphine waivered providers, low supply of opioid treatment programs and the fact that general psychiatrists frequently opt out of Buprenorphine treatment. In such cases, patients are often referred out to costly "addiction providers" who typically offer medications with little or no wrap around services or no treatment at all for co-occurring mental disorders.

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

1. The diagnosis and treatment of OUD are essential parts of psychiatric care. Patients with identified OUD should be educated about the condition and offered appropriate treatment;
2. The integration of care for OUD and co-occurring mental illnesses leads to improved patient care outcomes and should be practiced by general psychiatrists whenever possible;
3. Psychiatrist should be familiar with treatment options for OUD, manage non-complicated patients with OUD and seek consultation or referral with an addiction specialist for complicated cases;
4. Psychiatrists should train in Buprenorphine prescribing and be encouraged to complete the additional licensing requirements to prescribe it;
5. In rural areas, consultation services with psychiatrists and addiction specialists be made available via telemedicine service to assist the local providers in treating complicated cases.

Authors: Elie Aoun, MD, Hector Colon-Rivera, MD, John A. Renner, MD on behalf of the Council on Addiction Psychiatry

Background:

Over the past two decades, the prevalence of Opioid Use Disorders (OUD) has increased significantly in the United States (Bup 8). While it is true that rates of heroin use have increased in many parts of the country, the most noteworthy factor driving these numbers is the dependence on narcotic pain medications (Bup 8:4-9). According the Substance Abuse and Mental Health Services Administration (SAMHSA) 2013 national survey on drug use and health, 4.5 million Americans (1.7% of those older than 12 years old) were non-medical users of opioid pain medication, 289,000 or 0.1% used heroin in the past month and 681,000 or 0.2% used heroin in the past year. Overall, it estimates that close to 2.5 million Americans meet diagnostic criteria for OUD (SAMHSA2). This correlates with mortality from opioid overdoses, whereby, in 2009, lethal overdoses from pain medications were reported four times more frequently than from heroin, a three fold increase since 1999 (Bup8: 9).

Effective treatments for OUD have been developed and are supported by the understanding that it is a chronic relapsing illness and aim at halting illicit opioid use. Medication assisted treatment using naltrexone, methadone or buprenorphine is a very effective form of treatment for OUD. Buprenorphine is of particular interest in view of its less complicated prescribing and similar effectiveness compared to methadone (Cochrane). Buprenorphine is a partial agonist at the *mu* opioid receptor, it is a controlled scheduled III substance that has been approved by the Food and Drug Administration (FDA) since October of 2002 for the treatment of OUD. Physicians can prescribe it after taking an eight-hour course and obtaining a special waiver (Bup 8).

Not unlike other substance use disorders, patients with OUD often suffer from co-occurring other mental illnesses. In fact, SAMHSA estimates that 17.5% of those with a non-substance related mental illness have a substance use disorder, more than twice the rates among those who do not (6.5%). Similarly, 37.8% of those with a substance use disorder (7.7 million adults) suffered from a co-occurring mental illness, more than twice the rates among those without a substance use disorder (16.7%) (SAMHSA 1). In fact, heroin use is 9 times more prevalent among those with co-occurring mental illness (0.9 Vs 0.1%) (SAMHSA 1). Such findings bear clinical significance as dual diagnoses are associated with worse outcomes in terms of relapse rates, hospital admissions, aggression, imprisonment, homelessness and infectious diseases such as HIV and HCV (Bup 25).

Individuals with co-occurring OUD and other mental illnesses have been shown to require more costly crisis oriented services including visits to the emergency departments, in patient psychiatric admissions as well as the criminal justice system (Bup 19. Drake Bartels, Teague, Noordsy & Clark 1993). Conventionally, such individuals receive treatment from at least two parallel systems, one for their OUD, often using buprenorphine, and another for their other mental illnesses. This parallel but non-integrated treatment approach undermines the benefits of an integrated treatment program.

Dual diagnosis treatment models have been developed to address the fragmentation of care for those with a SUD with a co-occurring mental illness. Such models appear to address the difficulties that patients could face by navigating separate health systems. These patients often get non-concordant opinions on recovery, and are being excluded from one system because of their co-morbid disorder (Bup 25). Multiple controlled studies have demonstrated improved

outcomes in treatment models that rely on multidisciplinary treatment teams for a comprehensive approach to providing clinical and psychosocial services, as compared to non-integrated programs (Bup 25). A longitudinal study comparing integrated treatment models to parallel models found that the former leads to improved quality of life, reduced symptoms of co-occurring mental illness, increased engagement in treatment and employment rates and a reduction in substance use. This study also showed a reduction in positive drug tests, hospitalization rates and number of hospital days, felony or misdemeanor arrests, probation violation and days of incarceration. In addition, the integrated model was found to be advantageous from a financial point of view as it lead to overall reduction in expensive crisis-oriented services (Bup 19). One study studied specifically the effects of integrating Buprenorphine treatment in patients with HIV and demonstrated improved outcomes in terms of continued substance use and compliance with treatment both for OUD and HIV (Bup 21).

For patients, access to treatment with buprenorphine often proves to be difficult as there is a lack of buprenorphine providers. Currently, fewer than 3% of physicians in the US are licensed to prescribe buprenorphine (Bup8.39). Contributing factors include the eight-hour course additional training, the limits to how many patients on buprenorphine a provider can treat at any given time and the fact that it is not uncommon for general psychiatrists to opt out of buprenorphine treatment. A survey of Buprenorphine providers in Washington State reported that psychiatrists constitute only 29.5% of the overall pool, and 0% in rural areas, where primary care physicians were virtually the only providers licensed to prescribe leading to added hurdles for the treatment of complicated patients with dual diagnoses (Bup 6). A recent national analysis of buprenorphine prescribing in the decade after it was approved by the FDA (from 2003 to 2013) found that while the number of prescriptions increased 13 fold (from 0.16 million to 2.1 million prescriptions), and that prescribing by primary care physicians increased from 6.0% to 63.5%, Buprenorphine prescribing by psychiatrists decreased from 92.2% to 32.8% (Bup 8). In fact, in general psychiatric practices, patients in need of buprenorphine are often referred out to "Buprenorphine providers". Such providers typically offer little or no wrap around services or treatment for co-occurring mental disorders, and often limit their practice to writing bi-weekly or monthly scripts for buprenorphine. Many opt out of health insurance plans and end up in programs that charge fees that many cannot afford and as a result many individuals relapse back to the abuse of opiates. In urban areas, buprenorphine providers are four times More likely to work in a private practice setting rather than in a safety net setting where patients with OUD are more commonly receiving treatment, opposite the trend in rural areas (Bup 6). Proponents of the model of non-integrated care argue that treatment of either condition with separate providers can be beneficial due to the "spillover effect", the principle that improvement in either domain will result in improvements in the other (i.e. treating SUD will lead to improving symptoms in co-occurring mental illnesses and vice versa). A study examining empirically whether such "spillover effects" are seen among individuals entering treatment for SUD found no evidence in support of such a claim (Bup 18). A survey of non psychiatric physicians who received training to use Buprenorphine revealed that almost three quarters were not prescribing it, and that a lack of mental health and psychosocial training and support was the most commonly reported barrier among those who prescribe and among those who do not prescribe buprenorphine (Bup 10).

Attachment #2

Position Statement
American Psychiatric Association

Title: Assuring the Appropriate Care of Pregnant and Newly Delivered Women with Substance Use Disorder

Issue: Substance use during pregnancy adversely affects the lives of both mother and the future child. It can contribute to obstetric complications such as placental abruption, premature birth and low birth weight, miscarriage, and a variety of behavioral and cognitive problems in children exposed such as those seen in fetal alcohol syndrome (1, 2, and 3). As a result of these complications several jurisdictions initiated policies of prosecuting pregnant and/or postpartum women who have used either alcohol or illegal substances during pregnancy on grounds of "prenatal child abuse". Subsequent incarceration in jails or prisons or in locked psychiatric units deprives the mother of her liberty and disrupts the incipient or nascent maternal-infant bond. This vulnerable patient population needs comprehensive care for both immediate and long term symptoms in order to restore a healthy maternal-infant relationship and improved functioning in the mother.

Departments of social services and/or associated agencies must advocate on behalf of pregnant and newly delivered women, their children and their affected families and encourage pregnant women with substance use disorders to obtain appropriate treatment. This advocacy will serve to encourage pregnant women with substance use disorders to obtain appropriate treatment without fear of negative consequences, enhance their parenting, preserve the integrity of their families whenever possible, ensure the safety of their children, and oppose laws that result in the incarceration of pregnant women on the basis of "prenatal child abuse,"

The APA adopts the following position on the appropriate care of pregnant and newly delivered women with substance use disorder:

Substance Abuse Prevention:

- Preventing, reducing and ceasing the use of alcohol, tobacco, and illicit drugs in pregnant, breastfeeding, and newly delivered mothers are essential goals in optimizing the health and wellbeing of women and their children.

- Prevention and treatment interventions should be provided in a way that will prevent stigmatization, discrimination and marginalization, negative legal and social consequences, and promote family, community, and social supports and social inclusion.

Screening:

Screening for alcohol, tobacco, and drug use should be provided to pregnant, breastfeeding, and newly delivered mothers as part of routine care regardless of ethnicity or social class without discrimination. The purpose of this screening is to initiate early intervention and treatment. They should also receive screening for other co-occurring mental disorders.

Treatment: Pregnant, breastfeeding, and newly delivered mothers with substance use disorder should be provided;

- Universal access and priority given to adequate, affordable, and timely initiation of evidence based prenatal care and prevention and treatment services for substance use disorders.
- Access to inpatient care, outpatient clinics, residential programs, outreach services, pretreatment intervention groups, and other comprehensive care. Also to comprehensive case management, integrated services of substance use disorder treatment, obstetric care as well as subsequent pediatric care as each of these components are essential in addressing threats, preventing stigma and improving birth outcomes.
- Information about risks, benefits and treatment alternatives should be provided to the mother in order to choose the best option for herself and her child.
- Continuation of methadone or buprenorphine treatment for pregnant and breast feeding women on maintenance treatment or initiation of medication assisted treatment for Opioid Use Disorder.
-
- Further, Substance Use Disorder treatment programs should maintain, affiliate or develop special program initiatives for pregnant, breastfeeding, and newly delivered women, which should involve care that is effective, culturally congruent and collaborative.

Education: Pregnant, breastfeeding, and newly delivered mothers with substance use disorder should be educated about;

- Substance use complications, including Neonatal Abstinence Syndrome and the possible treatment needs of the child immediately after delivery
- The availability of treatment options for substance use disorder
- The risk of acquiring and transmitting HIV to the fetus and how it can be prevented
- The health benefits and risks of breastfeeding the newly delivered infant
- Risks associated with pharmacotherapy or medication assisted treatment
- Childbirth, family planning, and activities that encourage and facilitate bonding and attachment
- Local and community resources available to support her and her family during the pregnancy and during the post-partum period

Safeguarding against discrimination and stigmatization:

- Prevention and treatment interventions must be provided to pregnant, breastfeeding, and newly delivered mothers in a way that will prevent stigmatization, discrimination and marginalization and promote family community and social supports well as social inclusion.

Criminal prosecution and civil commitment:

- The use of the legal system to address perinatal alcohol, tobacco, and other substance use disorders is inappropriate. APA opposes the criminal prosecution and incarceration of pregnant and/or newly delivered women on child abuse charges based on the abuse of substances during pregnancy. (Social services and legal actions may be appropriate if positive evidence of abuse or neglect is found following the birth of a child).

- If the State mandates reporting, APA recommends policymakers, legislators, and physicians work together to repeal punitive legislation and identify and implement evidence-based strategies outside the legal system to address the comprehensive treatment needs of women with substance use disorders and their children.
- APA opposes discriminatory implementation of involuntary commitment laws that are unduly applied to pregnant women in a manner which differs from its application in the evaluation of their male counterparts.

Collaboration:

- APA supports ongoing collaborations with other medical professional associations such as pediatrics, internal medicine, obstetric, and adolescent medicine professional associations to advocate, develop and deliver comprehensive and integrated care pre-partum, pregnant, and post-partum women with substance use disorders and other co-occurring psychiatric disorders."

Authors: Mona T. Thapa, MD; Hector A. Colon-Rivera, MD; Mandrill Taylor, MD; Shelly Greenfield, MD; Carla Marienfeld, MD and John Renner, MD on behalf of the Council on Addiction Psychiatry

Background:

Substance Use Disorders affect many women of childbearing age. These psychiatric disorders produce harm to the health and social functioning of the individual and may also affect the health and well-being of her children. Substance use disorders are often accompanied by other comorbid psychiatric disorders. In addition, many of the women who become addicted to substances are also victims of abuse and deprivation. Women living in poverty and members of minority groups may be disproportionately affected. Children of these mothers are at risk for growth retardation, facial abnormalities, and developmental deficiencies, arousal and affective regulatory problems, language disorders, and impulsive and hyperactive behavioral difficulties that require psychiatric assessment and intervention.

During the 1980s and 1990s, several jurisdictions initiated policies of prosecuting pregnant and/or postpartum women who have used either alcohol or illegal substances during pregnancy, on grounds of "prenatal child abuse". Subsequent incarceration in jails or prisons or in locked psychiatric units both deprives the mother of her liberty and disrupts the incipient or nascent maternal-infant bond. One state's highest court has upheld this practice. Several states have also established involuntary commitment laws applying solely to pregnant women in ways that are not applied to men or non-pregnant women. Such policies are likely to deter pregnant women with substance use disorders from seeking either prenatal care or addiction treatment, because of fear of prosecution and/or civil commitment.

The most effective way to prevent harm to both mothers and infants is to make available accessible, culturally appropriate prevention and treatment services designed specifically for adolescent girls and women. Adequate screening for substance-related disorders in all obstetric practices, with referral for

treatment and careful follow-up, are also necessary parts of the continuum of care. Screening instruments are available for this purpose. In many or most geographic areas, there are few voluntary substance use disorder treatment services willing to accept pregnant women, and few or no residential services in which a mother may bring her children. This is unfortunate, as during pregnancy and the two years postpartum, women are particularly open to treatment and treatment can be highly effective.

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Attachment #3

Position Statement
American Psychiatric Association

Issue: Persons with substance related disorders have often been excluded from both medical treatment and medical coverage by insurance companies due to false beliefs that a) there is no efficacious treatment, and b) to provide medical coverage for substance related disorders on par with medical disorders would result in skyrocketing health care costs. Given the prevalence of substance related disorders and the morbidity, mortality and costs associated with them, they can no longer be ignored or excluded.

Position Statement:

The American Psychiatric Association strongly and unequivocally affirms its position that all substance related disorders are diagnosable mental illnesses for which effective treatments are readily available. Furthermore, the American Psychiatric Association strongly opposes the exclusion of substance related disorders from legislation or programs that pertain to parity of insurance coverage, access to health care services and quality of care. The APA also strongly affirms the need for expanded access to effective prevention and treatment for substance related disorders, including medication assisted treatment. Other chronic illnesses such as heart disease, diabetes, and asthma, among others, are not subject to the same restricted limits on access to and coverage of care as are substance related disorders. The American Psychiatric Association considers such exclusion of substance related disorder diagnoses and patients with these diagnoses, as well as limitations to access to effective behavioral and medication assisted treatments, as discriminatory and contrary to the scientific findings of the clinical, research, health economics and policy communities. The American Psychiatric Association, therefore, unequivocally states its position that such exclusions and limitation of access to effective treatment is discrimination and should henceforth be ended.

Background:

Roughly 21.6 million people ages 12 and over in the United States were classified with substance abuse or dependence in 2013.(1) There is a large body of evidence that confirms both the biological underpinnings of these illnesses as well as the high rates of Substance Use Disorder treatment success.(2,3-9) A 1996 report of the National Treatment Improvement Evaluation Study (NTIES) demonstrated that 12 months after treatment completion, there were substantial reductions in the use of substances as well as other gains in employment, declines in criminal activity, and decreases in alcohol and drug related medical visits.(7) Yet, only 4.1 million people (19%) received treatment for alcohol or illicit drug use problems and only 2.5 million people (12%) received treatment in a specialty setting in 2013, which represents a consistently large gap in the number of people needing treatment and those who receive it.(1)

In 2008, the US Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), which required health insurers to provide equal coverage for mental health and substance use disorder (SUD) services and general medical services. It also prohibited health plans from using nonquantitative treatment limitations (NQTL) such as medical necessity, prior authorization, and utilization review that are more restrictive than those used for medical/surgical health benefits. The Affordable Care Act (ACA) of 2010 added to that by expanding the parity

requirement to Medicaid and Medicaid-managed plans, as well as state health insurance exchange plans. It also mandated that coverage for SUD treatment be included in health plans as an essential health benefit, equivalent to that provided for medical and surgical treatment. Historically, employers and health insurers have stated concerns about the implementation of parity regulations; that it would result in significant increases in healthcare costs.(10) While many studies exploring the effect of state-level parity mandates prior to MHPAEA have shown this not to be the case (2,11-14), a more recent study exploring the effect of the addition of NQTL have confirmed these findings. The study explored Oregon's 2007 state parity law, which is similar to MHPAEA in that it also limits use of NQTL for behavioral health that is not on par with medical and surgical services, and found that spending on drug abuse treatment was not associated with statistically significant spending increases.(15) Furthermore, a study that explored the effect of the MHPAEA on costs associated with treatment of SUD in a large health plan provider across 10 different states found only a modest increase of $9.99 per enrollee.(16)

While the effects of parity have not resulted in a significant increase in healthcare costs, neither has it resulted in an substantial increase in utilization of substance use disorder treatment services which is needed to close the aforementioned treatment gap (16-18), nor has it extended access to effective behavioral and medication assisted treatment for substance use disorders.(19) Another significant barrier to care is societal stigma and the internalization of that stigma by those who suffer from these disorders.(2) Such internalization may deter individuals from seeking care. On the other hand, legislation of full parity, as well as implementation of enhanced access to effective treatment including behavioral and medication assisted treatments, for those with both mental health and substance related disorders can send a strong message to the public that these are medical disorders for which effective and evidence-based treatments exist, and that these treatments are offered within a health care system that provides equivalent care for all disorders whether they be medical, surgical, or psychiatric, including all substance related disorders.

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COUNCIL ON ADVOCACY AND GOVERNMENT RELATIONS

EXECUTIVE SUMMARY:
The Council on Advocacy and Government Relations (CAGR) met on Friday, September 11 during the American Psychiatric Association's September Component Meeting in Arlington, VA. The Council received updates from the Department of Government Relations Administration on major federal and state legislative issues, and also received an update on APA*PAC*.

The Council discussed several key issues and APA advocacy efforts including:

- Comprehensive Mental Health Reform Legislation
- APA Scope of Practice Toolkit
- Health Insurance Mergers
- Jacob K. Javits Award for Public Service
- APA*PAC* CAN Initiative
- 2015 State Advocacy Conference

The draft minutes from the meeting are attached (Attachment #1)

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

1. **JACOB K. JAVITS AWARD FOR PUBLIC SERVICE AWARD**
   U.S. Representative Tim Murphy is the leading advocate for mental health in Congress. This year, he reintroduced a comprehensive mental health reform bill, the *Helping Families in Mental Health Crisis Act*, after collaboration with the APA. APA supported the legislation upon introduction, following a review by the Council and the APA Board of Trustees. Representative Murphy continues his fight for improving mental health care on a daily basis on Capitol Hill and around the country.

   Will the Joint Reference Committee recommend that the Board vote to approve the Council's recommendation to award the 2016 Jacob K. Javits Award for Public Service to U.S. House of Representative Tim Murphy of Pennsylvania? (Meeting minutes – Attachment #1; Nomination supporting documents – Attachment #2 and Attachment #3)

2. **REVISE COMPOSITION OF THE COUNCIL ON ADVOCACY & GOVERNMENT RELATIONS**
   In conjunction with the PAC Board, the Council proposed strengthening APA's advocacy efforts through coordinating and aligning the two entities. The Council request expanding the Council's composition to include one additional member for a total of 15 members, meeting the conditions as stated. The new composition for the Council would include:
   a) The Chair of the APA*PAC* shall serve as an ex officio member of the Council;
   b) The position held would remain a voting member of the Council; and
   c) The position held will be term-limited to align with the term length as chair of the APAPAC Board of Directors.

   According to the standard costs for the Component Budget for the Year 2016 budget, the cost estimate for an addition to the Council will be approximately $1298.00.

Will the Joint Reference Committee recommend that the Board vote to approve revising the composition of the Council? (Meeting minutes – Attachment #1)

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

1. **JRC REFERRAL: PROMOTING MILITARY CULTURAL KNOWLEDGE AMONG PSYCHIATRISTS (ASMMAY1512.M)**
   The Council on Advocacy and Government Relations discussed the JRC referral of the Action Paper, "Promoting Military Cultural Knowledge among Psychiatrists." Of the five Resolves within the Action Paper, the Council unanimously supported the three Resolves concerning the promotion of educational awareness and the development of military cultural competency educational materials and resources. While the Council supported Resolve #5, members agreed the development of a position statement would not be in the purview of the Council. Furthermore, from the Council's discussion members remained divided in supporting the first Resolve requiring the question as a core professional component of the clinical evaluation.

   In summary, there was general support by the Council for Resolves #2, #3, #4 and #5; and an inconclusive outcome on Resolve #1. The Action Paper addresses an important issue impacting the field of psychiatry, in which educational modules should be made available to physicians. The APA should urge our membership to become familiar with military cultural competency in order to be a well-educated psychiatrist. The Council has shared their recommendations with the Council on Medical Education and Lifelong Learning (LEAD) and will await feedback for further participation in the development of a position statement.

2. **JRC REFERRAL: EMERGENCY DEPARTMENT BOARDING OF INDIVIDUALS WITH PSYCHIATRIC DISORDERS (ASMMAY1512.S)**
   The Council on Advocacy and Government Relations discussed the JRC referral of the Action Paper, "Emergency Department Boarding of Individuals with Psychiatric Disorders." From the discussion, members of the Council were of a mind that boarding is unacceptable and needs to be remedied. In response to the JRC directive, the Council established the following recommendations:

   a) The Council should continue advising APA on relevant federal advocacy both in terms of current policy and recommendations. APA will continue to support federal legislation driving forward comprehensive mental health reform, because of its significant impact on psychiatric bed availability.
   b) APA should—through the Department of Government Relations and Communications—collaborate with state associations/district branches so states encountering this problem can develop a campaign which will inform citizens and state legislators about the consequences of diminishing mental health funding and the repercussions on bed availability. The Council and APA's State Government Affairs infrastructure could assist APA's DBs/SAs in their advocacy activities related to expanding community and inpatient access.

c) In working with state associations/district branches, APA should use the crisis of the boarding issue and the handling of violent patients to inform state legislators of the ramifications associated with substantial cuts to mental health budgets; emphasizing the justification for expanding mental health resources and program allocations.
d) APA should continue to highlight the consequences of trans-institutionalization.

Understanding this is a complicated issue; the Council will collaborate with the Council on Psychosomatic Medicine (LEAD) in exploring these mechanisms. A position statement examining these causes is currently being developed by the Council on Psychosomatic Medicine in consultation with other Councils including CAGR. The Council has shared their recommendations with the Council on Psychosomatic Medicine (LEAD).

3. **JRC REFERRAL: LOCATION OF CIVIL COMMITMENT HEARING (ASMMAY1512.V)**
The Council on Advocacy and Government Relations discussed the JRC referral of the Action Paper, "Location of Civil Commitment Hearing." The Council's directive is to provide input on the issue to the Council on Psychiatry and Law (LEAD). In advance of the October 2016 deadline, CAGR member (Newkirk) and visiting RFM (Reid) volunteered to participate as Council representatives to the newly created Council of Psychiatry and Law work group to address the issue. The Council has shared their recommendations with the Council on Psychiatry and Law (LEAD); DGR staff will remain attentive to the progress of the work group.

4. **JRC REFERRAL: MULTIPLE CO-PAYMENTS CHARGED FOR SINGLE PRESCRIPTIONS (ASMMAY1412.A)**
The Council on Advocacy and Government Relations discussed the JRC referral of the action paper, "Multiple Co-payments Charged for Single Prescription." DGR staff has worked closely with the Office of Healthcare Systems and Financing. They have learned that the Council on Healthcare Systems and Financing (LEAD) is in the process of reviewing the developed survey. It is our understanding that once this survey is approved by the lead Council, it will be sent to APA membership requesting feedback on this issue. Following the compilation of the survey results, the lead Council will forward their recommendations to be reviewed by our Council.

5. **JRC REFERRAL: ENDORSEMENT OF PRINCIPLES FOR THE PROVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES: A BILL OF RIGHTS (JRCOCT148.G.17)**
The Council on Advocacy and Government Relations discussed the JRC referral of the position statement, "Endorsement of Principles for the Provision of Mental Health and Substance Abuse Treatment Services: A Bill of Rights." Following the May 2015 meeting, the Council moved to form a work group led by Drs. Bailey and Badaracco (Council on Health Care Systems and Financing). DGR staff worked with other council staff liaisons to gather facts on the use of the current *Bill of Rights* and made inquiries with APA Administration policy staff to best inform deliberation by the work group.

The Council members, being advised of the CHSF initial recommendation to retire the paper and the ongoing deliberation by the joint Council work group, voted the following recommendations, while the work group continues their work:

a) Retire the position statement (originated 1996, reaffirmed 2007);
b) Notify signatories and other components;
c) The joint Council work group will review existing APA policies to see if said policies satisfy the need of members with regards to having an organizational statement of a patient's bill of rights.
d) Based on their evaluation, the joint Council work group will determine the potential need, recommending whether or not the drafting of a new bill of rights is essential.

Contingent on the results of reviewing APA policies and if determined as necessary, the Council instructed the work group to craft a new APA document which would address the rights of patients, revised to reflect developments in law and policy over the past 15 years. Additional members of the Council volunteered to serve on the work group: Drs. Jenny Boyer, Napoleon Higgins, and Morgan Melock (RFM).

Attachment #1

Council on Advocacy and Government Relations
September 11, 2015
9:00 AM – 5:00 PM
Hilton Crystal City, Arlington, VA
Meeting Minutes

Members in Attendance:
Barry B. Perlman, M.D., *Chair*
John T. Bailey, D.O., *Vice-Chair*
Bem Atim, M.D.
Cassandra Newkirk, M.D
Charles Price, M.D.
David Lowenthal, M.D.
David Pickar, M.D.
Debora Koss, M.D.
Jacob Michael Izenberg, M.D.
Jenny Boyer, M.D.
Joshua Berezin, M.D.
Katherine Gershman Kennedy, M.D.
Michael Christopher Hann, M.D.
Morgan Medlock, M.D.
Napolean Higgins, M.D.
Nicole Wimberger, M.D.
Steve Koh, M.D.
Wilsa Charles Malveaux, M.D.

Members with Excused Absence:
Altha Stewart, M.D.
Brenda Jensen, M.D.
Craig Zarling, M.D
Matthew Erlich, M.D.

Members with Unexcused Absence:

Guests in Attendance:
Renee Binder, M.D., APA President-elect
Saul Levin, M.D., M.P.A., APA Medical Director and CEO
Colleen Coyle, General Counsel
Kristin Kroeger Ptakowski, Chief of Policy, Programs & Partnerships
Jason Young, Chief Communications Officer
Ranna Parekh, M.D., M.P.H., Director of Division of Diversity & Health Equity
Raquel Reid, M.D. (visiting RFM)
Krysti Lan Chi Le Vo, M.D.(visiting RFM)

APA Administration in Attendance:
Rodger Currie
Adam Lotspike
Ashley Mild
Brian Smith
Deana McRae
Janice Brannon
Matt Sturm
Nevena Minor
Scott Barnes
Vincent Pacileo

I. Welcome, Introductions & Review of Agenda

Dr. Perlman welcomed the Council and provided an overview of the meeting agenda. Following the introductions of the Council members, the chair moved and it was seconded for the approval of CAGR meeting minutes submitted to the Joint Reference Committee (July 2015).

II. Jacob K. Javits Award for Public Service

Dr. Perlman read the name of the one nomination, U.S. Representative Tim Murphy, received from the Washington Psychiatric Association. Dr. Pickar spoke in support of the nomination. APA Administration provided background to the Council offering insight on the Congressman's continued commitment to improving mental health care on a daily basis as a leading Congressional advocate for reform of the nation's mental health system. Staff emphasized APA's engagement with Murphy as well as the companion legislation in the Senate. Rodger Currie highlighted how Representative Murphy has been a real champion on mental health issues and he was the only nomination received for this year's award. Dr. Perlman outlined the importance of Representative Murphy's legislation. After discussion amongst the members, it was moved and unanimously voted to submit for approval U.S. Representative Tim Murphy as the Jacob K. Javits Award recipient.

Action Item #1
Will the Joint Reference Committee recommend that the Board vote to approve the Council's recommendation to award the 2016 Jacob Javits Award for Public Service to United States Representative Tim Murphy (R-PA)?

III. Action Items

Action Paper: Promoting Military Cultural Knowledge among Psychiatrists

As directed by the JRC, the Council discussed the action paper to determine mechanisms to implement promoting military cultural knowledge among psychiatrists. Prior to the component meeting, APA Administration solicited feedback from Council members. In addressing how to implement rising psychiatric awareness of these education materials and resources, one Council member recommended for APA to develop marketing poster materials, assemble a booth, or some other presence at the Annual Meeting/IPS meeting alerting membership to this issue.

From the limited Council feedback, Dr. Perlman proposed, CAGR support the educational intent of the Action Paper. However, the email correspondence revealed concerns about establishing the referenced question as a "core professional practice." During the meeting, members offered mixed feedback into the importance of educating psychiatric physicians at non-VA facilities. Dr. Boyer spoke in defense of the educational intent of the Action Paper, as well, believes that the referenced question should be included as a core professional practice since it is only a question that can appear alongside many others already used. Dr. Perlman clarified that the action paper calls for the creation of educational modules to help residents understand consequences of military service better. Dr. Koh believed that this specific question about what should be considered a core professional practice is better suited to be directed to another council like Education and Lifelong Learning. Dr. Perlman determined that the Council was in accord supporting four of the Action Paper's recommendations; in which the Action Paper addresses an important content area and APA should support the development of educational materials and support promoting existing educational

resources. The members were unable to come to a consensus on the first recommendation; and therefore, the Council, as a body, did not support the core professional practice of asking such a question as part of the clinical evaluation. The comments will be shared with the Council on Medical education and Lifelong Learning (lead council).

Action Paper: Emergency Department Boarding of Individuals with Psychiatric Disorders
As directed by the JRC, the Council discussed the action paper introduced to address impact of emergency boarding of patients. Prior to the component meeting, APA Administration solicited feedback from Council members. In addition, Dr. Perlman spoke with Dr. Gitlin, chair of the Council on Psychosomatic Medicine, to identify the objective of the Action Paper and coordinate the individual councils' next steps. After discussion, Dr. Perlman synthesized that the Council would recommend a stronger statement; in which several members were in agreement that the Action Paper should include a more resolute position.

The suggested language to be shared—

> The causes of emergency department psychiatric boarding are multifold, and a position statement exploring these causes is currently being developed by the Council on Psychosomatic Medicine in consultation with other Councils including CAGR. While certain federal statutory or regulatory policies including the Medicaid IMD exclusion exacerbate the problem of available staffed psychiatric hospital beds, significant responsibility for available community and inpatient psychiatric resources rests in State legislatures and other State government bodies that manage spending. For example, the state of Washington (and APA's Washington district branch) is currently dealing with the aftermath of a state Supreme Court decision related to gross lack of psychiatric bed capacity. CAGR and APA's expanded State Government Affairs infrastructure should assist APA DB/SAs in their advocacy activities related to expanding community and inpatient access, and CAGR can continue advising APA on relevant federal advocacy both in terms of current policy and recommendations that may be surfaced by the Council on Psychosomatic Medicine's leadership in this area.

While APA has existing policy, a Council member recommended linking APA's federal advocacy efforts with the significance of the issue; the need for more hospital and long-term residential care for individuals with serious mental illness which in particular is nonexistent in some states. He suggested that APA should insert a nationwide state campaign to draw attention to this issue. The Council recognized that state mental health budgets have suffered enormously. A member expressed her concerns that the Action Paper suggests re-institutionalization as a cure for boarding those individuals directed to emergency rooms; if they had access to state hospital beds—the problem would be solved. It was suggested that the order in which the issue is addressed should be reserved to the availability of community beds, as the first priority. A Council member recommended that APA should use the crisis of the boarding issue and the handling of violent patients as a way to work with state organizations, as well as at the federal level, to improve the policies regarding access to mental health care. The Council request APA to vigorously advocate for the cessation of the IMD exclusion. The Council advised the Department of Government Relations to continue advocacy efforts in the passage of comprehensive mental health reform. Dr. Perlman emphasized—keeping aligned with APA president's interest—APA should highlight consequences of trans-institutionalization; including the fact that people with SMI do not belong in prisons rather they belong in hospitals in order to receive appropriate treatment. The Council will also work collaboratively with other councils on this issue. Dr. Perlman recommended the Council provide feedback to the lead Council as input in developing a position statement.

Action Paper: Location of Civil Commitment Hearing

As directed by the JRC, the Council discussed the Action Paper. After some consideration, the consensus was to postpone action on the paper and offer a volunteer from CAGR to assist the lead Council as the paper is further deliberated. The chair noted the deadline for a final product to the JRC is October 2016. Staff was directed to notify the Council on Psychiatry and Law that CAGR would like to provide a representative—one member of CAGR (Newkirk) and one RFM volunteer (Reid) willing to work more closely on the development of this paper. Dr. Newkirk was assured that Council members would remain available to poll for feedback or comments.

IV. JOINT REFERENCE COMMITTEE ASSESSMENT OF THE COUNCIL

Dr. Perlman described a routine assessment of different APA components by the Joint Reference Committee. This year, the Council has been selected to submit an assessment report to be reviewed by the JRC. He noted the deadline for the submission of the Council's report is October 2nd in preparation for the JRC's October meeting. The chair emphasized to the Council that the assessment will be submitted to the Joint Reference Committee before the October deadline.

V. WORK GROUP: PRINCIPLES FOR THE PROVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES: A BILL OF RIGHTS

Dr. Perlman provided the Council a brief background leading to the current status of the Bill of Rights document. The chair noted, following the May 2015 component meeting, Dr. Bailey agreed to form a work group to undertake the JRC directive of this paper. The work group—led by Dr. Bailey and Dr. Mary Badaracco, a member on the Council on Health Care Systems and Financing—set forth with the task to determine whether the organization should retain the action paper. Per the July 27 memo to the JRC, the Council convened calls between CAGR and CHSF members in advance of the September Component Meeting. Dr. Bailey noted the Council on Health Care Systems and Financing previously voted a recommendation to retire this policy as it incorporates components that have been legislated by Congress since its inception. Dr. Perlman suggested the document is archaic; since constructing the Bill of Rights, there are now laws addressing patient protection (ACA), health information privacy (HIPAA) or mental health parity (MHPAEA). Thus the policy, as written, insinuates a status quo that no longer exists.

APA's Policy Director Matt Sturm clarified that Council staff worked with other council staff liaisons (and other council chairs) to gather facts on the use of the current Bill of Rights. In addition, Council staff made inquiries with APA Administration policy staff to best inform deliberation by the workgroup. The result of the exploration revealed no knowledge of the Bill of Rights existence or use of the document in their policy development activities. Moreover, staff researched if the document was referenced by original participating and supporting organization; discovering of the nine cosigning organizations, only two organizations reference the document on their website

Dr. Boyer noted that we might want to leave the option open for having a bill of rights since the Assembly is very patient-oriented and a bill may be helpful for that effort. Dr. Koss asked what the procedural differences were in creating a new document versus retiring the current Bill of Rights. The chair and APA staff acknowledged that the development of a new document would require a significant amount of staff time, as well as reengaging the other nine organizations who initially signed on.

Dr. Higgins believed that the document still has relevancy and should not be retired until we have a new draft to update APA's Bill of Rights. He stated that all components mentioned in the document still persists

today. Dr. Bailey agreed to the extent if the policy were continued, it would require "more teeth." Dr. Higgins again noted that APA should not retire it and it should replaced; we need to revise it and make it stronger.

Dr. Kennedy asked whether the AMA has a bill of rights that they could endorse; and what is their rationale for doing so? How does their document compare to the document we are discussing? She continued asking, if the AMA has a bill of rights that covers concerns we have raised, then we wouldn't necessarily need to revise this document since we are covered by the AMA bill of rights. APA staff informed the Council that AMA does have a Patient's Bill of Rights, also originating before the ACA and HIPAA. A Council member pointed out that the AMA policy would not address the same issues specific to psychiatry and mental health/substance abuse.

Dr. Higgins wondered whether he was the only psychiatrist around the table that takes insurance and finds that this document still has relevancy because insurers aren't doing many of the things listed on this Bill of Rights. Dr. Perlman noted again, that many monumental laws have passed that address some of these items.

Dr. Koh believed that from an internal policy perspective, this document needs updating. As far as addressing the question on the table, we should retire it. The current discussion among the group is about coming up with new language; if it is an actionable document that membership can utilize on the ground, then perhaps we work on a new document. He continued by recommending, if this is the direction the Council chose to go, we would need to think carefully about language.

The chair noted Dr. Binder's concern of the number of people affected by trans-institutionalization in which a great number of people do not belong in prisons but belong in hospitals for appropriate treatment. If a new document is created this is a component that should be included.

Following the Council's robust discussion, Dr. Bailey reached the conclusion that the Council would recommend to retire the policy as well. Due to how old the document is, Dr. Koh emphasized his recommendation to retire the current document and then set up a small workgroup in CAGR to begin work on a new document. Dr. Bailey noted that if there is an interest in having a document like this, he is willing to work with other CAGR members to create a new, more pointed document. Several Council members volunteered to serve on the work group: Drs. Jenny Boyer, Napoleon Higgins, and Morgan Melock (RFM).

The Council members, being advised of the CHSF initial recommendation to retire the paper and the ongoing deliberation by the joint Council workgroup, voted the following recommendations while the workgroup reviews existing APA documents:

- The Council would recommend retiring the policy (originated 1996, reaffirmed 2007)
- APA Administration will notify the nine signatory organizations
- APA Administration will notify other APA components and APA subject matter policy experts
- Dr. Bailey—working with Drs. Badaracco, Boyer, Higgins, and Melock—will review existing APA documents to determine if APA has policy that would satisfy the gap which would occur if the policy were retired

The Council instructed the work group to craft a new position statement, contingent on the results of reviewing APA policy.

VI. GUEST SPEAKERS:

Renee Binder, M.D., APA President-elect

APA's current president visited the Council during the component meeting to thank them for their continued service on this important component. Dr. Binder shared a recent conversation with Dr. Perlman, to which they agreed the role CAGR plays is significant to the organization; particularly as most action papers seek advocacy action. This Council determines how the position paper will impact advocacy and how we change laws and policy. She emphasized the role each member plays in what will be an active year for legislation. We will continue to commit our resources—both within the Department of Government Relations and Division of Communications—to educate people about the field of psychiatry; scope of practice; mental illness and violence; and AOT. Lastly, Dr. Binder stressed the role of RFMs and ECPs as the future of both psychiatry and more importantly mentees within APA.

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

APA's CEO and Medical stopped by the Council's meeting to thank them for their commitment to APA and more importantly the Council and the work accomplished through the group. He noted that although we were half way through 2015, this year has brought opportunity for moving aspects of our legislative agenda forward. With anticipation of the movement of comprehensive mental health reform legislation—bipartisan companion bills in both chambers of Congress are gaining traction in their committees of jurisdiction—these bills would expand access to care, enforce parity, and increase the mental health workforce. Both bills remain a big priority of the association; as we expect the legislation will transform critical governmental programs, ensure better coordination, and shape new policies to meet escalating U.S. mental health need. Additionally, the year is shaping up to present opportunities on APA strategic priorities on reimbursement, workforce, and parity. But there remain significant challenges ahead in the field. Dr. Levin noted that this year, the Council would be tackling a number of important issues for which the association needs their help and expert counsel as we continue to encounter challenges in scope of practice, psychiatric reimbursement, and ensuring access to mental health services and treatment to Americans. And we look forward to APA hosting the first State Advocacy Legislative Conference in 15 years. This is an excellent opportunity for APA members, District Branches executives and legislative representatives from around the country to work closely with APA Administration discussing key state-level issues and how to best represent physicians and patients to state policymakers.

VII. PREVIOUS ACTION PAPERS

Multiple Co-Payments Charged with Single Prescriptions

Dr. Perlman shared that he has discussed this issue in depth with Rodger Currie, as well as Becky Yowell (APA Administration, OHSF). APA staff has worked closely with the Office of Health Care Systems and Financing. They have learned that the lead Council –the Council on Health Care Systems and Financing will be reviewing the recently developed survey this weekend at the Component Meeting. Once this survey is approved by the Council, it will be sent out requesting feedback from APA membership on this issue. After compiling survey results, the lead Council will share their recommendations with CAGR as to how best to move forward on the issue. In addition to seeing their recommendations, the Council request for the Council on Health Care Systems and Financing to share the data results, providing transparency of the survey. The chair noted the Council will move forward once staff has received the results of the survey.

VIII. NEW COMPOSITION OF THE COUNCIL ON ADVOCACY & GOVERNMENT RELATIONS

Dr. Perlman shared with the Council a prior discussion between APA*PAC* Board Chair and CAGR member Charles Price, regarding the advantages of including a member of the Council on the PAC Board, and a member of the PAC Board on the Council. Dr. Perlman assured the Council that staff has investigated if there were legal ramifications of revising the Council's composition to include a PAC Board member.

Dr. Price has already addressed the PAC Board, receiving a vote of approval to move forward with adding the CAGR chair as an ex-officio member of PAC Board. Once approved by APA's governing body, the current chair of CAGR will be an ex-officio member of the APA*PAC* Board.

Dr. Perlman called for a motion, receiving a unanimous vote of support by the Council to submit a request to the JRC for approval. Seeing that the Council currently holds a limited number of seats, Dr. Perlman suggested creating a new position to be placed on the Council. The Council consented to revise the standard composition of the Council to include the chair of APAPAC Board of Directors; for a total of 15 available positions on the Council for APA members. The amended language for the composition of the Council shall include: (1) the position held would be an ex-officio member of the Council; (2) the position held would remain a voting member of the Council; and (3) the position held will be term-limited to reflect the term length as chair of the APAPAC Board of Directors.

The chair noted that they JRC request would be for the expansion of the Council composition to include an additional Council member, as an ex-officio member. Taking in consideration the budget increase, the Council may have to consider an alternate approach. If the JRC does not approve the request, then one member of the existing composition of the Council will be appropriated to the chair of the APA*PAC* Board.

Action Item #2
Will the Joint Reference Committee recommend that the Board vote to approve revising the composition of the Council?

IX. PRE-SUBMITTED ACTION PAPERS

Parity in Permanent Licensure Policy (Hovav)
Dr. Hovav forwarded the Action Paper seeking comments from the Council. Prior to the component meeting, APA Administration solicited feedback to share with the author. The Council proceeded into a discussion on the importance of the issue in the Action Paper.

Dr. Koh spoke to his experience as a medical director in a resident clinic, which runs into similar problem from time to time. In his experience, the issue is that if IMGs were able to meet the requirements to get into an ACGME program and were able to transition from year 1 to 2 to 3, etc., then they would be at same pace as US grads. So to then, have arbitrary licensure requirements is not good. For the Action Paper, he noted he didn't find the "moonlighting" argument to be valuable. The bigger issue is that training programs are more often being designated to provide care for underserved populations via funding from State or County and they often have licensure requirements. So this is putting limits on training and also stretching resources of training programs. Dr. Izenberg expressed concern if this was an issue that AMA is currently working on, as well. And if they are, wouldn't it be in the best interest of the author to suggest working in collaboration with the AMA. Dr. Higgins noted that extra licensing for IMGs with the same credentials is quite questionable on reasoning. He asked if there is an explanation or reasoning of this requirement other than on face value being a discriminatory policy. The chair advised the Council to consider support of the

paper, as it advocates for the nondiscriminatory licensure of international medical graduates. Upon further discussion of the Action Paper, the Council came to the consensus to support the paper as written.

Systems to Coordinate and Optimize Psychiatric Inpatient Bed Availability for Referral of Psychiatric Emergencies (Blinder/Granese)

Drs. Blinder and Granese forwarded the Action Paper seeking comments from the Council. Prior to the component meeting, APA Administration solicited feedback to share with the author. Further discussion of action paper engaged dialogue among the Council members as to whether this paper was out of the Council's purview. One Council member noted in their state, the Office of Mental Health has a similar registry, which is very harsh about inpatient units going over their legal census number, and tries to push emergency departments to transfer patients needing admission to those units with open beds regardless of how far from the patient's community may be. This creates tension, especially for children and adolescents who would prefer to have families intimately involved in their care. He suggested that such registries would be helpful if their use were non-coercive and utilized at the discretion of the treating psychiatrist and patient; offering non-mandatory options. Another member expressed his concerns about the Action Paper, in understanding the need for it, but this is a county to county and state to state issue and one size model will not fit all. He suggested that APA look at different models that exist, in order to report on their function as a potential resource to membership; as opposed to individual components coming up with a model program that may not be workable at ground level at different places.

The Council suggested the author consider assigning the paper to other components—Psychosomatic, Committee on Mental Health Information Technology, or Health Care Systems and Financing. Members agreed they have no objection to having a repository for different models. However, the Council expressed concern, in which members would advise against granting states the authority to mandate these models, creating a coercive system based on the bed availability.

Access to Care Provided by the Veterans Administration (Ginzburg)

Dr. Ginzburg forwarded the Action Paper seeking comments from the Council. Prior to the component meeting, APA Administration solicited feedback to share with the author. Dr. Boyer spoke to the Action Paper highlighting the frequency of pay inequity among VA psychiatric physicians, particularly the more senior staff in comparison to the new hires. Council members called for more detail on the issue to be included in the Action Paper, including one member's suggestion to reference the Medscape report on medical school debt. She also stressed that the current pay rate in California VA facilities was not comparable to the amount of debt accumulated out of medical school. The Council agreed they could not support the Action Paper as currently drafted. They recommend including more detail on areas— measures of school debt versus loan forgiveness repayment; the varying loan forgiveness allocations in each state; and increasing physician's compensation.

Advocating for Medicaid Expansion (Fleming)

Dr. Fleming forwarded the Action Paper seeking comments from the Council during the component meeting. One member felt the Action Paper addressed a number of complicated issues, making it difficult to address each issue assembled into one paper. The chair recommended a different approach to assist state organizations, where they may want to advocate in their respective states for the expansion of Medicaid. Another member immediately stated this was not a method easily executed in his state, because the issue was too hotly debated. Another member agreed that the method described in the Action Paper would be a difficult feat for APA to sway state legislatures to expand Medicaid. As an organization, the

Council agreed, APA should continue to advocate for the expansion; however, the Council could not support the Action Paper as currently drafted.

X. BOARD OF TRUSTEES WORK GROUP ON TELEPSYCHIATRY

Dr. Jay Shore as Chair of the BOT Work Group described the targeted objective of the work group. Convened by Dr. Binder, the work group is tasked with addressing psychiatrists' expanding role in the practice of telemedicine. Dr. Shore defined the group's priorities and deliverables, including: (1) the creation of a resource/toolkit for APA members that provides an orientation to telepsychiatry; (2) facilitate meeting content/programs on telepsychiatry during the APA IPS meeting and APA Annual Meeting; and (3) develop policy and advocacy recommendations for telepsychiatry. As part of APA's advocacy efforts, Dr. Shore wanted feedback from the Council on a draft policy statement.

> *Telepsychiatry is the practice of medicine. While telepsychiatry is a viable option to deliver high-quality care to patients, the APA supports the preservation of a patient's choice to have access to in-person psychiatric care. There are differences between care delivered via telepsychiatry and care delivered in person, both of which are advantageous in different care circumstances. Whether in-person or via telepsychiatry, the optimal delivery of psychiatric care involves a fully trained and licensed psychiatrist.*

Dr. Shore asked for the Council's approval of the policy statement in order for it to move forward for the Board to review and approve. Members were concerned the statement was too neutral to garner support from the Council on this important issue. Dr. Koh acknowledged that there were advantages to having telepsychiatry; however, regulation is not keeping in pace with the ever-evolving technology. Other areas of concern include: inpatient settings; sourcing to non-physicians; universal definition of telemental health or telepsychiatry; the barrier of a "disconnect" with the patient via telepsychiatry; and insurance liability. The Chair emphasized while the work group continues developing policy, the Council would advise collaborating with the group in an effort to steering advocacy efforts for the organization.

XI. STRENGTHENING OUR DEPARTMENT OF GOVERNMENT RELATIONS

Policy Infrastructure

Mr. Currie presented an organizational chart of the changes to the structure being implemented in the Department. APA has fully established the new policy unit, consisting of a four person policy team. Where previously the policy apparatus of the Department was underdeveloped, the new Legislative and Regulatory Policy unit has expanded APA's policy development. Leading up the team, Matt Sturm as Director of the unit; with Deana McRae and new hire Vincent Pacileo; and the team will be round out with the recent hire of Nevena Minor from ACOG. Scott Barnes has transitioned to the role of full-time federal lobbyist; leaving a vacancy for Ashley Mild as the new Deputy Director, Political Affairs & Grassroots, and Director, APAPAC. And lastly, the Department has hired Adam Lotspike as the Manager of Federal Affairs—closely working with both Ms. Mild in developing APA's advocacy and grassroots, as well as Jeff and Scott in lobbying federal affairs.

APA*PAC* CAN Initiative

APA's Deputy Director of Political Affairs and Grassroots presented to the Council APA's new initiative to influence political grassroots. Ms. Mild described the Congressional Advocacy Network (CAN) as a new program that APA is rolling out to help develop, train and energize a national network of psychiatrist who will commit to communicate and build personal relationships with their members of Congress. DGR wanted

to make the Council aware of APA's plans to roll out this new advocacy program initiative in the coming weeks. The next steps would be to identify APA members to serve as Congressional Advocates or "key contacts" for their members of Congress. This would provide the opportunity for members to speak on behalf of APA on issues facing mental health care. Specifically when important issues come up before the Congress, APA can quickly get our message/request to targeted members of Congress through direct, personal communication. The Chair of the PAC Board, Dr. Price encouraged the Council to be more active and participate in the CAN initiative in a leadership role.

Ms. Mild took a moment to remind the Council on the importance of contributing the *APAPAC.* She reminded the members how previous support led to two major legislative victories for psychiatry in 2015. This past year, Members of Congress set aside their political differences to permanently repeal the sustainable growth rate formula (SGR). Congress also worked in a bipartisan manner to pass the Clay Hunt Suicide Prevention Act to improve mental health care for veterans. Ms. Mild noted that these legislative successes could not have happened without APAPAC's work with legislators to ensure positive progress for mental health. And the next months would be critical for the organization to stay in the forefront as we anticipate Congress will work on the passage of comprehensive mental health reform, mental health parity implementation, and protecting psychiatrists' scope of practice across the country. Dr. Price noted he has targeted all the Council members to ensure that each one is a PAC contributor. It is significant to the organization that the Council charged with establishing advocacy efforts is one of the biggest contributors to the association's PAC.

State Affairs Infrastructure

The newly hired State Affairs Director Brian Smith thanked the Council for the opportunity to address them. He provided the Council with an abbreviated background on the expansion of the Department of Government Affairs State Affairs infrastructure. With a number of states encountering non-physician scope of practice legislation, APA wanted to position itself to allocate additional resources to help district branches and state associations with legislative efforts. With the State Affairs infrastructure expanding—inclusive of the four new regional representatives—APA will provide a more adequate base to meet the various scope threat. As the on-the-ground field members, they will coordinate with DBs/SAs—in their respective regions—being efficient and effective lobbyists. He shared with the Council that APA is in the hiring process to complete the new team.

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

Mr. Smith noted that the APA will be leading up the State Advocacy Conference in Hollywood, Florida on October 23rd.

XII. CAGR AND COUNCIL ON COMMUNICATION COLLABORATIVE DISCUSSION ON APA SCOPE TOOLKIT

During the component meeting, the Council was joined by the Council on Communications for an executive session dedicated to scope of practice bills and how APA can work to defeat them. Rodger Currie shared with both Councils a recent BOT presentation regarding the impact scope of practice activity gaining momentum across the nation. He noted the significance of expanding APA's State Affairs Department, in order to quickly disseminate APA staff and concentrate advocacy efforts to avert any further psychologist victories in the scope of practice battle. Jason Young, APA's Chief Communications Officer, presented the results of messaging research conducted for APA in the spring of 2015. He also provided an overview of a toolkit APA is preparing for District Branches and State Associations to help them organize against scope of practice bills in their states.

XII. APA FELLOWSHIPS AND THE DIVISION OF DIVERSITY AND HEALTH EQUITY

Dr. Ranna Parekh, APA's Director of Division of Diversity & Health Equity, presented to the Council on the important role APA's fellows offer the organization. She encouraged the Council to utilize the presence of RFMs, their knowledge and experiences. Pausing to introduce the Council's RFMs, each fellow spoke to their expectations from working with the Council over the next year. Dr. Parekh recommended for the Council to consider a mentor-mentee program as an effective method to have the fellows actively involved in the Council.

XIII. FEDERAL LEGISLATIVE AND REGULATORY UPDATE

Mr. Sturm updated the Council on what to expect when Congress returns from the summer recess. He highlighted that the 2016 presidential race is underway and will exert strong influence on Congressional activity in the fall and leading up to the campaign in November 2016. This fall, we anticipate that Congress will grapple with a number of political and policy issues—federal appropriations for fiscal year 2016, expecting a continuing resolution; debate over federal funding of Planned Parenthood in the wake of controversial videos; an up-or-down vote on the negotiated Iran nuclear framework in the Senate; a showdown over raising the federal debt ceiling in December; and the possible use of reconciliation procedure to repeal/replace Affordable Care Act. And most importantly, we anticipate the passage of comprehensive mental health reform legislation.

<u>Comprehensive Mental Health Reform</u>

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

Both bills are currently under consideration by the leadership of key House and Senate Committees – with the APA Administration deeply involved. APA continues to engage with relevant members of Congress through direct lobbying and grassroots contact, as well as third party stakeholders, in order to drive APA's agenda forward through enactment of bipartisan comprehensive mental health reform. Mr. Sturm referenced a new resource for APA membership that provides a side-by-side analysis of the House and Senate bills highlighting components that impact the APA.

Insurance Mergers

As a result of proposed major health insurance company mergers and acquisitions, in July the Council—by a unanimous vote—crafted a resolution to present to the Assembly Executive Committee. The measure recommended the APA assess and advocate accordingly regarding the proposed insurance company mergers. With support of the AEC, the resolution quickly moved through the Board of Trustees gaining support for the APA Administration to prepare a letter to the antitrust regulators focusing on access to clinically appropriate psychiatric care. In September, APA submitted a letter to the antitrust regulators at the Department of Justice (with a copy to the Federal Trade Commission) expressing APA's concerns about the proposed insurance company mergers (Anthem-Cigna, Aetna-Humana, and Centene-HealthNet). This issue has drawn considerable Congressional attention. In response, the U.S. House and Senate Judiciary Committees will be holding several hearings on insurance industry consolidation. APA is continuing to work collaboratively with the American Medical Association and other medical specialty organizations to raise our concerns with the Congressional members and their staff. The Council has advised APA Government Relations staff throughout this process. We anticipate more movement on this in the future as federal review of the proposed mergers unfolds.

Biography

In January 2015, Congressman Tim Murphy, Ph.D. of Upper St. Clair began serving his seventh term in Congress representing the 18th District of Pennsylvania, encompassing the South Hills of Pittsburgh and portions of Greene, Allegheny, Washington and Westmoreland counties.

Congressman Murphy relies on his three decades as a psychologist to advocate for meaningful reforms in the U.S. healthcare system. As one of only a handful of members of Congress with a background in healthcare, Tim quickly established himself as a leader on the issue. He is Co-chair of the Mental Health Caucus and a founding member of the GOP Doctors Caucus, giving him a platform to educate other members of Congress and the public on ways to make healthcare more affordable and accessible for all families.

Representing Southwestern Pennsylvania, a world leader in the research, development, and transmission of energy, Congressman Murphy holds a senior position on the House Energy and Commerce Committee as Chairman of Oversight and Investigations. Rep. Murphy also sits on two additional subcommittees: Health and Environment & Economy.

As the oldest-standing legislative committee in the U.S. House of Representatives, Energy and Commerce has jurisdiction over telecommunications, consumer protection, food and drug safety, public health research, environmental quality, energy policy, and interstate and foreign commerce. Oversight Chairman Murphy is continuing with a vigorous review of the administration's stimulus spending, implementation of the healthcare law, elimination of government waste, fraud and abuse, and outlining steps to prevent future incidents of food and drug contamination.

In December 2013, following a year-long investigation by his subcommittee into the nation's broken mental health system, Mr. Murphy unveiled his landmark mental health reform legislation, the Helping Families In Mental Health Crisis Act. Praise and support for the Helping Families In Mental Health Crisis Act has poured in across the country from the American Psychiatric Association, National Alliance on Mental Illness, and numerous media outlets such as CNN, the Wall Street Journal, Washington Post, and Pittsburgh Post-Gazette.

Legislative accomplishments include authoring the 'Generic Drug and Biosimilar User Fee Act of 2012' (H.R. 3988), which was signed into law by President Obama in July 2012 as part of a larger Food and Drug Administration (FDA) Reform package. Murphy's innovative legislation closes a major safety gap in the global drug supply chain and establishes the first-ever program bringing life-saving generic medications to market faster. In addition to requiring the FDA to inspect foreign factories with the same rigor and biennial frequency as domestic plants, Murphy's bill will add to the $1,000 in savings each senior citizen receives due to access to safe generic medications.

Murphy also authored the Seniors Access to Mental Health Act, which ended the discriminatory

practice of charging higher co-pays to seniors on Medicare seeking mental healthcare services. The legislation became federal law as part of the Medicare Improvements for Patients and Providers Act on July 15, 2008.

Most recently, Murphy's 'Strengthening Medicare and Repaying Taxpayers Act' (SMART Act, H.R. 1063) was signed into law by President Obama. Murphy's bill eliminates bureaucratic hurdles to the Medicare Secondary Payer program and recoups billions of dollars owed to taxpayers. The new law accelerates the processing of Medicare secondary payer reimbursement from liability and workers' compensation settlements; removes bureaucratic delays at Medicare that can jeopardize seniors' benefits; and collects billions of dollars owed by insurance companies to the Medicare Trust Fund.

He also introduced the Mental Health Security for American Families in Education Act and passed legislation into law to get college students suffering from depression or other mental illnesses the help they need before tragedy strikes.

Before coming to Congress, Congressman Murphy served in the Pennsylvania State Senate from 1997-2002. There he penned the state's historic Patient Bill of Rights and increased funding for medical research, while consistently supporting responsible fiscal management of government to promote job creation and reduce the tax burden on families.

In addition to his work in Congress, Commander Murphy currently serves in the Navy Reserve Medical Service Corps at Walter Reed National Military Medical Center at Bethesda. There he works as a Navy psychologist with service members with traumatic brain injury and post traumatic stress. His ADT has included service with Navy Special Warfare Coronado and on the USS Carl Vinson.

He and his wife Nan now reside in Upper St. Clair and attend St. Thomas More Catholic Church in Bethel Park. They are the parents of Bevin and proud grandparents of one granddaughter.

Congressman Murphy earned a bachelor's degree from Wheeling Jesuit University, a master's degree from Cleveland State University, and his PhD from the University of Pittsburgh.

Additional Articles:

http://murphy.house.gov/latest-news/murphys-mental-health-legislation-gains-100-cosponsors/

http://murphy.house.gov/latest-news/murphy-honored-with-paul-wellstone-mental-health-advocacy-award/

Washington Psychiatric Society

August 10, 2015

Ms. Deana McRae
American Psychiatric Association
advocacy@psych.org

Dear Ms. McRae,

I am writing to nominate U.S. Congressman Tim Murphy, PhD of the 18th District of Pennsylvania for the 2016 Jacob K. Javits Public Service Award.

As a psychologist for more than three decades he is the leading Congressional advocate for the reform of the nation's broken mental health system and has introduced bipartisan landmark mental health reform legislation entitled "Helping Families in Mental Health Crisis Act" which now has more than 102 members of Congress as cosponsors. He is also Co-Chair of the Mental Health Caucus and sits on subcommittees for Health, Environment & Economy. In addition, he serves as a commander in the Navy Reserve Medical Service Corps as a psychologist treating Wounded Warriors with post-traumatic stress.

Now serving his seventh term in Congress, Congressman Murphy has used this platform to educate politicians and the public on ways to improve the government's approach to mental health's stigmas, treatment, transparency and research. His "Helping Families in Mental Health Crisis Act" expands inpatient and outpatient psychiatric treatment; training for caretakers and first responders; additional Medicare and Medicaid coverage and brings accountability to mental health and substance abuse providers.

As a staunch advocate of immediate mental health reform, especially in the wake of so many recent mass killings in the U.S. by disturbed individuals, Congressman Murphy should be recognized for his unconditional devotion to help patients, families, healthcare providers and communities to provide better quality care for those in need. It is our hope that this honor will show our nation's gratitude for his relentless efforts as well as motivate others in leadership positions to provide more education, professionals and resources for mental health care and reform in an effort to mitigate personal and societal tragedies resulting from mental illness.

In anticipation and appreciation of your interest, I look forward to hearing from you.

Sincerely,

Constance E. Dunlap, MD
President
Washington Psychiatric Society
550M Ritchie Highway, #271
Severna Park, MD 21146

EXECUTIVE SUMMARY

Council on Children, Adolescents and Their Families

Council Overview

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

The Council met in Arlington, Virginia, on Friday, September 11, 2015. Stemming from the meeting are the following action items.

Action Items

Will JRC recommend that the Board of Trustees vote to establish a Caucus on Infancy and Early Childhood? See Attachment 3

JRC Referrals

1. **Assembly Action Paper: Mental Health Leave in Colleges (ASMMAY1512.Y)**
   A work group of council members was formed at the September council meeting to determine if the existing APA Position Statement on College Mental Health should be revised to address college mental health leave or if a separate policy should be developed. Upon consideration, the work group believes the action paper has merit (in that forced leave of absence due to mental health issues may be detrimental) and is best served as part of a revised Position Statement on College Mental Health. The work group intends to have this revised position statement prepared and vetted by the entire council in time for submission to JRC in January.

2. **Revision to Position Statement: Psychiatric Hospitalization of Children and Adolescents (JRC 8.C.1)**
   Drs. Michael Houston and Swathi Krishna have prepared a reworked draft of the position statement. The draft incorporates within the body of the position statement salient points articulated in the Recommendations section of the previously revised document, as was suggested by JRC last July. This latest draft is currently being evaluated by the council. The council-approved iteration will be forwarded to JRC in January.

Attachments

1. Minutes, September 11 meeting
2. Minutes, August 19 conference call
3. Proposal for a Caucus on Infancy and Early Childhood

ATTACHMENT 1
Council on Children, Adolescents and Their Families
Meeting Minutes
9am – 4pm, September 11, 2015
Crystal City Hilton, Arlington, VA

Attendance:
Members:
Joseph Penn, MD (chair)
John Sargeant, MD (vice chair)
Eraka Bath, MD
Karen Pierce, MD
Steve Adelsheim, MD
Anish Dube, MD
Christopher Kratochvil, MD
Louie Kraus, MD
Michael Houston, MD
Jean Thomas, MD
Mary Ann Schaepper, MD
Kim Gordon, MD
Caitlin Costello, MD
Gabrielle Shapiro, MD
Fellows:
Caroline Brozyna, MD
Megan Baker, MD
Swathi Krishna, MD
Isheeta Zalpuri, MD
James Murphy, MD
Misty Richards, MD
Yetunde Akins, MD
Maria Jose Lisotto, MD
Guests:
Jay Shore, MD
Carmen Head, MD
APA Administration:
Saul Levin, MD, MPA
Kristin Kroger
Yoshie Davidson
Ranna Parekh, MD, MPH
Alison Bondurant
Philip Wang, MD, DrPH
Tristan Gorrido, MD

Excused: Drs. John Walkup and Andres Martin
Unexcused: Drs. Amy Ursano and Sarah Bougary

The meeting opened with attendee self-introductions and disclosures of conflicts. Members admitted finding bios of council members and fellows helpful; to do so and in advance was credited to Dr. Sargent. Following introductions, Dr. Penn gave highlights of the council charge; Ms. Bondurant reviewed the various member types on councils. Addressing the resident fellows assigned to the council, Dr. Penn remarked that council participation is a tremendous opportunity for mentorship and interaction. Dr. Parekh noted that councils are an excellent source for material for fellows' year-end fellowship reports, adding that resident fellowships are now unified under the Division of Diversity and Health Equity.

Discussion highlights:

- Dr. Penn reported on Dr. Binder's chairpersons roundtable meeting held earlier in the day, noting that the key message from the meeting is that councils must produce meaningful products to guide the field of psychiatry and inform leadership.

- Dr. Levin welcomed Dr. Penn in his new role as council chairperson and thanked Dr. Kraus for his prior leadership. Dr. Levin also introduced Dr. Philip Wang, new Director of the APA Division of Research. Dr. Levin commended the council for its strong meeting agenda but cautioned that councils do not work alone but cross-functionally with other councils and in adherence to the authority of the Board of Trustees.

- The council received and approved the nominees for the 2016 McGavin and Ittleson Awards, presented to council by Ms. Bondurant and Dr. Houston, chairperson of the Ittleson Award Selection Committee. Ms. Bondurant advised council members not disclose the names of the individuals until after Board approval in December.

- The council addressed three referrals from the Joint Reference Committee:

    - *Action Paper Addressing Impact of Environmental Toxins on Neurodevelopment and Behavior.* The council was unclear about its role in the review of this action paper. Given the broad nature of this subject area, council resolved to wait for an assessment by the Division of Education, the lead reviewer of the action paper, before formally submitting council feedback. Dr. Penn resolved to confer with Dr. Gorrindo, division director.

    - *Action Paper on Mental Health Leave in Colleges.* The council was unanimous in its support of the action paper decrying the discriminatory nature of the requirement by some colleges that students with mental health problems take a year off. The ensuing discussion underscored the need for broad-based educational and advocacy campaigns directed at colleges, residency training programs, and parents. More awareness and policy around transitioning youth is critical.

      Following discussion, Dr. Penn appointed a work group to determine if the existing position statement on college mental health should be revised to address college mental health leave or if a separate policy should be developed. Members of the work group are Drs. Schaepper, Richards, Gordon, and Zalpuri. Dr. Dube, author of the action paper, will serve as work group chair. Drs. Penn and Adelsheim will confer with the co-chairs of the APA College Mental Health Caucus, Drs. Leigh White and Amy Poon. Ms. Head will seek counsel from the AACAP committees on transitional aged youth and college student mental health. Ms. Bondurant will circulate to the work group the revised college mental health position statement prepared by Dr. White prior to the action paper. The work group is to report back to the council before October 2

    - *Position Statement on Psychiatric Hospitalization of Children and Adolescents*. Drs. Houston and Krishna volunteered to consider, per JRC's request, if the recommendations for APA action specified in the previous rewrite of the position statement document be integrated within the official statement of APA's position. If so, they will pass on the reworked version to council for review before October 2. Dr. Houston credited Dr. Desiree Shapiro, a former fellow on the council, for updating the position statement last May.

- Dr. Binder accentuated the importance of well referenced, meticulous council work products, as they provide the basis and substance for legislator education and APA leadership and media talking points. With regard to the media, she advised council members to notify the APA Communications Office whenever approached for comment by the media. Communication

staff will work with the member to deliver the best message or will identify an alternate spokesperson if appropriate.

Dr. Binder also reiterated that council should not duplicate AACAP's efforts and those of other organizations. APA may formally endorse external products or policies.

- POSITION STATEMENTS
  - *Corporal Punishment in Schools*. The council voted to retire the position statement upon recommendation of a small work group who met over lunch to assess the position statement. Members of the work group, Drs. Kraus, Bath, Lisotto, and Gordon recommended that APA endorse AACAP version.

  - *Reactive Attachment Disorder*. Ms. Head reported that AACAP has developed a practice parameter on this subject, which will be reviewed by the AACAP Executive Committee next month. Council concluded that the APA position statement is archaic and voted to retire it in view of the upcoming AACAP practice parameter.

  - *Patient Access to Treatments.* Based on a request for input from the Council on Healthcare Systems/Financing, the council voted to rewrite #7 of this position statement to stress that APA strongly encourages broad evidence based-research. The council determined no need for a separate statement addressing research around children's access to treatment.

- Dr. Thomas announced that the proposal to establish an APA caucus on infant and early childhood mental health is nearly complete. The requisite number of member letters of support of the caucus, 10, have been collected but she will continue to accept more.

- ANNUAL MEETING.
  - For the benefit of the fellows, Dr. Sargent described the process/timeline for submitting proposals for Annual Meeting scientific sessions. He encouraged fellows to seek guidance from experienced psychiatrists in December and spend the remaining nine months perfecting the abstract and securing presenters before the submission deadline in September. Critical and interesting topics better the chances for acceptance. Several fellows recommended creating a "tipsheet" or web video presentation for fellows in this regard.

  - Dr. Penn relayed the Child and Adolescent Psychiatry program fellows' requests for council endorsement of their Annual Meeting submissions, marveling at the high quality of their work. In the interest of time, there was consensus by council that Dr. Penn be given the authority to endorse on the council's behalf any subsequent requests for council sponsorship.

- Dr. Shore described the charge of the Work Group on Telepsychiatry, namely to develop content for APA meetings, a toolkit of web resources for various audiences, and APA policy recommendations. He recited a draft APA policy statement whereby APA advocates the use of telepsychiatry but at the discretion of the patient. Reaction has been positive about the statement thus far, with the council in agreement.

- The council engaged Dr. Lu from the Council on Minority Mental Health and Health Disparities in discussion ways in which the two councils may collaborate around on at risk-youth of different ethnicities. The effects of violence, poverty, and incarcerated parents on children were identified as key areas of concern, as is the disproportionate confinement of minority youth. Ideas put forward for collaborative work products included educational material for psychiatrists and stakeholders alike (e.g., policy makers, lawyers, law enforcement) as well as APA policy statements. Following discussion Drs. Lisotto (lead), Gordon, and Costello volunteered as a work group to flesh out these concepts and to report back to the council on its next conference call. A parallel work group from the Council on Minority Mental Health, Dr. Lu agreed, will be formed as well. He also suggested that the chairs of both work groups encourage Dr. Binder to include child-related issues in her April 2016 conference criminalization of mentally ill.

- Dr. Gorrindo summarized ABPN president's request of APA to submit comments regarding proposed policy changes to subspecialty certification requirements. Specifically the change will require diplomats who hold a subspecialty certification to also maintain the general psychiatry certification. In the ensuing discussion the council recommended that each subspecialty exam be separate, with individuals being able to recertify in any field as long as they maintain certification in their specialty. In addition psychiatrists should retain the right to take a combination exam if desired. The council also recommended that the option for multiple recertification in one exam be sustained based on the prerogative of examinee.

- Ms. Head announced that the parent medication guide on autism, a joint project between AACAP and APA, is nearly complete. Ms. Bondurant noted the guide will have to pass through APA channels before publication. Upon question of the need to make existing parent medical guides DSM5 compliant, Ms. Head agreed to consult with AACAP authorities. Reporting on other AACAP news, Ms. Head announced the June 2016 Congress of the Spanish Child and Adolescent Psychiatry Association, co-sponsored by AACAP. Dr. Penn added that he will attend tomorrow's AACAP Executive Committee tomorrow, viewing the invitation as way to increase collaboration and to keep AACAP apprised of the activities of the council.

- Other discussion:
    - Dr. Kraus encouraged council members to contribute to the American Psychiatric Association Foundation, on which he is a Board member.
    - A moment of silence was held in memory of 9/11.
    - Dr. Penn recommended the addition of more choices of specialty and interest areas to that section of the Member Profile Update. Drs. Levin and Parekh agreed to call this to the attention of Jon Fanning, APA Chief of Membership.

  - Dr. Wang mentioned that one his goals as director of research is to keep councils resourced with useful and customized information about interventions based on research.

- A conference call will be scheduled for 7PM Eastern during first week of November to hear work group reports and to begin to identify subject areas for council attention, to include teen suicide, gender dysphoria, foster care in crises in different states, and guidance to adult psychiatrists who treat adults with autism. Drs. Kraus and Schaepper offered to flesh out potential council projects around transition-aged autistic children.

ATTACHMENT 2
Minutes
Council on Children, Adolescents, and Their Families
Conference Call
August 19, 2015
7:00 PM Eastern

Present: Drs. Joseph Penn (chair), John Sargent (vice chair), Caitlin Costello, Kimberly Gordon, Louis Kraus, Maryann Schaepper, Gabrielle Shapiro, Jean Thomas, Steve Adelsheim, Eraka Bath, Anish Dube, Karen Pierce, John Walkup
APA Administration: Kristin Kroger, Dr. Ranna Parekh, and Alison Bondurant
Excused: Drs. Christopher Kratochvil and Michael Houston
Not excused: Dr. Andres Martin

- After introductions, Ms. Bondurant reviewed the council charge and expectations of council members, which were distributed before the call.
- Dr. Penn reviewed the draft agenda for the upcoming council meeting in September. Discussion focused on clarification of the JRC referrals and how the council is expected to act upon them.
- The council pondered the idea of a possible collaboration with AACAP around integrated care at the 2016 APA Annual Meeting in Atlanta. Collaborative care in juvenile justice and presentations of collaborative models of care were suggested as possible themes. Dr. Penn resolved to confer with Dr. Binder in view of her invitation of AACAP to deliver a presidential symposium at the Atlanta meeting. Dr. Penn added that he will attend the AACAP Executive Committee, by invitation, in September and will bring up the subject there. Ms. Kroger supported the idea of more linkages with AACAP to avoid duplication of efforts.
- Ideas for council presentations at the 2016 Annual Meeting were proposed: cyber bullying, youth of color in detention facilities, solitary confinement of juveniles, the foster care crisis in California, and police aggression toward young African American men. Ms. Bondurant confirmed that council members may submit a meeting abstract until September 24 but only if the submission had been started by September 17. The frequency of conference calls will be determined at the council meeting. A suggestion was made for work groups to meet by phone more regularly with the council as a whole meeting in the intervening periods.
- Ms. Kroeger advised council to develop a work plan for the next year or two.
- Dr. Thomas reported that she continues to develop a proposal to establish a caucus on infancy and early childhood.
- Dr. Parekh reported that recipients of 2015 resident fellowships will participate in the All Fellows Orientation Day in September.
- Dr. Penn ended the call by reminding council members to read the September meeting materials carefully and to come to the council meeting prepared with thoughtful feedback and to volunteer for council work groups.

ATTACHMENT 3

Proposal to Establish a Caucus on Infancy and Early Childhood

Prepared by Jean Thomas, MD

Why the Caucus is needed:

The purpose of a Caucus on Infancy and Early Childhood is to promote communication and networking among APA members who share deep concern about the emotional and behavioral health of all children and recognize the need to identify and treat children as early as possible. Research demonstrates that the first year of life is the most influential in a child's development and children are most malleable to intervention in their earliest years. The goal in establishing the Caucus on Infancy and Early Childhood, within the Council on Children, Adolescents and Their Families is to support clinicians', parents', and policy makers' understanding of the urgency of earlier intervention and to trigger more research, collaboration and funding for the youngest children and their families.

Approximately 10% of 1-and 2-year-old children have behavioral and emotional difficulties as reported by parents and pediatricians. Similarly, approximately 10% to 15% of preschool children have behavioral/emotional difficulties. Longitudinal studies demonstrate that many early behavioral and emotional difficulties persist. Disruptive behavior disorders comprise a substantial majority of the behavioral and emotional disorders diagnosed in toddlers and preschool children. Furthermore, children with early disruptive disorders are at increased risk for continuing externalizing difficulties and also for internalizing and academic difficulties. Child externalizing and internalizing disorders, especially when combined, are predictive of later antisocial behavior. Of greatest concern, early onset aggression is a precursor of life-course persistent antisocial behavior.

The transactional model of development (Sameroff & Chandler, 1975) conceptualizes development as the unfolding of the biological potential within the ever evolving, specific context of the caregiving environment, including the child-parent relationship, community, and culture. Developmental changes are driven by the regulatory influence of the primary caregivers and environment-gene interaction.

Three domains, child, parent and parent-child relationships, all contribute well-known risk for psychopathology in early childhood. *Child characteristics,* including externalizing and internalizing difficulties, especially when combined, are predictive of later antisocial behavior. Neurodevelopmental vulnerabilities often found in children with disruptive disorders appear associated with difficulties in cognitive, autonomic, neuroendocrine, neurochemical, prenatal, and genetic factors. *Parent characteristics* (locus of control, anxiety, depression) associated with both parental psychopathology and adjustment problems, correlate with disruptive behavior in young children. Risk associated with the caregiving environment centers around parenting that is negative and inconsistent, and family social adversity. Parent mental illness is the most widely studied and best understood risk factor. *Parent-child relationship characteristics* (parent-child conflict,

intrusiveness, and difficulties with reciprocity, non-compliance, and coping with non-compliance) are also associated with psychopathology in young children.

The young child must be understood and treated within the specific caregiving context, most importantly, within the primary caregiving relationships. Risk associated with the caregiving environment centers on critical and inconsistent parenting and family social adversity. The National Institute of Child Health and Human Development (NICHD) Child Care Research Network (2004) demonstrated in a large multi-site study the central role of parents and parent-child interactions in affect dysregulation and behavioral competence at 24 and 36 months. They also demonstrated the importance of affect regulation in later cognitive and social competence.

In summary, the goal in establishing the Caucus on Infancy and Early Childhood, within the Council on Children, Adolescents and their Families is to support clinicians', parents', and policy makers' understanding of the urgency of earlier intervention and to trigger more research, collaboration and funding for the youngest children and their families. Research demonstrates that the first year of life is the most influential and that early childhood is the most malleable time of a child's development. These years are also fraught with the normative behavioral transitions around age two years that trigger parent-child relational challenges. These behavioral challenges often signal parents to seek help, which is an opportunity to identify early neurodevelopmental differences and to intervene most effectively with parents and other caregivers. This is also a time when parental affective vulnerability exacerbates these challenges. Increased understanding of etiologic pathways that guide specific intervention, treatment and prevention strategies is required (American Academy of Child and Adolescent Psychiatry, 1997).

Goals of the Proposed Caucus on Infancy and Early Childhood:

Overarching goals of the proposed Caucus on Infancy and Early Childhood are grounded in burgeoning early childhood mental health research that documents the urgency of early intervention. The Caucus' overarching goal is to support: understanding, teaching, research and implementation of collaborative mental health guidelines and programs for infants and young children, within the APA and beyond.

Proposed Caucus Leadership:

Jean M. Thomas, M.D., the Chair of the APA Corresponding Committee for Infancy and Early Childhood brought forth the Committee's resolve to continue their critical work after the discontinuation of all Corresponding Committees. At that time it was well known that research documents the urgency of earlier intervention. In 2014, with the recommendation of Council Chair, Louis Kraus, M.D., the Council supported this goal and Dr. Thomas's leadership during the first year of the Caucus, until, by APA design, the Caucus elects new leadership. With Dr. Thomas's support, during the Council's September 2015 meeting, members volunteering for the Caucus initiated and are now submitting an abstract titled: Early Disruptive Behavior: What Does It Mean? Differential Diagnosis and Pharmacologic Approaches.

Proposed Year One Activities:

During the first year, the Caucus will meet at the APA's Annual Meeting and via listserv deliberations to more clearly define it's goals and plans. In addition, it will select a topic for abstract submission to present at the next Annual Meeting. It will also create a plan to build Caucus membership and to ensure a minimum or 25 APA members. Initiatives will focus on increasing understanding of the urgency of earlier identification and intervention among: 1) Clinicians, 2) Parents, 3) Policy makers and 4) Researchers. Collaborations with the American Academy of Child and Adolescent Psychiatry's Infant and Preschool Committee and the American Academy of Pediatrics will be initiated.

Caucus Activities Year Two and Beyond:

In the second year, the Caucus membership will elect a new leader who will continue to ensure a minimum of 25 or more members. Work groups begun in the first year will report on their completed and ongoing work products and new ideas for the second year. The Caucus leader will also strongly support members initiating new work groups. During the year the Caucus will develop and submit an abstract to present at the APA's Annual Meeting. Ongoing initiatives will focus on increasing understanding of the urgency of earlier identification and intervention among: 1) Clinicians, 2) Parents, 3) Policy makers and 4) Researchers. Ongoing and new collaborations, including those with the American Academy of Child and Adolescent Psychiatry's Infant and Preschool Committee and the American Academy of Pediatrics will be actively explored.

Cost Estimate:

$175 annually ($75 for meeting room space at the Annual Meeting + $100 for listserv costs). Estimate is based on standard costs for component budgets.

Letters of Support for a Caucus on Infancy and Early Childhood

1.
I am submitting this letter in support of the caucus for Infancy and Early Childhood. Infant Psychiatry is a field that needs more attention. It is abundantly clear from recent research that genetics are impacted by early childhood environment and those two factors determine most of psychopathology. An emphasis on Infant Psychiatry is essential to our field.
Elias H. Sarkis, MD, DFAPA, DFAACAP

2.
I am writing to support the formation of a Caucus for Infancy and Early Childhood, which will be able to spearhead continued research in early childhood mental health, teach and implement collaborative mental health guidelines and programs for infants and young children. As a fellow in training in the field of Child and Adolescent Psychiatry, I am acutely aware of the challenges that this population face and believe the formation of a caucus would be beneficial given how underserved and at risk this phase of childhood is. I am interested in being a member of the caucus because in developing my career as a Child and Adolescent Psychiatrist, I have a particular interest in early developmental interventions and how these can positively impact outcomes. Please consider approving this caucus.
Caroline De Oleo Brozyna, MD

3.
A Caucus on Infancy and Early Childhood is important because it recognizes that early life experience has an impact on human emotional development that is unique to any other period in our lives. Identifying this as a significant developmental phase for attachment and growth by designating a separate caucus will allow us to focus work in this area of trainee education and physician education.
I would like to be a member of this Caucus because this is an area that I have been personally involved with in my own training and that I am incorporating into my own private practice as an early career child psychiatrist. It is important to me to have a venue to learn from others as I develop my expertise in this age group and that I can contribute to the education of trainees.
Celeste Lopez, MD

4.
I support initiating an APA Caucus for Infancy and Early Childhood. Rapidly developing early childhood mental health research demonstrates the genesis of many mental health disorders in infant and preschool developmental processes. APA members should be cognizant of this research and aware of the urgency of early intervention for prevention of later psychopathology. I would be happy to support the Caucus to expand understanding, teaching and implementation of collaborative mental health guidelines and programs for infants and young children, within the APA and beyond.
Penny Knapp, MD

5.
I am writing to support the formation of a Caucus for Infancy and Early Childhood. While most of our treatments target psychopathology as they manifest, psychiatrists are not involved enough in primary prevention and public health efforts aimed at the prevention of pathophysiological processes from arising in the first place and addressing the social determinants of mental health. This Caucus could serve to further research in the Infancy and Early Childhood developmental periods and advocate for social/policy level changes. I am interested in becoming a member due to my own interest in public systems, policy and population level interventions to address mental health and well-being.
Anish Ranjan Dube, MD, M.P.H.

6.
I would like to write to support the formation of a Caucus for Infancy and Early Childhood. This caucus would be an important addition to APA and its Components because of its ability to focus on the early diagnosis and treatment of early childhood mental health disorders. These disorders are still not understood as well as disorders in older children and adults and the caucus could lead current efforts for education and additional research regarding risk factors and treatments. I would be honored to be a member of the Caucus because, as a resident psychiatrist, I am interested in participating in the development of early childhood diagnostic and treatment directives that I may use in my practice as I move forward in my practice.
Swathi Krishna MD

7.
I serve in my local branch of the APA council as a region councilor. I am a child and adolescent psychiatrist who works in an outpatient clinic in southern CA. I work with an underserved population. I am always impressed by the level of trauma this population has been exposed to. I am even more fascinated by the resilience and positive outcome that this population exhibits when there has been early detection of issues with use of early intervention techniques. I am particularly interested in early life issues. Of note is the overwhelming evidence gathered in studies looking at the outcomes of children whose mothers were supported during pregnancy and in infancy and early childhood. These studies have shown that when mothers are adequately supported, they are bound to be better caregivers to their infants and this interaction makes for a better attachment. Attachment is critical to resilience and ability to deal with stressors. An APA group addressing issues affecting infancy and early childhood is of immense value to the practice of Psychiatry in general and particularly to Child and Adolescent Psychiatry. This group will serve the very important role of advocating for strong family life, preventing or minimizing trauma to the unborn and very young, educating various parties about the importance of a solid beginning, providing adequate treatment for disorders that have their root in early life and encouraging research in this very dynamic and vibrant aspect of Psychiatry.
I would love to be part of the Infancy and Early Childhood caucus as soon as the APA allows it.
Ijeoma Ijeaku MD, MPH

8.
I am interested in the development of an APA Caucus for Infancy and Early Childhood. I think it is very important to approve the formation of this caucus given the positive impact of early intervention and prevention efforts for young children with mental illness. This caucus would allow for a group of interested and passionate psychiatrists to join together to investigate and collaborate on improving the mental health treatment and delivery for those youth suffering in their early childhood. I also think it is important to collaborate with other organizations, such as AACAP, to promote greater awareness of early childhood mental health efforts.
Desiree Shapiro, MD

9.
I am writing in support of the formation of a caucus on infant mental health within the APA. This are is crucial for prevention and early intervention of the entire spectrum of mental disorders. While the majority of APA members treat adults-it is our work with parents and young children that will be most effective in addressing the environmental antecedents to psychiatric illness. I would be an active member of an infant mental health caucus and would think such a group would interact cooperatively with a number of APA components.
Michael Houston, MD, DFAPA, DFAACAP

10.

I am writing to support the formation of a Caucus for Infancy and Early Childhood which will be able to spearhead continued research in early childhood mental health and teach and implement collaborative mental health guidelines and programs for infants and young children. Please consider approving this important caucus.
Gabrielle Shapiro, MD

11.
As previous Chair of the Committee on Infancy and Early Childhood for the APA's Council on Children, Adolescents and Their Families, I am eager to support the Council's proposal for a Caucus on Infancy and Early Childhood. I have specialized in infant and early childhood feeding disorders for more than 30 years, published many research papers, and given many national and international talks in this area. I strongly support the establishment of this Caucus and would like to be one of the core members. A greater focus on infants, young children and their families will foster additional, greatly needed research and clinical expertise for this most vulnerable and promising age group.
Irene Chatoor, MD

12.
I am pleased to provide this statement of support for the formation of a Caucus for Infancy and Early Childhood. This critical topic is in need of additional attention from our professional organization in order to identify current and reliable resources/guidelines for our members, identify gaps, and provide guidance towards opportunities to improve care and outcomes for infants and young children. As a researcher with a history of clinical research with young children, I would be pleased to help support the initiation and operationalization of this caucus.
Christopher J. Kratochvil, MD

9/14/2015

2015 September Meeting of the Council on Communications

Executive Summary:

The 2015/2016 Council on Communications convened on September 12, 2015. During the meeting, no action items were presented, but several topics were discussed in depth. These included APA Messaging on Scope of Practice Legislation, the development of communications policies aimed at protecting APA media assets such as the APA email list and new brand, and the APEX awards and the council's own Member Communications Award. A detailed summary follows.

September Components Meetings

Friday, September 11 and Saturday, September 12, 2015

Friday meeting was conducted jointly with the Council on Advocacy and Government Relations in executive session.

The following Council members were present: Chairman Arshya Vahabzadeh, M.D.; Vice Chairman John Luo, M.D.; Stephen Allison, M.D.; Carol Bernstein, M.D., Jeff Borenstein, M.D.; Gene Beresin, M.D. (call-in); Lloyd Sederer, M.D.; Lara Cox, M.D.; Jack Drescher, M.D.; Stephanie Hernandez, D.O.; Steven Chan, M.D.; Juliana Chen, M.D.; Olanrewaju Dokun, M.D.; Ayana Jordan, M.D.; Stefani La Frenierre, M.D.; Chuan Lee, M.D.; Deepak Penesitti, M.D.; David Tran, M.D.; Aparna Atluru, M.D.; and Amanda Harris, M.D.

See attachment for meeting attendance sheet.

The following APA staff were in attendance: Jason Young, Chief Communications Officer; Amanda Davis, Deputy Director of Corporate Communications and Public Affairs; Ryan Vanderbilt, Director of Integrated Marketing; Cathy Brown, Executive Editor of Psychiatric News and Director of Member Communications; and James Carty, Corporate Communications Specialist.

The meeting began at 9:10 am and the council unanimously approved the minutes of the last council meeting held in a conference call on July 24, 2015.

Jason introduced Ryan Vanderbilt, newly hired as Director of Integrated Marketing, as well as James Carty, newly hired as Corporate Communications Specialist and staff liaison to the council, and Charrosé King, newly hired as Senior Social Media Specialist.

Council Chairman Vahabzadeh said in his opening remarks that setting a concrete agenda was important as the council moves into 2016, and that collaboration with other councils such as the Council on Advocacy and Government Relations (CAGR) would be key.

APA President Renee Binder then made remarks on the importance of collaboration between councils, since many tackle overlapping issues. Binder specifically highlighted the collaboration between COC and CAGR as an example to emulate.

In her remarks, President Binder:

- Introduced the APEX Awards to the council, which are intended to recognize people doing "great work" on behalf of mental health. These will not be limited to psychiatrists, but may also include celebrities, sports figures, etc.
- Said that the APEX Awards would be decided by a committee
- Highlighted the specific focus of the first APEX Awards: working to decrease the criminalization of the mentally ill. The awards will be held in conjunction with the Stepping Up Conference, which is sponsored by the American Psychiatric Association Foundation (APAF)
- Stressed the importance of APA's stature as a national organization in recognizing people who do good

Binder then gave a brief summary of APA's #givestigmatheboot campaign, and some short background on Kenneth Cole's offensive billboard that inspired it. She stressed that the APA must take the lead in ensuring that appropriate language is used to address people with mental illness in order to combat stigma.

During the Chief Communication Officers Update, Young:

- Recapped the join session the members of the COC had with CAGR on scope of practice. Young noted that he feels confident that reinvigorating the messaging and providing DBs with a three-tiered toolkit on this issue would result in a win.
- Described the polling methodology and number polled. Most polled were likely voters, meaning they were more engaged. 1010 people were polled by phone, around 50-60 in focus groups, along with additional policy makers interviewed about the subject. Around 1100 in total were polled.
- Outlined the starting position of APA in scope of practice arguments. Young highlighted that APA starts at a 61/19 split in favor of scope of practice bills, but after messaging, that comes to 40/40 draw with 20% undecided. Young stressed that the messaging is strong, but it behooves APA to be proactive on this issue.

APA President-elect Maria Oquendo joined the council briefly and praised the work of the council and the Communications team. Oquendo highlighted the need to stay current and reach the next generation of psychiatrists. She also promoted diversity, both ethnic and geographic, within the organization.

The Council had a lengthy discussion on the scope of practice issue, during which the following issues were raised:

- Embedded confusion of public about the role of psychiatrists vs psychologists
- The perception that access to care is a bigger issue than safety of care available in USA
- Public awareness of collaborative care, and the need for APA to be able to prove collaboration with facts
- How aggresive the APA plans to get with its messaging against scope of care bills. Jason Young stated that there are parts of the higher tier toolkits that address the link between psychologists and torture. He noted that APA polling on the issue was done before the *New York Times* piece on the American Psychological Association's involvement in torture with the US government .
- Ways for council members to help on this issue. These included participating in social media; writing letters to the editor; standing with patients , other like-minded physician groups and politicians; and educating colleagues.
- Toolkits which will serve as rapid response kits for DBs and state associations. Toolkits will also allow DBs and SAs to act proactively against scope of practice legislation.

Council Chair Vahabzadeh asked what resources APA was up against on this issue. Jason Young responded that the "other APA" is in a uniquely weak spot due to the torture link, but noted that they have strong positions in states like Hawaii and New Jersey which are "carryover states" where gains from previous legislative sessions carry over to the next session.

APA CEO and Medical Director Saul Levin, M.D., visited the council briefly. He thanked the council and communications staff for their work, and expressed his full support for the COCs efforts. Levin emphasized the need to protect intellectual properties of APA, which extend beyond DSM-5 to email lists and social media etc. He then introduced Director of Research Philip Wang, M.D., who said the APA is in a unique position to become a regulator for a new wave of mental health focused technology. Ethics and privacy issues of such devices were briefly discussed.

Jason Young gave an update on APA branding efforts:

- The brand is now ~90% implemented, up from approx. 72% during the July call.
- Young demonstrated the difference between old, fractured branding efforts by different orgs within the APA. He noted it was reasonable for someone to assume that they were looking at logos for 20+ different organizations rather than different components of one body.

Amanda Davis presented on efforts to license the APA brand to DBs and SAs. Council members were surprised that this was a free service, and expressed unanimous approval. A few council members implied that they would bring this service in front of their home DB or SA. Davis noted that there has been a swell in interest in the new brand among DBs and SAs since it was introduced at the annual

meeting particularly in the last 3 months. Jason Young noted that the licensing service is an offer not a decree.

Amanda Davis presented an update on the #GiveStigmaTheBoot Campaign involving the Kenneth Cole billboard to the council. She noted the tremendous positive response the campaign has received, including more than 500 followers and counting for APA on Twitter, and over 100K impressions on APA tweets. Jason Young stressed the need for APA to speak out on issues like this because it enhances the stature of the organization. He emphasized a need for APA to aggressively enhance the capability to issue a rapid response to issues like the Kenneth Cole billboard situation.

Jason Young delivered a presentation on APAs eblast campaigns. He noted:

- Email is not free, but has tremendous value. Possibly up to $2 million/year.
- Financial and non-financial value of emails, in that they can generate revenue, drive membership renewals, boost advocacy, etc.
- APA has had 5,800 opt-outs over the last 5 years, 2,400 in the last two years.
- The reason for this was attributed to a lack of targeting in audience selection for emails. In 2014/2015, 22 and 46 "universal" email blasts were sent, a far higher number than previous years.
- Due to the large number of recent opt-outs, APA is unable to communicate via email with ¼ of its members. If the trend continued, by 2018, the APA would be able to communicate with less than half of its members.
- The Partnership for Workplace Mental Health was noted as the #1 reason for opt-outs. Young commented that this was due to messaging in emails, and the communications team would work with them to improve this.
- IPS was responsible for a large number of opt-outs. Young noted that previous messaging was not audience-centric, and that under the current, revised plan, there have been almost no unsubscribes attributed to emails for IPS 2015.
- Job Central was listed as the #1 cause of opt-outs over time, responsible for over 1,300. Young resolved to sit down with program directors and strategize better ways to implement email.
- Young noted that open rates have climbed 50%.

Ranna Parekh gave a brief talk on the work of DDHE. She urged the council to engage with fellows, and praised the work of the council and communications staff.

The council held a lengthy discussion of the #iampsychiatry campaign:

- Two videos were screened briefly
- Some members said they had never heard of the campaign
- The advertising around the campaign was criticized

- The videos are to be screened at IPS

Ryan Vanderbilt delivered a brief talk on IPS marketing efforts, including the photo wall, social media monitors and the app that are designed to promote engagement at the 2015 meeting and grow attendance at future meetings. The council delivered mixed feedback about the necessity of these efforts.

The council held a lengthy discussion on the APEX awards:

- Celebrities who were authentic to the cause of mental health were floated as honorees or key note speakers.
- The council agreed that it would be more powerful for someone to share their own story about an experience with mental illness, rather than an actor who had merely offered a portrayal.

The APEX discussion then evolved into a talk on the overall Communications Council's awards process and whether it should be overhauled. Jason Young said that decision lives with the council. The council agreed to form a working group to reevaluate the awards process, led by John Luo.

Jason Young gave a presentation on the need for the council to help APA develop communications policies. He noted:

- Even several months after the re-branding entities within APA continue to produce their own logos, newsletters, social media accounts, etc.
- Young stressed a need for the council to support the chain of command
- The council agreed to form a task force aimed at drafting communications policies and protecting APA media assets such as email, led by Ayana Jordan and Lara Cox.

Young gave a brief presentation on the Daily Bulletin, to be rebranded as "APA Daily."

- APA Daily will be produced in-house by the Psychiatric News staff.
- APA will be able to keep up to 85% of ad revenue generated by the app and APA Daily, up from less than 35% from previous contract.

The council briefly discussed audience segmentation.

- Those in transitional period between residency and early career psychiatry were highlighted as priority target. The biggest dropoff in membership occurs in that group.
- The council unanimously supported a pilot program aimed at targeting this audience.

The council closed with a discussion on how to inspire innovation at APA and highlight innovation in psychiatry at large. A large part of that discussion centered on what devices are available to patients, and how physicians can learn about and communicate with patients about these devices.

The council adjourned at 3pm.

Executive Summary

Council on Geriatric Psychiatry

Description of the Council:

The Council supports the APA in its work on behalf of older adults and the psychiatrists who care for them. To this end, the Council develops Position Statements and Resource Documents on important issues in geriatric psychiatry, thereby providing the APA with background information essential for advocacy efforts and interactions with the media. The Council also works collaboratively with other professional groups to develop best practices in geriatric psychiatry, to promote research, and to provide education and training to psychiatrists, other physicians, residents, medical students, and allied mental health professionals.

Information Items:

- In addition to meeting in-person in May and September, the Council meets monthly via conference call. Minutes of the meetings attached. (June, July, August)
- The Council has submitted a workshop, To Use or Not to Use: The Clinical Challenges of Antipsychotic use for Aggression and Psychosis in Patients with Dementia for the Annual Meeting.
- The Council reviewed four position statements (Role of Psychiatrists in Palliative Care, Role of Psychiatrist in Assessing Driving Abilities and Use of Antipsychotics for the Treatment of Behavioral Disturbances in Persons with Dementia and Role of Psychiatrists in Long Term Care Settings) in the meeting that was held on September 11.

Referral Updates:

- Revised Position Statement: Role of Psychiatrists in Assessing Driving Ability (JRCJAN158.E.2; ASMMAY154.B.8) : The Council has submitted the final draft of the position statement for the approval from the Assembly.
- Revision of Position Statement: Principles of End-of-Life Care for Psychiatry (2001) [JRCJAN158.E.3] : The Council is working with the Council on Psychosomatic Medicine to create a document. Both the councils have appointed volunteers to serve on a workgroup that will start drafting this document. The council plan to discuss this further in the October conference call.

Action Items:

- Will the Joint Reference Committee recommend that the Assembly approve the position statement on Role of Psychiatrists in Assessing Driving Ability? (JRCJAN158.E.2; ASMMAY154.B.8) (Attachment#1)

Council on Geriatric Psychiatry, Arlington, VA

Minutes of the Meeting

Council Members Present:

1. Robert Paul Roca, MD (Chair)
2. Anand Kumar, MD (Vice-Chair)
3. Brent Forester, MD
4. Ipsit Vihang Vahia, MD
5. Maureen Nash, MD
6. Elizabeth Santos, MD
7. Marilyn Price, MD
8. Paul Kirwin, MD
9. Marsden McGuire, MD (Via phone)
10. Susan Schultz, MD (Via phone)
11. Bret Rutherford, MD (Via phone)
12. Seon Brian Kum, MD (RFM)
13. Pachida Lo, MD (RFM)
14. Michael Mirbaba, MD (RFM)

APA staff in attendance:

- Sejal Patel, Staff Liaison
- Ranna Parekh, MD

Council members absent with excused absence

1. Peter Ureste, MD (RFM)

Council members absent with unexcused absence

1. Olivia Okereke, MD
2. Maria Llorente, MD
3. David Hsu, MD

Guests in attendance:

- Christopher Woods, Executive Director, American Association of Geriatric Psychiatry (AAGP)
- Jay Shore, MD, Chair, Workgroup on Telepsychiatry

APA staff in attendance

1. Renee Binder, MD, President, APA
2. Saul Levin, MD, CEO and Medical Director, APA
3. Kristin Kroeger, Chief of Policy, Programs, & Partnerships, APA
4. Ranna Parekh, MD, Director, Division of Diversity and Health Equity, APA
5. Karen Sanders, Associate Director for Publicly Funded Services, Healthcare Systems & Financing, APA
6. Karen Kanefield, Practice Guidelines Program Director, APA

Introductions and Review of Council Charge

The meeting began with introductions of all participants and review of the agenda for the meeting. Dr. Robert Roca reviewed the Council work plan and updated the members about the progress of each activity.

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

Review of the Practice Guideline on the Use of Antipsychotics to treat agitation and psychosis in patients with dementia:

The Council formed a workgroup ahead of the Council meeting to review the draft Guidelines. Dr. Laura Fochtmann attended the Council meeting to receive feedback and answer questions about the Guidelines. The Council proposed a number of changes.

One concern was the potential misuse of the guidelines. The group felt that the suggested timeframes for tapering in statements 10 and 11 could well become hard stops in the minds of regulators and policymakers, and this could lead to burdens on clinicians and, worse, bad outcomes for patients. For this reason it seemed desirable to the group to extend the timeframes, be more general about the timeframes, or soften the language. It was suggested that the language in statement 12 ("the potential risks and benefits of antipsychotic medication should be reviewed by the clinician to determine if tapering and discontinuing the medication is indicated") might be substituted for the language stating that "an attempt to taper and withdraw the drug should be made."

A second concern was that the tone of the document may obscure the fact that these medications, when used appropriately, relieve distress, prevent violence, and improve quality of life for both patients and caregivers.

The Council also suggested consider developing a section that calls attention to some of the important clinical questions that the data do not yet help us answer.

Position Statements:

- The Role of Psychiatrists in Assessing Driving Ability: Feedback from the Council on Psychiatry and the Law was reviewed. Their input was favorable. The only concern expressed was that the position in the draft statement that psychiatrists are generally not equipped to do thorough assessments of driving ability may be somewhat inconsistent with an AMA document that appears to endorse the notion that all physicians may have an obligation to assess driving ability. Our Council felt that the draft statement did in fact identify a role for psychiatrists in this assessment that was not inconsistent with the AMA position and that would meet with the approval of APA membership.
- Role of Psychiatrists in Long-term Care Settings- The JRC asked the Council to review an old position statement entitled "Consensus Statement on Improving the Quality of Mental Health Care in US Nursing Homes: Management of Depression and Behavioral Symptoms associated with Dementia". The group strongly supported the importance of meeting the mental health needs of persons in long-term care (LTC) and is undertaking a revision of the position statement. The new statement will focus on the specific role of the psychiatrist in systems where LTC services are provided in interprofessional models where the psychiatrist is most often in a consultative, collaborative or supervisory role

- The Use of Antipsychotic Medications for the Treatment of Behavioral Disturbances in Persons with Dementia – The Council had put a hold on working on this statement pending review of the Practice Guidelines. The Council will now resume its work and complete the statement in next two months.
- Role of Psychiatrists in Palliative Care: The Council members participated in a joint meeting with the Council on Psych and Law on the role of psychiatrists in end-of-life care with a particular focus on physician-assisted dying. It was decided that the Council on Geriatric Psychiatry will work with the Council on Psychosomatic Medicine to develop a resource document on Role of Psychiatrists in Palliative Care. Both the councils are working to put a workgroup together.

Integrated Care:

Ms. Sanders informed the council members about APA's comments to the CMS on the 2015 Proposed Medicare Physician Fee Schedule. The most important aspect of the Request for Comment was CMS' ask for input on payment methodologies for collaborative care in primary care practices. Psychiatry was specifically identified as a part of this model. This is large step forward for CMS and psychiatry. The group was actively engaged in conversation around payment, coding, populations served and the collaborative care model.

Update from American Association of Geriatric Psychiatrists (AAGP):

Christopher Woods, Executive Director of the AAGP provided an update on the AAGP activities. The 2016 AAGP Annual Meeting will be held on March 18 – 21 in Washington DC. He also talked about the GMHF Scholarship Program which was established in 2008 to help expose psychiatry residents and medical students to the field of geriatric psychiatry with the goal of inspiring interest in the pursuit of a Geriatric Psychiatry fellowship. He encouraged the members to help promote this program.

Visits by APA Leadership

Dr. Renee Binder thanked the members for serving on the Council and mentioned that the Council has been working on very important and timely projects. She congratulated the Council for creating the widely-appreciated Resource Document on Interacting with Caregivers. Dr. Binder stressed the value of up-to-date position statements and resource documents and asked the Council to create position statements on timely issues as well as to review existing position statements and resource documents to ensure that they reflect current thinking and new research. She also encouraged the members to submit educational sessions for the Annual Meeting.

Dr. Saul Levin appreciated the work done by the Council and thanked all the members for their contributions. He also admired the Council for meeting every month via conference calls, and advised that the Council should continue this practice. Dr. Levin encouraged the Council to work collaboratively with other components to create position papers and resource documents.

Long Term Care – CMS's new proposed regulation:

The Centers for Medicare and Medicaid services recently released a comprehensive overhaul of long term care facility requirements. This is the first amendment of its scale and scope in nearly 20 years, and the proposed regulations outline a wide range of new quality and ethics rules for facilities that

participate in the Medicare and Medicaid program. Among many other provisions, the proposed rule touches on staffing adequacy and training, psychotropic medication administration and oversight, the discharge process, and a variety of lifestyle issues. The Council reviewed the document and provided feedback to the Department of Government Relations.

ABPN Proposed Changes to Subspecialty Certification Requirements:

ABPN is proposing a policy change which would require those who hold subspecialty board certification to also maintain general psychiatry certification. The Council discussed this proposal and conducted a poll. Of the Council members present, a slight majority leaned in favor of NOT requiring maintenance of general certification, although everyone admitted to having divided sentiments.

Geriatric Awards:

The Council formed a subcommittee to review the nominations received for two awards: Hartford-Jeste Award for Future Leaders in Geriatric Psychiatry and Jack Weinberg Memorial Award in Geriatric Psychiatry. Five applications were received for the Jack Weinberg Memorial Award and three for the Hartford-Jeste Award. The recommendations of the subcommittee were reviewed by the entire Council, and proposed honorees were selected for consideration by the JRC.

Work Group on Telepsychiatry:

Dr. Jay Shore talked about the role and work of the Work Group on Telepsychiatry. The Council members have agreed to work with the Work Group on Telepsychiatry to develop resources/toolkit related to geriatric psychiatry for the APA members. The Council will put a workgroup together to get started on this project.

Annual Meeting Submissions:

- The Science of Late life Depression Prevention: Updates from the VITALDEP (Vitamin D and Omega 3 TriaLDepression Endpoint Prevention) Study; Olivia Okereke, MD (Chair)
- Practical Assessment and Management of Behavior Disturbance in Patients with Moderate to Severe Dementia; Maureen Nash, MD (Chair)
- To Use or Not to Use: The Clinical Challenges of Antipsychotic use for Aggression and Psychosis in Patients with Dementia; Maureen Nash (Chair) **This proposal is sponsored by the Council.**

Joint Meeting with the Council on Psychiatry and Law:

Council members participated in this joint meeting to discuss the issues related to Physician-Assisted Suicide. The meeting included presentations entitled "Ethical and Legal issues in Physician-Assisted Suicide", "The Oregon Death with Dignity Act- 17 years' Experience" ," Perspectives on Decisional Capacity" (presented by Council Chair, Robert Roca), and "A View from Geriatrics".

Attachment: 1

Position Statement on the Role of Psychiatrists in Assessing Driving Ability (JRCJAN158.E.2; ASMMAY154.B.8)

The presence of a mental or neurocognitive disorder per se does not imply impaired driving capacity. Nonetheless, persons suffering from mental disorders may experience symptoms that can interfere with their ability to operate motor vehicles safely. Accurate assessment of the impact of symptoms on functional abilities usually is not possible in an office or hospital setting because such an assessment typically requires specialized equipment or observation of actual driving, which goes well beyond the scope of ordinary psychiatric care. *However, psychiatrists may discover impairments affecting driving ability in the course of a comprehensive psychiatric evaluation, including an assessment of cognition.*

Therefore, psychiatrists do have a role in advising patients about the potential impact of their illnesses and treatments on driving ability

1. When appropriate, psychiatrists should discuss with patient, caregivers, and family members symptoms of the patient's mental disorders that may be serious enough to substantially impair their driving ability.

2. Physicians should warn their patients about the possible effects of medications, including psychotropic medications, on alertness and coordination.

3. When clinically appropriate, medication with a low potential to impair driving ability should be chosen preferentially, depending on the patient's driving requirements and habits.

Maintaining confidentiality in physician patient relationships is important. At the same time psychiatrists should follow the laws in their state regarding reporting information on their patients' driving ability to the appropriate authority. Ultimately the responsibility for assessing driving ability resides with the Department of Motor Vehicles or the appropriate state agency. In states where reporting is not mandatory, reports made in good faith should be accompanied by immunity for psychiatrists from subsequent liability.

Minutes of the Phone Meeting: Council on Geriatric Psychiatry
June 10, 2015 8-8.45pm

Participants:

Robert Roca, MD
Ranna Parekh, MD
Maria Llorente, MD
Maureen Nash, MD
Marilyn Price, MD
Marsden McGuire, MD
Paul Kirwin, MD
Ipsit Vahia, MD

Position Statement on Substance Use in Elderly:

The council members approved the final draft. Please see attached the revised draft .

Position Statement on the Use of Antipsychotics:

The participants discussed the edits suggested by Dr. Maureen Nash (Attached in the email).

Dr. McGuire suggested two changes as marked on page two as highlighted in the attached document.

Position Statement on End-of-Life Care

- As discussed in the May meeting, the Council will consider making a resource document instead of a position statement.
- The Council on Psychiatry and Law and the Council on Psychosomatic Medicine held a joint meeting during the Annual Meeting to discuss this topic. Sejal will collect the updates from the Council liaisons and report back to the Council by tomorrow.
- There was a suggestion to use the word "palliative" in place of "End-of-Life".
- The participants agreed that the statement lacks information on psychiatry.

Position Statement on Role of Psychiatrists in Assessing Driving Ability:

- The statement was not approved by the Assembly and was returned to the Council for reworking.
- The statement doesn't have any information related to geriatrics and dementia patients.
- Need to spell out DMV – Driving Motor Vehicle or use another term like "appropriate state agency".
- The document should advise psychiatrists to follow the laws of the state in which they practice.
- The statement should talk about Neuro-cognitive disorders.
- Sejal will send a revised document the Council for further review.

Jack Weinberg Award Fund:

- Dr. Parekh and Sejal are working with the American Psychiatric Foundation on this and will get back to the Council with a few ideas by next week.
- As discussed in the May meeting, the participants have agreed to contact the award alumni for fundraising. The members agreed that it's a good idea to create one fundraising campaign that can create a decent endowment, which can support the award for the next few years.
- The participants also discussed asking APA members to voluntarily make a small contribution to the awards fund when they pay their annual dues. The amount can be as small as $1. This could help raise substantial fund for the awards.

AMA Stakeholders Survey questions:

The Council members will send the answers to Sejal and later a consolidated response will be sent to the AMA.

Geriatric Award Announcements:

Dr. McGuire suggested one change in the Jack Weinberg Award announcement. Please see attached the edited document.

Minutes of the Meeting

Council on Geriatric Psychiatry –Phone Meeting Agenda
July 8, 2015/ 8-8.45pm EST

Participants:

1. Robert Roca, MD
2. Anand Kumar, MD
3. Bret Rutherford, MD
4. Maureen Nash, MD
5. Marsden McGuire, MD
6. Olivia Okereke, MD
7. Maria Llorente, MD
8. Susan Schultz, MD
9. Ipsit Vahia, MD

Position Statement on Role of Antipsychotics in the Treatment of Behavioral Disturbances in Persons with Dementia.

The statement indicates that the antipsychotics should not be prescribed as a first-line therapy. It gives an impression that the antipsychotics should be prescribed only when other interventions fail.

Dr. Anand Kumar, Dr. Susan Schultz and Dr. Maureen Nash offered to work on the language.

Position Statement: End of Life Care & A potential meeting with The Council on Psychiatry and Law

Dr. Roca informed the Council about the upcoming joint meeting with the Council on Psychiatry and Law which aims to discuss and debate the issues surrounding the end-of-life care and role of psychiatrists in this area.

The meeting will be held on September 11, 2015 1-5 pm in the Crystal Room, Hilton Crystal City.

Dr. Roca and Dr. Maureen Nash have invited Dr. Linda Ganzini who is a subject-matter expert to join the meeting, either in person or via phone call.

Position Statement: Consensus Statement on Improving the Quality of Mental Health Care in US Nursing Homes: Management of Depression and Behavioral Symptoms associated with Dementia

Participants agreed that the position statement should not be retained in its original form. The information is outdated, and the document is too long and doesn't follow APA's position statement format.

The Council members offered to develop an updated position statement which will focus on the role of psychiatrists in long term care.

Jack Weinberg Fund letter

Dr. Kumar suggested proposing an amount in the letter which should be contributed by each award alumni. Sejal will check about it with Mr. Paul Burke (Executive Director, APF) and revise the letter.

Dr. Okereke suggested asking alumni to write "Jack Weinberg Award" in the memo line.

AMA Stakeholder Survey

The response for this request is due on August 31. This will be discussed further in the August Council meeting.

Geriatric Awards – Call for Nominations

Sejal requested that Council members spread the word about these awards.

Council on Geriatric Psychiatry
August Phone Meeting
Wednesday, August 12, 2015 / 7.30-8.15pm

Minutes of the meeting

Participants:

1. Robert Roca, MD
2. Maureen Nash, MD
3. Marilyn Price, MD
4. Brent Forester, MD
5. Marsden McGuire, MD
6. Ranna Parekh, MD
7. Sejal Patel

Quick review of Practice Guidelines on the use of antipsychotics to treat agitation and psychosis in patients with dementia.-Creation of workgroup to review these documents in detail- (Email attached)

The council members agreed to form a workgroup to review the guidelines. The following members volunteered to serve on the workgroup. Dr. Maureen Nash has agreed to take a lead and steer the discussions.

1. Robert Roca, MD
2. Maureen Nash, MD
3. Ipsit Vahia, MD
4. Marilyn Price, MD
5. Marsden McGuire, MD

If anyone else is interested in joining this group, please send me an email.

Dr. Brent Forester offered to share the draft with AAGP's Clinical Practice Committee for their input.

Revised position statement on Role of Psychiatrists in Assessing Driving Ability (Revised Statement attached)

- The council members agreed that the document is ready to be shared with the Council on Psychiatry and Law for their comments.
- Sejal will submit send the document to staff liaison with a copy to Dr. Ken Hoge (Chair-Council on Psychiatry and Law) and Dr. Roca

AMA Stakeholder Survey (Email attached)

Comments on this document are due on August 30. Sejal requested that members submit their comments by **August 21st** so a summarized document can be submitted to the AMA on time.

Long Term Care – CMS's new proposed regulation (email attached) (also attached are the Highlights of the CMS Proposed Reform of Requirements for Long-Term Care Facilities- Prepared by APA Department of Government Relations)

- Dr. Roca has suggested forming a committee to look into this request. Please send Sejal an email if you are willing to participate in this review.
- Dr. Forester will forward this document to the AAGP's Clinical Practice Committee for their input. Dr.
- Marsden McGuire will check with VA pharmacy and geriatric practice staff to see if they have any comments on this topic.

AMA's position on Screening Elderly Physicians (Brief description of the topic attached- written by Dr. Marilyn Price)

- We need to contact the AMA to see how the council can get involved in this discussion.
- Sejal will check with the APA Governance to identify people who are representing at the AMA.
- The Council will discuss this topic further in the September component meeting.

Position Statement: Consensus Statement on Improving the Quality of Mental Health Care in US Nursing Homes: Management of Depression and Behavioral Symptoms associated with Dementia (Original statement and proposed description for revised statement attached (written by Dr. Susan Schultz))

- The meeting participants agreed that the old position statement should be retired and the Council should work on a new statement.
- Sejal will check with the APA Governance about how to approach this.
- The Council will discuss this assignment at a length during the September component meeting.

Geriatric Awards:

- So far, we have received 3 nominations for Jack Weinberg Award and 2 nominations for Jack Weinberg Award. The application submission deadline is extended from Aug 15 to Aug 30.
- We need to form a selection committee to review these applications. Please send an email to Sejal if you can serve on this committee.
- As a part of the process, Sejal will send application packets with a rating sheet for review. Later, the committee members will decide on the nomination in a conference call in September. This nomination will be submitted to the JRC for Board's approval.

Executive Summary

Will the Joint Reference Committee recommend that the Board of Trustees approve that Dr. David Satcher receive the 2016 APA Human Rights Award?

Attachment #1: Council Minutes – September 2015
Attachment #2: Council Minutes – August 2015
Attachment #3: Council Minutes – July 2015

Council on International Psychiatry

The Council on International Psychiatry is focused on increasing international membership by working cross-collaboratively with the governance of the APA, including the Assembly, Councils and their Components, and Administration, to identify and develop benefits that support the education and training of psychiatrists inside and outside the United States.

Education & Training

The Council is developing a comprehensive strategy to address the strengthening of health systems outside the United States by supporting the education and training of international psychiatrists.

The Council is also developing a comprehensive presentation on the training of psychiatrists in the United States as global mental health investigators, implementers, and collaborators in order to identify best practices. This presentation follows the successful collaboration between Council members and the APA's Caucus on Global Mental Health and Psychiatry, partially comprised of international psychiatrists, on the workshop "US and Low and Middle Income Countries Models of Education and Training on Global Mental Health" at the 2015 APA Annual Meeting.

The Council is focused on developing opportunities for the exchange of knowledge and experiences between psychiatrists inside and outside the United States, including international medical graduate psychiatrists in the United States. To support this goal, the Council is in the process of identifying individuals and organizations inside and outside the United States to collaborate with to investigate issues that can address the global burden of mental health and substance use disorders through the education and training of psychiatrists. Additionally, the Council is reviewing global mental health opportunities offered by psychiatry training programs in the United States in order to determine their level of impact.

Membership

The Council tracked a 26% rate of growth in international membership over the past year to over 2,000 international members from over 100 countries. The Council works closely with the APA Membership Committee on various international membership initiatives including the recent review and approval of an international resident fellow membership category and a pilot project offering international group membership discounts to international psychiatric organizations. The Council is also currently discussing opportunities to enhance the recognition and recruitment of international attendees at APA meetings.

Referral Update

- ***The Impact of Global Climate Change on Mental Health (ASMMAY1512.L):*** The Council is in the process of reviewing the Action Paper after being assigned it, along with several other reviewing components, by the Joint Reference Committee. Feedback will be forwarded to the lead reviewing Council, the Council on Minority Mental Health and Health Disparities.

During, the initial review of the Action Paper at their annual in-person September meeting generated a brief discussion regarding the investigation of increased suicide rates in Arctic populations impacted by climate change. A greater understanding of this issue could focus on the impact of global climate change on mental health in minority, under-represented and under-served populations in geographically Arctic areas such as Alaska and the Northwest territories of Canada. It was noted that this may be a potential issue for discussion with the Assembly Caucus of American Indian, Alaska Native and Native Hawaiian Psychiatrists. This discussion was reported to the Assembly through the Council's report to the Assembly.

Position Statements

The Council is reviewing the following APA position statements to determine if they are in need of updating and whether the APA should reaffirm them as policy or not.

- ***Use of Psychiatric Institutions for the Commitment of Political Dissenters:*** This position statement was last approved by the Board of Trustees and Assembly in 1994.

- ***Identification of Abuse and Misuse of Psychiatry:*** This position statement was last approved by the Board of Trustees in 1998 and was developed by the sunset components the Committee on Abuse and Misuse in Psychiatry in the U.S. and the Committee on the International Abuse of Psychiatry and Psychiatrists.

- ***Abuse and Misuse of Psychiatry:*** This position statement was last approved by the Board of Trustees and Assembly in 1994 and reaffirmed in 2007. It was developed by the following sunset components: Committee on Abuse and Misuse of Psychiatry in the U.S., Council on National Affairs.

- ***Resolution Condemning the Role of Psychiatrist Radovan Karadazic in Human Rights Abuse in the Former Yugoslavia:*** This position statement was last approved by the Board of Trustees in March 1993 and reaffirmed in 2007. It was developed by the following sunset components: Committee on Human Rights, Council on International Affairs.

- ***Telepsychiatry:*** During its annual in-person September meeting, the Council met with Dr. Jay Shore, the Chair of the task force assigned to review telepsychiatry and develop an APA position statement supporting its use. The Council offered feedback including edits for consideration by the task force to define telepsychiatry as the practice of medicine "using technology" and to be inclusive of the use of telepsychiatry for residents and psychiatrists-in-training which doesn't seem to be clearly communicated in the current version of the statement. Dr. Shore ended by noting that there could be a chance for collaboration with the Council where the telepsychiatry task force focuses on the technology and regulation aspects, while the Council could focus on programming and systems.

Assembly Action Paper

- ***Parity in Permanent Licensure Policy:*** The Council discussed the Action Paper during a conference call and again during their annual in-person September meeting. While the Council was in general support of the Action Paper, it was communicated to the author that the term "parity" may not be the most appropriate term in this context and that alternate terms, such as "equity" or "equality", should be taken into consideration as effective substitutes. This Action Paper is being presented by the author at the October 30, 2015 Assembly meeting.

Human Rights Award

Will the Joint Reference Committee recommend that Dr. David Satcher receive the 2016 APA Human Rights Award?

The Council is recommending that Dr. David Satcher receive the 2016 APA Human Rights Award.

David Satcher, MD, PhD is director of The Satcher Health Leadership Institute, which was established in 2006 at the Morehouse School of Medicine in Atlanta, Georgia. The Institute's mission is to develop a diverse group of public health leaders, foster and support leadership strategies, and influence policies toward the reduction—and, ultimately, the elimination—of disparities in health. The Institute's programs reflect Dr. Satcher's demonstrated track record in improving public health policy and his commitment to eliminating health disparities for underserved groups, such as minorities and the poor, and shedding light on neglected issues, such as mental and sexual health. Dr. Satcher was sworn in as the 16th Surgeon General of the United States in 1998. He also served as Assistant Secretary for Health in the Department of Health and Human Services from February 1998 to January 2001, making him only the second person in history to have held both positions simultaneously. His tenure of public service also includes serving as director of the Centers for Disease Control and Prevention (CDC) and administrator of the Toxic Substances and Disease Registry from 1993 to 1998. He is the first person to have served as director of the CDC and then surgeon general of the United States. In addition, Dr. Satcher has held top leadership positions at the Charles R. Drew University for Medicine and Science, Meharry Medical College, and the Morehouse School of Medicine. He has been a Macy Foundation fellow, Robert Wood Johnson Foundation clinical scholar, and a senior visiting fellow of the Kaiser Family Foundation. Having also held the position of director of the National Center for Primary Care (NCPC) at the Morehouse School of Medicine from 2002 to 2004, Dr. Satcher currently occupies the Poussaint-Satcher-Cosby chair in mental health at the Morehouse School of Medicine. This reflects his long commitment to removing the stigma attached to mental illness, as evidenced by *Mental Health: A Report of the Surgeon,* the first surgeon general's report on mental health released during his tenure as surgeon general. As surgeon general and assistant secretary for health, Dr. Satcher led the department's effort to eliminate racial and ethnic disparities in health, an initiative that was incorporated as one of the two major goals of Healthy People 2010. Dr. Satcher has received over 40 honorary

degrees and numerous distinguished honors including top awards from the National Medical Association, the American Medical Association, and the American Academy of Family Physicians; he is also the recipient of the Symbol of H.O.P.E. Award for health promotion and disease prevention. In 2005, Dr. Satcher was appointed to serve on the World Health Organization Commission on Social Determinants of Health. Currently, Dr. Satcher serves on the Board of Directors of Johnson & Johnson, MetLife, and the CDC Foundation. He also serves locally on the board of United Way of Greater Atlanta and The Community Foundation for Greater Atlanta. Dr. Satcher graduated from Morehouse College in Atlanta, Georgia, in 1963 and is a member of Phi Beta Kappa. He holds MD and PhD degrees from Case Western Reserve University in Ohio. He is a member of Alpha Omega Alpha Honor Society and a fellow of the American Academy of Family Physicians, the American College of Preventive Medicine, and the American College of Physicians. He is a member of the Institute of Medicine, National Academy of Sciences, the 100 Black Men of Atlanta, and the American Academy of Arts and Sciences.

The Council is also currently in the process of reviewing the Human Rights Award in the context of the other APA recognition awards to determine its future status as a viable award of the APA.

ATTACHMENT 1: COUNCIL MINUTES – SEPTEMBER 2015

Council Name: Council on International Psychiatry
Date: September 11, 2015
Time: 9:00 AM – 5:00 PM
Location: In person - September Components Meeting

Council Members Present: M. Riba, A. Becker, K. Busch, D. Baron, J. Griffith, S. Okpaku, E. Pi, U.K. Quang Dang, G. Raviola, P. Ruiz, E. Sorel, J. Srinivasaraghavan (Dr. Van), M. Morse, R. Winer, N. Natala, J. Severe, V. Tate, J. Iluonakhamhe, D. Loo, A. Sabur

Council Members with Excused Absences: D. Jeste, A. Tasman, B. Acharya, N. Juthani, J. McIntyre, S. Rataemane, M. Soliman, S. Jani, C. White

Council Members with Unexcused Absences: None

Guests in Attendance: Renee Binder, MD, Saul Levin, MD, MPA, Jay Shore, MD

Staff in Attendance: J. Fanning, R. Juarez

Summary

This is the third in-person meeting of the Council on International Psychiatry since its establishment in 2014. The Council discussed a range of issues, with input from leadership, regarding the mission and the goal of the Council. A list of considerations for the Council to address streamed out of the discussion that would provide APA members, domestic and international, with resources to support their educational and professional development. The Council addressed several strategies to develop such resources and established five work groups to identify and develop opportunities for collaboration between the Council and various international and domestic special interest groups. Additionally the Council began to investigate possible opportunities for international recognition and began to identify and review policies that will provide the APA with useful resources to address issues in global mental health and international psychiatry.

Minutes

The Council approved the minutes of the August 28, 2015 conference call.

Council Business

The Council discussed working together to gain a comprehensive understanding of how the Council defines the terms "global mental health" and "international psychiatry" in its work as it may help to clarify the scope of the Council's work.

It was noted by APA President, Dr. Renee Binder, that while the charge of the Council includes a strong focus on increasing international membership, she stated that the "goal of this Council is still in flux"

and that the Council should consider expanding into the global community. Dr. Binder specifically indicated that the Council must begin to produce products in the form of position statements, resource documents, or white papers related to subjects that support the work of the APA. She went on to provide examples of resources addressing the "burden of illness" and the global "rates of depression."

The Council discussed several areas of focus for evaluation and consideration including the following:

- **Strengthen health systems outside the U.S. through education and services**: It was noted that this could refer to countries and regions beyond receiving attention and relief efforts following disasters, also receive longer term support in the strengthening of their overall health system through the integration of mental health services, development of psychiatry residency training programs, and "task-sharing" to non-specialists in low resource contexts which lack specialists.

- **Support the education and training of psychiatrists outside the U.S**.: This was discussed as being specific to focusing on countries that only provide minimal training and education opportunities.

- **Address global workforce shortage for mental health treatment**: This may be an opportunity for the APA to contribute to health system strengthening and capacity building, however this raises several questions for the Council to consider first:

    - When we address the issue of global workforce shortage are we talking about the lack of psychiatrists in training or are we talking about what the psychiatrist's role in expanding the workforce for mental health treatment among non-specialists? Task-sharing?

      (A reference was made to the March 16, 2012 *Science* article "Who Needs Psychiatrists?")

    - What is the psychiatrist's role in the expanding workforce of other mental health professionals? Task-sharing? Psychiatric expertise? Sustained supervision? Monitoring quality of treatment? Does this new role legitimize our existence as psychiatrists?

    - How can we, as an organization, address the workforce issues raised in the 2014 WHO Mental Health Atlas with allied organizations? Can World Mental Health Day be a central point for communicating information?

- **Global mental health training programs in the U.S.**: It was noted that residency training programs in the U.S. seem to be competing for residents by offering global mental health training as part of their curriculum. However, the reality may be that the global mental health opportunities presented during recruitment are actually not supported in a manner making them available. This raised the question of whether if it was possible to hold such training programs in U.S. offering global mental health as part of their curriculum accountable. Additionally it was noted that global mental health training is not widely offered. Jon Fanning, APA Director of Membership, discussed how while at the American Medical Association, that model curriculums for global health training were developed for training directors and that to get the support of AADPRT (American Association of Directors of Psychiatry Residency Training) in the

development and communication of such a resource. The Council discussed identifying what the main issues are and to delineate the range of issues that need to be reviewed.

WORK GROUP 1: The Council established a work group to review current global mental health training programs and draft a template of required competencies for global mental health training programs. **- Michael Morse, Jennifer Severe, James Griffith, Giuseppe Raviola,**

- **Regional issues**: This refers to the need for Latin America and the Caribbean to be brought together on issues, the increased focus on autism in Africa by English speaking countries such as Nigeria, South Africa, Kenya, and Ghana, and the large number of psychiatrists from India, 5,000-7,000, practicing in the U.S. and their professional development needs.

- **International collaborations**: Identifying and discussing opportunities for collaboration with regional, international and transnational collaborations, such as those presented in through the Mental Health Innovation Network.

- **International Recognition**: Work with the Membership Committee to make the New International Member Reception at the Annual Meeting to be more formal and include programming.

The Council noted that they will be scheduling conference calls for every month and will meet in person at the 2016 APA Annual Meeting in Atlanta, GA. The Council will revisit the discussions listed above and review the progress of the established work groups on future conference calls.

Education and Training

A review and update of the APA's new website and learning management system revealed an opportunity for the Council to identify and develop educational content for U.S. and international psychiatrists for posting. The Council discussed several resources for consideration including the following:

- Information for international residents transitioning to early career psychiatrists
- Information on training and licensure requirements for U.S. psychiatrists wishing to practice outside the U.S.
- Information on training and licensure requirements for psychiatrists outside the U.S. wishing to practice in the U.S.
- A comparison of the different policies, regulations, practices and systems inside and outside the U.S. regarding the use of telepsychiatry.
- Collaboration opportunities across the medical specialties that address integrative care

WORK GROUP 2: The Council established a work group to review, consolidate and draft a document with information on training and licensure requirements for U.S. psychiatrists wishing to practice outside the U.S., as well as information on training and licensure requirements for psychiatrists outside the U.S. wishing to practice in the U.S. **– TBD**

The Council also considered the possibility of making resources available in Spanish. Dr. Pedro Ruiz discussed his close relationship and work with the Latin American Psychiatric Association (APAL) by presenting on various topics in Spanish in different countries in Central and South America including Paraguay, Costa Rica, and Ecuador. It was noted that presentations at APA Annual Meetings could be recorded and provided on the APA's online learning management system.

The Council discussed identifying current courses and curriculums at universities and institutes that can be "tweaked" for presentation at the Annual Meeting or developed into online courses or resources. The Council considered the benefit of creating a long-range (2-3 years) plan to develop such content and resources for the web and to properly align abstract submissions for future APA meetings. Staff will provide the Council with the list of courses set to be added to the APA's online learning management system so that the Council can identify any gaps in learning to focus on.

The Council discussed identifying groups to work with to better understand the needs of international medical graduate residents and psychiatrists in the U.S. and international residents and psychiatrists outside the U.S. The suggestion of the Council setting up focus meetings at the APA Annual Meeting with different countries was made and led to a discussion of the work of the International Discussion Groups that meet each year at the APA Annual Meetings and now report to the Caucus on Global Mental Health and Psychiatry – the Africa Discussion Group (Chair: S. Okpaku), the European Discussion Group (Chair: E. Sorel), and the Southeast Asia Discussion Group (Chair: J. Van).

It was noted that there is value with meeting "face-to-face" with international groups at the APA Annual Meeting and allow discussions to have some "slow time" in order to accomplish two things (1) learn about the group or organization and (2) conduct a "needs assessment." The Council discussed meeting with different groups at the APA Annual Meeting although it was noted that the Annual Meeting may be difficult to coordinate since there are so many competing programs. It was considered that the *IPS: Mental Health Services Conference* may be another opportunity for the Council to meet with groups. Additionally, scheduling the respective groups on Council conference calls may be best to initiate interaction. It was noted that it would be important to request that groups forward the Council any relevant materials and resources for discussion prior to the conference call. It was also noted that all interactions with these groups should have some structure to them with appropriate questions and topics for discussion available in advance. A work group was formed to identify the activity level of the following psychiatric special interest groups and conduct a needs assessment to determine collaboration opportunities with the Council:

• Association of Chinese American Psychiatrists	China
• Hellenic American Psychiatric Association	Greece
• Haitian American Psychiatric Association	Haiti
• Indo American Psychiatric Association	India
• Society of Iranian Psychiatrists in North America	Iran
• Association of Korean American Psychiatrists	Korea (Republic of)
• Nigerian American Psychiatrists Association	Nigeria
• Philippine Psychiatrists in America	Philippines
• Turkish American Neuropsychiatric Association	Turkey

WORK GROUP 3: The Council established a work group to identify psychiatric special interest group organizations in the U.S. (i.e. Association of Korean-American Psychiatrists, Haitian-American Psychiatric Association) and reach out to them in order to determine their current level of activity and conduct an initial needs assessment. **- Dyani Loo, Ed Pi**

WORK GROUP 4: The Council established a work group to coordinate with psychiatric special interest group organizations in the U.S. to identify possible topics of intersection and interest for presentation at future APA meetings together. **- Jennifer Severe, Pedro Ruiz**

A discussion of the groups listed above revealed that the Association of Chinese American Psychiatrists is very active on an individual basis, but face challenges when being active as a group. Additionally, the Association of Korean American Psychiatrists may have over time transitioned from being very active to not active and the Indo American Psychiatric Association was noted as being very culturally and linguistically diverse with a population of 5,000-7,000 psychiatrists from India in the U.S. Council members also mentioned a Hellenic American Psychiatric Association and a Pakistani American Psychiatric Association as existing in the U.S. that should be considered for outreach by the Council. It was also mentioned that it may be beneficial to offer space in *Psychiatric News* for feature articles on the active psychiatric special interest groups.

When discussing opportunities for interaction with international groups and attendees at the Annual Meeting it was noted that in the past the APA held an international dinner, hosting an international lecturer, for international attendees and international psychiatric organization presidents at the APA Annual Meeting. However, it was also noted that the high-cost annual event was completely supported by pharmaceutical funding, which was effectively cut when the APA instituted a policy preventing the funding of educational programs by pharmaceutical companies.

The Council discussed some important aspects of forming relationships including the intent to create relationships through dialogues and to ensure that opportunity for learning is bi-directional. Additionally, it was noted that it was important to keep an attitude of "what can we learn from places

and people who have done just as much with less" and that there be an "assessment of outcomes" through measuring outcomes and sharing outcomes."

Dr. Michelle Riba announced that the call for papers for the journal *Academic Psychiatry* on the series "Advancing Understanding of Global Mental Health" is still open and that people should encourage submissions to the journal Editor-in-Chief, Dr. Laura Roberts. Guest editors include Dr. Milton Wainberg, Dr. Frances Lu, and Dr. Michelle Riba. It was noted that Dr. Anne Becker provided a submission and that an introduction from Dr. Pamela Collins from the National Institute of Mental Health will be included. The publication date is yet to be announced.

APA CEO and Medical Director, Dr. Saul Levin, came by the Council with the new APA Director of Research, Dr. Philip Wang, who was previously the Deputy Director of the National Institute of Mental Health (NIMH). Dr. Levin and Dr. Wang discussed the registries project the APA is working on and requested that if there is any information regarding available data sources that would make the registry more widely available, that Council members should feel free to share it with them. Additionally, any feedback from the Council about the benefit of registries for developing countries would be welcomed.

Components and Liaisons

Caucus on Global Mental Health and International Psychiatry

Dr. Eliot Sorel, the Caucus Chair, discussed the work of the Caucus to pull together regional content from around the world for a newsletter that will now be published in the Washington Psychiatric Society's Career, Leadership, and Mentorship program newsletter after experiencing some issue with initially branding it as an APA newsletter for distribution. It was noted that there are opportunities for blog posts on the new APA blog through the new APA website.

United Nations Advisors

While Dr. Vivian Pender was not able to attend the Council meeting, she did provide the Council with a report describing the APA's special consultative status with the UN Economic and Social Council (ECOSOC), the formation of a UN Committee by the New York County Psychiatric Society, as well as a list of activities Dr. Pender and the appointed APA advisors on the UN have participated in or are planning to participate in for 2015.

The Council will ask Dr. Pender to provide more information to the Council to understand the relationships between the APA and the different organizations the APA is presenting with and partnering with at UN panels and other activities. This includes the UN Committee of the New York County Psychiatric Society and the International Psychoanalytic Association. Additionally, the Council is requesting that Dr. Pender provide a list of the other organizations that are also members of the UN ECOSOC for possible opportunities for collaboration with the APA, such as the World Psychiatric Association or the World Federation for Mental Health.

The Council also discussed the possibility of identifying and/or developing APA Board approved statements that can be communicated at the UN. It was noted that there have been several different efforts from APA members and APA leadership to include mental health in the development and execution of the UN's Sustainable Development Goals (SDGS). This includes the work of Dr. Eliot Sorel and Dr. David Satcher, as noted in the *Psychiatric News* editorial "The UN's Unfortunate Exclusion", which notes mental disorders as not being included in the discussion of non-communicable diseases, and the work of Dr. Paul Summergrad, the APA Immediate Past President, and other mental health leaders with the coalition FundaMentalSDG to advocate for target indicators for mental health in the SDGs. Staff will provide Dr. Pender with information on this work for review and feedback to the Council.

World Psychiatric Association (WPA) Liaison

Dr. Ed Pi, the Zone 2 (USA) Representative on the WPA Board, discussed a communication from the WPA President, Dr. Dinesh Bhugra, announcing a campaign to promote a position statement recently adopted by the WPA "Social Justice for Persons with Mental Health Illness (Mental Disability)" and the establishment of the "World Mind Matters Day." Dr. Bhugra seems to be asking for feedback to disseminate the position statement and promote the observation of World Mind Matters Day. It was mentioned that Council member Alan Tasman worked closely with the development of this campaign, so the Council will ask for his input on the matter on an upcoming conference call.

It was additionally noted that there are opportunities for participation by Council and APA members to serve as a member of one of the 70 sections of the WPA by getting in contact with the WPA Secretary for Sections. Also, anyone interested in joining the Section on Quality Assurance can reach out to Dr. Van on the Council for more information. Additional information on the WPA Sections, including contact information, is available on the WPA website.

Council Awards

Human Rights Award

The Council discussed the Human Rights Award which was assigned to the Council by the Joint Reference Committee after previously being managed by the Council on Psychiatry and Law. After establishing the history of the award and issues with the nomination and awarding process (only being awarded three times in the past six years), the Council raised several questions in order to determine the appropriateness of maintaining the award.

- What are the APA's goal and objectives to give awards?
- Should it be given every year? Should it be given only to an individual? Only an organization? A psychiatrist? A physician? A psychiatric group or organization? Rotate between an individual and an organization?
- What do we mean by "human rights"? Does it refer to "countering stigma"? What is the context of human rights in the APA?
- Is this an opportunity to engage and maintain APA membership?

- Is this an opportunity to award an International Member?
- Is this an opportunity to bring someone to the Annual Meeting to lecture, engage and inspire attendees?
- Can this award be given for something else? Should we explore different concepts for the award? Health equity? The impact of social suffering on producing poor mental health? Advocating for the equity and non-discrimination of disabilities? The best interest of the patient?
- The narrower the focus, the better. The APA is not interested in this award the way it is.
- You want specificity, but you also want breadth.

It was noted that the criteria for the award, provided to the Council on the drafted nomination form, is too broad as it can be given to any individual or organization. It was suggested the award objectives could be "tweaked" to make it "something meaningful."

WORK GROUP 5: The Council established a work group to review the Human Rights Award and provide recommendations that range in options from keeping the award as it is, changing the criteria and name of the award, or sunset the award and apply the Council's limited resources into another avenue for recognition **– Josepha Iluonakhamhe, Michael Morse, UK Quang-Dang, James Griffith**

While the Council established a work group to review the award, there was concern that if the award was not awarded to someone in this award cycle it would be taken away from them – a "use it or lose it" scenario. Council members then began to suggest candidates for consideration by the Council. Those making the recommendations will provide a summary (one paragraph) of the following individuals for Council members to review and vote on electronically:

- David Satcher (recommended by: Eliot Sorel)
- Vikram Patel (recommended by: James Griffith)
- Sue Bailey (recommended by: Ken Busch)
- Norman Sartorious (recommended by: Dave Baron)
- Arthur Kleinman (recommended by: Anne Becker)

Position Statements and Action Papers

APA Position Statement Review

APA staff presented the Council with the following APA position statements for review and discussion on future Council conference calls to determine if they are in need of updating or editing and whether the APA should reaffirm them as policy or not.

- *Use of Psychiatric Institutions for the Commitment of Political Dissenters* (Approved 1994)
- *Identification of Abuse and Misuse of Psychiatry* (Approved 1998)
- *Abuse and Misuse of Psychiatry* (Reaffirmed 2007)

- *Resolution Condemning the Role of Psychiatrist Radovan Karadazic in Human Rights Abuse in the Former Yugoslavia* (Reaffirmed 2007)

The Council requested that APA staff also provide the Council with the 2014 APA *Joint Resolution Against Torture* with the American Psychological Association to serve as a resource when reviewing the position statements.

Action Paper: *Parity in Permanent Licensure Policy*

The Council continued their discussion of the action paper and reaffirmed that the appropriate feedback is to let the author know that the term "parity" may not be the most appropriate term in this context and to consider "equity" or "equality" as alternate terms. Staff will relay this feedback to the action paper author.

Action Paper: *The Impact of Global Climate Change on Mental Health*

APA Staff notified the Council that they have until November to provide the Joint Reference Committee with feedback regarding the action paper.

The Council did raise a related issue around the effect of climate change on Arctic populations with regards to increased suicide rates. This feedback is something the Council can share with the Assembly to add to the conversation around the impact of global climate change on mental health with respect to minority, under-represented and under-served populations and it may be a potential issue for consideration by the Assembly Caucus of American Indian, Alaska Native and Native Hawaiian Psychiatrists.

APA Position Statement on *Telepsychiatry*

The Council invited Dr. Jay Shore, the Chair of the task force assigned to review telepsychiatry and develop an APA position statement supporting its use. Dr. Shore explained that they were looking at three core areas of telepsychiatry including fundamental basics and information on billing and protocol for presentation at the Institute on Psychiatric Services (IPS) and the Annual Meeting that can be captured and added to the APA's online learning management system. He stated that this is an opportunity for the APA get in front of the issue to have policy and implementation dictated by the provider as well as taking advantage of the opportunity to strengthen its implementation by addressing both the advantages and limitations of telepsychiatry.

Dr. Shore shared the draft position statement on telepsychiatry with the Council and requested feedback. It was noted that the position statement is meant to help the APA at the federal and state level.

The Council offered feedback including edits for consideration by the task force to define telepsychiatry as the practice of medicine "using technology" and to be inclusive of the use of telepsychiatry for

residents and psychiatrists-in-training which doesn't seem to be clearly communicated in the current version of the statement.

The Council asked Dr. Shore whether this position statement will address the international use of telepsychiatry not only for treatment and disaster response, but also for education purposes. It was discussed that while there may not be much literature addressing international telepsychiatry there are best practices, guidelines and data available regarding the use of telepsychiatry with different cultures and age groups. Dr. Shore ended by noting that there could be a chance for collaboration with the Council where the telepsychiatry task force focuses on the technology and regulation aspects, while the Council could focus on programming and systems.

ATTACHMENT 2: COUNCIL MINUTES – AUGUST 2015

Council Name: Council on International Psychiatry
Date: August 28, 2015
Time: 12:00 PM – 1:00 PM
Location: Conference Call

Council Members Present: M. Riba, D. Jeste, A. Becker, K. Busch, D. Baron, J. Griffith, N. Juthani, , E. Pi, P. Ruiz, J. McIntyre, E. Sorel, M. Soliman, M. Morse, N. Natala, J. Severe, J. Iluonakhamhe, A. Sabur

Council Members with Excused Absences: S. Okpaku, A. Tasman, B. Acharya, U.K. Quang Dang, S. Rataemane, G. Raviola, J. Srinivasaraghavan , R. Winer, S. Jani, V. Tate, C. White, D. Loo

Council Members with Unexcused Absences: None

Guests in Attendance: Vivian Pender, MD

Staff in Attendance: R. Juarez

Summary

The Council welcomed Dr. Vivian Pender as one of the APA's advisors on the United Nations and received updates from the Global Mental Health Caucus and the Council members managing the Council's Atlanta presentation submission. Additionally, the Council discussed the Human Rights Award, several Assembly Action Papers submitted to the Council for feedback, and a position statement from the WPA.

Minutes

The Council approved the minutes of the July 16, 2015 conference call with an amendment to the minutes clarifying that the WPA statement on Collaborative and Integrated Care was "adopted" by the World Psychiatric Association.

Education and Training

Council Abstract Development

Dr. Anne Becker, Dr. James Griffith and Dr. Michael Morse provided an update on the Council's abstract submission for the 2016 Annual Meeting "Training American Psychiatrists as Global Mental Health Investigators, Implementers, and Collaborators: What Have We Learned That Can Inform Best Practices." The final presentation speakers were identified and any additional feedback from the Council was requested to be provided as soon as possible as to meet the submission deadline of September 17.

Components and Liaisons

Caucus on Global Mental Health and International Psychiatry

Dr. Eliot Sorel, Chair of the Caucus on Global Mental Health and International Psychiatry, discussed the Caucuses newsletter being finalized for distribution to the Caucus and the Council and thanked the Council Chair for her contributions.

United Nations Advisors

Dr. Vivian Pender, Area 2 Trustee on the APA Board of Trustees, is one of several advisors to the APA on the United Nations and was recently asked to report regularly to the Council on International Psychiatry by APA President Renee Binder, MD. Dr. Pender reported that the APA received special consultative status with the United Nations Economic and Social Council (ECOSOC) in July of 2014. A list of activities for 2014-2015 will be shared with the Council. It was noted that the eight Millennium Development Goals (MDGs) that expired in 2015 were recently updated to seventeen Sustainable Development Goals (SDGs). The third SDG is on "health" and getting mental health on the agenda is an aspect of the work the APA advisors to the UN are engaged in. Other advisors to the United Nations, in addition to the APA President and CEO and Medical Director, include Dr. Linda Freeman, Dr. Sarah Herbert, Dr. Felix Torres, and Dr. Andriy Yur'yev. It was requested that staff share the WPA statement on Collaborative and Integrated Care from the 2015 WPA International Congress in Bucharest with Dr. Pender.

Council Awards

Human Rights Award

APA staff requested feedback from the Council regarding the impact and administration of the Human Rights Award which was recently assigned to the Council by the Joint Reference Committee. It was noted that the Human Rights Award has been awarded only three times in the past six years, can be awarded to non-psychiatrists and has been awarded to notable individuals in the past such as President Jimmy Carter. It was also clarified that the Council is responsible for vetting and recommending awardees to the Joint Reference Committee for approval by the Board of Trustees. Feedback from Council members included the following:

- This award should go to the best possible individual and/or organization
- This award is an opportunity to highlight the work of psychiatrists so it should go to psychiatrists
- This award should be awarded specifically for accomplishments related to human rights
- It may make sense to look at the list of overall APA awards to see how this award fits in
- Dr. David Satcher, former U.S. Surgeon General, was suggested as a possible nominee for consideration

Position Statements and Action Papers

WPA Position Statement on Social Justice for Persons with Mental Illness (Mental Disability)

APA Administration recently reached out to the Council and other components for input and feedback regarding signing on to a position statement from the WPA. Since several Council members provided feedback indicating concern with some of the wording despite overall approval of the statement, this position statement will be introduced into the component review process for greater review and feedback. It was noted that this position statement was already approved by the WPA Executive Committee.

Action Paper: *Parity in Permanent Licensure Policy*

Staff shared the Assembly Action Paper "Parity in Permanent Licensure Policy" submitted to the Council for input and feedback from the action paper author Dr. Sarit Hovav, Chair of the Assembly Committee on Residents and Fellows. Dr. Ken Busch, the Council's Assembly Liaison, discussed with the Council the importance of Council feedback on such action papers. He noted that this particular action paper garnered a lot of discussion upon preliminary review by Assembly members, but was generally supported. Feedback from the Council included the following:

- Perhaps "parity" is not the correct term to use in this context
- "Equality" may be a better term to replace "parity" in this action paper
- Does the American Medical Association (AMA) already support a similar statement?
- Does the arrangement indicated in the action paper apply to both international medical graduate trainees in U.S. training programs and U.S. medical graduates in foreign training programs?

Action Paper: *The Impact of Global Climate Change on Mental Health*

Staff notified the Council that the Joint Reference Committee referred the Assembly Action Paper "The Impact of Global Climate Change on Mental Health" to the Council for feedback. Since feedback is not necessary until November 2015, the Council will discuss the action paper at the upcoming September Components meeting.

ATTACHMENT 3: COUNCIL MINUTES – JULY 2015

Council Name: Council on International Psychiatry
Date: July 16, 2015
Time: 12:00 PM – 1:00 PM
Location: Conference Call

Council Members Present: M. Riba, D. Jeste, A. Becker, D. Baron, J. Griffith, N. Juthani, S. Okpaku, E. Pi, U.K. Quang Dang, P. Ruiz, A. Tasman, B. Acharya, J. McIntyre, S. Rataemane, G. Raviola, E. Sorel, M. Soliman

Council Members with Excused Absences: K. Busch, P. Ruiz, J. Srinivasaraghavan

Council Members with Unexcused Absences: None

Guests in Attendance: None

Staff in Attendance: R. Juarez

Summary

The Council reviewed and discussed actions made by the Board of Trustees and recommendations from the Joint Reference Committee. This included the addition of an international membership category for residents and a pilot project offering discounted group rates for international associations. Updates were also provided regarding the Council's administration and reporting components.

Minutes

The Council approved the minutes of the May 20, 2015 in-person meeting in Toronto, Canada

International Membership

Dr. Jeste provided a summary of the Board of Trustees meeting on July 11 and 12 regarding the addition of two member generating initiatives introduced by the Membership Committee and Finance and Budget Committee:

Membership Committee:

The Board of Trustees voted to approve the recommendation of the Membership Committee to establish a new category of membership, as follows:

International Resident-Fellow Member: Physicians enrolled in a psychiatry residency training program or fellowship in a psychiatry subspecialty outside of the U.S. and Canada, verified with a letter from the training program.

Finance and Budget Committee:

The APA Board of Trustees voted to approve a two year pilot project of discounted group rates for international associations.

Dr. Jeste noted that with the addition of the International Resident Fellow Membership (IRFM) category, the increase in the number of international membership categories to four, including International Member, International Fellow, and International Distinguished Fellow, represents a positive direction for the international growth of the APA.

The Council discussed various sensitivities around recruiting international psychiatrists to become international members of the APA including a possible feeling from international psychiatric organizations that the APA is "intruding" or "competing" with them. The Council suggested that it may be ideal for the APA President to connect with the leadership of the international interest groups in the United States to develop a joint communication to international psychiatric organizations regarding the benefits of international membership with the APA. It was noted that this type of advisory role by the Council on such initiatives regarding how to best navigate potentially sensitive issues with international organizations

International Education and Training

Council Abstract Development

Dr. Becker and Dr. Griffith provided an update on the development of the Council's submission for the APA Annual Meeting in Atlanta – "Training American Psychiatrists as Global Mental Health Investigators, Implementers and Collaborators: What Have We Learned That Can Inform Best Practices?"

With the understanding that there are about 17-25 residency training programs with global mental health training, the goal of this presentation will be to bring together those best practices from each program, taking into consideration the competencies and milestones set by the ACGME, and use them to "tailor" psychiatric education with regards to global mental health.

The Council discussed that while the need to train individuals in different countries is an important issue that will take time to address, it can begin to be addressed by training American psychiatrists to work bi-directionally with in-country collaborators to foster capacity building.

Dr. Becker and Dr. Griffith noted a need to identify two additional speakers to incorporate their perspectives into the presentation. Dr. Raviola discussed his work with the Partners in Health fellowship programs operating in multiple countries around the world and mentioned the possibility of identifying some past fellows for consideration. Once the final abstract is ready, it will be circulated to the Council.

International Relationships

Dr. Sorel discussed the "Statement on Collaborative and Integrated Care" that was adopted by the World Psychiatric Association during the WPA International Congress in Bucharest. It was noted that the statement could be forwarded by WPA and the individual national psychiatric organizations, including the APA, to their respective ministries of health as well as to the United Nations Secretary General.

NOW BE IT RESOLVED THAT

United Nations member states adopt collaborative and integrated care as a means toward achieving total health for all in the 21st Century; and be it further resolved that this goal be included in the updated United Nations Sustainable Development Goals; and be it further resolved that, United Nations member states allocate the necessary human, financial, and technological resources for training, education, and implementation of this resolution.

Council Administration

Dr. Riba provided a summary of the Joint Reference Committee (JRC) meeting on July 10 regarding requests from the JRC Chair, Dr. Maria Oquendo, and Dr. Saul Levin for the Council to work with the Assembly and international interest groups in the United States such as the Indo American Psychiatric Association and the Association of Korean American Psychiatrists.

It was noted that Dr. Ken Busch on the Council serves as the Assembly Liaison. The Council also agreed on a strategy to incorporate individuals from the different international interest groups by first compiling a comprehensive list of relevant organizations and key contacts. The Council will then review the list to schedule 1-2 organizations to participate in future Council conference calls. The Council also suggested potentially developing a plan to recruit the leadership of international interest groups to become APA members and then recognize them at the APA Annual Meeting.

Dr. Riba announced that the APA representatives to the United Nations will now be reporting to the Council regarding their activities at the United Nations Headquarters in New York, NY. Dr. Vivian Pender, one of the current representatives will be invited to discuss with the Council their work with the United Nations and the Economic and Social Council (ECOSOC).

Caucus on Global Mental Health

Dr. Sorel, the Caucus Chair, mentioned a newsletter that will go out to all Caucus members, which stands now at over 200 members, which will include a welcome and update from Dr. Rahn Bailey, the Membership Committee Chair. It was noted that the Caucus will be included in the agenda for all future Council meetings.

International Discussion Groups

Dr. Okpaku, Chair of the Africa Discussion Group, recommended that the Council should be careful not to subsume all objectives into one group. It was noted that the Africa Discussion Group also disseminates a newsletter to its participants.

Human Rights Award

The Council discussed how to best manage the Human Rights Award and decided to develop a formal nomination form that outlines the criteria which can be sent to APA international members, APA international medical graduates, and to the international psychiatric special interest groups in the United States to solicit nominations.

Report of the Council on Healthcare Systems and Financing

Harsh K. Trivedi, MD, MBA, Chair

Executive Summary

The Council on Healthcare Systems and Financing has formulated its workplan for the next 12 to 18 months for submission to the JRC for review. The workplan is focused on the strategic priorities of the APA Board of Trustees (BOT) and the recommendations of the BOT Workgroup on Health Reform, both of which were adopted in March 2015. The workplan is more fully discussed below.

Action Items

Action Item 1: Position Statement on Any Willing Physician
CHSF members reviewed the position statement and the general consensus was that this position statement could be retired as it was no longer necessary. Members asked that the position statement also be reviewed by CAGR prior to a request to retire the document is put forward to the JRC.

Will the Joint Reference Committee ask the Council on Advocacy and Government Relations review the APA Position Statement on Any Willing Physician and make a recommendation as to whether or not to retire or revise the document?

Action Item 2: Parity in Payment, Parity in Policy Implementation (ASMMAY1512.U)
The CHSF discussed this at their September meeting. Much of this falls within the ongoing work plan regarding parity. A communications plan should be developed in conjunction with relevant APA offices to ensure that parity information is communicated to key stakeholders/decision makers. The CHSF recommends that the Department of Government Relations draft a letter to the VA to address specific concerns raised within the VA system.

Will the JRC ask the Division of Government Affairs to draft a letter to the VA to address the specific concerns within the VA system raised in the Parity in Payment, Parity in Policy Implementation Assembly Action Paper?

Assembly/JRC Referral Updates

See chart

Informational items:

The Council is currently developing or revising essential APA position statements of import to APA advocacy efforts. Including statements on the:

- Care for the SPMI population,
- Principles of collaborative care,
- ER boarding, and
- Off label prescribing

APA will be collaborating with other medical professional associations on the development of CPT codes to describe the work involved in the Collaborative Care Model (CoCM). This will include outreach to CMS who has expressed its decision to provide coverage for these services beginning in 2017. We will also be collaborating with others on recognition of Medicare coverage for the interprofessional consultation codes, improvement for coverage of telepsychiatry, and increased recognition of cognitive work essential for appropriate clinical care. These efforts will be led by members of the Committee on RBRVS, Codes and Reimbursements.

The CHSF will review and provide preliminary analysis of what the SGR reform legislation means for psychiatrists in terms of options for participation and feasibility of alternative payment methods and achieving eligibility for bonus status under the Merit-Based Incentive Payment System (MIPS).

The CHSF will be reviewing with APA staff its various efforts on increasing oversight and enforcement of the Federal parity laws including engagement of employers (as purchasers of health insurance) on the issue of payment equity and network adequacy for psychiatry.

At the request of the JRC, the CHSF has prepared a workplan for the next 12 to 18 months. It is attached to this document. It is not presented the exact format that the JRC forwarded, but it does contain all of the essential information elements the JRC format includes.

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.2	Developing an Access to Care Toolkit (ASMMAY1512.C) The action paper asks: 1. That an Access to Care Tool Kit be developed and maintained by the Council on Healthcare Systems and Financing to include relevant Action Papers, Position Statements, Guidelines, model or sample state legislation, survey instruments and a repository of related legal actions from states. The Tool Kit should include links to the Parity Tool Kit and other related resources and to be easily downloadable to members. 2. The availability of the Tool Kit and its components should be publicized in APA News, and to District Branches and State Organizations through the Federal Legislative Representative Network and the Office of Ethics and District Branch/State Association Relations.	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing.	Council on Healthcare Systems and Financing Report to JRC: January 2016	The Council reviewed the three access to care related items at their fall meeting. The Council supported the actions and will incorporate this work into its workplan. It was felt that the survey would provide data that will be necessary to advance advocacy efforts. Consideration will be given to existing instruments as well as doing a survey on a routine basis to capture trends. A communications plan will be developed as appropriate. Dr. Mawhinney will be the project lead.
6.3	Compendium of Access to Care Action Papers and Position Statements (ASMMAY1512.D) The action paper asks that a compendium of Action Papers and Position Statements relating to access to care be included in an easily downloadable Access to Care Tool Kit to be developed and maintained by the Office of Health Care Systems and Financing.			
6.4	Access to Care Survey (ASMMAY1512.E) The action paper asks that one or more patient centered Access to Care Surveys, such as the Area 6 Access to Care Survey, be included in an Access to Care Toolkit, to be developed and maintained by the Council on Health Care Systems and Financing.			

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.5	Level of Service Intensity Instrument (ASMMAY1512.F) The action paper asks: 1. Within six months the APA Administration will research what level of care/intensity of service tools are available and used by insurance companies and other organizations for determination of appropriate psychiatric and substance abuse care for adults. 2. This data will be presented to the Councils on Quality Care and Healthcare Systems and Financing to determine whether APA should: a. Endorse a specific tool or set of criteria, or; b. Propose development of such a tool by APA 3. That the Councils will report their recommendations to the Joint Reference Committee the following year.	The Joint Reference Committee referred items #1 and #2 to the Office of Healthcare Systems and Financing and items #2 and #3 to the Council on Healthcare Systems and Financing.	Office of Healthcare Systems and Financing Council on Healthcare Systems and Financing Report to JRC: October 2015 (Due 10/2/2015)	APA staff have begun to compile information on the various level of care criteria (i.e. LOCUS, CANS, ANSA, Interqual/Milliman) to see what is currently available. This is an important issue as it is tied to medical necessity decision making and there are many parity issues inherent in this. CHSF thinks that this task is a very large undertaking and likely involves expertise from several APA councils and perhaps from experts who are not currently on an APA component. **CHSF recommends that if this project is to be accomplished due consideration needs to be given to creating a special APA workgroup to do this.**

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.6	Timely Reimbursement for Psychiatric Treatment (ASMMAY1512.G) The action paper asks: That the Council on Healthcare Systems and Financing and the Division of Government Affairs will encourage state and national governments to enact enabling legislation and grants to psychiatrists to voluntarily use effective systems of immediate payment to insurance -paneled psychiatrists (and patients of psychiatrists who have opted out of third party payers excluding Medicare), using secure card or mobile technology for web-based patient identification, registration, and payment; and That the APA/AMA Delegation will work with the American Medical Association to promote the adoption of a national voluntary system of immediate electronic medical claims filing, adjudication, and payment.	The Joint Reference Committee referred the action paper to the Council on Quality Care [LEAD], and the Council on Healthcare Systems and Financing and requested a report in October 2015. The councils are asked to determine what the appropriate scope or universe would be to implement this paper and if legislation might be needed. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Council on Quality Care [LEAD] Council on Healthcare Systems and Financing Report to JRC: October 2015 (Due 10/2/2015)	The Council discussed the paper and suggests that it be sent back to the author for further clarification including a definition of the problem that is being addressed. It was noted that there are state laws currently in place that dictate allowable turnaround times for claims payment. How this proposal would interact with those laws is unclear. CHSF further recommends, given this, and the paper's request for legislation, that this be refer to CAGR for input as well.

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.7	Removing Barriers to Providing Compassionate Care to Victim of Sexual Assault (ASMMAY1512.H) The action paper asks that: 1. The APA develop a Position Statement and a Resource Document regarding the psychiatric morbidity associated with sexual assault, including the psychological difficulties attendant to sexual assault evidence procurement and the failure of acting upon such evidence; 2. The relevant component of the APA work with the American Association for Emergency Psychiatry to ascertain that the emergency treatment of sexual assault victims, including that the administration of sexual assault evidence assessment kits, be coupled with provision of information about access to mental health treatment resources; 3. The relevant component of the APA liaise with the entities responsible for analyzing sexual assault victim evidence kits and acting upon their results in order to educate those entities to the psychiatric morbidity of their failing to do so, and to be available to assist those entities in their efforts to obtain adequate funding by providing them with information about the psychiatric morbidity associated with sexual assault; 4. The APA Council on Healthcare Systems and Financing advocate for the adequate provision of psychiatric treatment benefits to assure the provision of needed psychiatric services to victims of sexual assault.	The Joint Reference Committee referred the action paper to the Council on Minority Mental Health and Health Disparities (LEAD), Council on Quality Care, Council on Healthcare Systems and Financing and the Council on Psychiatry and Law. The councils were asked to provide feedback and comment on the feasibility of the action paper and to whom the APA would advocate. The JRC noted that the Council on Minority Mental Health and Health Disparities is currently developing a position statement on rape and human trafficking. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Council on Minority Mental Health and Health Disparities [LEAD] Council on Quality Care Council on Healthcare Systems and Financing Council on Psychiatry and Law Report to JRC: January 2016	The CHSF discussed item 4 at their September meeting. There was general consensus that an individual's health insurance provides coverage for mental health services. There is no evidence to show that benefits/coverage for these services do not already exist. **Absent specific data to the contrary the CHSF has no basis for further recommendations. CHSF does not feel it is the appropriate Council to deal with this request.**

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.13	Emergency Department Boarding of Individuals with Psychiatric Disorders (ASMMAY1512.S) The action paper asks: That the Council on Psychosomatic Medicine and the Council on Healthcare Systems and Financing jointly develop a position statement for the elimination of the conditions contributing to emergency department boarding of individuals with psychiatric disorders; and That the Council on Advocacy and Government Relations explore mechanisms towards expanding all community resources, including the increasing the availability of staffed State Psychiatric Hospital beds and funding additional psychiatric beds and units in community hospitals, with special attention to establishing high-risk psychiatric units capable of accepting complicated and aggressive patients, so as to end the practice of psychiatric boarding.	The Joint Reference Committee referred the action paper to the Council on Psychosomatic Medicine (LEAD), the Council on Healthcare Systems and Financing, the Council on Advocacy and Government Relations and the Council on Psychiatry and Law. A progress report was requested for October 2015. The Council on Psychosomatic Medicine is asked to develop a position statement with input from the other councils, and once the input has been received and incorporated into the draft statement, the proposed statement should be forwarded to the JRC.	Council on Psychosomatic Medicine [LEAD] Council on Healthcare Systems and Financing Council on Advocacy and Government Relations Council on Psychiatry and Law Report to JRC: October 2015 (Due October 2, 2015)	The CHSF is in the process of reviewing the draft position statement and will provide comments back to the Council on Psychosomatic Medicine. Dr. McLeer is the lead reviewer.

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.15	Parity in Payment, Parity in Policy Implementation (ASMMAY1512.U) The action paper asks: That the APA request the Council on Advocacy and Government Relations explore and then implement media coverage, and support regulatory, administrative and amicus briefs, against insurance companies, as the insurance companies continue to fail to be in compliance with the Affordable Care Act, and the Mental Health Parity Act. That the APA publically state that in the requiring preapproval directly from Department of Veterans Affairs mental health service providers or any other licensed mental health provider, adversely affects the treatment of patients with psychiatric and psychological problems requiring regularly scheduled appointments, That the APA will advocate at the highest level for comparability of length and procedural review, administrative action and reimbursement for professional services. That a joint Board of Trustees and Assembly Task Force be appointed to coordinate, oversee and guide this process.	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing [LEAD], the Division of Government Affairs, the Department of Healthcare Systems and Financing and APA Legal Counsel. All feedback and comments on this referral should be contained within the lead's report to the JRC	Council on Healthcare Systems and Financing [LEAD] Division of Government Affairs Department of Healthcare Systems and Financing APA General Counsel. Report to the JRC: January 2016	The CHSF discussed this at their September meeting. Much of this falls within the ongoing work plan regarding parity. A communications plan should be developed in conjunction with relevant APA offices to ensure that parity information is communicated to key stakeholders/decision makers. **The CHSF recommends that the Department of Government Relations draft a letter to the VA to address specific concerns raised within the VA system.**

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
6.17	Reconfiguring the Health Care Percentage of the GDP (ASMMAY1512.W) The action paper asks: That the APA delegation to the AMA House of Delegates present a motion in that body that calls on the AMA to establish a process for providing the public with separate percentages of the GDP corresponding to actual health care provision and to ancillary, administrative-management-type economic activities that have been linked to health care.	The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing to develop a motion for the APA AMA Delegation to present to the AMA.	Council on Healthcare Systems and Financing Report to the JRC: January 2016	CHSF recommends that this paper be sent back to the author for further clarification to define what is being sought/what is the desired outcome, how this information can shape public opinion in a way that leads to meaningful change, and how this information might help shape how much of the health care dollar is being spent on behavioral health conditions. The author is also asked to explain why the newly created medical loss ratios are insufficient to meet these concerns.

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
8.B.4	Referral Update Proposed Position Statement: Patient Access to Treatments Prescribed by Their Physicians [JRCOCT148.G.9] The Council on Advocacy and Government Relations was asked by the Council on Healthcare Systems and Financing (CHSF) to review a draft revision of the 2007 APA position statement, "Patient Access to Treatments Prescribed by Their Physicians," which addresses off-label use. The position statement under review is modeled after an AMA statement, since modified. As requested by CHSF, the Council discussed the suggested language affirming a physician's authority to use off-label drug products and medical devices. The Council recommends to the Council on Healthcare Systems and Financing to retain the more detailed 2007 off-label position statement without revisions.	The Joint Reference Committee requested that the Council on Healthcare Systems and Finance to obtain feedback from all councils as originally noted and make a recommendation to the JRC on the disposition of the position statement in October 2015.	Council on Healthcare Systems and Financing Report to JRC: October 2015 (Due October 2, 2015)	The CHSF was advised of the CAGR recommendation to maintain the existing position statement. A subsequent discussion with CAGR resulted in CAGR endorsing our support for the revised statement. It was reiterated that members of the CHSF thought that the original statement combined too many issues, and lacked clarity for that reason. The Councils on Government Relations and Research support the revised position statement as proposed by the CHSF. The Council on Children has been asked to determine if a separate statement on encouraging Clinical Research in Child and Adolescent Psychiatry was necessary.
8.G.3	Referral Update Multiple Co-payments Charged for Single Prescriptions [ASMMAY1412.A]	The Joint Reference Committee thanked the Council for the update and requested an updated report in October 2015.	Council on Healthcare Systems and Financing Report to JRC: October 2015 (Due 10/2/2015)	The CHSF provided feedback on the draft PBM survey. The document will be finalized and sent to survey participants and this is incorporated as part of the council's workplan for the next 12 months.

Agenda Item #	Action	Comments/Recommendation from the JRC	Referral/Follow-up & Due Date	CHSF/OHSF Comments/Actions
8.G.4	Referral Update Critical Psychiatrist Shortages at Federal Medical Centers [ASMNOV1412.D] The Joint Reference Committee referred the action paper to the Council on Healthcare Systems and Financing and the Council on Psychiatry and Law and its Work Group on Mental Illness and Criminal Justice. The Council on Healthcare Systems and Financing was asked to determine if the compensation issues raised in the action paper are covered in other APA documents and to identify current statistics on this question. There are no current APA position statements that speak to the issue of compensation. OHSF has begun to identify preliminary data on salary/income (see the chart within the Council's report) and will share this information with the Council on a future conference call.	The Joint Reference Committee thanked the Council for the update.		The CHSF reviewed the action paper and recommends that the author consider broadening the issue to encompass not only Federal Medical Centers but also the Indian Health Service, VA, and other federal programs. General consensus that this is an issue in other areas as well. CHSF does not think there are any current APA position statements that speak to the issue of compensation. **The council thinks the issue of developing a position statement that concerns compensation needs careful consideration from a number of components and the APA's General Counsel. We will report back on what kinds of salary income data we are able to discover.**

American Psychiatric Association
Council on Healthcare Systems & Financing
Harsh Trivedi, M.D., M.B.A., Chair
Hilton Crystal City (at Washington Reagan National Airport)
Yorktown, Lobby Level
Friday, September 11, 2015 10:00 AM – 4:30 PM
Saturday, September 12, 2015 9:00 AM – 12:00 NOON

DRAFT MINUTES

Participants
Council Members: Harsh Trivedi, MD, MBA, Chair; Lori Raney, MD, Vice Chair; Mary Anne Badaracco, MD, Robert Cabaj, MD; Joseph Mawhinney, MD; Grant Mitchell, MD; Bruce Schwartz, MD; Eliot Sorel, MD; Ole Thienaus, MD;
Fellows: Uche Achebe, MD; Pilar Abascal, MD; Neha Chaudhary, MD; Jason Schweitzer, MD; Tua-Elisabeth Mulligan, MD
Consultants: James Dilley, MD, Laurence Miller, MD
APA Leadership: Renee Binder, MD (President); Maria Oquendo, MD; Saul Levin, MD, MPA, APA CEO/Medical Director;
APA Administration: Sam Muszynski, JD; Ellen Jaffe; Karen Sanders; Becky Yowell; (OHSF); Kristin Kroeger (APA Chief Policy, Programs, Partnerships); Philip Wang, MD, DrPH (Director of Research); Eve K. Mościcki, Sc.D., M.P.H. (Division of Research)

Guests: Steve Daviss, MD; Jay Shore, MD
Absent**:** Ranota Hall, MD; Susan McLeer, MD; Sabina Lim, MD, MPH; Azeesat Babajide, MD

I. Welcome/Administration

A. Introductions: Dr. Trivedi welcomed all, reviewed the agenda and began with a round of introductions by all with disclosures/conflicts noted. He welcomed the new members and encouraged all, especially the Fellows to participate in the discussions.

B. Minutes: The minutes from the May 2015 meeting were reviewed and approved as written.

C. Agenda Overview: Dr. Trivedi provided an overview of the agenda noting that the Council will be discussing their workplan at this meeting and challenging the members to think about there the field is moving. There was a general discussion of the aligning forces -- CMS' move to coverage for the Collaborative Care Model (CoCM) and the positive response to APA's SAN grant application; AHA's Board level decision to address mental health issues; interest in replicating the financial success (in large part due to well managed mental health care) of the Montefiore ACO elsewhere; bi-partisan mental health legislation in both houses of Congress that stand a strong chance of passage -- that are creating huge opportunities and how best to position the APA to facilitate this process. The suggestion was made to consider using APA's strategic plan as a guiding principle throughout the meeting as the workplan is developed; both to identify what is in line with the plan and to understand the level of priority.

Some of this work will involve collaboration with other Councils (communications plans, educational outreach, legislative advocacy). Much of the discussion focused on understanding and communicating the value of psychiatry and the roles psychiatrists can play.

Dr. Trivedi identified four large areas of work for the CHSF which will be used as a reference as we develop the workplan and going forward as we conduct the ongoing work of the Council:

1. Emerging Models/Technologies/Opportunities
2. Parity/Regulations/Legislative Implications
3. Payment/Coding/Payers
4. Governance/Educating Membership

Members were assigned to specific areas based on interests and background. These informal workgroups will take the lead in reviewing and developing recommendations, statements or products within their assigned area.

III. Position Statement Review

A. PS A Call to Action for State Mental Health Authorities: Care of Persons with Persistent or Recurrent Major Mental Illness/A Call to Action for the Chronic Mental Patient (III.C.1_01-02)
Members offered edits which will be incorporated into the document which will then be sent to the JRC for review.

B. PS Any Willing Physician
Members reviewed the position statement and the general consensus was that this position statement could be retired as it was no longer necessary. Members asked that the position statement also be reviewed by CAGR prior to a request to retire the document is put forward to the JRC.

Action Item 1: Will the JRC ask the Council on Advocacy and Government Relations review the APA Position Statement on Any Willing Physician and make a recommendation as to whether or not to retire or revise the document?

C. PS Psychiatry and Primary Care Integration across the Lifespan
Members reviewed the position statement and recommended that it be revised. Suggestions included specific mention of the Collaborative Care Model, revisions to the title so that it is clear as to the intent of the document. Drs. Raney and Sorel will take the lead on the revisions. The revised statement will be sent to the JRC as soon as it has been finalized. Members of the Council stressed that care has to be taken to ensure APA has consistent messaging about Collaborative Care. There are two additional items that relate to Collaborative Care working their way through the components (items from the Council on Psychosomatic Medicine and the Division of Research). A small group of Council members and staff will be identified to review the full set of documents.

D. PS Minimum Necessary Guidelines for Third-Party Payers for Psychiatric Treatment
Staff is in the process of reviewing this document and will report back to the Council as to specific recommendations at a later time.

IV. Assembly/JRC Action Items

A. Developing an Access to Care Toolkit (ASMMAY1512.C)
Compendium of Access to Care Action Papers and Position Statements (ASMMAY1512.D)
Access to Care Survey (ASMMAY1512.E)
The Council reviewed the three access to care related items. The Council supported the actions and will incorporate this work into its workplan. It was felt that the survey would provide data that will be necessary to

advance advocacy efforts. Consideration will be given to existing instruments as well as doing a survey on a routine basis to capture trends. A communications plan will be developed as appropriate. Dr. Mawhinney will be the project lead.

B. Level of Service Intensity Instrument (ASMMAY1512.F)
APA staff have begun to compile information on the various level of care criteria (i.e. LOCUS, CANS, ANSA, Interqual/Milliman) to see what is currently being used. This is an important issue as it is tied to medical necessity decision making and there are many parity issues inherent in this. CHSF thinks that this task is a very large undertaking and likely involves expertise from several APA councils and perhaps from experts who are not currently on an APA component. **CHSF recommends that if this project is to be accomplished due consideration needs to be given to creating a special APA workgroup to do this.**

C. Timely Reimbursement for Psychiatric Treatment (ASMMAY1512.G)
The Council discussed the paper and suggests that it be sent back to the author for further clarification including a definition of the problem that is being addressed. It was noted that there are state laws currently in place that dictate allowable turnaround times for claims payment. How this proposal would interact with those laws is unclear. CHSF further recommends, given this, and the paper's request for legislation, that this be refer to CAGR for input as well. This information will be sent to the Council on Quality Care [Lead] for consideration.

D. Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault (ASMMAY1512.H)
The CHSF discussed item 4 (The APA Council on Healthcare Systems and Financing advocate for the adequate provision of psychiatric treatment benefits to assure the provision of needed psychiatric services to victims of sexual assault.). There was general consensus that an individual's health insurance provides coverage for mental health services. There is no evidence to show that benefits/coverage for these services does not already exist. Absent specific data to the contrary the CHSF has no basis for further recommendations. CHSF does not feel it is the appropriate Council to deal with this request. This information will be sent to the Council on Minority Mental Health and Health Disparities [Lead] for consideration.

E. Emergency Department Boarding of Individuals with Psychiatric Disorders (ASMMAY1512.S)
The CHSF is in the process of reviewing the draft position statement and will provide comments back to the Council on Psychosomatic Medicine. Dr. McLeer is the lead reviewer.

F. Parity in Payment, Parity in Policy Implementation (ASMMAY1512.U)
The CHSF discussed this at their September meeting. Much of this falls within the ongoing work plan regarding parity. A communications plan should be developed in conjunction with relevant APA offices to ensure that parity information is communicated to key stakeholders/decision makers. The CHSF recommends that the Department of Government Relations draft a letter to the VA to address specific concerns raised within the VA system.

Action Item 2: Will the JRC ask the Department of Government Relations to draft a letter to the VA to address the specific concerns within the VA system raised within the Assembly Action Paper?

G. Reconfiguring the Health Care Percentage of the GDP (ASMMAY1512.W)
CHSF recommends that this paper be sent back to the author for further clarification to define what is being sought/what is the desired outcome, how this information can shape public opinion in a way that leads to meaningful change, and how this information might help shape how much of the health care dollar is being spent

on behavioral health conditions. The author is also asked to explain why the newly created medical loss ratios are insufficient to meet these concerns.

H. Proposed Position Statement: Patient Access to Treatments Prescribed by Their Physicians [JRCOCT148.G.9]
The CHSF was advised of the CAGR recommendation to maintain the existing position statement. It was reiterated in a subsequent discussion with CAGR, that members of the CHSF thoroughly reviewed the document and came to the conclusion that the original statement combined too many issues, and therefore lacked clarity. CAGR reversed their decision and supported the original recommendation by the CHSF; as did the Council on Research. We are awaiting feedback from the Council on Children who has been asked to determine if a separate statement on encouraging Clinical Research in Child and Adolescent Psychiatry was necessary.

I. Multiple Co-payments Charged for Single Prescriptions [ASMMAY1412.A]
The CHSF provided feedback on the draft PBM survey. The document will be finalized and sent to survey participants and this is incorporated as part of the council's workplan for the next 12 months.

J. Critical Psychiatrist Shortages at Federal Medical Centers [ASMNOV1412.D]
The CHSF reviewed the action paper and recommends that the author consider broadening the issue to encompass not only Federal Medical Centers but also the Indian Health Service, VA, and other federal programs. There was general consensus that this is an issue in other areas as well.
Members of CHSF do not think there are any current APA position statements that speak to the issue of compensation. The council thinks the issue of developing a position statement that concerns compensation needs careful consideration from a number of components and the APA's General Counsel. We will report back at a future meeting on a broader salary survey as well.

K. CHSF Evaluation and Workplan
As part of the workplan development and identification of the four key topical areas for the Council, members had a general discussion of the range of activities required to fulfill not only actions moving through the APA governance process but ongoing regulatory, legislative and private sector advocacy efforts. Dr. Trivedi will work with staff to incorporate the identified topics into the workplan for review by the JRC.

V. Guests

A. Jay Shore, MD, Chair, APA BOT Telepsychiatry Workgroup spoke to the Council about the ongoing work of the new workgroup. The group is moving forward with new educational content both at in person meetings and on line, including a Telepsychiatry 101 type of session. Dr. Shore shared the proposed position statement on Telemedicine. Members made some suggested edits but as a whole supported the statement. There was a general discussion of issues/barriers around reimbursement for telemedicine (e.g., limiting payment for telemedicine to specific regions, generally rural). Dr. Shore, or a member of his workgroup, was invited to join the Council on a subsequent conference call to discuss these sorts of barriers.

B. Saul Levin, MD, MPA, APA CEO and Medical Director, and
Philip Wang, MD, DrPH, Director, APA Division of Research
Dr. Levin thanked the members of the Council for their time and service to the APA. He stressed the importance of the work of this Council to the field and encouraged members to continue their hard work. Dr. Levin introduced Dr. Wang, the new Director of APA's Division of Research. Dr. Wang, former Deputy Director of NIMH, joined the APA in the last several months. He is interested in feedback from Councils as to how the Office of Research can assist their work, especially in areas of data gathering.

C. Renee Binder, MD, APA President, and
Maria Oquendo, MD, APA President-Elect
Drs. Binder, MD, and Oquendo briefly spoke to the Council, thanking them for volunteering their time to the organization on behalf of the field. They both encouraged the younger members to be active participants, challenging them to take the lead on projects when they can. Dr. Binder talked briefly about her presidential initiatives which touch on the issues of ethics, mental health and the criminal justice system, and telepsychiatry. Dr. Oquendo spoke to the Council about her desire to increase the diversity of the organization and to train new leaders.

VI. New Business:

A. The Council reviewed and supported The WPA Bucharest Statement on Collaborative and Integrated Care.

B. The Council discussed an action paper from Steve Davis set to go to the Oct/Nov Assembly in 2015. The paper speaks to problems in coverage for prescriptions written by non-participating providers. States are interpreting ACA legislation around this issue in different ways. The Council was generally supportive of the paper. It was noted that OHSF is already working on this issue.

VII. Adjournment

The meeting was adjourned at 11:30 AM. The next conference call will be held in October.

Emerging Models/Technologies/Opportunities

Lori Raney

Mary Anne Badaracco

Robert Cabaj

Grant Mitchell

Bruce Schwartz

Ole Theinhaus

Jason Schweitzer

Tua-Elisabeth Mulligan

Laurence Miller

Pilar Abascal

Neha Chaudhary

Payment/Coding/Payers

Bruce Schwartz

Ranota Hall

Jason Schweitzer

Steve Daviss

Parity/Regs/Legislative Implications

James Dilley

Robert Cabaj

Joseph Mawhinney

Pilar Abascal

Jason Schweitzer

Governance/Educating Membership

Lori Raney

Laurence Miller

James Dilley

Joseph Mawhinney

Susan McLeer

Uche Achebe

Pilar Abascal

Tua-Elisabeth Mulligan

To be assigned

Sabina Lim

Eliot Sorel

Azeesat Babajide

Item 2015A1 12.U
Assembly
May 15-17, 2015

ACTION PAPER
FINAL

TITLE: Parity in Payment, Parity in Policy Implementation

WHEREAS:
Whereas, the Veterans Administration (VA) is required by law (Public Laws 99-272 and 101-508, 38 US Code 1729) to recover from individual insurance carriers the government's cost of providing medical treatment to veterans for non-service connected conditions, whether the policy is held by the veteran, the veteran's spouse, or veteran's guardian,

Whereas, preapproval is required by insurance companies for mental health services, including 50-60 minute psychotherapy sessions, but not for continuing routine medical appointments,

BE IT RESOLVED:
That the APA request the Council on Advocacy and Government Relations explore and then implement media coverage, and support regulatory, administrative and amicus briefs, against insurance companies, as the insurance companies continue to fail to be in compliance with the Affordable Care Act, and the Mental Health Parity Act.

That the APA publically state that in the requiring preapproval directly from Department of Veterans Affairs mental health service providers or any other licensed mental health provider, adversely affects the treatment of patients with psychiatric and psychological problems requiring regularly scheduled appointments,

That the APA will advocate at the highest level for comparability of length and procedural review, administrative action and reimbursement for professional services.

That a joint Board of Trustees and Assembly Task Force be appointed to coordinate, oversee and guide this process.

AUTHOR:
Harold Ginzburg, M.D., J.D., M.P.H., DLFAPA, Deputy Representative, Oklahoma Psychiatric Physicians Association

ESTIMATED COST:
Author: $3,340
APA: $13,599.49

ESTIMATED SAVINGS: To VA- not calculable

ESTIMATED REVENUE GENERATED: For VA and providers, not for APA:
Not precisely calculable for the VA, potentially millions of dollars; if implemented for all providers, even more.

ENDORSED BY:

KEY WORDS: Professional Practice, Financial payment to service providers, Patient Care, Patient Access

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

REVIEWED BY RELEVANT APA COMPONENT:
Insufficient time for feedback from any component – suggest it be sent to CAGR

Position Statement on Any Willing Physician

Approved by the Board of Trustees, July 1995
Approved by the Assembly, May 1995

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

The APA believes that treatment by a non-medical licensed professional cannot substitute for medical treatment by a physician.

Accordingly, the APA supports "any willing physician" legislation which requires any public or private third party payer, health plan, or organized system of health care (hereinafter referred to as "payer") to contract with any duly licensed physician who is willing to accept the payer's published criteria, terms and conditions for participation and payment for the medical treatment for which the payer is responsible.

However, the AP recognizes that the concept of patient freedom-of -choice and the concept of an affordable point-of-service option may be superior to "any willing physician" in their value to physicians and patients.

Criteria for Evaluating Councils – Council on Healthcare Systems and Financing

1) How many times did the Council meet?
    - 2015: 2 in person; 5 conference calls
    - 2014: 2 in person; 7 conference calls
    - 2013: 2 in person; 4 conference calls

    a) Please provide the attendance at each meeting (data for past year only)
    Sept 2014 (face-to-face); 8 members, 1 consultant 5 absences
    Oct 2014 (call); 7 attendees
    Dec 2014(call); 7 attendees
    Jan 2015 (call); 10 attendees
    Feb 2015 (call); 4 attendees
    April 2015 (call); 13 attendees
    May 2015 (face-to-face); 9 members, 3 fellows attended; 8 absences
    Aug 2015 (call); 11 attendees
    Sept 2015 (face-to-face); 9 members, 2 consultants, 5 fellows and 4 absences

2) Education
    a) What workshops/symposia, etc. have been submitted for presentation at APA Annual Meetings?

        - The CHSF has not presented at the either of the APA meetings for the last several years.

        - The Committee on RBRVS holds a CPT coding and documentation seminar and workshop at every APA Annual Meeting and intermittently at the IPS.

        - Members of the Workgroup on Integrated Care present a large number of workshops and other CME related activities at the APA Annual Meeting and IPS.

    b) What was the attendance at these events and what was the feedback on these events?

        - RBRVS: Both sessions are well attended (seminar fills to capacity each year)

        - Workgroup on Integrated Care: All are well attended (rooms are full)

3) What are the council's current activities and what activities are planned for the coming years?
[See attached workplan]

4) Has work product been sent to the Assembly and the Board of Trustees?
Yes. We have submitted new and revised position statements and reported on issues such as mental health parity, CPT coding and documentation, network adequacy, health reform, reimbursement, collaborative care and so on.

5) What is the Council doing for RFM and ECP members?
As defined by our charge - we are working to foster MH parity, advocating for adequate funding and reimbursement; monitoring and evaluating emerging trends and disseminating information to the membership on developments relating to healthcare systems and financing in an effort to provide a positive and sustainable work environment for the field. We encourage

all Fellows assigned to the Council to participate fully and have tasked individuals to lead specific projects (e.g., liability resource document, workforce document)

6) Evaluate the staff support to the Council and its components
OHSF is a group of high-skilled, outcomes-oriented, and detail-oriented professionals who manage some of the most complex issues that our organization deals with. In light of healthcare reform, passage of mental health parity, new payment models, and a myriad of other significant developments - the number of active work products as well as the complexity of the knowledge-base to successfully maneuver our association and its member has increased multiple-fold. While the sheer volume of work has grown with an increase in the need for more immediate churning of projects to completion - there has not been any increase in staff to support the Council and its components.

Outcome:

- ☐ Continue the component in its current form
- ☐ Recommend changes to the component
- ☐ Discontinue the component

Draft Council on Healthcare Systems and Financing (CHSF)
Workplan

In formulating its workplan for the next 12-18 months the Council considered it essential to fully consider the Strategic Initiatives of the Board issued in March 2015 and the recommendations of the current Board of Trustees Workgroup on Healthcare Reform in its most recent, March 2015, report. The council also requested input from staff as to pertinent developments that fall within the foregoing.

Throughout its discussions CHSF acknowledged that it is essential that any component workplan that is to be meaningful should contain: 1) a clear statement of the issue and rationale for a given work product and its strategic utility; 2) the work product(s) defined for the given issue/topic; e.g., a position statement, educational resource document, specific recommendations for a given public/private policy, etc.; 3) identification of the key resources needed to develop/implement the product; e.g., key governance components and administration expertise; 4) a specific plan for development and implementation of the work product (i.e., the tasks to be performed), assignment of responsibility for each task and coordination thereof with a defined timeline for completion; and 5) a plan to execute and monitor/evaluate.

It is obvious that resources, especially time, are limited and that there must be prioritization. The scope of work referred to the CHSF is large and often highly variable. Sometimes the work requested does not relate to what the council has defined as its priorities. CHSF thinks it is essential that, in the important and rapidly changing healthcare environment, the council must remain focused on the issues within its purview that have significant implications for the future place of psychiatry. We will accept whatever guidance is provided by the JRC as to priority items, with the obvious reality that these will still have to be sequenced based on the manpower resources of the council and the Office of Healthcare Systems and Financing (OHSF). The council recognizes that OSHF has many important work functions that are essential and beyond the workplan of the council.

With the foregoing in mind, CHSF has identified the following as key categories for product development and implementation over the next 12- 24 months. Each of these will necessitate collaboration and priority alignment with various other APA councils and will draw on staff expertise and skills from various departments:

1) Integrated/Collaborative care

a) Development of an APA position statement

Background: It is a given that integrated care delivery policy initiatives are fundamental to help both public and private payers in pursuing better quality care and desired cost efficiencies. The APA has been in the forefront of placing emphasis on the essential role the treatment of behavioral conditions has in respect to these objectives. However, the APA does not have a current position statement that sets forth the principles it thinks should guide payor initiatives. The Council will undertake a lead role in the development of a position statement to be processed through appropriate APA channels.

Key Persons Involved: The key actors involved include the members of CHSF and the Council on Psychosomatic Medicine, and input will be requested from other councils as well. Key administrative personnel are within OHSF.

Key Tasks:

1. To immediately begin drafting a position statement that articulates APA principles with input from other key stakeholders within the APA.
2. Secure JRC approval to begin to process this through governance quickly for eventual final approval of an APA Position Statement.

Timeline: As we understand the standard timeline, between the JRC, the Assembly, and the Board, this statement cannot properly go through channels and be fully considered until the May 2016 meeting of the Assembly. In our view, there is an urgency to expedite the review and approval of this position statement inasmuch as APA is now fully engaged with CMS and the AMA CPT and RUC to develop new codes, value them, and secure Medicare coverage for collaborative care. A defined APA position would be extremely useful in this negotiating process (as there are many many competing interests—e.g., psychology—that are seeking coverage for "collaborative care" in a manner that we feel would be inconsistent with APA principles).

We respectfully ask that consideration be given to how to expedite this process, and would reference remarks made by various Board Health Reform Work Groups that have noted that the APA governance structure may need to develop a rapid response mechanism for certain APA actions. In our opinion, the need for this position statement falls within this category of rapid response.

b) Development of specific coding and valuation amounts for the evidence based collaborative care model for persons with behavioral conditions in primary care settings to enable sustainable reimbursement

Background: The problem of access to psychiatric services in primary care settings has been well documented. Care models to improve access in primary care settings have been developed and tested over time. The most prominent evidence-based collaborative care model is the one that the AIMS Center at the University of Washington has stewarded over time. The key barrier to the proliferation of the model has been payment for the essential functions of the model. CMS announced in July 2015 that it intends to move to coverage of, or further demonstration of, this evidence based model, and specifically intends to address how to appropriately reimburse for it. The Council will work to develop and advocate for a specific coding proposal with CMS. This will be done primarily through the Committee on RBRVS, Codes, and Reimbursement.

Key Persons Involved: A subset of the Council has been designated to work with the Committee on RBRVS and OHSF staff to shepherd this through. We anticipate that the Councils on Psychosomatic Medicine, Quality and the Council on Geriatric Psychiatry will be key contributors, along with their respective staff, as will other APA member experts and consultants we have already engaged for this. We will also be working extensively with other medical associations who either support or have a direct interest in facilitating payment for this type of care delivery model. CMS, AMA CPT and AMA RUC will primary throughout the entire process.

Key Tasks: There are many, many decision points in the following tasks that cannot be specified at this time.

1. Key CPT and RUC representatives will be assessing our options for playing this through given the many stakeholders involved.
2. Designation of a workgroup to begin to draft the required specifications for code development for CPT.

3. Convening a teleconference with APA experts for other medical specialties to explain the model and its requirements.
4. Convening meetings with CMS to provide additional information to the comments APA submitted Sept 2015 on CMS request for information.
5. Developing the content and strategy for when a proposal is submitted to CPT and/or the development of a G code by CMS. This may require two concurrent paths of actions with CPT and CMS.
6. Key tasks that follow from point 5 can only be delineated once we have a more defined pathway which should emerge by December 2015.

Timeline: The foregoing will occur over the next 18 to 24 months. The timelines that the AMA CPT and RUC work on and that of CMS are complex with respect to completion dates for codes to be considered for Medicare rule-making. However, CMS's announced target for coverage is January 2017. It should be noted that target does not mean that we will not be involved with CPT and RUC after that deadline for refinements in evaluation of the eventual codes.

c) Convening an expert workgroup of psychiatrists involved in new care models, e.g. ACOs and health homes (and working with public and private payers around issues for psychiatry in the new care models)

Background: Accountable Care Organizations (ACOs), medical and health homes, and efforts by CMHCs to secure better access for physical health services for the SMI population permeate the landscape. There are stellar examples of achievement--e.g., the Montefiore Pioneer ACO--where the successful integration of treating individuals with behavioral conditions has led to overall success. There are also examples in the health home world where sophisticated approaches to treating behavioral conditions in primary care settings have been successful. There are also a number of CMHC efforts that have been successful. However, the overall penetration of psychiatry in these models has been highly variable as documented in the literature. There is a need to draw on the experience of psychiatrists who have been involved to understand the elements necessary for success and barriers to successful integration. There is also a need to better understand the payer perspective on barriers to the implementation of better care models for behavioral conditions.

Key Persons Involved: The key persons involved will be a designated group of the Council who have had experience with these models, OHSF staff, and experts from the Council on Psychosomatic Medicine.

Key Tasks:

1. Develop an outreach plan throughout the existing APA structure, including the Assembly, to identify psychiatrists who are involved in these alternative arrangements.
2. Establish an outreach effort with commercial and public payers to begin discussions. Note that a meeting has already been had with Aetna.
3. Identify existing APA meetings (e.g., area council meetings, the annual meeting and IPS) to convene forums on these issues.

Timeline: The plan to identify individuals involved and/or interested parties should be developed by December 2015. It should be noted that the APA has received notice that it is the recipient of a major Support Availability Network (SAN) grant from CMS. The general purpose of this grant is to provide education for psychiatrists working in collaborative care situations as well as to bring training opportunities to primary care practices. We think this will be a major vehicle to identify and coalesce the

community of psychiatrists involved or interested in these models and to conduct important outreach with the primary care and payer communities.. The timeline for a potential working group summit for psychiatrists and payers would be spring 2016.

2) Coding and Payment Issues (separate from those for the CoCM model)

a)Working to enable payment for the interprofessional consultation codes and/or the possible development of new EM add-on codes for cognitive work, new or revised care coordination codes for all physician specialties and improvement in coverage for telepsychiatry.

Background: Independent of a specific coding proposal for the CoCM model noted above , there are a number of coding issues that are relevant for all physician specialties in the new healthcare delivery environment. Psychiatry has specific interest in the development of any of these new codes as well as payment for existing codes. We think there are special issues that need to be addressed to expand coverage and payment for telepsychiatry. CHSF, through the Committee on RBRVS, Codes and Reimbursement and with input from the BOT Workgroup on Telepsychiatry, will be actively working on each of these as agenda items.
Key Persons Involved: A designated subgroup of the Council and its Committee on RBRVS will be the primary responsible parties. We anticipate close collaboration with the Council on Psychosomatic Medicine and the Council on Geriatric Psychiatry and working with the BOT Workgroup on Telepsychiatry. Obviously, the key stakeholders of interest include the AMA CPT and RUC and CMS. Other than specific advocacy around telepsychiatry, we anticipate that most of the key work will be done conjointly with relevant coalitions. That is, no one party will carry the day on these issues with CPT, RUC, or CMS.

Tasks:

1. To monitor strategies along with other medical groups to persuade CMS to pay for the existing interprofessional consultation codes (CPT XXXXX to XXXXX).
2. To continue and ensure psychiatry's participation with key coalition groups that have emerged to expand recognition for essential cognitive work and care collaboration and potential new add on codes to the EM CPT codes.
3. Work with the BOT workgroup on telepsychiatry to identify key coverage and payment issues for telepsychiatry and develop an advocacy agenda based on them.

Timeline: Activities around this have already commenced and given prior experience we expect that they will continue actively throughout the next 12 to 18 months.

b) Production of a background paper on the feasibility of alternative payment models for psychiatric/SUD care across all levels of care and payers

Background: Numerous proposals (e.g., value-based payment, bundled payment, episodes of care, and so on) are emerging from both public and private payers as alternatives to fee for service. The feasibility of these alternatives for psychiatric care has not been systematically reviewed. There are many technical issues involved in alternative payment methods (e.g., the cost basis for the unit of payment, however defined; how it is risk adjusted for case mix; how to define the beginning and end points for what triggers an end to an episode and payment for same; and so on). The long-standing APA experience with prospective payment for inpatient care under Medicare, for instance, bears out that this is an extremely complex task. There are also distinct subset issue with other specialty APMs with respect to

how psychiatry should be included for essential consultation functions. Before proceeding to specific proposals the Council thinks it is essential that the APA fully analyze the issues. Even if a way to design an alternative payment model(s) (APM) for psychiatry cannot be found, this effort will assist in defining why these approaches are not appropriate, which may prove to be important in itself in advocating with payers as to how to appropriately deal with psychiatric care. Note that the development of APMs under Medicare is in some respects a special case because of to be stipulated CMS criteria and will be included in the initial work.

Key Persons Involved: The Council will designate a subgroup to work with OHSF staff to identify additional expertise needed to work with APA that does not reside within the Council. This may include outside help from economists, academicians in the services research area, and potential APA member experts who have experience with this issue. We will explore with the APA's Offices of Research and Quality several important roles for them to play in this process.

Key Tasks:

1. Assemble a group with the requisite expertise to begin to develop the necessary background paper/resource document.
2. Convene the group to begin to identify the essential review and analysis tasks that need to be undertaken to produce a definitive paper/resource document
3. Implement and coordinate the development of the document.
4. Ongoing collaboration with other medical associations regarding Medicare APMs.

Timeline: W**e** will begin exploring establishment of this group in October and develop an appropriate timetable to produce the needed resource document. At a minimum, in order to be timely with Medicare's objectives, we believe we need a resource paper/document by spring of 2016.

c) Optimizing payment for psychiatry under the new MIPS formula for Medicare (which cuts across quality, education, and HIT especially) including establishing appropriate exemption thresholds for practicing psychiatrists.

Background: SGR reform (i.e., MACRA) has reconfigured how much physicians will be paid or not paid depending upon how they interact with the various programs and alternative options established under the reform legislation. There are four potential paths that psychiatrists can occupy under MACRA, with each having different physician reporting, risk taking, and bonus/penalty implications. Psychiatrists can choose to:

1. Opt out of Medicare entirely;
2. Participate through the to-be-established MIPS payment formula;
3. Participate and be part of an alternative payment method and potentially be exempt from the MIPS payment formula; or
4. They can participate and be exempt from the MIPS payment formula if they fall under yet-to-be-established low-volume thresholds that exempt physicians from MIPS.

Key Persons Involved: The key persons involved will be the Councils on HSF and Quality. Internally, key administration will include OHSF, the Office of Quality, and potentially the Office of Research

Tasks:

1. Develop materials that fully explain options and implications for APA members;

2. Develop proposals that make it feasible for psychiatrists to meaningfully participate in the MIPS formula (this includes quality measures, meaningful use, and recognized clinical practice improvement activities and appropriate patient attribution methodology) and advocate for same with CMS;
3. Develop a background paper and work with other appropriate medical professional societies to explore the feasibility of an APM for psychiatry consistent with the yet to be developed criteria from CMS; and
4. Develop a specific low-volume threshold exemption for psychiatrist participating in Medicare.

Timeline: A timeline for this will be more fully mapped out once CMS has provided more clarity about its own timeline for development of essential regulations in this arena.

3) Mental health /SUD parity

MHPAEA took more than a decade to come to fruition. It is a complex and not well understood statute and regulations. Currently all individual DBs and State Associations are dealing with MHPAEA issues on their own. APA deals with member issues directly with insurance plans and with the federal government and brings in DBs when possible. It is a patchwork approach that is not strategic.
To successfully implement MHPAEA and obtain payment parity for psychiatrists, which is essential before healthcare reform payment models take hold, APA needs a coordinated and multipronged strategy that continues to demonstrate its strength in the area and mobilizes district branches to work together. APA's credibility and ability to succeed, particularly with the more recalcitrant insurance companies, depends on its ability to join forces in a coordinated fashion nationwide. Key elements of where we are headed are described below.

a) Continuation of current plan of action to secure network adequacy and reimbursement equity for psychiatry

Background: Under MHPAEA network adequacy and reimbursement parity are closely related non-quantitative treatment limitations (NQTLs). It is critical for the APA to successfully engage employers as purchaser and regulators as enforcers to move on the issue of network adequacy for psychiatrists, which is a well-documented problem. There have been many ongoing activities by OHSF staff in conjunction with the APA's General Counsel to pursue this, and there are indications that there is a beginning understanding by purchasers and regulators that network inadequacy is a parity violation. Moreover payment equity is fundamental to this. [Mention Parity and Medicaid Managed Care and Exchange Plans]

Key Persons Involved: CHSF has a working subgroup, and OHSF staff work closely with the APA's General Counsel, the Partnership for Workplace Mental Health, and DGR.

Key Tasks:

1. Building on the current workplan, we need to finalize a letter, which has been prepared, that will go from the New England Business Group on Health to numerous major insurers requesting specific data and documentation about the status of their psychiatric networks.
2. District Branches need to be educated on the issues and provided with the tools needed to address network adequacy at the state level with legislators and regulators. A series of materials are being finalized to be presented at the state legislative conference in October in Florida. A plan for follow-up with the District Branches will be executed at this meeting.

3. Other outreach efforts on network the adequacy issue as a parity problem need to be made to state insurance commissioners, attorney generals, and others.
4. Develop an appropriate internal and external communications plan around thes issues.

Timeline: these efforts have been ongoing and will continue aggressively over the next twelve months.

b) Development of education/action materials for APA state affiliates to identify and act on parity issues under health plans

Background: Many district branches have indicated a desire to move forward on mental health parity issues, but some do not understand the intricacies of the statutes, the enforcement scheme, or the insurance industry. There is need for a coordinated strategy between the APA and its DBs regarding dealing with all relevant stakeholders around the parity issue. The enforcement authorities and the insurance industry do not distinguish the APA from its district branches and our credibility is tied together.

Key Persons Involved: CHSF, OHSF staff, APA General Counsel, and Division of Government Relations staff.

Key Tasks:

1. Work with DBs to identify and define the educational materials most needed to proceed on a local basis regarding parity issues. Some of the needed materials have already been identified, e.g., understanding the enforcement scheme under MHPAEA, and will be disseminated at the October state conference.
2. To prepare other materials needed by the DBs
3. To develop educational opportunities for DBs or other state entities such as in-person meetings or webinar/go-to-meeting events
4. Develop a communications strategy to engage and sustain DB activities on parity with the central office.

Timeline: These activities have been ongoing and there will be scheduled events prior to the May 2016 Annual Meeting. The October 2016 state conference will feature much of these materials.

d) Release of resource document on disclosure and transparency re MHPAEA compliance with model recommendations for state advocates

Background: A fundamental issue regarding MHPAEA compliance and enforcement is the virtual total lack of disclosure by health plans and insurers on details that would permit evaluation of compliance with the statute. Disclosure is essential to transparency, and without real transparency there can be no assurances that plans have a legitimate basis for their assertions of parity compliance. An extensive resource document on disclosure under MHPAEA has been prepared and will be reviewed by the Council. A series of recommendations with model disclosure requests will be prepared for advocates at the state or individual level (should we link or attach the paper?).

Key Persons Involved: The CHSF and OHSF staff and legal consultant.

Key Tasks:

1. Review by Counsel and discussion with staff
2. Approval of recommendations and disclosure templates to be distributed
3. Develop and launch an implementation plan to engage APA affiliates on this important issue.

Timeline: The bulk of the work has already been done and we will target a launch for winter 2016.

4) <u>Development of communications/marketing materials that illustrate psychiatry's value proposition for healthcare reform care delivery and payment initiatives</u>

Background: APA has asserted that psychiatry has a direct value proposition of health reform and the many health systems and payers involved. For example, it has produced the Milliman report (title) which illustrates the extent of the behavioral health problem, its total impact, and psychiatry's potential contribution to ameliorate it. The relevance of psychiatry's value proposition varies from audience to audience. However, we have not effectively communicated this. CHSF will work with the councils on communications and psychosomatic medicine to develop a set of communications/marketing materials and a dissemination strategy.

Key Persons Involved: A subset the OHSF Council has been designated to work with staff and input from the communications, research, and psychosomatic councils will be required.

Key Tasks:

1. CHSF and staff will first survey and inventory the research literature relevant to this as well as materials that have already been developed (such as those from the Academy of Psychosomatic Medicine)
2. Convene a conference call with all necessary parties to develop an appropriate message platform and identify materials for internal and external audiences. This would include materials that would be available to members for use on a local basis.
3. Request that the Council on Communications draft and finalize, with review by CHSF, the needed communications materials
4. Request that the Council on Communications develop a distribution plan for the materials and execute it

Timeline: The target deadline for these materials would be the 2016 Annual Meeting. Consultation with the Division of Communications will commence as soon as practicable and will include specifics of a workplan timeline to achieve the May target deadline.

5) Pharmacy Benefit Management issues

a) Execute a survey of APA members on current PBM issues, produce a background document on current issues and options for APA advocacy

Background: The presence of PBMs is not new but the tremendous increase in micromanagement of pharmacy requests and the associated time burden is. There are many variations in the types of barriers or hurdles PBMs put in place, from securing approval for on or off-label use, to demanding justifications for why step therapy protocols are not in order or why patients who switch plans should be grandfathered on their effective drugs. The volume of complaints coming from members has increased

as has the number of action papers from the Assembly on various aspects of this issue. This problem is not limited to psychiatry. We are aware of many other physician specialties that have voiced similar concerns. The council will explore and potentially recommend a plan of action for resolving this managed care problem.

Key Persons Involved: the Council and OHSF staff.

Key Tasks:

1. Execution of a member survey on a wide variety of PBM issues to enable better definition and identification of what should be considered priority areas. This will also enable better identification of what if any parity issues may be embedded in current practices.
2. Due diligence with other medical associations and the PBM industry to identify potential collaboration and potential points of intervention.
3. The development of a draft action plan for APA for review and consideration by relevant components and governance.
4. Pending consensus on and action plan, implementation of same.

Timeline: We expect to complete tasks 1 and 2 shortly. The survey instrument has been finalized and mechanisms for distribution have been worked out. Explorations with other medical societies and key players in the PBM world will begin this fall.

6) Continued processing of action items referred to the Council with priority attention given to those which fall within the above mentioned categories

CHSF continually receives requests to act on Action Papers and/or Position Statements and other documents. This is an ongoing process and function of the Council. We would note that material triaged to CHSF and timelines assigned should fully consider where a particular matter fits in terms of the APA's priorities.

The Council reviewed several Action Papers referred to it concerning the development of an Access to Care Toolkit. The Council agreed with these Action Papers that such a toolkit would be useful and will begin to develop it with a target date of May 2016. The toolkit will include a compendium of access to care Action Papers and Position Statements as well as an Access to Care Survey, based on one utilized by Area 6, that can be employed by other state associations.

We enthusiastically welcome comment and feedback on all the material submitted here.

COUNCIL ON MEDICAL EDUCATION AND LIFELONG LEARNING REPORT TO THE JOINT REFERENCE COMMITTEE

The Council's purview covers issues affecting the continuum of medical education in psychiatry – from undergraduate medical education to lifelong learning and professional development of practicing physicians. The Council is a convening body for the allied educational organizations including PsychSIGN, AADPRT, ADMSEP, AAP and the ABPN.

EXECUTIVE SUMMARY

The Council on Medical Education and Lifelong Learning met during the Fall Components Meeting on September 11th in Crystal City, Virginia. The Council organized its agenda into discrete sections to focus on issues related to UME, GME, CME, and MOC. Key issues discussed included:

1. CMELL voted to support ABPN's current policy of requiring MOC certification in general psychiatry for subspecialists.
2. There was a general consensus that the Education Summit went very well and was useful. Next steps created.
3. An ad hoc task force was created to work on curriculum toolkit project recently funded by NIDA. CMELL will provide 2 representatives and the Addictions Council will provide 2 as well.
4. The Council is supportive of Francis Lu's proposal to have the selection committees also select mentors for fellows

The meeting included visits from Drs. Binder, Saul Levin, Jay Shore, Francis Lu, and Francis Levin. Highlights from the day's discussions are included below.

JRC Action Items

The Council reviewed the 4 items referred to CMELL for discussion. A summary of their discussion is noted below. CMELL would like to refer the following action item back to the JRC for consideration.

ASMAY1512.T – Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior

Proposed Action: Will the JRC remove CMELL from this action paper and advise the Council on Children, Adolescents, and their Families to create a workgroup on this topic?

Brief rationale: CMELL is supportive of this AP but does not see a role for the Council. Primary responsibility for implementation should remain with the Division of Education. The Council on Children should constitute a workgroup of advisors on this topic to advise the Division of Education [Attachment 1]

Update to APA Minority Fellowship Selection and Advisory Committees

Proposed Action: Will the JRC ask the Board of Trustees to approve the updated charters for the:

- APA/SAMHSA Minority Fellowship Selection and Advisory Committee [attachment 2]
- APA Public Psychiatry Fellowship Selection and Advisory Committee [attachment 3]
- American Psychiatric Leadership Fellowship Selection [attachment 4]

Brief rationale: The selection committees for these fellowships report to CMELL. The selection committees would like to expand their charge to include assignment of mentors to fellowship recipients.

ABPN Policy Discussion

The Council had a robust discussion regarding ABPN's current requirement that individuals be required to maintain general certification in order to maintain subspecialty certification. The Council voted to approve the following statement:

> *We support the general certification requirement. We support the importance of maintaining current standards. We support ABPNs efforts to make exams as flexible and affordable as possible.*

BOT Workgroup on Training and Education Report

The Council reviewed the 20 recommended action steps in the BOT Workgroup on Training and Education Report. The Council was pleased with the overall implementation progress of the Division of Education.

#IAmPsychiatry YouTube Campaign

The Council reviewed the success of the recently launched I Am Psychiatry social media contest sponsored by the APA (lead), ADMSEP, AADPRT, and PsychSign. They would like to see this content continue in future years as a way to humanize psychiatry and focus on destimgamatization of the field.

National Substance Abuse Curriculum Curation and Dissemination

The Council reviewed and discussed the implementation of a recent award from NIDA to the APA to develop a toolkit of curricular resources for educators. An editorial board of members from CMELL and the Council on Addictions will work together to review existing substance abuse curriculum. and evaluate the scope and quality of what is out there. CMELL members Ashley Curry (fellow) and Jose Vito (member) have agreed to represent CMELL in this project.

Telepsychiatry

The Council is supportive of efforts by Jay Shore to develop a Telepsychiatry 101 toolkit. The Council encouraged Dr. Shore to think about the various target audiences within the context of their developmental sophistication as related to technology. The Council considered the idea of advocating

for a telepsychiatry milestone with RRC, but suggested that there may need to be some model programs first. Reviewed the value of Donald Hilty's AADPRT model curriculum on this topic.

REFERRAL UPDATES – REPORTS TO THE JOINT REFERENCE COMMITTEE

ASMAY1512.T – Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior
Division of Education lead [Attachment 1]

Update: CMELL feels that the Council does not need to be involved in this effort and that the Council on Children, Adolescents, and Families should work directly with the Division of Education to develop a webinar on this topic. The Division of Education has already been in contact with the Chair of the Council on Children, Adolescents, and Families. The Council on Children is willing to constitute a workgroup to advise the Division of Education.

Action: Will the JRC remove CMELL from this action paper and advise the Council on Children, Adolescents, and their Families to create a workgroup on this topic

ASMAY1512.J – Fostering the Next Generation of Leaders within the APA
CEO Office Lead [attachment 5]

Update: The Council on Medical Education and Lifelong Learning had a robust discussion of this topic which they deemed important. Focusing on this issue primarily through the lens of GME training, the Council noted that there is already a day-long leadership conference for residents at the Annual Meeting. In future years, this conference will be available to all senior residents and fellows, not just chief residents. Additionally, the scientific program committee is evaluating a number of proposals which would also include leadership forums at the next Annual Meeting in conjunction with potential sponsorship from the Association for Academic Psychiatry. The new transition to practice curriculum will also focus on basic leadership and managements skills that residents require. The Council will continue to support leadership opportunities of this nature for trainees. The Council is supportive of one to one mentorship with APA leadership, but does not have specific recommendations for implementation.

Action: No further action is requested by CMELL at this time.

ASMAY1512.M – Promoting Military Cultural Knowledge among Psychiatrists
Division of Education lead [attachment 6]

Update: The Division of Education is working with the APA's webmaster to ensure that a link to the suggested resource is included in the special population page of the psychiatry.org website (instructions 2). Additionally there is an ad-hoc review committee which advises the Scientific Program Committee on the selection of military submissions for the Annual Meeting Program (instruction 3). . The Director of Education will also convey to the ACGME RRC the APA's belief that military culture is a valuable component of training during his next report to the

review committee in Winter 2016 (instruction 4). CMELL feels that the development of a position paper should be the work of the VA Caucus or the Council on Minority Mental Health and Health Disparities (instruction 5). The Council feels that request to include the question "Have you or someone close to you served in the military?" as part of the clinical evaluation (instruction 1) is the purview of the Council on Quality Care and if not already under consideration, should be folded into the next patient assessment guideline. While CMELL is supportive of the development of education on this topic, the Council feels that they do not need to be involved in this effort and that implementation should fall to the Division of Education.

Action: No further action is requested by CMELL at this time.

ASMAY1512.O – Improving APA Support of Mental Health of African American Males
Division of Education lead [attachment 7]

Update: While CMELL is supportive of the development of education on this topic, the Council feels that they do not need to be involved in this effort and that the Council on Minority Mental Health and Health Disparities should work directly with the Division of Education to develop a webinar on this topic. The Division of Education has already been in contact with the Director of Diversity and Health Equity with a request for them to identify a subject matter expert who could begin developing content on this topic. The Council also recommends that the SPC give special consideration to the importance of this topic when reviewing annual meeting submissions. The Council also recommended to its AADPRT representative that AADPRT also examine this issue.

Action: No further action is requested by CMELL at this time. Division of Education implementing.

ATTACHMENTS:

- *Attachment 1: Background for ASMAY1512.T*
- *Attachment 2: APA/SAMHSA Minority Fellowship Selection and Advisory Committee*
- *Attachment 3: APA Public Psychiatry Fellowship Selection and Advisory Committee*
- *Attachment 4: American Psychiatric Leadership Fellowship Selection*
- *Attachment 5: Background for ASMAY1512.J*
- *Attachment 6: Background for ASMAY1512.M*
- *Attachment 7: Background for ASMAY1512.O*
- *Attachment 8: CMELL Meeting Notes*
- *Attachment 9: ABPN MOC briefing materials*
- *Attachment 10: BOT workgroup on Training and Education Scorecard*

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.14	Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior (ASMMAY1512.T) The action paper asks: That the APA will establish a Work Group comprised of researchers and clinicians knowledgeable in the area of the neuro-developmental and behavioral effects of environmental toxins to advise the Division of Education. That the Assembly of the APA requests that the APA Division of Education develop an educational plan aimed at educating the general membership of the APA on the scientific, clinical and regulatory aspects of the neuro-developmental and behavioral effects of environmental toxins. **Will the Joint Reference Committee refer action paper *2015A1 12.T: Addressing the Impact of Environmental Toxins on Neurodevelopment and Behavior* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Division of Education [LEAD], the Council on Children, Adolescents and Their Families and the Council on Medical Education and Lifelong Learning. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Tristan Gorrindo, MD Ranna Parekh, MD, MPH Alison Bondurant Tristan Gorrindo, MD	Division of Education [LEAD] Council on Children, Adolescents and Their Families Council on Medical Education and Lifelong Learning Report to the JRC: January 2016

FORM TO PROPOSE AN APA COMMITTEE EXISTING

COMPONENT NAME AND TYPE: APA/SAMHSA Minority Fellowship Selection and Advisory Committee

PROPOSED COMMITTEE NAME: APA/SAMHSA Minority Fellowship Selection and Advisory Committee

PROPOSED COMMITTEE CHARGE: (if charge differs from charge of existing component)

The Selection and Advisory Committee is responsible for recommending policy, evaluating applications, and selecting fellows. The committee serves in an advisory capacity to the staff in monitoring and evaluating the program in terms of meeting objectives and the impact on training programs. *The committee also serves in an advisory capacity to the fellows in establishing a relationship with a mentor*.

Annotation:

The proposed charge addition is the last sentence in italics. The Committee will be responsible for asking selected fellows if they wish a mentor, and if so, advise the fellow as to possible mentors. The committee can accomplish this responsibility as it chooses. One way would be to provide a list of mentors. Another way would be to match one mentor to the fellow taking into account their needs and preferences (i.e., goals of mentorship, areas of mutual interest, importance of geographic proximity, preferences about the cultural identity of the mentor, etc.). The Committee will contact possible mentors ahead of time to check on their actual availability and interest. The minimal expectation would be a one-hour discussion in person or on the phone on a quarterly frequency. Should the pairing not work out for either party, the fellow would contact the committee to solicit another mentor if desired. This entire process would occur on a voluntary, optional basis as requested by the fellow.

JUSTIFICATION FOR CHANGING TO COMMITTEE STATUS:

1. How is the proposed committee charge consistent with current APA goals? This committee already exists. This action item asks only for the charge addition that is consistent with 3 goals of the APA as stated on page 75 of the Operations Manual (March 2015):
   1) To improve psychiatric education and training
   2) To promote optimal conditions for practice and career satisfaction
   3) To improve functioning of the APA in the service of its mission.

   Mentorship has been demonstrated to be helpful in career development, and it has been requested by the APA fellows. It would directly support their involvement in APA during fellowship and during their careers, thereby strengthening APA's future leadership.

2. The proposed work product:
   a) Why is it needed? See #1
   b) How long will it take to produce? If approved by the Council, the JRC, and the Board, this charge addition could take effect with the 2016 cohort of selected fellows.
   c) What is currently available? The Minority Fellowship Program fellows have had access to the National Minority Mentors Network (NMMN) where fellows could meet mentors at breakfast meetings at both the Annual Meeting and the IPS. This effort could continue, since it encourages development of mentoring relationships. Certainly, those mentors in the NMMN could be the mentor pool from which to draw upon in the pairing process with the fellows if the committee chooses to do this.

3. What are the potential benefits of the committee's work product to APA members? See #1
4. What are the costs involved and the available funds? Committee members' time and staff time
5. What is the component's track record? Please provide details as per the general principles.

COST ESTIMATE: To be determined

Conference Calls
Postage _____
Meeting Room Costs (one-half) _____
List serve Costs _____
Staff time required _____hours/week @ $_____/hour

SOURCE OF FUNDING: APA/SAMHSA funds

PROPOSED BY: Francis Lu, MD, Council on Minority Mental Health and Health Disparities

ENDORSED BY: Council on Medical Education and Lifelong Learning, Sept. 11, 2015

FORM TO PROPOSE AN APA COMMITTEE

EXISTING COMPONENT NAME AND TYPE: APA Public Psychiatry Fellowship Selection Committee

PROPOSED COMMITTEE NAME: APA Public Psychiatry Fellowship Selection and Advisory Committee [*"and Advisory"* would be added to the committee's name]

PROPOSED COMMITTEE CHARGE: (if charge differs from charge of existing component)
The APA Public Psychiatry Fellowship Selection Committee is composed of five members appointed by the APA President for three-year terms. It has representation from the IPS Program Committee, APA Public Psychiatry alumni, and three members at large. The committee is not authorized to meet in person except at the APA Annual Meeting. *The Selection and Advisory Committee is responsible for recommending policy, evaluating applications, and selecting fellows. The committee also serves in an advisory capacity to the fellows in establishing a relationship with a mentor.*

Annotation:
The proposed charge addition are the last two sentence in italics.

The first sentence is the same one that exists in the current charge of the APA/SAMHSA Minority Fellowship Selection and Advisory Committee, which simply states the fundamental responsibility of the committee of "recommending policy, evaluating applications, and selecting fellows."

In the second sentence, the Committee will be responsible for asking selected fellows if they wish a mentor, and if so, advise the fellow as to possible mentors. The committee can accomplish this responsibility as it chooses. One way would be to provide a list of mentors. Another way would be to match one mentor to the fellow taking into account their needs and preferences (i.e., goals of mentorship, areas of mutual interest, importance of geographic proximity, preferences about the cultural identity of the mentor, etc.). The Committee will contact possible mentors ahead of time to check on their actual availability and interest. The minimal expectation would be a one-hour discussion in person or on the phone on a quarterly frequency. Should the pairing not work out for either party, the fellow would contact the committee to solicit another mentor if desired. This entire process would occur on a voluntary, optional basis as requested by the fellow.

JUSTIFICATION FOR CHANGING TO COMMITTEE STATUS:

1. How is the proposed committee charge consistent with current APA goals? This committee already exists. This action item asks only for the charge addition that is consistent with 3 goals of the APA as stated on page 75 of the Operations Manual (March 2015):
   -To improve psychiatric education and training
   -To promote optimal conditions for practice and career satisfaction
   -To improve functioning of the APA in the service of its mission.

   Mentorship has been demonstrated to be helpful in career development, and it has been requested by the APA fellows. It would directly support their involvement in APA during fellowship and during their careers, thereby strengthening APA's future leadership.

2. The proposed work product:
   a) Why is it needed? See #1
   b) How long will it take to produce? If approved by the Council, the JRC, and the Board, this charge addition could take effect with the 2016 cohort of selected fellows.
   c) What is currently available? No mentorship program exists currently.

3. What are the potential benefits of the committee's work product to APA members? See #1

4. What are the costs involved and the available funds? Committee members' time and staff time.

5. What is the component's track record? Please provide details as per the general principles.

COST ESTIMATE: To be determined

Conference Calls
Postage _____
Meeting Room Costs (one-half) _____
List serve Costs _____
Staff time required _____hours/week @ $_____/hour

SOURCE OF FUNDING: APA funds currently used to support the American Public Psychiatry Fellowship

PROPOSED BY: Francis Lu, MD, Council on Minority Mental Health and Health Disparities
ENDORSED BY: Council on Medical Education and Lifelong Learning, Sept. 11, 2015

FORM TO PROPOSE AN APA COMMITTEE

EXISTING COMPONENT NAME AND TYPE: American Psychiatric Leadership Fellowship Selection Committee

PROPOSED COMMITTEE NAME: American Psychiatric Leadership Fellowship Selection and Advisory Committee *["and Advisory" would be added to the committee's name]*

PROPOSED COMMITTEE CHARGE: (if charge differs from charge of existing component)

The Selection and Advisory Committee is responsible for recommending policy, evaluating applications, and selecting fellows. The committee also serves in an advisory capacity to the fellows in establishing a relationship with a mentor.

Annotation:
The proposed charge addition are the last two sentence in italics.

The first sentence is the same one that exists in the current charge of the APA/SAMHSA Minority Fellowship Selection and Advisory Committee, which simply states the fundamental responsibility of the committee of "recommending policy, evaluating applications, and selecting fellows."

In the second sentence, the Committee will be responsible for asking selected fellows if they wish a mentor, and if so, advise the fellow as to possible mentors. The committee can accomplish this responsibility as it chooses. One way would be to provide a list of mentors. Another way would be to match one mentor to the fellow taking into account their needs and preferences (i.e., goals of mentorship, areas of mutual interest, importance of geographic proximity, preferences about the cultural identity of the mentor, etc.). The Committee will contact possible mentors ahead of time to check on their actual availability and interest. The minimal expectation would be a one-hour discussion in person or on the phone on a quarterly frequency. Should the pairing not work out for either party, the fellow would contact the committee to solicit another mentor if desired. This entire process would occur on a voluntary, optional basis as requested by the fellow.

JUSTIFICATION FOR CHANGING TO COMMITTEE STATUS:

1. How is the proposed committee charge consistent with current APA goals? This committee already exists. This action item asks only for the charge addition that is consistent with 3 goals of the APA as stated on page 75 of the Operations Manual (March 2015):
   -To improve psychiatric education and training
   -To promote optimal conditions for practice and career satisfaction
   -To improve functioning of the APA in the service of its mission.

   Mentorship has been demonstrated to be helpful in career development, and it has been requested by the APA fellows. It would directly support their involvement in APA during fellowship and during their careers, thereby strengthening APA's future leadership.

2. The proposed work product:
   a) Why is it needed? See #1
   b) How long will it take to produce? If approved by the Council, the JRC, and the Board, this charge addition could take effect with the 2016 cohort of selected fellows.
   c) What is currently available? No mentorship program exists currently.

3. What are the potential benefits of the committee's work product to APA members? See #1

4. What are the costs involved and the available funds? Committee members' time and staff time
5. What is the component's track record? Please provide details as per the general principles.

COST ESTIMATE: To be determined

Conference Calls
Postage _____
Meeting Room Costs (one-half) _____
List serve Costs _____
Staff time required _____hours/week @ $_____/hour

SOURCE OF FUNDING: APA funds currently used to support the American Psychiatric Fellowship

PROPOSED BY: Francis Lu, MD, Council on Minority Mental Health and Health Disparities

ENDORSED BY: Council on Medical Education and Lifelong Learning, Sept. 11, 2015

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.8	<u>Fostering the Next Generation of Leaders within the APA</u> (ASMMAY1512.J) The action paper asks: That the APA develop a comprehensive and coordinated set of leadership, team building and enrichment activities aimed at fostering leadership and promoting positive relationships between the young leaders* of the APA and established APA leadership. That the APA look to consolidate and coordinate current offerings to prevent duplication of efforts and to ensure the best use of resources That these activities occur at the APA Annual Meeting in May. That these activities be coordinated by the Chief RFM-ECP Officer, the Director of the Division Diversity and Health Equity, and the Director of Education. **Will the Joint Reference Committee refer action paper 2015A1 12.J: *Fostering the Next Generation of Leaders within the APA* to the appropriate Component(s) for inpu or follow-up?**	The Joint Reference Committee referred the action paper to the Office of the Chief Executive Officer/Medical Director for refinement and a cost estimate.	Saul Levin, MD Jon Fanning Tristan Gorrindo, MD Ranna Parekh, MD, MPH	Office of the CEO & Medical Director Report to JRC: January 2016

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.10	Promoting Military Cultural Knowledge among Psychiatrist (ASMMAY1512.M) The action paper asks: 1. That the APA support as a core professional practice that psychiatrists consider asking the question: "Have you or someone close to you served in the military?" as part of the clinical evaluation. 2. That the APA support psychiatrists' attaining a basic level of military cultural knowledge through the completion of Module I of the free, accredited, online DoD/VA course at http://deploymentpsych.org/military-culture 3. Through the APA Department of Education's website and educational activities, the APA promote the availability of resources for attaining military cultural knowledge. 4. That the APA, through its educational liaisons to other medical education organizations, promote education about military cultural knowledge among clinicians. 5. That the APA consider drafting a position paper on the importance of promoting military cultural knowledge among psychiatrists. **Will the Joint Reference Committee refer action paper *2015A1 12.M: Promoting Military Cultural Knowledge among Psychiatrists* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Council on Medical Education and Lifelong Learning [LEAD]. Council on Advocacy and Government Relations, Council on Quality Care and the Caucus of VA Psychiatrists and report to the JRC on the ways to implement this and the potential to develop a position statement at the October 2015 meeting. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Tristan Gorrindo, MD Rodger Currie, JD Deana McRae Kristin Kroeger Samantha Shugarman	Council on Medical Education and Lifelong Learning [LEAD] Council on Advocacy and Government Relations Council on Quality Care Caucus of VA Psychiatrists Report to JRC: October 2015 (Due 10/2/2015)

Agenda Item #	Action	Comments/Recommendation	Staff Responsible	Referral/Follow-up & Due Date
6.11	Changing ECP Status to 8 Years Following Completion of Training (ASMMAY1512.N) The action paper asks that the APA adopt a similar position to the AMA in defining the ECP period as eight years following the completion of residency/fellowship training. **Will the Joint Reference Committee refer action paper *2015A1 12.N: Changing ECP Status to 8 Years Following Completion of Training* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Membership Committee and then to the Finance and Budget Committee. It was requested that both committees look into the feasibility of implementing the action paper including a cost/benefit analysis.	Jon Fanning, MS, CAE Susan Kuper Shaun Snyder, JD Margaret Hunte	Membership Committee Finance and Budget Committee Report to the JRC: January 2016
6.12	Improving APA Support of Mental Health of African American Males (ASMMAY1512.O) The action paper asks that the Council on Medical Education and Lifelong Learning and the Office of Education investigate, in collaboration with experts, how to provide training opportunities for psychiatrists to provide community-based, culturally competent therapeutic interventions for traumatized African American communities. **Will the Joint Reference Committee refer action paper *2015A1 12.O: Improving APA Support of Mental Health of African American Males* to the appropriate Component(s) for input or follow-up?**	The Joint Reference Committee referred the action paper to the Division of Education, the Division of Diversity and Health Equity and the Council on Minority Mental Health and Health Disparities for implementation. All feedback and comments on this referral should be contained within the lead council's report to the JRC.	Kristin Kroeger Tristan Gorrindo, MD Ranna Parekh, MD, MPH Ranna Parekh, MD Alison Bondurant	Division of Education Division of Diversity and Health Equity Council on Minority Mental Health and Health Disparities Report to JRC: October 2015 (Due October 2, 2015)

Attachment 8: CMELL Meeting Notes

September 11, 2015
Crystal City, Virginia
8:30 AM – 3:00 PM

1. Pre-meeting (Dr. Gorrindo) with fellows to discuss ways in which fellows can be more involved in the Council. Reviewed career goals for residents.
2. Welcoming remarks (Dr. Summers)
3. Verbal disclosures provided by each member present
4. Previous minutes reviewed and accepted from 2015 CMELL meeting at the Annual Meeting

5. Debrief on first APA Education Summit from Sept 10, 2015. (Dr. Summers). See notes from Education Summit.

- Action Item: Concept Map and facilitation of access to existing resources
- Action Item: Encourage an individual to apply for ABPN fellowship to take this on as a project
- Inclusion of future attendees: Medical student representative, Resident representative, and CME learner representative
- Future topic consideration: Assessment and Feedback

6. Visit from Dr. Levin and Dr. Wang

7. 5 minute mini-reports from liaison groups

   ADMSEP - Dr. Dube - Medical student milestones pamphlet generated and shared with the Council.
   Discussed research and scholarship grants meant to foster medical student education research.

   AADPRT - Dr. Boland - Discussed importance of shifting attention now to evaluating milestones. Looking now at how they should be refined.

   AAP - Dr. Luo - Will be looking to conduct CV bootcamp again at APA Annual Meeting. Looking for ways to continue peer-mentoring and support outside of the AAP meeting. Looking for ways to share infrastructure and deepen partnership with APA.

8. Visit from Dr. Renee Binder

9. Psychiatric Evaluation practice guideline and potential ADMSEP/AADPRT collaboration - With the new APA practice guideline lend itself to being a nidus for collaboration. Are there opportunities to dovetail with CSV's in GME.
- Can we include in RFM handbook and on resident page
- Should we make an abstracted version for medical students; distilled down
- ***Next steps: None. Council not sure they want to take this on.***

10. APEx talks and #IAmPsychiatry YouTube Campaign
- Talks should humanize psychiatry and focus on destimgatization
- Talks should tell the public "what we do", how do we think, what do our patients look like
- **Next steps: Can we work with council on communications to develop an Annual Meeting submission on this topic.**

11. National Substance Abuse Curriculum Curation and Dissemination (Guests: Dr. Francis Levin and Bea Eld at 10:15am) - Discussed NIDA dissemination project to curate existing curriculum.
- ***Next steps: Create a workshop based on the curated resources of these projects.***
- ***Next steps: Champions from CMELL include Ashley Curry and Jose Vito***

12. Visit from Francis Lu - Discussion of the importance of mentorship for APA fellows. We need to do a better job of connecting mentor/mentees and structuring their interactions.
- ***Next steps: Council approved notion to allow selection committees to also assign mentors.***

13. Visit from Dr. Jay Shore (Telepsychiatry) and Kristin Kroeger. Currently building a toolkit for APA members, in addition to developing IPS and Annual Meeting content which focuses on Telepsychiatry 101. Discussed the development of a number of policy statements related to the regulation of telehealth. Feedback provided by Council which focused on including the importance of Telepsych as a strategy for addressing access challenges. The Council considered the idea of advocating for a telepsychiatry milestone with RRC, but may need some model programs first. Reviewed the value of Don Hilty's AADPRT model curriculum. Dr. Shore raised the question of developing a certification program in telepsychiatry -- concern that it would actually reduce access. Should education be pitched differently for those with different levels of technology comfort/skill? The Council approved the proposed position statement as described in draft form.

14. Review BOT WGTE score-card and summarized the activities of the Division of Education and the APA on the 20 recommendations listed.

15. Needs assessment data (guest: Michelle Damare, APA staff) - Needs assessment data from 2015 Annual Meeting reviewed.
The Council has oversight for CME issues of the APA. The council has an oportunity to provide advice and input. Reviewed member expressed needs assessment data from 2015 Annual Meeting. 1) Psychopharmacology 2) Mood disorders 3) other disorder topics 4) CBT

16. Action papers

- Fostering the Next Generation of Leaders within the APA (ASMMAY1512.J) - Agreed to support with notation that we will be expanding the chief resident leadership conference.
- Improving APA Support of Mental Health of African American Males (ASMMAY1512.O)
- **Next steps: Let the JRC know that the Division of Education would be willing to develop a CME module focusing on specific therapeutic interventions for traumatized communities. CMELL feels that the Division of Education should work with DDHE and the Council on Minority Affairs as content experts.**
- **Next steps: Work with the SPCs for the Annual Meeting and IPS to elevate the promotion of accepted content on this topic.**
- **Next steps: The Council will look to its partnership with AADPRT to encourage them to consider developing GME curricula on this issue.**
- **Above noted actions approved.**

17. Draft action papers - The four action papers that Division of Education and CMELL Chair have been asked to review where described to the Council. The Council agreed with the informal feedback provided to the authors.

AP	**Author**	**CMELL recommendation**
Strengthening the Role of Residency Training to Improve Access to Buprenorphine	Abellard	Will discuss at components
Action Paper on Partial Hospital Training	sudhakar madakasira	Reviewed current ACGME rules; supportive overall
Parity in ACGME-accredited training required for International Medical Graduates	Sarit Hovav	Okay to support
Create a foundation for loan repayment for those willing to work in under-served areas	Lisa Catapano-Friedman <psingpsych1@gmail.com>	No new recommendations since last time this paper was circulated

19. Comments to ABPN on requirement that individuals be required to maintain general certification in order to maintain subspecialty certification. "Psychiatry is an integrative specialty; we shouldn't fragment our care." "If I'm an addition doctor and I receive a patient with bipolar disorder, I need to be able to diagnose and treat bipolar disorder." "Opposing this policy would put us in conflict with our stance that we are a primary care specialty and that we promote integrative care." "We should avoid creating two classes of general psychiatry training."

- ***Next steps: Report comments back to Dr. Binder "We support the general certification requirement. We support the importance of maintaining current standards. We support ABPNs efforts to make exams as flexible and affordable as possible."***

20. Concluding remarks. Next CMELL call on November 9th at 6pm ET.

Attendance

First Name	Last Name	Participation
Richard	Summers (chair)	X
Erick	Hung	X
Chris	Thomas	X
Marshall	Forstein	X
Benoit	Dube	X
Sarah	Johnson	o
Lisa	Mellman	X
Pedro	Ruiz	o
Edward	Silberman	X
Melinda	Young	X
Steven	Fischel	X
Justin	Hunt	o
Nutan	Atre-Vaidya	o
Brendan	Roman	o
Larry	Faulkner	o
John	Luo	X
Jason	Kaplan	o
Carlos	Pato	o
Robert	Boland	X
John	Young	o
Mark	Rapaport	o

Jose	Vito	X
Rashad	Hardaway	X
Lisette	Rodriquez-Cabezas	X
Jose	Rengifo	X
Robert	Montenegro	X
Stefania	Prendes Alvarez	X
Lynneice	Bowen	X
Ashley	Curry	X
Loreen	Pimie	X
Nicole	Albrecht	X
Mawuena	Agbonyitor	X
Kristen	Moeller (staff)	X
Tristan	Gorrindo (staff)	X
Michelle	Damare (staff)	X
Francis	Lu (guest)	X
Francis	Levin (guest)	X
Jay	Shore (guest)	X
Renee	Binder (guest)	X
Saul	Levin (staff/guest)	X
Kristin	Kroeger (staff/guest)	X
Bea	Eld (staff/guest)	X

Attachment 9: ABPN Handout for Discussion

ABPN Evaluation of Subspecialty Certification Requirements

The APA has been asked to submit comments to the ABPN with regards to a potential change to the MOC program.

Currently diplomates who are board certified in both General Psychiatry and a Subspecialty (Addiction Psychiatry, Forensic Psychiatry, Geriatric Psychiatry, Psychosomatic Medicine) **are** required to maintain both certifications in the maintenance of certification (MOC) process. Those with certification in Child and Adolescent Psychiatry are not required to maintain a General Psychiatry certification.

The ABPN, however, is evaluating this policy in light of a recent American Board of Internal Medicine (ABIM) change which no longer requires their diplomats with subspecialty certification to also maintain a general internal medicine certification.

As noted below, ABPN has sought input from the psychiatric community at meetings in 2014 and 2015, but they are now asking for formal comments from APA. The APA is reaching out to councils and leaders within the organization to solicit input which will help inform Dr. Binder's response to ABPN.

By way of background, for those who are currently in the MOC process and maintaining dual certification, there is significant overlap in the MOC program requirements.

- MOC-1 which requires an active medical license holds true for General Psychiatry and Subspecialty certification. No additional work is required to hold certification in both.
- MOC-2 (self-assessment) allows completed activities to count for both General Psychiatry and Subspecialty recertification; no additional work is required for diplomats.
- MOC-4 (PIP and Feedback) allows completed activities to count for both General Psychiatry and Subspecialty recertification; no additional work is required.
- For MOC-3 (10 year cognitive exam/test), there is a difference depending on recertification date. For those who have different expiration dates for their General Psychiatry and Subspecialty certifications, diplomates must complete a 200 question multiple choice exam in general psychiatry and a separate 200 multiple choice exam in their subspecialty. However, if the diplomate has chosen to align expiration dates for the General Psychiatry and Subspecialty Certifications, then the diplomate is only required to complete one 200 question exam with 100 general psychiatry questions and 100 subspecialty questions. The price for both exams separately is $2800: General

Psychiatry Certification ($1400) and a Subspecialty Certification ($1400). The price for a combined exam is $1675.

Although not expressed in Dr. Faulkner's letter, the ABPN has conveyed concerns that those physicians who allow their general psychiatry certification to expire may be ineligible for participation in insurance panels at future dates and that the process for re-establishing certification may be onerous.

These changes occur in the context of a number of changes to the MOC program over the last 2 years including: patient safety requirement (2016), optional MOC-4 feedback modules (2015); change in the number of MOC-4 PIP and MOC-2 self-assessment activities (2014).

Attachments: ABPN_letter_SubspeciltyCert.pdf

American Board of Psychiatry and Neurology, Inc.

A Member Board of the American Board of Medical Specialties (ABMS)

Please address all communications to:
Larry R. Faulkner, M.D.
President and CEO
2150 E. Lake Cook Road, Suite 900
Buffalo Grove, IL 60089
Phone: 847.229.6500
Fax: 847.229.6600
www.abpn.com

August 12, 2015

Renée L. Binder, M.D.
President
American Psychiatric Association
1000 Wilson Boulevard
Suite 1825
Arlington, VA 22209
SENT VIA EMAIL

Dear Renée:

The current ABPN policy on subspecialty certification is that most subspecialties are dependent upon the primary specialty. Diplomates with certificates in any subspecialty other than child and adolescent psychiatry must also maintain certification in their specialty in order to maintain certification in the area of subspecialization. **If certification in the primary specialty lapses, certification in any subspecialty except child and adolescent psychiatry is no longer valid.**

The ABPN discussed this complex issue with representatives from our related professional societies at our 2014 Crucial Issues Forum on Subspecialties. The consensus of opinion at that time was that the ABPN should retain the requirement for subspecialists other than those in child and adolescent psychiatry to maintain certification in a primary specialty as a prerequisite for certification in a subspecialty. The ABPN discussed this issue once more at its 2015 Summer Policy Meeting and decided to again solicit opinion from our related professional societies before considering any change in policy.

Would you please respond in writing with the official position of your organization on this issue. Responses may be sent to me at lfaulkner@abpn.com. We would appreciate receiving a response by October 1, 2015.

Sincerely,

Larry R. Faulkner, M.D.
President and CEO

LRF/pv

CC: Saul Levin, M.D.

AMERICAN PSYCHIATRIC ASSOCIATION
Education

Training the Psychiatrist of the Future

Board of Trustees Ad Hoc Work Group on Education and Training

Item	Status
APA Position Statements	
Position Statement on neuroscience	Complete
Position Statement on 4 year training	On Hold
Programmatic Initiatives for the Department of Education	
The APA should organize an education summit on critical issues	Complete
The APA should promote the following educational efforts: i. Dissemination of best practices in training for integrated care models. ii. Communication and collaboration among primary care specialty organizations, including inter-specialty collaboration on curriculum development. iii. Communication and collaboration among mental health professional organizations, including inter-professional collaboration on curriculum development. iv. Development of neuroscience curricular materials and pedagogic innovations. v. Collaborations to tackle pressing workforce pipeline issues.	i. In process ii. Not yet started iii. Not yet started iv. In process v. In process
The APA should promote faculty development by: i. Collaborating with AADPRT and AAP to conduct a needs assessment for faculty development, particularly in the areas of neuroscience, research, and quality improvement. ii. Creating a competitive Visiting Scholar Program focused on faculty development and training. iii. Considering the potential value of an APA Academy of Master Educators in Psychiatry to support faculty development, retention, advancement and recognition at their home institutions.	vi. Not yet started vii. On Hold viii. Not yet started
The APA should consider how current APA educational awards could be better aligned to promote current educational goals.	In process

AMERICAN PSYCHIATRIC ASSOCIATION
Education

Training the Psychiatrist of the Future

Board of Trustees Ad Hoc Work Group on Education and Training

Legislative Advocacy Initiatives	
The APA should vigorously advocate for maintaining and increasing funding for graduate medical education, including funding for training in innovative care delivery systems.	In process
The APA should advocate for the continued designation of Psychiatry as a primary care specialty.	In process
Collaboration with Councils	
The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Council for Psychosomatic Medicine and the Council on Healthcare Systems and Financing to promote training for integrated behavioral health care.	In process
The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Department of Research and the Council for Research, along with partner educational organizations, to: i. Determine the most effective strategies to enhance research training and encourage the development of physician-scientists in psychiatry. ii. Gather and synthesize data on recruitment into psychiatry and disseminate the findings.	i. Not yet started ii. In process
The APA Department of Education and the Council on Medical Education and Lifelong Learning should collaborate with the Steering Committee on Practice Guidelines to: i. Identify priority topics for residency teaching, as well as assist with the development of curricular materials for medical students and residents. ii. Make the Practice Guidelines available online for ready access by all those involved in psychiatric education.	i. Not yet started ii. In process

AMERICAN PSYCHIATRIC ASSOCIATION
Education

Training the Psychiatrist of the Future

Board of Trustees Ad Hoc Work Group on Education and Training

Executive Summary
Council on Minority Mental Health and Health Disparities

Council Overview

The Council has the responsibility for the representation of and advocacy for both minority and underserved populations and psychiatrists from minority and underrepresented groups. The Council seeks to reduce mental health disparities in clinical services and research, which disproportionately affect women and minority populations. The Council aims to increase awareness and understanding of cultural diversity and to foster the development of attitudes, knowledge, and skills in the areas of cultural competence through consultation, education, and advocacy within both the APA and the field of psychiatry and public policy. The Council aims to promote the recruitment into the profession and into the APA and retention/leadership development of psychiatrists from minority and underrepresented groups both within the profession and in the APA.

Action Items

None

JRC Referrals

1. **Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault** (ASMMAY 1512.H). The Council established a work group to study the feasibility of this action paper and to whom the APA would advocate around this issue. Members of the work group are Drs. Ludmila De Faria (chair), Daena Petersen, Pamela Montano, Matthew Dominguez, and Racquel Reid. The work group met for one hour during the September Components Meetings and will have its first conference call on October 20. A report of this effort will be submitted to JRC in January.

2. **Impact of Global Climate Change on Mental Health** (ASMMAY 1512.L). Dr. Nyapati Rao is leading a work group, including Drs. Puneet Sahota, Debbie Carter, and Pamela Montano, that will study and produce a position statement on the mental health impact of severe weather events and disasters resulting from global climate change. As part of the process, the work group is seeking additional input from the Councils on International Psychiatry and Communications and Committee on Psychiatric Dimensions of Disasters. Dr. Rao will submit a report in January.

3. **Improving APA Support of Mental Health of African American Males (ASMMAY15.12O).** Attachment 1 presents input from the Council concerning this action paper. The document was delivered to the action paper's lead, the Division of Education.

Attachments

1. Council input regarding the action paper on Improving APA Support of Mental Health of African American Males (ASMMAY15.12O)
2. Minutes of the September 12 Council meeting
3. Minutes of the August 13, 25, and 27 Council conference calls

ATTACHMENT 1

From: **Council on Minority Mental Health and Health Disparities**
To: **Joint Reference Committee**
Date: **October 2, 2015**
Re: **JRC request for comments on the implementation of "Improving APA Support of Mental Health of African American Males" (ASMMAY1512.O)**

While this council recognizes that targeted violence is experienced by a variety of specific groups in the United States, here we are asked to focus on African-American men. African-American men bear a disproportionate burden of violence by law enforcement, are the most likely to be incarcerated in the United States, and are given longer sentences than members of other groups. The large number of recent, nationally publicized killings of unarmed African-American men by police officers makes it timely for the APA to mobilize its membership, partner with affected communities, and engage the public to prevent and ameliorate systemic, institutional violence.

Given the ever-growing frequency of these events within minority communities, many have come to view violence as a social norm. The stance of this council is that violence, regardless of its source or frequency, is a form of trauma. Thus, African-American men find themselves facing a disproportionate risk of exposure. As these events gain increasing media coverage, that risk is now being spread nationwide, touching the lives of individuals who, in decades past, may have been less noticed. This new form of mass traumatization can be viewed as akin to a viral spreading of violence, now at risk of reaching epidemic proportions. By taking this stance, we call for a change of perspective, moving away from either a strict individual psychopathology assessment/treatment approach or a purely social justice view of the problem towards advocating for methods of addressing the mental health disparities caused by the violence epidemic in America.

The United States witnesses a disproportionate amount of violence towards African-American males and other members of minority communities committed by law enforcement officials. The ever increasing presence of social media has recently given light to an issue that is more chronic than acute. The growing awareness of this issue has created an opportunity for the APA to involve itself in both education and needed changes in policies of law enforcement. The council feels a strong need for the APA to be both outspoken towards the public and active in communities to reflect our concern and support of the African-American and other minority communities.

In regards to how psychiatrists can help address this growing public health problem, we offer these suggested preventive and systemic approaches to violence:

1. Reframing of Race-Based Violence as a Health Issue: We believe that psychiatrists have the unique education and skill set required to reframe community violence and to educate patients on the basic concepts of trauma. It is important that we acknowledge the resilience shown by the African-American community in the face of trauma experienced through violence by law enforcement. It is important to appreciate both the physical and mental health threatened by this violence. We encourage GME/CME training programs to include questions regarding exposure to community violence as part of their typical screening interview for trauma with appropriate follow-up questions. We recommend the use of the DSM-5 Outline for Cultural Formulation and the Cultural Formulation Interview where concepts of resilience, racism, and discrimination are incorporated.

2. Collaborative work with Other Disciplines: We encourage GME/CME training programs to develop relationships with local organizations (DCFS, faith-based programs, community outreach centers, schools, etc.) in order to offer innovative community psychiatry rotations/trainings which promote trauma-informed care with a focus placed on violence prevention and developing

resiliency within communities. This also provides an opportunity to offer care to front-line providers and social service staff (EMS's, ED's, Urgent Care, etc.), who often experience secondary trauma and burnout.

3. Working with Law Enforcement: We encourage the psychiatric community to engage with local law enforcement agencies to provide education and training on culturally sensitive approaches to interacting with diverse communities in order to further reduce the risk of traumatization. Providing screening and treatment to police officers themselves may also aid in reducing violent interactions with community members.

4. Public Policy Change: Finally, we support the involvement of the psychiatric community in policy change advocating for more forms of non-carceral reform. By providing mental health treatment to those involved with violent crime, we can reduce numbers of repeat offenders, the development of life-long criminals, and the crippling effects they have upon their communities.

ATTACHMENT 2

Minutes, Council on Minority Mental Health and
Health Disparities
September 12, 2015
9:00 am – 4:00 pm
Arlington, VA

Attendance

Members:
Francis Lu, MD (Acting Chair)
Enrico Castillo, MD
Ludmila De Faria, MD (ASM)
Jose Vito, MD (ECP)
Sidney Hankerson, MD
Amanda Ruiz Graves, MD
Donald Williams, MD
Helena Hansen, MD
Nyapati Rao, MD
Debbie Carter, MD
Excused Members:
Christina Mangurian, MD
Brian Benton, MD

Consultants:
Evaristo Akerele, MD
Sandra Walker, MD
Corresponding Member:
Edmond Pi, MD
Fellows:
Pamela Montano, MD
Lauren Douglas, MD
Travis Meadows, MD
Daena Peterson, MD
Jessica Moore, MD
Puneet Sahota, MD
Jared Taylor, MD
Annabelle Simpson, MD
Matthew Dominguez, MD
Excused Fellow:
Amy Gajaria, MD
Guests:
Renee Binder, MD
Napoleon Higgins, MD
Maria Oquendo, MD
Elie Aoun, MD
Jay Shore, MD
Racquel Reid, MD
APA Administration:
Saul Levin, MD, MPA
Kristin Kroger
Ranna Parekh, MD, MPH
Philip Wang, MD
Yoshie Davidson
Nicole Lewis

- Dr. Lu chaired the meeting on behalf of Dr. Mangurian, who is on a medical leave of absence. Dr. Lu reviewed the agenda then summarized the Council charge. He outlined the responsibilities of Council members as described in the Council Orientation Packet that he prepared with Ms. Bondurant and distributed before the Council meeting. Dr. Lu pointed out that fellows were strategically seated next to a Council member with shared interests based on the demographic survey members completed before the meeting. To facilitate fellows working with non-fellow Council members, Dr. Lu created a seating chart and table-top name placards to help with name recognition. Council members introduced themselves.

- Dr. Oquendo gave greetings and commendation to the Council. She announced that she has begun the process of appointing members to fill vacancies on APA components that begin in May after the Annual Meeting. She is challenging Council chairs to suggest a diverse pool of members from which to draw upon for appointments. She added that any member may recommend others for appointment, but it best to submit names via a Council chair. Dr. Lu asked Council members to submit the Recommendation Form appended to the Council Orientation Packet to Dr. Mangurian by September 30.

- Dr. Levin lauded Council for a strong meeting agenda and stressed the importance of tracking meeting attendance and participation, citing the bylaw which stipulates a member's removal if

two meetings are missed. He spoke of a work group to determine criteria for APA responses to social issues and introduced Philip Wang,MD, new Director of Research. Dr. Wang wants to work cross-collaboratively with the Council and DDHE to develop research training opportunities for diverse population groups.

- Dr. Shore gave an update of the activities of the Board Work Group on Telepsychiatry. He pointed out that a key charge of the work group is to make policy recommendations related to advocacy germane to telepsychiatry. The group has already prepared a policy statement stating that telepsychiatry is the decision of the doctor within state medical regulations. Members of the Council applauded the initiative, citing telepsychiatry as a means to improve access, reduce stigma to getting care, and alleviate inequalities in mental health care. Some members reported having technical difficulties with telepsychiatry, while others noted other challenges like malpractice. Dr. Shore invited the Council to submit questions and concerns about telepsychiatry to the work group. Drs. Vito, Dominguez, and Carter (chair) consequently volunteered to serve as a work group to address telepsychiatry with disadvantaged populations including issues of cultural and linguistic competence.

- Dr. Binder apprised Council of the creation of the American Psychiatric Excellence (APEX) Award. These awards will be presented annually at the APEX Conference to high-profile individuals for outstanding achievement. The first conference will be held in Washington, DC, in April 2016 and will focus on the criminalization of the mentally ill. She also noted the Stepping Up Initiative. The initiative promotes mental health courts and the diversion of minor offenders with mental illness to treatment rather than incarceration.

- Dr. Douglas and other fellows volunteered to assist Dr. Higgins in efforts to identify corporate and non-profit organization donors to support the APA Solomon Carter Fuller Award.

- Dr. Lu offered to provide technical assistance or answer any questions concerning the submission process for the 2016 Annual Meeting. Fellows were encouraged to send their abstracts for Annual Meeting sessions to the Council by September 14. The Council will take a formal vote to endorse the submission. It was noted that sessions endorsed by Council will increase visibility both for the presentation and the Council. Ms. Bondurant advised that the submission process must begin by September 17 and completed by September 24. Drs. Rao and Pi were acknowledged as members of the scientific program committee who can help facilitate selection of MUR content. [*Subsequent to the Council meeting, nine submissions were supported by the Council that consisted of two symposia and seven workshops prior to September 17.]*

  Council discussed potential Annual Meeting Council submissions. Dr. Higgins described his IPS presentation on police aggression with African Americans and his desire to work with the Council on similar submissions for the Annual Meeting. Dr. Aoun mentioned that he developed a cultural sensitivity training for Rhode Island police officers and the reaction has been positive.

- Council received and approved five of the seven 2016 MUR lecture award nominees presented by the Council representatives from the respective selection work groups. Dr. Carter reported

that the Fryer Award selection is pending. Ms. Bondurant noted likewise about the Simon Bolivar Award. Ms. Bondurant announced that next year the Symonds, Tarjan, and Soo lectures will be presented at the IPS in Washington; the Fryer, Pfister, Bolivar, and Fuller lectures at the Atlanta Annual Meeting. She also advised Council meeting participants to not announce these nominees until after the BOT approves in December. [Subsequent to the Council meeting, the Fryer and Simon Bolivar Award nominees were approved].

- **JRC referrals**

  - Action Paper on Removing Barriers to providing Compassionate Care to Victims of Sexual Assault. The Council believed the subject matter to be very broad, encompassing education, advocacy and access components. There was further questioning concerning the actual charge to the Council: to determine the feasibility of the action paper/resource document or to create them? Dr. Walker offered for reference the University of Washington's web site -- The Center for Sexual Assault & Traumatic Stress. A work group was formed to study the action paper and to draft the response for JRC by January: Drs. De Faria (chair), Petersen, Montano, Dominguez and Reid. Regardless of the work group's determination, consensus was that resources need to be culturally competent.

  - Impact of Climate Change. To respond to the action paper, Dr. Rao offered to lead a work group that will focus on the mental health aspects of climate change. Others volunteering were Drs. Sahota, Carter and Montano. Dr. Parekh mentioned that there is literature that supports disproportionate impacts of natural disasters on minority populations. Dr. Rao recommended as a reference his article about the psychiatric impacts of Hurricane Sandy to the Council as reference -- *Hurricane Sandy: Shared Trauma and Therapist Self-Disclosure* published in May 2015 in the Journal of Psychiatry: Interpersonal and Biological Processes. The work group will coordinate its January response JRC with the Councils on International Psychiatry and Communications and the Committee on Psychiatric Dimensions of Disaster.

  - Improving Support of Mental Health of African-American Males. It was noted that there is a disconnect between title of the action paper and description; specifically,the title references African American men, but the tasks concern traumatized African-American communities. There also was concern that the young African-American male is being treated like a patient in the way the action item is conceived. Dr. De Faria gave background on the action paper, noting that what has been presented to Council now did not reflect the breadth of the initial action paper proposed. Nevertheless, the Council agreed that this referral presents the opportunity to provide feedback and to direct the conversation.

    The Council deemed resilience and prevention of traumatization as of core importance for awareness-raising for both communities and psychiatrists. Psychiatry is too focused on acute care intervention; psychiatrists must have training around prevention and resilience beyond just focusing on diagnosis by DSM-5 and interventions focused on

relieving symptoms. There is also a role for teaching psychiatrists to advocate for conflict resolution.

Drs. Williams (co-chair), Walker, Meadows, Hansen, Dominguez (co-chair), Taylor, Hankerson, Simpson, Montano, and Moore were charged to craft the Council's response to JRC by October 1. Dr. Williams will confer with Dr. Tristan Gorrindo, Director of Education, for guidance.

- Dr. Parekh reported on a number of initiatives of the Division of Diversity and Health Equity (DDHE). These include the *Conversation on Diversity and Health Equity for APA Members* event facilitated by Marc Nivet at IPS, the new e-newsletter for fellows and the member-generated diversity segment of the *Health Minds Blog*. She announced that all resident fellowships are housed within DDHE, which had convened the first day-long *All Fellows Orientation* on September 10. Dr. Parekh wants Council input and participation in all DDHE endeavors, especially mentorship for fellows and *On Tour* programming. Dr. Lu will circulate the PowerPoint he presented at the *All Fellows Orientation* breakout session on the subject of mentorship.

- Three additional work groups were created to work on specific projects:
    - The at-risk children/juvenile justice work group (Drs. Simpson, Graves [chair], Reid, Douglas, Simpson, Moore and Puhota) charged with crafting a collaboration with a similar work group of the Council on Children, Adolescents and Their Families.
    - Work group on recruitment/retention of MUR members (Drs. Lu [chair] Akerele, Montano, Castillo and Hankerson)
    - Work group on the revisions to the affirmative action and diversity position statements (Drs. Lu [chair], Hansen, Meadows and De Faria).

- Council resolved to hold a one-hour conference call in November 2015, January 2016, and March 2016. Work groups should hold conference calls between these Council conference calls to move their projects forward.

- In the remaining 45 minutes of the Council meeting, the above work groups convened.

ATTACHMENT 3

Minutes, Council on Minority Mental Health and
Health Disparities
August 2015 Conference calls

August 13, 2015, Noon – 1:00 PM

Present: Drs. Brian Benton, Francis Lu, Jose Vito, Don Williams, Debbie Carter, Helena Hansen, Ludmila De Faria, Amanda Graves, and Enrico Castillo. Fellows: Drs. Puneet Sahota, Daena Petersen, Travis Meadows. APA Administration: Dr. Ranna Parekh and Alison Bondurant. Excused: Drs. Rao and Mangurian.

- Dr. Lu announced that he is serving as acting chairperson during Dr. Mangurian's medical leave of absence. Referring to the handout packet circulated before the conference call, Ms. Bondurant highlighted the charge of the Council and the responsibilities of Council members. Dr. Lu briefly described the workings of the Joint Reference Committee.
- Dr. Lu requested that Council members and fellows to submit a brief bio and areas of interest with photo by August 30. This will allow Council participants to learn a little about each other prior to the September meeting. [Ms. Bondurant subsequently circulated a survey amongst the Council for this purpose.]
- Ms. Bondurant reminded call participants that submissions for 2016 Annual Meeting are due September 17 and that submitters will have until September 24 to finish, but only if a submission had been started in the system and supported by the Council. Dr. Lu encouraged members to submit session proposals and offered his technical assistance. Dr. Benton emphasized the importance of spotlighting diversity and cultural psychiatry content in the scientific program, noting that Council sponsorship of a session is advantageous. Dr. Lu noted that all session presenters do not have to be Council members, but at least one should be.
- Dr. Parekh reported that she and Dr. Mangurian represented APA at a recent White House Forum on Excellence and Innovation through Diversity in the STEM Workforce. She added that APA is partnering with the White House Office of Science and Technology on an event around best clinical practices for cultural sensitivity programs. She offered to share the proceedings and outcomes of the event with Council members. Dr. Parekh also spoke of the All Fellows Orientation session in September and of APA's current effort to strengthen cultural psychiatry content on the website. Ms. Bondurant suggested that at each meeting Council members refer DDHE to any new resources.
- In discussion of the preliminary agenda and preparation for the September 12 Council meeting:
    - Dr. De Faria announced that she has finished the drafts of the rape and human trafficking resources documents. She will send the drafts to Drs. Lu and Rao for review.
    - Dr. Lu pointed to the position statements in line for review by the Council this year (on affirmative action, diversity, domestic violence). He also reiterated the Council's idea to write a position statement on police violence. All will be examined in detail at the Council meeting.

  - Ms. Bondurant noted that the nominees for the seven MUR awards are due at the meeting. Dr. Carter was designated as the Council representative to the Fryer Award selection committee.
  - Dr. Williams recommended the book *Between the World and Me* by Ta-Nehisi Coates as good background reading for the Council's discussion of the Assembly action paper calling for improved support of mental health of African American males.
  - Ms. Bondurant encouraged members to submit names of qualified individuals for appointment to APA components. Dr. Lu agreed to circulate instructions on how.
  - Dr. Lu urged members to pair with fellows on Council projects. He volunteered to match mentors with fellows based on their respective interests.

- Dr. Lu noted the importance of having more frequent contact, i.e. conference calls. Some felt monthly meetings were too much, but agreed to decide on a schedule at the meeting.
- In closing, Dr. Lu noted that the Council will have access to Wi-Fi in the meeting room thanks to Christina's efforts and urged members to make their room and travel reservations if they had not.

August 25, 2015, 7PM – 8PM (Make up call #1)

Present: Drs. Francis Lu, Evaristo Akerele, Sandy Walker. Fellows: Drs. Jared Taylor and Amy Gajaria. APA Administration: Dr. Ranna Parekh and Alison Bondurant

- Dr. Lu read the Council charge. He also announced that the September meeting packet will be distributed on September 2 and that the material will include the affirmative action and diversity position statements that are due for reassessment.
- Subsequent discussion focused on the face-to- face meeting agenda, with Dr. Lu urging call participants to read meeting material fully in advance. He also emphasized the responsibilities of Council members and what is expected of them by APA governance.
- Dr. Lu invited those planning to submit a session proposal for the next Annual Meeting to consider seeking Council sponsorship of the session.
- Dr. Walker reported that Dr. Kimberly Gordon is presenting an IPS session about violent police interactions. Dr. Walker also noted that Dr. Elie Aoun has crafted a cultural sensitivity training for Rhode Island police departments. Dr. Lu agreed to invite these individuals to present at the Council meeting. Dr. Gajaria proposed the idea of a possible co-presentation on these topics.
- There was brief discussion on the frequency of Council conference calls and the purpose of the calls. Dr. Lu resolved the find out the teleconference patterns of other Councils for reference.

August 27, 2015, 7PM – 8PM (Make up call #2)

Present: Dr. Francis Lu. Fellows: Drs. Jessica Moore and Lauren Douglas. APA Administration: Dr. Ranna Parekh and Alison Bondurant

- Most of the call's discussion focused on the Council charge, with special emphasis on the responsibilities of fellows assigned to the Council. Dr. Lu stressed to the fellows that they are to attend all Council meetings, conference calls, and to participate in Council workgroups.
- Dr. Lu outlined the process for submitting abstracts for the scientific program of the Annual Meeting and described the various kinds of meeting formats. He encouraged fellows to consider organizing a session and offered his technical assistance.
- Dr. Lu ended the call by reminding the fellows to send in their bio sketches and their professional areas of interest, noting that a compilation of Council members' and fellows' backgrounds will be circulated before the Council meeting.

COUNCIL ON PSYCHIATRY AND LAW

EXECUTIVE SUMMARY:
The Council on Psychiatry and Law met during the September Components Meeting in Arlington, VA. The Council heard updates from a range of its committees and workgroups including the Workgroup on Location of Civil Commitment Hearings, Workgroup on Confidentiality and Probation/Parole, Workgroup on College and University Mental Health, and the Sex Predator Commitment Laws Workgroup. The draft minutes from the meeting are attached. (Attachment #1)

The Council on Psychiatry and Law had a joint meeting with the Committee on Judicial Action and the Council on Geriatric Psychiatry on "Physician Assistance with Dying". There were several guest speakers including Dr. Dan Larriviere, a neurologist, Dr. Linda Ganzini, Dr. Bob Roca, and Dr. Joanne Lynn. The group had a lively discussion and decided to develop a resource document. A workgroup was formed by the Council on Psychiatry and Law.

1. **ACTION: PROPOSED POSITION PAPER ON COLLEGE AND UNIVERSITY MENTAL HEALTH**
   The Council on Psychiatry and Law has developed a position statement on College and University Mental Health. (Attachment #2)

   Will the Joint Reference Committee approve the request of the Council to approve the proposed position statement "College and University Mental Health"?

2. **ACTION: PROPOSED RESOURCE DOCUMENT ON COLLEGE MENTAL HEALTH AND CONFIDENTIALITY**
   The Council on Psychiatry and Law has developed a resource document on College Mental Health and Confidentiality. (Attachment #3)

   Will the Joint Reference Committee approve the request of the Council to approve the resource document on "College Mental Health and Confidentiality"?

3. **ACTION: PROPOSED RESOURCE DOCUMENT ON INVOLUNTARY OUTPATIENT COMMITMENT AND RELATED PROGRAMS OF ASSISTED OUTPATIENT TREATMENT** The Council on Psychiatry and Law with review from the APA Ethics Committee is resubmitting to the Joint Reference Committee the Proposed Resource Document on Involuntary Outpatient Commitment. (Attachment #4)

   Will the Joint Reference Committee approve the request of the Council to approve the resource document on "Involuntary Outpatient Commitment"?

4. **ACTION: PROPOSED POSITION STATEMENT ON PATIENT ACCESS TO ELECTRONIC MENTAL HEALTH RECORDS** The Council on Psychiatry and Law along with review from the Committee on Mental Health Technology is resubmitting the Proposed Position Statement on Patient Access to Electronic Mental Health Records for approval. The Council has addressed the concerns of the Assembly. (Attachment #5)

   Will the Joint Reference Committee approve the proposed position paper "Patient Access to Electronic Mental Health Records"?

5. **ACTION: PROPOSED POSITION STATEMENT ON TRIAL AND SENTENCING OF JUVENILES IN THE CRIMINAL JUSTICE SYSTEM** - The Council on Psychiatry and Law rewrote the "2005 Adjudication of Youths as Adults in the Criminal Justice System" and is now submitting the Proposed Position Statement on Trial and Sentencing of Juveniles in the Criminal Justice System. (Attachment #6)

   Will the Joint Reference Committee approve the request of the Council to approve the proposed position statement "Trail and Sentencing of Juveniles in the Criminal Justice System"?

6. **ACTION: SUNSET THE 2005 POSITION STATEMENT ON "2005 ADJUDICATION OF YOUTHS AS ADULTS IN THE CRIMINAL JUSTICE SYSTEM" –** The Council on Psychiatry and Law rewrote the position paper and it is now titled "Trail and Sentencing of Juveniles in the Criminal Justice System". (Attachment #7)

   Will the Joint Reference Committee approve the request of the Council to sunset the 2005 Position Statement on "Adjudication of Youths as Adults in the Criminal Justice System"?

Informational Item:

1. **JRC REFERRAL: NEW POSITION STATEMENT ON FIREARM ACCESS, ACTS OF VIOLENCE, AND THE RELATIONSHIP TO MENTAL DISORDERS AND MENTAL HEALTH SERVICES**

   The Council on Psychiatry and Law discussed the JRC referral. The Council felt that the suggested changes would not strengthen the paper and believe that no edits are necessary at this time to the existing position statement.

2. **JRC REFERRAL: REMOVING BARRIERS TO PROVIDING COMPASSIONATE CARE TO VICTIMS OF SEXUAL ASSAULT**

   The Council discussed the referral and there was some confusion on the Council as to why this was referred to the Council on Psychiatry and Law since there are no legal issues. The Council has no comment at this time. (This has been reported back to the lead, Council on Minority Mental Health and Health Disparities.)

3. **JRC Referral: Location of Civil Commitment**

   The Council on Psychiatry and Law discussed this issue at their meeting in September. A workgroup was formed and is being chaired by Dr. Elizabeth Ford. A proposed position paper will be available for JRC review at their meeting in January.

COUNCIL ON PSYCHIATRY AND LAW
APA September Component Meeting
Saturday, September 12th, 9:00 am – 5:00 pm
Hilton Crystal City – Adams, Plaza Level

Members: Steven K. Hoge, MD, Chair; Debra A. Pinals, MD, Vice-Chair; Stuart Anfang, MD; Elissa Benedek, MD; Carl Erik Fisher, MD; Elizabeth Ford, MD; Richard Frierson, MD; Jeffrey Metzner, MD; Patricia Recupero, MD, JD; Robert Trestman, MD, PhD Corresponding Members: Liza Gold, MD; David Lowenthal, MD; Marvin Swartz, MD Ex-Officio/APPL: Jeff Janofsky, MD; Legal Advisor: Richard Bonnie, LLB; APA Diversity/Leadership Fellows: Vivek Datta, MBBS; Tanuja Gandhi, MD APA Public Psychiatry Fellow: Rachel Robitz, MD APA/SAMHSA Fellows: Kali Cyrus, MD; Akansha Thakur, MD APA/Leadership Fellow: Seth Judd, DO

Excused Absent: Peter Ash, MD; Ezra Griffith, MD; Paul Appelbaum, MD

Guests from the Committee on Judicial Action: Howard Zonana, MD; Michael Champion, MD; Robert Weinstock, MD

Additional Guests: Renee Binder, MD, APA President; Maria Oquendo, MD, Incoming APA President; Saul Levin, MD, CEO and Medical Director of APA; Philip Wang, MD, Research Director of APA; Jay Shore, MD, Chair, BOT Workgroup on Telepsychiatry; Mardoche Sidor, MD; Alec Buchanan, MD, PhD; Joseph Penn, MD

APA Staff: Lori Klinedinst Whitaker; Jennifer Tassler, JD.

I. Greetings, Introduction, and Conflict of Interest Disclosures
Dr. Hoge opened the meeting and welcomed the attendees. Attendees identified themselves and any reportable conflicts of interest. Drs. Fisher and Shore identified that they consult to outside companies.

II. Report from the BOT Workgroup on Telepsychiatry
Dr. Jay Shore, Chair, gave a report from the Board of Trustees workgroup on telepsychiatry. He noted that the workgroup has a number of issues which overlap with those of the Council and he wants to promote collaboration and consultation between the groups. Dr. Renee Binder, APA President, created the group in March of 2015, and they just had an in person meeting to assess the group goals. The Workgroup is planning on creating content to guide psychiatrists in the practice of telemedicine, develop a web-based toolkit for members, and put forth policy level recommendations for the APA. The Workgroup is also planning a three hour workshop at the IPS which is still under development. The content that the group is working on are guidance and streaming videos on the practice of telepsychiatry on 35-45 content areas as well as a position statement from APA. The position statement is based on a similar statement from the dermatologists and Dr. Shore asked the Council for review and feedback to make the statement legally appropriate and jurisdictionally accurate. Dr. Metzner pointed out that the statement focuses on patient choice, which leaves out correctional settings and suggested that the Workgroup narrow the focus of the statement based on care setting. There was also discussion about the participation of forensic psychiatrists and those with a VA background. Dr. Recupero

mentioned that there is a 2014 Resource Document on Telepsychiatry and Related Technologies in Clinical Psychiatry available and Dr. Shore said that they would incorporate that in their work. Dr. Hoge agreed that the Council would review a draft via email and provide feedback as necessary when the Workgroup had a draft product.

III. Approval of the Minutes

Dr. Hoge presented the minutes from the Annual Meeting and motions were made to approve the minutes without edits.

ACTION: The Council on Psychiatry and Law voted to approve the minutes from the May 2015 meeting.

IV. Review of Joint Meeting: Physician Assistance with Dying

Dr. Hoge began by discussing the prior day's Joint Meeting on Physician Assisted Dying and stated that he believed the Council should begin work on a Resource Document. For psychiatry, this topic raises concerns about competence evaluations and is becoming increasingly relevant as California has recently passed an ordinance permitting physician assisted death. Dr. Benedek suggested that the Council start by gathering and reviewing the statements from all the other medical organizations, especially the AMA. Dr. Hoge noted that the neurologists are considering making changes in their policy . Dr. Anfang noted that it was an excellent meeting and that most of the data was from Oregon since they have the oldest physician assisted dying statute, but wondered if that was really representative of the country as a whole. Dr. Hoge and Dr. Zonana talked about what the Council's role would be on this topic, whether the Council could generate their own data, which is difficult, or whether they are tasked with providing guidance to psychiatrists in states where such a practice is legal. Dr. Pinals said that many states have reporting requirements around the laws and that it may be possible to gather this information and work on creating a resource document. There was a consensus that a resource document was preferable to a position statement, given how divisive the topic is. The resource document could provide guidance to state associations facing proposed legislation. Mr. Bonnie said that the Council should consider some of the issues that the legislatures address when writing the law, including whether a psychiatric evaluation is mandated to identify lack of capacity and treatable depression. He said a position statement may evolve from the resource document eventually. Drs. Janofsky, Trestman, and Swartz expressed concerns about psychiatry's involvement in the process and what are the appropriate indications for physician assisted death. Dr. Hoge suggested putting together a workgroup to grapple with some of these issues in consultation with the Councils on Geriatric Psychiatry, Psychosomatics and Ethics. The workgroup consists of Dr. Anfang (chair), Dr. Datta, Dr. Weinstock, Dr. Gandhi, Mr. Bonnie, and Dr. Hoge.

V. Visit from Incoming APA President Maria A. Oquendo, MD

Dr. Oquendo, the incoming APA president, visited the Council to introduce herself and to thank the Council for all their hard work. She stated that the work product of the Council was excellent and that they are looking to replicate the efforts in some of the other components. She emphasized that APA should be the main resource for facts about psychiatry and a leader in medicine. Dr. Oquendo talked about how the Council works in a unique way by engaging so many members and fellows outside of the Council and she was hoping to emulate that in other groups during her tenure.

VI. College and University Mental Health

Mr. Bonnie led the update on this topic, stating that the goal of this workgroup was to enhance the materials currently available. The workgroup refined and corrected some of the literature references in the position statement and added a new section to the Resource Document on the transition needs of young adults. Dr. Metzner raised the topic of "beta teams" which assess threat levels. Many institutions have them but they are all different and it is unclear how they work. There was discussion around whether the Council should get more involved in this area and Mr. Bonnie mentioned that he has worked with the FBI and colleges which have model programs. Since there is substantial variation across programs, the FBI is trying to put together a more practice oriented guidance. This was suggested as a potential topic for the upcoming Joint Meeting. Dr. Trestman raised the question of whether the document was designed to include or exclude graduate and professional schools. Dr. Pinals and Mr. Bonnie confirmed that they intended to include such schools and that they would review the document and make that explicit. Dr. Ford echoed Dr. Trestman's concerns and also brought up the issues concerning confidentiality and parental notification. Mr. Bonnie stated that these policies are very troubling and there is evidence that some students do not seek services based on the institution's policy of parental notification.

VII. Visit from APA CEO and Medical Director, Saul Levin, MD, MPH

Dr. Levin joined the Council briefly to thank Dr. Hoge, Dr. Pinals, and the full Council for all their work and for always being available as an invaluable resource for the APA. He also wanted to introduce Philip Wang, MD, the new Research Director at APA. Dr. Wang talked about how he planned to work in a cross collaborative way to support the work and positions of the Council. Dr. Wang noted that Research could serve as a resource for the Council and provide an evidence base to support positions and policy decisions. He also said that the Council could contact him directly if they needed any information. Dr. Levin also thanked Lori Klinedinst Whitaker who staffs the Council for her hard work and thanked Drs. Benedek and Zonana for serving as mentors.

VIII. 2005 Adjudication of Youths as Adults in the Criminal Justice System

Mr. Bonnie and Dr. Benedek presented the current draft position statement on transferring juveniles to adult courts. The new draft endorses the old position statement and states first and foremost that juvenile courts should have original jurisdiction for all individuals under eighteen (18) years of age. The statement also clearly states that the only suitable way to transfer a juvenile to adult court is at the discretion of a judge through a standard of "clear and convincing evidence." The statement does not endorse legislative waivers or transfer at through prosecutorial discretion. APA also recommends that the minimum age that an individual can be transferred to adult courts is fourteen (14) years old and that the offense should be a violent crime with an individual has a significant risk of recidivism. The statement seeks to restore the idea that juveniles are amendable to treatment in many cases as it has been dropped in so many states. Dr. Penn, Chair of the Council on Children, Adolescents and their Families, stated that he was happy with the document; it was well crafted and would be very important in many jurisdictions. The Council discussed that the document should remain aspirational, assuming that the juvenile services are available in the area. The authors stated that they would add in language about the evidence base of the age limits in the position statement and talk about the fact that the statement is about what should be available to these individuals. The Council recommended that the position statement be sent to the JRC by the October 2nd deadline with those edits.

IX. Report of the Manfred S. Guttmacher Award Committee

Dr. Lowenthal, Chair of the Guttmacher Award Committee, gave the update on the nominees for this year's award. Dr. Lowenthal revisited the events of last year's award when the Committee felt that

there was no submission worthy of the award and one was not given. This year, there were five submissions, all of them books, and several of them were excellent. The Committee discussed the nominations and brought forward a recommendation to the Council.

ACTION: The Council voted to approve the recommendation of the Manfred S. Guttmacher Award Committee for the 2016 award.

X. Report of the Committee on Judicial Action

Dr. Swartz, Chair, gave the report from the Committee on Judicial Action which met the prior day. There are a number of cases which CJA is involved:

- *Allmond v. DHMH* (Maryland) CJA has provided District Branch support for brief involving involuntary administration of medication and is currently deciding whether APA should sign on to the brief.

- Volk v. DeMeerleer (Washington State) CJA has provided District Branch support for brief involving potential expansion of Tarasoff duties to events without foreseeable consequences.

- Wollschlaeger v. Governor of Florida (Florida) Dr. Swartz gave an update on case involving 'Physician Gag Law' which used a First Amendment argument strategy which was not effective.

- N.Y. State Psychiatric Ass'n v. UnitedHealth Grp. Dr. Swartz gave an update on case involving Mental Health Parity in New York State where the District Branch was granted standing to pursue the case on behalf of patients.

- N.J. Division of Youth and Family Services v. Y.N. Dr. Swartz let the Council know that a case involving a mother in methadone treatment charged with child abuse was dismissed.

Dr. Swartz also gave the Council a report about two new cases which the Committee is reviewing.

- *State of Louisiana v. Doyle* This case concerns whether individual with serious mental illness should be eligible for death penalty. Dr. Swartz stated that they may write a brief at this stage.

- *Whole Woman's Health v. Cole* This is a Supreme Court case involving challenge to omnibus Texas abortion law. The law in question requires clinics performing abortions to meet the same standards as surgical centers and that the physicians practicing there must have admitting privileges at a hospital within 30 miles (?). The statute forces many, if not all, of these clinics to close. CJA will follow the case, which has petitioned for certiorari before deciding whether to act.

There was some Council discussion about the *Allmond* case. Dr. Swartz explained that the case involves a disability rights group and treatment over objection. CJA has supported the Maryland District Branch and is deciding whether to sign on to a brief as well. The purpose of the brief would be to educate the

court on medication and treatment over objection. There was discussion about the standards of "dangerousness" and what exactly that means in different settings. Dr. Swartz welcomed feedback and said that CJA had recommended signing on to the brief and would be sending out to the Council shortly for approval.

XI. Psychiatric Boarding

Dr. Pinals gave an update on the workgroup on psychiatric boarding. This is a multi-council workgroup and Psychosomatics is taking the lead. Dr. Pinals stated that they received a draft but that more edits were coming. Dr. Janofsky pointed out that that draft says "mental health provider" instead of "psychiatrist" and advocated for the latter term to be included. Dr. Trestman stated that the document does not address the issue of "streeting" or discharging patients to the street without treatment, to avoid boarding which is an equally damaging policy. There was some discussion about the lack of scientific citations and support for definitions in the background of the document and Dr. Lowenthal stated that it does not address the issue behind boarding and why the boarding is occurring.

XII. Confidentiality and Probation/Parole

Dr. Buchanan led the discussion on this topic which is to educate people about the role of psychiatrists in treating those individuals on parole or probation. The working group has produced an outline for a resource paper which is intended to widen the scope of the topic and address issues like who is the point of contact for law enforcement, what is the role in specialty courts, and reentry into the community. Dr. Pinals talked about the intended audience, which are both psychiatrists who are treating these individuals as well as parole boards and judges. She pointed out that Massachusetts was creating a number of specialty courts and that this raises issues of whether the psychiatrist is truly treating the patient or simply becoming a "behavioral monitor." Dr. Hoge stated that there are cases, like *Garcia,* where the plea agreement stipulated that the defendant would enter treatment and waive confidentiality and submit to polygraphs. There are issues then about what a treating psychiatrist needs to report. Dr. Zonana indicated that he believed that the document should state that a psychiatrist must first find out what all the conditions of the parole are and then decide whether or not to participate in that arrangement. Dr. Recupero had concerns about these arrangements could be construed as a violation of APA policy against participating in custodial interrogation, but others on the Council pointed out that that line is crossed only if one was actively asking or designing questions for a polygraph exam. Dr. Hoge stated that the goal of the document is to state what legitimate activities a psychiatrist could be involved with and why confidentiality does not apply in these cases. Dr. Pinals stated that this document would take a position for APA, and perhaps they could design another product for other audiences. The workgroup will continue to flesh out the outline and have another product for the Council to review soon.

XIII. Segregation of Juveniles with Serious Mental Illness in Juvenile Detention and Rehabilitation Programs

Dr. Hoge led the discussion on this topic. AMA and AACAP both have strong positions against the practice for all children and stated that they may want to work with the Council on Children, Adolescents and their Families. Dr. Metzner pointed out that the adult statement is adequate but that it is focused only on the mentally ill, and there are questions about whether or not to broaden the scope of the position. Dr. Hoge said that he would consult with Dr. Penn, Chair of the Council on Children, Adolescents and their Families, on this topic and get back to the Council.

XIV. Location of Civil Commitment Hearings

Dr. Ford began the discussion on the location of civil commitment hearings which was referred to the Council from the JRC. There are of patients in some jurisdictions being transported to a courthouse in shackles. Dr. Swartz stated that this is often less expensive than transporting a patient via ambulance, but in turn criminalizes the civil commitment process. Several Council members provided anecdotal evidence of how the procedure works in their state. Some members stated that judges would refuse to come to a hospital to conduct the proceeding, but that some hospitals had a "courtroom" at the facility to expedite things. Dr. Lowenthal pointed out that some patients actually prefer being in a courtroom and that the transportation was not necessarily traumatic for them. Dr. Pinals also pointed out that there was a potential ADA or parity issue to address. Dr. Ford said that maybe a solution would be to broaden the topic to the criminalization of the commitment process. Dr. Gold and Dr. Pinals offered to help with the drafting process. Dr. Ford thanked the Council for the feedback and said that the workgroup could have a draft for circulation in about 3 months.

XV. Access to Mental Health Records

Dr. Hoge reviewed the background on this topic, which has come up numerous times. There had been a draft produced by the workgroup, but the Assembly did not accept it and it was revised based on the feedback that they received. There was some sentiment by members of the Council that the statement might not be of tremendous value to the APA as patients have a right to access their medical records, whether in paper or electronically. There were questions about how to screen and redact certain sections of the electronic record. Dr. Datta did echo some of the concerns about the immediacy with which patients can access their electronic medical record versus a paper record and others raised the issue that systems do not contain the functionality to put certain comments "under the glass" so that patients do not have access. Many members agreed that this might be more of a technical problem, as opposed to a legal problem. Dr. Hoge said that he would polish the document and discuss with Dr. Grayson Norquist who chairs the Council on Electronic Health Records.

XVI. Sex Predator Commitment Laws

Dr. Zonana stated that the goal in this topic was to update the task force report from 1999 and to review reports which have been very good. In a case in Minnesota, the program was deemed unconstitutional as applied because no one had actually been discharged. There have been a number of problems with programs that treat these patients. It is hard to recruit people to work in these programs and there is a lack of defined treatment. There are a few pilot programs with outpatient components, but they are not very organized and there are no set standards. Dr. Zonana asked whether they should do a comprehensive review of the programs out there or just a few programs. Dr. Pinals showed her support for the review and stated that some treatment doesn't have any empirical support for both in and outpatient treatment. There is no study to demonstrate the effectiveness of the treatment and it is diverting money away from other treatments in the mental health system.

XVII. JRC Referral: New Position Statement on Firearm Access, Acts of Violence, and the Relationship to Mental Illness

Dr. Pinals addressed this referral, which concerns a movement to fix some of the problems with the existing position statement on firearm access, but she didn't believe that the potential changes actually remedied the problems. The Council agreed that they were not amenable to taking up this issue and they would report back to the JRC that no edits were necessary to the existing position statement.

XVIII. JRC Referral: Removing Barriers to Providing Compassionate Care for Victims of Sexual Assault

There was some confusion on the Council as to why this was referred to Psychiatry and Law since there are no legal issues. They agreed to report back that they have no comments.

XIX. Assisted Outpatient Treatment Position Statement and Resource Document Update
Dr. Swartz began the update on this topic by stating that these programs are effective, but there are significant concerns about the racial disparities. There was discussion about adding in some key search terms so that people would be able to find the documents when they searched for them. Dr. Swartz also mentioned that he would be attending the Board of Trustees meeting to talk about the data in the documents. Dr. Weinstock stated that the documents had been through the APA Ethics Council and that Dr. Ezra Griffith had some concerns. Drs. Zonana and Janofsky discussed whether any of the states have forced medication provisions and that most require more due process before that is the case. Dr. Recupero wanted to know if physicians can discharge patients from AOT, a concern which was shared by the Ethics Council. The next steps would be for the Resource Document to go to the JRC for approval, while the position statement would go to the JRC, then the Assembly and finally the Board of Trustees before final approval.

XX. Workgroup on Mental Illness and Criminal Justice
Dr. Trestman gave the update from the workgroup and thanked everyone for their hard work. The text is in production by APPI and they have printed 3,000 copies and sold 157, which is excellent. Dr. Trestman then asked for ideas of other things that the workgroup could focus on. Dr. Ford raised the issue of the psychiatric clearance process and how to determine if an individual was stable enough to be placed in segregation. Dr. Metzner brought up the issues around long term segregation and whether or not that amounts to torture. Both talked about the difficulties around the serration process and how difficult it is to participate as a psychiatrist and there is no guidance available. Dr. Champion thought a good idea would be to examine the role of the psychiatrist in the community. While there was on text on the topic by Dr. Osher, some may have reservations about getting involved with patients in the criminal justice system. It could be good to look at how and where community psychiatrists can get involved. Other potential topics suggested included how mentally ill individuals were being killed by police, ICE demential issues, response to trauma and trauma informed treatment, demential in correctional facilities, and the use of force in correctional facilities. Dr. Trestman also asked for more volunteers for the workgroup since several members had rotated off the Council. Drs. Datta, Sidor, Cyrus, and Robitz asked to join and Dr. Hoge asked to be kept in the loop as well.

XXI. Entry into the US
Dr. Metzner began the discussion on this topic wherein the Canadian Psychiatric Association wanted to do a joint statement with APA concerning a policy of data sharing between the Canadian health system and their border control. Apparently if an individual has attempted suicide, this information can be shared by the CPIC with US immigration officials and the individual may be denied entry to the US. There is no uniformity across provinces, but this has become a problem. The statement would say that psychiatric clearance must be nondiscriminatory and equally applied. There was also discussion of a recent regulatory update from the CDC regarding the medical examination for aliens. The APA response stated that there needs to be a psychiatrist on the medical panel, the diagnoses must be consistent with DSM-V (the most current version) and stated that the process in and of itself is discriminatory. There has been no response on this yet.

XXII. Component Workshop
Dr. Hoge asked for potential submission topics for the Component Workshop at the Annual Meeting. Several suggestions were mentioned, including the border issue discussed above, physician assisted

death, and parity issues. Dr. Hoge said that he would follow up with members of the Council and try to work on submissions.

XXIII. New Business

Dr. Levin has asked the Council to look into state physician health programs which identify impaired physicians as a potential violation of due process. The programs impose high costs on physicians and there is an expansive definition of "impaired physician." Dr. Recupero pointed out that there have been suicides based on these interventions and there are problems with conflicts of interest and fraud. Apparently Colorado has a model program, but most are far from exemplary. Dr. Trestman mentioned that he believed that Connecticut's program was actually coercive. Dr. Hoge asked for volunteers to begin a workgroup on this topic. Drs. Recupero, Fisher, Pinals, Swartz, Janofsky, Anfang, Sidor, Datta, Benedek and Hoge all volunteered.

Meeting of the Council on Psychiatry and Law adjourned at 3:50 P.M.

American Psychiatric Association
Position Statement on College and University Mental Health

Approved by the Council on Psychiatry and Law, September 12, 2015*

The need for mental health services on college and university campuses is increasingly recognized. Many students enter college already taking psychiatric medications and most colleges report that the number of prescriptions written at their student health and counseling centers has grown in recent years (National Survey of College Counseling Centers, 2015). Mental health visits are among the most frequent types of healthcare visits among college students (Turner and Keller, 2015). Further, most colleges report increasing numbers of students with histories of binge drinking, substance abuse, and severe psychopathology (Center for Collegiate Mental Health, 2015). Suicide is the second leading cause of death in college students (Blanco et al, 2008). Attending college is often very stressful for young adults, especially when faced with intense academic pressure to perform. Stressors also include separation from parents and other family members and the ongoing process of forming one's personal identity. In addition, several psychiatric disorders begin during late adolescence and early adulthood, highlighting the importance of early identification and treatment during this time.

Strong evidence shows that mental health problems adversely affect rates of graduation among college students (Hunt et al., 2010). Unfortunately, however, utilization of mental health services varies greatly among colleges (Lipson, et al, 2015). Many college students do not have ready access to psychiatric services or do not take advantage of the services that are available to them. Most community colleges do not have student health or counseling services at all. Many college students continue to lack health insurance. Moreover, students who leave home for college typically also leave their adolescent health care providers and do not successfully negotiate a transition to new providers who understand the special needs and vulnerabilities of young adults. (IOM, 2014)

It is the position of the APA that:

1. All colleges and universities, including community colleges, should have an established arrangement for timely access to psychiatric evaluation and treatment and other necessary and appropriate mental health services for all students in need of them. All colleges without student health programs should have the capacity to provide screening and referral for mental health services. Every student health program should make arrangements for access to an employed or consulting psychiatrist or for referral to a local private psychiatric practitioner or community clinic. Arrangements should be in place for psychiatric care to be coordinated in an appropriate manner with care delivered by the student health service or counseling center. Psychiatrists should have the opportunity to participate in assessment and treatment planning to a degree commensurate with their clinical responsibility.

2. A treating psychiatrist should not serve as a decision-maker regarding academic matters, including withdrawal from classes or from school, due to the potential conflict of interest between the academic mission of the university and fidelity to the welfare of the student. A

* This Position Statement replaces the 2005 statement by the same name

treating psychiatrist should serve in a consultative capacity in academic decisions, but the final decisions should rest with those not involved in the direct health care of students.

3. All colleges and universities should either require or strongly encourage students to have comprehensive health insurance coverage, especially for mental health and substance abuse treatment, and should assist students to obtain coverage if they are not insured. Psychiatric problems arising while students are enrolled should be treated on or off campus adequately and at parity with any other health problems.

4. Colleges and universities should provide students, parents and staff with easily accessible and culturally sensitive orientation, and ongoing education, regarding health and wellness. Particular attention should be paid to mental health literacy, including recognizing mental health problems and understanding appropriate interventions, including how to respond to disturbing behavior or apparent distress, whom to contact and how to access services both for routine care and for urgent and emergency interventions. Colleges should implement comprehensive programs to reduce suicide risk, prevent alcohol and substance use problems, and reduce sexual assault and respond compassionately to its victims.

5. Colleges and universities should work with community partners and state, federal agencies (such as NIMH, NIDA, SAMHSA) and college MH focused non-profits (such as JED Foundation and Active Minds) to educate the public regarding challenges and risks related to young adulthood, the prevalence of mental disorders among young adults, the importance of recognizing and responding to signs of distress and strategies for stress management and resiliency.

6. Protection of confidentiality and trust in the treatment relationship are especially important for college students. Colleges are relatively self-contained communities and college students transitioning from adolescence to adulthood are growing into their sense of themselves as independent individuals. At the same time, parents also have a strong interest in being involved in their children's health care -- even when their child has become an adult, legally speaking. In rare cases involving students who present a risk of harm to themselves or others, the university administration also has a strong interest in being aware of the student's status. The primary regulations governing privacy in college mental health settings are FERPA, HIPAA, state confidentiality statutes, and codes of professional practice. Clinicians and college officials should encourage young students who may be still dependent on their parents emotionally and financially to share appropriate information with them and seek their support when clinically indicated. Even in case of student's refusal to contact the parent, the perceived impediments to disclosures by college officials in situations in which the health or safety of students may be endangered seem often to be the result of a misunderstanding of FERPA and other relevant laws and regulations. The federal laws and regulations, including updated guidance on FERPA, generally provide an adequate framework for thoughtful clinical decision-making and allow disclosure to university officials and parents when there is genuine concern about the students' safety or the safety of others.

7. Indiscriminately requiring students with mental health problems to take a medical leave can exacerbate students' mental health conditions and adversely affect their self-esteem, and it also violates the American with Disabilities Act. Mandated withdrawals or leaves of absence can be appropriate in dangerous situations where the risk of violence to self or others cannot be managed safely in the school environment, but students should have appropriate due process protections in these determinations. Students' safety prior to returning to college should be determined by a mental health care provider on a case-by-case basis.

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APA Council on Psychiatry and Law

Resource Document on College Mental Health and Confidentiality

Approved by Council on Psychiatry and Law, September 12, 2015*

College homicides and suicides often precipitate reviews of regulations, statutes and case law governing treatment and confidentiality.[1] In April 2007, for example, a college senior at Virginia Polytechnic Institute and State University killed 32 students and faculty, wounded many others and then killed himself. The review panel appointed by the Governor found significant confusion among university officials about the Family Educational Rights and Privacy Act (FERPA),[2] the federal law governing confidentiality of educational records, leaving them uncertain about what information could be revealed to each other as well as to the student's parents.[3] Psychiatrists seeing students as patients in college settings, either as employees of student mental health services or as private practitioners in the community, have also been confused as to their relationship to the university and the effect of federal and state laws governing confidentiality. This resource document was prepared to give practitioners a guide to providing good clinical care within the framework of relevant law.

I. Clinical Background

College students experience a variety of mental health concerns ranging from anxiety, depression, eating disorders, alcohol and substance abuse to the emergence of psychotic

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* Prepared for the Council on Psychiatry and Law by the Council's Work Group on College Mental Health: Richard J. Bonnie, Vivek Datta, Carl Fisher, Wun Kim, Debra Pinals, Victor Schwartz and Howard Zonana. This replaces the Resource Document of the same name approved by the Council in 2009.

[1] Student Mental Health and the Law, A Resource for Institutions of Higher Education- published by the Jed Foundation 2008 http://www.jedfoundation.org/assets/Programs/Program_downloads/StudentMentalHealth_Law_2008.pdf This publication presents an overview of disability law and how schools should deliver mental health services including referrals, peer counseling supervision and peer hotlines. See also Campus Mental Health- Know Your Rights, A guide for students who want to seek help for mental or emotional distress by the Judge David Bazelon Center for Mental Health Law, 2008. See http://www.bazelon.org/l21/YourMind-YourRights.pdf

[2] 20 U.S.C. § 1232g. The pertinent provisions of FERPA and implementing regulations issued by the Department of Education are reproduced in Appendix A.

[3] Virginia Tech Review Panel, "Mass Shootings at Virginia Tech April 16, 2007: Report of the Review Panel," August 2007, http://www.vtreviewpanel.org/report/index.html (accessed 2 February 09).

disorders such as bipolar disorder and schizophrenia. Colleges and universities enrolled about 21 million students in the fall of 2014, with an estimated 85% enrolled in undergraduate programs.[4] Surveys of 94,197 students from 168 campuses participating in the Spring 2014 ACHA National College Health Assessment revealed that 12% reported a diagnosis of or treatment for depression within the past year while 14.3% reported a diagnosis of or treatment for anxiety in the past year. Of the surveyed students, 32.6% said they "felt so depressed it was difficult to function", 54% felt overwhelming anxiety and 8.1%% said they "seriously considered suicide" within the prior twelve month period. [5]

Although violence towards others was prominent in the Virginia Tech case, such violence is much less common on college campuses than suicide. Suicide is the second leading cause of death among American college students.[6] Research indicates that young adults (ages twenty to twenty-four) are more likely to commit suicide than are adolescents (ages fifteen to nineteen). Males in each of these age groups are more likely to die from suicide attempts than females.

Each year approximately 1500 college students commit suicide.[7] The majority of these students are not receiving mental health treatment at the time of their deaths. College students, however, are about half as likely to kill themselves as their age-matched peers in the community. Campus prohibitions against firearms contribute to this lower rate.[8] Instead of using firearms, "students who commit suicide [in college] are

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[4] National Center for Education Statistics "Back to school statistics - Fast Facts," nces.ed.gov/fastfacts/display.asp?id

[5] American College Health Association-National College Health Assessment Spring 2014 Reference Group Data Report(Abridged).

[6] http://www.acha-ncha.org/docs/ACHA-NCHA-II_ReferenceGroup_ExecutiveSummary_Spring2014.pdf. Because of drop in rates of homicide among non-college attending 15-25 year olds, suicide is now 2nd leading cause of death in general (both college and non-college attenders).

[7] Suicide Prevention Resource Center: Promoting Mental Health and Preventing Suicide in College and University Settings. Newton, Mass, Education Development Center, 2004 and the Jed Foundation, http://www.jedfoundation.org/
The Jed Foundation was founded in 2000 by the family of Jed Satow, who committed suicide as a college sophomore. See also Paul Joffe, An Empirically Supported Program to Prevent Suicide Among a College Population 1 (2003), available at http://www.jedfoundation.org/articles/joffeuniversityofillinoisprogram.pdf. The estimated rates of suicide are still about 6.5-7.5/100,000/year. This estimate has increased because the number of higher ed students has increased.

[8] American Association of State Colleges and Universities, A Higher Education Policy Brief (November 2008): Concealed Weapons on State College Campuses: In Pursuit of

more likely to hang themselves, jump from unprotected buildings or ingest lethal chemicals commonly found in campus labs." Less than twenty percent of college students who commit suicide ever seek help from college counseling centers.

Since 1981, data have been compiled from directors of college counseling centers across the United States and Canada to determine trends in student counseling. According to the 2014 National Survey of Counseling Center Directors, which surveyed 275 colleges and universities across the United States and Canada, 58% of colleges offered psychiatric services on campus, often with insufficient psychiatric consultation time. Eleven percent of college students (363,000) sought counseling in 2014. Twenty-six percent of student-patients were taking psychotropic medications, which was up from 20% in 2003, 17% in 2000, and 9% in 1994. Counseling center directors reported that nearly 52% of their patients had severe psychological problems and 8% had impairment so serious that they could not remain in school or required extensive mental health treatment. In 2014, 4950 students in this survey (a rate of 1.5 hospitalizations for each 1000 students covered in survey) were hospitalized for mental health reasons.[9]

It is unclear whether the number of students seeking treatment is rising because the incidence of mental health problems among college students is rising or because more students are willing to talk about their problems and seek counseling. However, a recent study[10] in which college students and their non-college attending peers were interviewed found that almost 50% of college-aged individuals and their non-college attending peers had met DSM-IV criteria for a psychiatric disorder within the past year. The most common disorders in college students were alcohol use disorders and personality disorders. Moreover, the highest rates for treatment-seeking in the previous year were reported for mood disorders, whereas the lowest rates were for alcohol disorders.

II. Transition Needs of Young Adults

College students are young adults in transition, a discrete group with specific developmental needs distinguishable from those of adolescents and older adults. An important report by Institute of Medicine & National Research Council, *Investing in the Health and Well-Being of Young Adults* (2014), emphasized that young adulthood is a more hazardous period of the life course than is generally recognized. Moreover, even though young adults are at high risk of developing serious physical and mental health conditions (e.g., obesity/eating disorders, mood and addictive disorders) and have high

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Individual Liberty and Collective Security by Thomas L. Harnisch.

[9] See Gallagher, RP, Nat'l Survey of Counseling Center Directors 2008, http://www.iacsinc.org/2008%20National%20Survey%20of%20Counseling%20Center%20Directors.pdf.

[10] Blanco C, Okuda M, Wright C et al. Mental Health of College Students and Their Non-College-Attending Peers. Arch Gen Psychiatry 2008:65 (12): 1429-1437.

rates of suicide and violence, systems of care for this population are fragmented and ill-prepared to respond to their needs:

> "The transition from child to adult medical and behavioral health care often is associated with poor outcomes among young adults. Challenges include discontinuities in care, differences between the child/adolescent and adult health systems, a lack of available adult providers, difficulties in breaking the bond with pediatric providers, lack of payment for transition support, a lack of training in childhood-onset conditions among adult providers, the failure of pediatric providers to prepare adolescents for an adult model of care, and a lack of communication between pediatric and adult providers and systems of care" (p 219)

Transitioning from high school to college with a psychiatric diagnosis can be an especially challenging task. Psychiatrists treating youth entering college should take proactive efforts to facilitate their successful transition and to advocate for supportive professional practices, campus practices and public policies. Specifically, college and university officials should make information available to applicants concerning mental health resources at their institutions, including clinical, preventive, supportive services and any necessary educational accommodations. In addition, they should provide clear administrative information on confidentiality and academic leave or disciplinary policies in relation to mental health conditions.

Both sending and receiving educational institutions and clinicians before and after college should coordinate clinically appropriate transition (or sharing) of care, with active involvement of the student and interested adults. Training programs in both general psychiatry and child and adolescent psychiatry should devote a significant amount of their didactic and clinical training time to the unique developmental and clinical needs of transitional age youth on college campuses. [11]

III. Legal Issues

The Family Educational Rights and Privacy Act (FERPA) was enacted in 1974 to protect the privacy of parents and students regarding outside access to student educational records. FERPA states "no funds shall be made available under any applicable program to any educational agency or institution which has a policy or practice of permitting the release of educational records ... of students without the written consent of their parents to any individual, agency, or organization." Once a student reaches the age of eighteen, the rights accorded to the student's parents, including authority to permit access to

[11] JED currently has a website dedicated to transition issues, http://transitionyear.org. A successor website, *Set to Go*, being developed with guidance from AACAP and the American Academy of Pediatrics, is expected to be launched in 2015.

records, are transferred to the students themselves. After the student becomes eighteen, even the parents no longer have access to these records without the student's consent.[12]

FERPA allows university officials to disclose otherwise protected information to parents or others when "knowledge of the information is necessary to protect the health or safety of the student or other individuals." [13] Unless state laws are more restrictive, this means that university officials are permitted but not required to inform appropriate individuals when a student's behavior is thought to indicate a risk to health or safety. There remains some uncertainty whether a suicide attempt *per se* qualifies for disclosure. Since notice under FERPA is discretionary, universities often decide not to make disclosures without student consent. Because this was the Virginia Tech policy at the time of the 2007 shootings, Seung Hui Cho's parents were never notified of the escalating concerns among his teachers and others. Virginia enacted legislation following the Tech shootings requiring state colleges to notify a parent of a dependent student who receives mental health treatment at the school's student health or counseling center, if it is determined that there is a "substantial likelihood" that the student will, in the near future, cause serious physical harm to himself or others.[14]

FERPA does not apply to records of the treatment of students that are made or maintained by an independent physician, including psychiatrist, or a psychologist acting in his or her professional capacity that are used only in connection with treatment of the student and disclosed only to individuals providing the treatment.[15] Once information from the mental health or medical record is shared with or used by the institution for a purpose other than treatment (e.g., decisions about disability accommodations or medical withdrawal), FERPA applies to the shared records. In December 2008, the U.S. Department of Education amended its regulations implementing FERPA to provide additional guidance regarding sharing of information within the university and its disclosure to parents in emergency situations. The agency emphasized that institutions have a lot of leeway in making these determinations:

> (c) . . .[A]n educational agency or institution may take into account the totality of the circumstances pertaining to a threat to the health or safety of a student or other individuals. If the educational agency or institution determines that there is an articulable and significant threat to the health or safety of a student or other individuals, it may disclose information from education records to any person whose knowledge of the information is necessary to protect the health or safety of the student or other individuals. If, based on the information available at the time of the determination, there is a rational basis for the determination, the Department will not substitute its judgment for that of the educational agency or

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[12] There is an exception under FERPA, that schools may release any and all information to parents, without the consent of the eligible student, if the student is a dependent for tax purposes under the IRS rules.

[13] 34 CFR 99.36

[14] Va. Code Ann. § 37.2-815 (2009)

[15] 20 USCS § 1232g

institution in evaluating the circumstances and making its determination. [16]

Another federal statute with implications for the confidentiality of medical records is the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Regulations based on HIPAA apply if a health service or practitioner uses electronic billing, on-line insurance verification, or other specified electronic transactions and therefore is a covered entity.[17] However, treatment records covered under FERPA are excluded from coverage under the HIPAA regulations. In general, HIPAA requires patient authorization prior to release of information, but like FERPA, it contains an exception for emergency situations. A summary of the HIPAA regulations can be found on the APA website, www.psych.org, under the search term "HIPAA."

Confidentiality of health records is also regulated by state law, case law (e.g., duties to protect potential victims of patients' violence), and professional ethics. State health information privacy laws sometimes preclude disclosures that would otherwise be authorized under both FERPA and HIPAA. Practitioners therefore need to be familiar with how state laws apply in their own jurisdictions.

IV. Conclusions and Recommendations

Confidentiality is a core principle upon which trust in the treatment process is based. This concern is especially urgent for college students because colleges are relatively self-contained communities and college students are developmentally transitioning from adolescence to adulthood and just growing into their sense of themselves as independent individuals. Parents also have a strong interest in being involved in their children's health care-- even when their child might legally be an adult. In rare cases of potentially dangerous students, the university administration also has a strong interest in being aware of the student's status. The primary regulations governing privacy in college mental health settings are FERPA, HIPAA, state confidentiality statutes, and codes of professional practice. The perceived impediments to disclosures by college officials in situations in which the health or safety of students may be endangered seem often to be the result of a misunderstanding of FERPA and other relevant laws and regulations. The federal laws and regulations, including updated guidance on FERPA, generally provide an adequate framework for thoughtful clinical decision-making.

A. Guidance to Clinicians Regarding Disclosures of Students' Mental Health Status

1. Excellent clinical judgment, a thorough understanding of the needs of the various parties in college mental health systems (including parents, roommates/other students,

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[16] 34 CFR Part 99 FERPA; Final Rule Dec. 9, 2008. Excerpts from the regulations are reproduced in Appendix A.
[17] 45 CFR 164.501

and university administrators), and good common sense--in the context of a good understanding of the law--should be the primary determinants of decision making in college mental health settings (as in all settings).

2. Parental notification should not be mandated, even when students' health or safety may be at risk. The nature of the student's relationship with his or her parents needs to be explored and assessed prior to a decision about disclosure. These are common clinical judgments that often are made in emergency rooms and inpatient settings, requiring careful consideration in collaboration with the patient. Automatic notification may be clinically inappropriate.

3. In most cases, students with serious mental health problems will be prepared to cooperate with their therapist and involve parents and others as clinically indicated. When students refuse to allow disclosures to parents or school authorities, the initial attempts at resolving the problem should flow from clinical exploration and the therapeutic process, e.g., if students are hospitalized, it is in their interest to inform the school that they will be absent from the dorms or classes so that their failure to appear will be explained.

4. Recent initiatives aiming to educate parents and university administrators about the proper understanding of FERPA and other relevant laws have been salutary. However, there has also been a worrisome tendency to overreact to recent campus tragedies by weakening confidentiality requirements and even mandating parental notification. These changes could have unintended deleterious impacts on the care of college students. If students believe that discussing troubling thoughts, feelings, fantasies or impulses will result in unwanted parental or administrative involvement, they will be significantly less likely to seek assistance from college counseling services.

5. In almost all circumstances, the best interest of the patient/student should be the primary concern of college mental health clinicians. Policies encouraging or even mandating evaluations for treatment should be considered with homicidal or suicidal students but with a reasonable threshold. Sometimes sending a student home may increase suicide risk; decisions regarding withdrawal from school should take into account all relevant considerations.

6. Student Health Services need to be clear with students and families when they are not in a treatment relationship but are acting as an agent of the university, e.g., when doing assessments about whether a student may reenter the University after a medical leave or risk assessments at the request of university officials when students are thought to be a danger to their own or others' health or safety.

B. Guidance Regarding University Policies Affecting Student Mental Health

1. Whenever possible, schools should require students to carry health insurance

2. Clinicians should be aware of health insurance consequences of not being a full-time student. Some students may find themselves without insurance if they take a leave from school. Some school-based health insurance plans provide ongoing health insurance for a year.

2. Policies should be developed so as not to discourage students from seeking treatment. For example, forcing students to take a medical leave solely on the basis of seeking treatment for suicidal thoughts or attempts is likely to be counterproductive in encouraging students to seek needed care.

3. Mental health staff should provide education and consultation to appropriate faculty committees dealing with students' educational and disciplinary issues.

4. When the school requests or mandates a mental health evaluation, it is important to have explicit policies about what will be disclosed to the university. Generally the school is interested in whether the student is safe to be in school, and more detailed clinical information need not be revealed.

5. Schools should encourage active student-to-student involvement, peer counseling, and student support groups. Students are frequently aware of problems before the administration becomes aware of them and before they spiral out of control, and they are in a good position to encourage their colleagues to seek appropriate treatment. Schools should also give concerned students a contact-point for discussing their concerns within proper legal and ethical boundaries.

6. There can be real conflicts of interest between schools and students; what may be in the individual student's best interest may conflict with the school's obligation to provide a comfortable and safe environment for other students. Difficult balancing decisions require case-by-case consideration rather than rigid policies.

7. Serious consideration needs to be given by university and college administrations to how mental health services are provided to their students. As many as 40% of colleges and universities have no on-site psychiatric services, often making it difficult and expensive for students to obtain treatment.

8. Mandated withdrawals or leaves of absence can be appropriate in dangerous situations where the safety of the student cannot be managed in the school environment or when the student presents a danger to others on the campus. However, students cannot be removed from school involuntarily simply on the basis of suicidal ideation or attempt and the Department of Education's Office of Civil Rights issued a policy guidance on this topic in 2014. Withdrawal should be required only if the appropriate officials have determined, based on thorough evaluation, that that there is no reasonable way that the student's problems can be managed adequately with campus-based or local resources and

that remaining on campus presents an acute and unmanageable risk to this student. Students should have appropriate due process protections in these determinations.

9. The question of when to invoke a disciplinary proceeding instead of, or in addition to, a mental health referral can be a complicated administrative challenge. Consultation with mental health and legal affairs staff may be appropriate.

10. Mental health education and training with a focus on identifying pathology and knowing how to make referrals should be provided to campus police, faculty, student life, residence hall staff, and other institutional offices likely to come into contact with troubled students.

11. Since the Virginia Tech tragedy in April 2007, many colleges have established multidisciplinary committees charged with assessing threats of harm to self or others by students and formulating appropriate interventions. Some legislatures have directed colleges to create such "threat assessment teams." The composition and activities of these teams vary, with some focused solely on threat assessment and others dealing more broadly with struggling or at-risk students.[18] Notwithstanding their proliferation, use of these teams cannot yet be characterized as an evidence-based practice. Although some positive evidence has been published regarding threat assessment teams in secondary schools, the literature on threat assessment in colleges is largely descriptive and anecdotal.

[18] A review of campus behavioral intervention teams has been published by the Higher Education Mental Health Alliance.
http://www.jedfoundation.org/campus_teams_guide.pdf

Appendix A: Excerpts from FERPA and Applicable Regulations

The relevant portions of FERPA and the interpretive guidance issue by the Department of Education governing disclosures for behavioral and health-related information are set forth below:

20 USCA §1232(g):

(6) (A) Nothing in this section shall be construed to prohibit an institution of postsecondary education from disclosing, to an alleged victim of any crime of violence (as that term is defined in section 16 of title 18, United States Code [*18 USCS ß 16*]), or a nonforcible sex offense, the final results of any disciplinary proceeding conducted by such institution against the alleged perpetrator of such crime or offense with respect to such crime or offense.

(B) Nothing in this section shall be construed to prohibit an institution of postsecondary education from disclosing the final results of any disciplinary proceeding conducted by such institution against a student who is an alleged perpetrator of any crime of violence (as that term is defined in section 16 of title 18 [*18 USCS ß 16*], United States Code), or a nonforcible sex offense, if the institution determines as a result of that disciplinary proceeding that the student committed a violation of the institution's rules or policies with respect to such crime or offense.

20 USCA §1232(i): Drug and alcohol violation disclosures.

(1) In general. Nothing in this Act or the Higher Education Act of 1965 shall be construed to prohibit an institution of higher education from disclosing, to a parent or legal guardian of a student, information regarding any violation of any Federal, State, or local law, or of any rule or policy of the institution, governing the use or possession of alcohol or a controlled substance, regardless of whether that information is contained in the student's education records, if--

(A) the student is under the age of 21; and

(B) the institution determines that the student has committed a disciplinary violation with respect to such use or possession.

34 CFR § 99.31 (Effective Jan. 8, 2009)

Under what conditions is prior consent not required to disclose information?

(a) An educational agency or institution may disclose personally identifiable information from an education record of a student without the consent required by § 99.30 if the disclosure meets one or more of the following conditions:

(1)(i)(A) The disclosure is to other school officials, including teachers, within the agency or institution whom the agency or institution has determined to have legitimate educational interests.

(B) A contractor, consultant, volunteer, or other party to whom an agency or institution has outsourced institutional services or functions may be considered a school official under this paragraph provided that the outside party--

(1) Performs an institutional service or function for which the agency or institution would otherwise use employees;

(2) Is under the direct control of the agency or institution with respect to the use and maintenance of education records; and

(3) Is subject to the requirements of § 99.33(a) governing the use and redisclosure of personally identifiable information from education records.

(ii) An educational agency or institution must use reasonable methods to ensure that school officials obtain access to only those education records in which they have legitimate educational interests. An educational agency or institution that does not use physical or technological access controls must ensure that its administrative policy for controlling access to education records is effective and that it remains in compliance with the legitimate educational interest requirement in paragraph (a)(1)(i)(A) of this section.

(2) The disclosure is, subject to the requirements of § 99.34, to officials of another school, school system, or institution of postsecondary education where the student seeks or intends to enroll, or where the student is already enrolled so long as the disclosure is for purposes related to the student's enrollment or transfer.

Note: Section 4155(b) of the No Child Left Behind Act of 2001, 20 U.S.C. 7165(b), requires each State to assure the Secretary of Education that it has a procedure in place to facilitate the transfer of disciplinary records with respect to a suspension or expulsion of a student by a local educational agency to any private or public elementary or secondary school in which the student is subsequently enrolled or seeks, intends, or is instructed to enroll.

34 CFR § 99.36 (Effective Jan. 8, 2009)

What conditions apply to disclosure of information in health and safety emergencies?

(a) An educational agency or institution may disclose personally identifiable information from an education record to appropriate parties, including parents of an eligible student, in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals.

(b) Nothing in this Act or this part shall prevent an educational agency or institution from--

(1) Including in the education records of a student appropriate information concerning disciplinary action taken against the student for conduct that posed a significant risk to the safety or well-being of that student, other students, or other members of the

school community;

(2) Disclosing appropriate information maintained under paragraph (b)(1) of this section to teachers and school officials within the agency or institution who the agency or institution has determined have legitimate educational interests in the behavior of the student; or

(3) Disclosing appropriate information maintained under paragraph (b)(1) of this section to teachers and school officials in other schools who have been determined to have legitimate educational interests in the behavior of the student.

(c) In making a determination under paragraph (a) of this section, an educational agency or institution may take into account the totality of the circumstances pertaining to a threat to the health or safety of a student or other individuals. If the educational agency or institution determines that there is an articulable and significant threat to the health or safety of a student or other individuals, it may disclose information from education records to any person whose knowledge of the information is necessary to protect the health or safety of the student or other individuals. If, based on the information available at the time of the determination, there is a rational basis for the determination, the Department will not substitute its judgment for that of the educational agency or institution in evaluating the circumstances and making its determination.

RESOURCE DOCUMENT ON INVOLUNTARY OUTPATIENT COMMITMENT AND RELATED PROGRAMS OF ASSISTED OUTPATIENT TREATMENT [1]

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Approved by the Board of Trustees, TBD

Prepared by the Council on Psychiatry and Law.

Involuntary outpatient commitment is a form of court-ordered outpatient treatment for patients who suffer from severe mental illness and who are unlikely to adhere to treatment without such a program. It can be used as a transition from involuntary hospitalization, an alternative to involuntary hospitalization or as a preventive treatment for those who do not currently meet criteria for involuntary hospitalization. It should be used in each of these instances for patients who need treatment to prevent relapse or behaviors that are dangerous to self or others.

Executive Summary, Conclusions and Recommendations

In 1987, the American Psychiatric Association's Task Force Report on Involuntary Outpatient Commitment endorsed its use under certain circumstances (1) and reiterated its endorsement in the 1999 Resource Document on Mandated Outpatient Treatment (2). During the decades since publication of the 1987 Task Force Report, outpatient commitment has received a great deal of attention by advocacy groups, researchers and legislatures (3-14). Additionally, the nation has continued to struggle with the effects of the declining supply of psychiatric beds, community treatment capacity and public and private funding for psychiatric care (15). Involuntary outpatient commitment is getting more public exposure as pressure mounts to minimize treatment non-adherence, and to find effective treatment that reduces hospitalization and is cost-effective while still respectful of individual rights (13-14). As of 2015, 45 states and the District of Columbia have commitment statutes permitting involuntary outpatient commitment -- although many of these states do not consistently implement, provide treatment resources or evaluate their involuntary outpatient commitment programs (6,9).

This Resource Document supports the view that involuntary outpatient commitment can be a useful intervention for a subset of patients with severe mental illness who 'revolve' in and out of psychiatric hospitals or the criminal justice system. These individuals often improve when hospitalized and treated, but

[1] Outpatient court-ordered treatment may be referred to as 'assisted outpatient treatment', 'involuntary outpatient commitment', 'mandated community treatment', or 'community treatment orders'. Some regard the term 'assisted outpatient treatment' as a euphemistic term for treatment under coercion. In this document the term 'involuntary outpatient commitment' is used to refer to these programs. The current document is adapted from: Gerbasi JB, Bonnie RJ, Binder RL: Resource document on mandatory outpatient treatment. Journal of the American Academy of Psychiatry and the Law 2000; Vol 28(2): 127-144

frequently do not adhere to treatment after release, leading to a cycle of decompensation, re-hospitalization and, in many cases, arrest (3). Although important studies of involuntary outpatient commitment have been conducted within the past decade, there is no broad consensus about its effectiveness across jurisdictions (4, 6-12, 16-20). However because it is a complex community-based intervention, implemented in diverse local communities, its effectiveness would logically be expected to vary (9). Research in this field also faces substantial methodological problems (9, 21). It is difficult to separate the effects of the court order and the legal authority of the court from the effect of improved access to appropriate services. In fact, some advocates and persons with mental illness argue that both improved services and better access to services without a court order could yield comparable outcomes to those obtained by successful involuntary outpatient commitment programs.

As discussed in this Resource Document involuntary outpatient commitment programs have demonstrated improved patient outcomes when *systematically implemented, linked to intensive outpatient services* and *prescribed for extended periods of time* (9). Based on empirical findings and on accumulating clinical experience, it appears that involuntary outpatient commitment can be a useful tool in the effort to assist patients with severe mental illness with documented histories of relapse and re-hospitalization. It is important to emphasize, however, that all programs of involuntary outpatient commitment must include these elements of well-planned and executed implementation, intensive, individualized services and sustained periods of outpatient commitment to be effective (9). There is also clear evidence that involuntary outpatient commitment programs help focus the attention and effort of the providers on the treatment needs of the patients subject to involuntary outpatient commitment.

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

The purpose of this Resource Document is to provide information to federal and state policymakers, APA District Branches and state psychiatric societies who are working on drafting or implementing legislation related to involuntary outpatient commitment. The Resource Document begins with a statement of key conclusions and recommendations based on a review of recent empirical findings and legislative developments. The body of the document contains a more detailed discussion of each issue.

Conclusions and Recommendations

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

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

3. Involuntary outpatient commitment should be available in a preventive form and should not be exclusively reserved for patients who meet the criteria for involuntary hospitalization. The preventive form

should be available to help prevent relapse or deterioration for patients who currently may not be dangerous to themselves or others (and therefore are not committable to inpatient treatment) but whose relapse would likely lead to severe deterioration and/or dangerousness.

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

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

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

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

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

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

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

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

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

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

outpatient basis.

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

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

Background

Throughout the U.S., there is a substantial population of persons with severe mental illness whose complex treatment and human service needs have not been met by community mental health programs. For many, their course is frequently complicated by non-adherence with treatment and as a result, they frequently relapse, are hospitalized or incarcerated (15). They also interact with a variety of human service agencies— substance use disorder treatment programs, civil and criminal courts, police, jails and prisons, emergency medical facilities, social welfare agencies, and public housing authorities. The pressing need to improve treatment adherence and community outcomes, has led policymakers to focus on a range of legal mechanisms to improve treatment adherence, including court-ordered treatment or involuntary outpatient commitment (3). As a result many states have focused on involuntary outpatient commitment as one of several tools to address high rates of treatment non-adherence.

Involuntary outpatient commitment is a civil court procedure wherein a judge orders a person with severe mental illness to adhere to an outpatient treatment plan designed to prevent relapse and dangerous deterioration (2-4). Persons appropriate for this intervention are those who need ongoing psychiatric care owing to severe mental illness but who are unable or unwilling to engage in ongoing, voluntary, outpatient care. It should be distinguished from 'conditional release,' a form of treatment wherein a patient committed to an inpatient hospital is released to the community but remains under the ongoing supervision of the hospital -- if the patient's condition deteriorates he or she can be returned to the hospital (see Figure 1.). Additionally, there are three types of involuntary outpatient commitment: 1) the most common type is outpatient commitment as part of a discharge plan from an involuntary hospitalization; 2) an alternative to hospitalization for patients who otherwise meet the criteria for involuntary hospitalization; and 3) a 'preventive' treatment for those patients who do not presently meet criteria for inpatient hospitalization, but who are in need of treatment to prevent such decompensation. Orders initiated as a 'stepdown' from involuntary inpatient commitment (Type 1) are often later renewed as a method to prevent relapse (Type 3).

Figure 1. General types of involuntary outpatient commitment

Type 1	Post-discharge involuntary outpatient commitment plan unattached to hospital supervision
Type 2	Alternative to hospitalization for those meeting civil commitment criteria but for whom outpatient commitment is sufficient
Type 3	Preventive treatment for individuals who do not meet criterial for inpatient hospitalization but are in need of treatment to prevent decompensation

Although recently enacted statutes use the term 'assisted outpatient treatment', other phrases, such as 'mandatory outpatient treatment', 'community treatment orders' or 'involuntary outpatient commitment,' are also in use. The phrase "involuntary outpatient commitment" implies a more coercive approach than is envisioned by proponents of judicial treatment orders, however the term 'assisted outpatient treatment' is sometimes criticized as euphemistic. In practice, these legal devices are intended to reinforce the patient's own resolve to adhere to a treatment plan while marshalling the resources of local mental health authorities to more effectively serve the patient. In this Resource Document, the phrase 'involuntary outpatient commitment' will be used. In addition with a few exceptions the Document will focus on U.S. experience

with outpatient commitment.

Studies on the Effectiveness of Involuntary Outpatient Commitment

The empirical data on outpatient commitment in the U.S. broadly consists of two groups of studies (2, 4). The 'first-generation' studies, conducted prior to the mid-1990s, are largely observational or quasi-experimental in nature. They have been critiqued on a variety of methodological grounds, including the comparability of committed and non-committed observed groups, the comparability of treatment received, the variability of outcome measures across studies, the limited use of statistical controls and potential selection bias inherent in naturalistic studies selecting for candidates thought likely to succeed under involuntary outpatient commitment (21). Nevertheless, these studies, taken as a whole, suggest that outpatient commitment can be effective in reducing re-hospitalizations and improving other outcomes when effectively implemented, adequate services are provided and the programs have the support of the treatment providers (9).

Since the mid-1990s, several 'second-generation' studies of outpatient commitment have been conducted (4, 12-14, 16-20). These studies attempted to control for potentially confounding factors such as selection bias, varying intensity of treatment across patients and various sources of coercion designed to enhance treatment adherence. Most importantly, these studies sought to determine whether the court order itself was necessary, that is, whether the court order itself improves treatment outcomes over and above the effect of the provision of a well-designed and coordinated treatment plan.

The Duke Mental Health Study in North Carolina was the first randomized controlled trial of outpatient commitment (13, 16, 22). Under the study design, consenting hospitalized patients with severe mental illness who were being discharged from the hospital under a previously authorized outpatient commitment order were randomly assigned to remain on the outpatient commitment order while provided case management ('OPC' group) or be released from the order and receive case management services alone (the 'control' group). An additional group of patients with a recent history of serious violence also leaving the hospital on outpatient commitment were placed in a nonrandomized comparison group while staying on outpatient commitment (owing to ethical considerations that precluded them from being assigned to the control group). Involuntary medication is not authorized for patients under outpatient commitment in North Carolina. The outpatient commitment group was significantly less likely than the control group to be re-hospitalized in the 12-month follow-up period in repeated measures analyses examining the likelihood of re-hospitalization each month. In addition patients who underwent sustained periods of outpatient commitment for 180 days or more had 57% fewer admissions and 20 fewer hospital days over the study period compared to controls (16). Moreover, sustained outpatient commitment was shown to be particularly effective for patients suffering from non-affective psychotic disorders (72% decrease in readmissions and 28 fewer hospital days) (16). In further analyses they reported that sustained outpatient commitment was most effective when combined with frequent outpatient services (a median of three or more services per month), thus emphasizing the need to combine the court order with frequent outpatient services (16).

The outpatient commitment group also had lower rates of violent behavior (22). During a one-year follow-up period patients who underwent sustained periods of outpatient commitment had significantly fewer violent incidents in the community as compared to patients who were released from outpatient (control group) and to patients who underwent shorter periods of commitment (23% versus 37% and 40% rates of violence, respectively) (22). The authors also found that patients who underwent sustained

outpatient commitment and frequent outpatient services and who additionally abstained from substance use and were adherent with medications, had the lowest likelihood of any violence (13% predicted probability versus 53% predicted probability for patients who did not undergo regular, sustained outpatient commitment, misused substances and were medication non-adherent) (22). The authors also reported that patients who received sustained outpatient commitment had significantly lower total treatment and criminal justice costs (13).

Another randomized controlled trial of mandatory outpatient commitment was conducted in New York City (17). In 1994, the New York State legislature passed a bill providing for a three-year pilot project of involuntary outpatient commitment at Bellevue Hospital in New York City for a target population of patients with severe mental illness and contracted with Policy Research Associates, Inc. to evaluate the pilot program. Substantively, the program provided for a range of intensive outpatient treatment, including assertive community treatment or intensive case management. During the 11-month follow up period, inpatients at Bellevue Hospital who were deemed appropriate for outpatient commitment were randomized to receive intensive community treatment with a court order ("outpatient commitment") or intensive community treatment alone ("control"). The investigators found no statistically significant differences between the outpatient commitment and control groups in re-hospitalization or number of hospital days during the study period (17). However, both groups experienced a significantly fewer re-hospitalizations during the study period than during the year preceding the target admission (17). The authors of the study concluded that, although the court order itself did not seem to produce better patient outcomes, "the service coordination/resource mobilization function of the program seemed to make a substantial positive difference in the [patients'] experiences" (17). Observers of this study noted that, under the pilot program, no enforcement of the orders for non-adherence was available in NYC and that the study sample was likely too small to have detected meaningful difference between study groups. Another study reported that many participants in the control group receiving intensive service but no court order thought they were under a court order as well (23).

In August, 1999 the New York State legislature enacted a statewide outpatient commitment statute that required reauthorization in five years. It termed the program as 'assisted outpatient treatment' rather than 'involuntary outpatient commitment' and differs from the pilot program in that treatment can be court-ordered in a preventive form without a current hospitalization, and prohibited forced medication for non-adherent patients (18).

Several subsequent evaluations of New York's Assisted Outpatient Treatment program have been conducted since the statewide AOT statute went into effect. An evaluation of the program was conducted by the New York State Office of Mental Health in 2005 (18) and found an 89% increase in use of case management services among AOT recipients, and substantial increases in the use of substance use disorder treatment and housing support services. They also reported significant improvements in self-care and community functioning and a 44% decline in the incidence of harmful behaviors (e.g., suicide threats, self-harm, and harm to others). They also reported that rates for hospitalizations, homelessness, arrests, and incarcerations declined significantly (18).

A subsequent independent evaluation of the program ordered by the state was conducted by Duke University, Policy Research Associates, Inc. and the MacArthur Research Network on Mandated Community Treatment (14, 19, 24). Several sources of administrative data were linked to examine whether recipients under Assisted Outpatient Treatment experienced reduced rates of hospitalization, reduced length of stay and other related outcomes (24). Multivariable analyses controlling for relevant covariates were used to examine the likelihood that assisted outpatient treatment produced these effects. The investigators reported that the likelihood of psychiatric hospital admission was significantly reduced

by approximately 25% during the initial 6 month court order and by over one-third (during a subsequent 6 month renewal period compared to hospitalization records before initiation of the court order) (19,24). Similar significant reductions in days of hospitalization were evident in initial and subsequent renewals of court orders. Improvements were also evident in receipt of psychotropic medications and intensive case management services. The study concluded that assisted outpatient treatment recipients appeared to experience a number of improved outcomes: reduced hospitalization and length of stay, increased receipt of psychotropic medication and intensive case management services, and greater engagement in outpatient services. The study reported: "On the whole, AOT recipients and non-AOT recipients have remarkably similar attitudes and treatment experiences. That is, despite being under a court order to participate in treatment, current AOT recipients feel neither more positive nor more negative about their mental health treatment experiences than comparable individuals who are not under AOT. This suggests that positive and negative attitudes about treatment during AOT are more strongly influenced by other experiences with mental illness and treatment than by recent experiences with AOT itself (24)." The report also evaluated reports of racial bias in selection of patients for assisted outpatient treatment. Since 1999 about 34% of AOT recipients have been African-Americans who make up only 17% of the state's population. However, the vast majority of AOT cases are clustered in New York City where 25% of the population is African American. The report documents that individuals eligible for AOT are largely drawn from a population where blacks are overrepresented: psychiatric patients who have had multiple hospitalizations in public facilities. Among those *eligible* for AOT by dint of this hospitalization history, African Americans are represented roughly on par with the demographic profile of those other demographic groups who are eligible. That is, racial differences in receipt of assisted outpatient treatment reflect the demographics of persons who are eligible for assisted outpatient treatment (24). Other reports from this and other evaluations found reduced arrests for AOT participants and sustained improvements in reduced hospitalization after recipients left the AOT program (25).

Critics of this study argue that only randomized controlled studies and control of selection bias offer definitive evidence of the effectiveness of outpatient commitment and that the 'before-after' nature of these studies are subject to 'regression to the mean', whereby patients identified in their relapsed states might naturally return to their baselines, seemingly improved by the intervention. The investigators countered that this effectiveness study evaluated a 'real-world' program, employed rigorous quasi-experimental methods, including propensity score adjustments, to evaluate the experience of several thousand persons—far more than a randomized trial might reasonably recruit (9).

A follow-up cost analysis of the program using administrative, budgetary, and service claims data was conducted for 36 months of observational data from assisted outpatient treatment and voluntary recipients of intensive community-based treatment in New York City and 5 counties elsewhere in New York State (14). Using multivariable time-series regression analysis, controlling for relevant covariates, the investigators reported that in the New York City assisted outpatient treatment group, net costs declined 43% in the first year after assisted outpatient treatment began and an additional 13% in the second year. In the 5-county assisted outpatient treatment group, costs declined 49% in the first year and an additional 27% in the second year (14). Regression analyses showed significant declines in cost associated with both assisted outpatient treatment and voluntary participation in intensive services, though the assisted outpatient treatment-related cost declines were about twice as large as those seen for voluntary services. They concluded that AOT requires a substantial investment of state resources, but can reduce overall service costs for individuals with serious mental illness.

The Oxford Community Treatment Order Evaluation Trial (OCTET) conducted in the United Kingdom, was the third randomized trial of outpatient commitment's effectiveness (20). In OCTET, individuals who were involuntarily hospitalized were randomly assigned to be released in one of two study conditions. The

experimental condition consisted of a community treatment order, the U.K. equivalent of assisted outpatient treatment authorized under the 2007 Mental Health Act. The control condition consisted of an authorized 'leave of absence from hospital,' a form of conditional release authorized under Section 17 of the U.K.'s 1983 Mental Health Act. The primary outcome for the OCTET trial was whether or not the person was readmitted to the hospital during the 12 month follow-up period. Secondary outcomes included length of time to the first readmission, number of readmissions, total amount of time spent in hospital, clinical functioning, and social functioning. No significant differences were found across any of the outcomes at the 12 month follow-up (20). While this trial seemed to provide evidence of the lack of benefit of outpatient, commitment critics of this study suggest that it was not a clear replication of the previously conducted RCTs in the U.S. because OCTET lacked a true 'voluntary' treatment arm (26-29).

After several generations of studies, evaluations, legislative and systematic reviews of the evidence for involuntary outpatient commitment, there is no clear consensus about it effectiveness across different jurisdictions, including a recent Cochrane review (9, 12, 30). The evidence on the effectiveness is mixed, with effectiveness largely a function of systematic and effective implementation, the availability of intensive community-based services and the duration of the court order. However, rather than framing the question as to whether outpatient commitment orders 'are effective' –as if comparing Drug A to Drug B--it appears to be more appropriate to ask, "under what conditions, and for whom, *can* involuntary outpatient commitment orders be effective?" This Resource Document identifies the elements that can optimize its effectiveness.

Criteria for Involuntary Outpatient Commitment

Because of the liberty interests at stake under any scheme of involuntary outpatient commitment, it should be ordered by a court only after a hearing at which the judge finds, on the basis of clear and convincing evidence, that the patient meets the statutorily-prescribed criteria for involuntary outpatient commitment. Based on a review of the literature and statutes, this Resource Document proposes the following criteria as necessary and appropriate to limit the use of involuntary outpatient commitment to individuals who have demonstrated a strong probability of relapse and deterioration by their behavior and clinical histories. The criteria are listed below, followed by commentary on several of the key elements.

A person would be eligible for involuntary outpatient commitment if:

1. The person is suffering from a severe mental disorder [e.g., an illness, disease, or other condition that (a) substantially impairs the person's thought, perception of reality, emotional process, or judgment, or (b) substantially impairs behavior as manifested by recent disturbed behavior]; and

2. In view of the person's treatment history, the person now needs treatment in order to prevent a relapse or severe deterioration that would predictably result in the person becoming a danger to himself or others or becoming substantially unable to care for him or herself in the foreseeable future and/or meeting the state's inpatient commitment criteria in the foreseeable future; and

3. As a result of the person's mental disorder, he or she is unlikely to seek or voluntarily adhere to needed treatment; and

4. The person has been hospitalized or admitted to a crisis facility for treatment of a severe mental disorder within the previous two years and has failed to adhere on more than one occasion to the prescribed course of treatment after discharge; and

5. An acceptable treatment plan has been prepared which includes specific conditions with which the patient is expected to adhere, together with a detailed plan for reviewing the patient's medical status and

for monitoring his or her adherence with the required conditions of treatment; and

6. There is a reasonable prospect that the patient's disorder will respond to the treatment proposed in the treatment plan if the patient adheres to the treatment requirements specified in the court's order; and

7. The physician or treatment facility which is to be responsible for the patient's treatment under the commitment order has agreed to accept the patient and has endorsed the treatment plan.

The major purpose of involuntary outpatient commitment is to facilitate effective treatment of persons with mentally illness before their conditions deteriorate to the point where they relapse and are unable to live safely in the community. This goal is best served by substantive standards for involuntary outpatient commitment based chiefly on the need for and the availability of appropriate treatment to prevent substantial mental or emotional deterioration. Several statutes permit outpatient commitment of patients who currently may not be dangerous to themselves or others (and are not therefore committable to inpatient treatment), but whose predictable deterioration would lead to such dangerousness. For example, the New York statute criterion is: "In view of the patient's treatment history and current behavior, the patient is in need of involuntary outpatient commitment in order to prevent a relapse or deterioration which would be likely to result in serious harm to the patient or others (24)."

Several states like New York require that predictions of a "likely deterioration leading to dangerousness" be based on past treatment records. This approach has the virtue of providing specific evidence of past behavior, however the burden of obtaining certified treatment records – as is the case in New York - creates unnecessary procedural barriers to effective use of involuntary outpatient commitment. Attestation by the examining physician or psychologist to the requisite clinical history of hospitalization or dangerousness is preferable for documentation of the treatment history.

The suggested criteria also require development of a treatment plan that includes specific conditions with which the patient will be expected to adhere. The treatment plan should specify components of the patient's care, including classes of medications and other aspects of the treatment. It should also specify which substantive changes in treatment require court review in order to afford flexibility in treatment approaches and to avoid unnecessary hearings on adjustments to the treatment plan that are not substantive, in nature. Additionally, since a number of studies have shown that a large proportion of patients brought for psychiatric treatment also suffer from significant medical illness (31) - some of which are causally related to their psychiatric symptoms - a thorough medical examination should be a required component of outpatient commitment to psychiatric treatment. Clinical judgment should be employed in determining when, where, and how such examination is carried out.

The criteria require that the proposed treatment plan include services adequate to successfully treat the patient. Several authors have pointed out that effective outpatient treatment, whether voluntary or involuntary, presupposes the availability of the resources necessary to implement community-based treatment under involuntary conditions that may not be forthcoming. Many observers fear that involuntary outpatient commitment might authorize increased control by the mental health system, without the benefits of treatment to justify the intrusion (3, 8). These arguments are well-grounded in the history of involuntary commitment in general, and any system of involuntary outpatient commitment must provide both increased protections for those at risk, and increased resources to guarantee that effective treatment can be provided.

Clinicians who are expected to provide the involuntary outpatient commitment plan and court testimony must be directly involved in the decision-making process and the development of the treatment plan. Before involuntary outpatient commitment is ordered, the judge should be satisfied that the recommended course of treatment is available through the proposed providers and has a high likelihood of being

effective. These requirements, if taken seriously, would prevent the arbitrary use of commitment as a form of social control, a use of commitment laws that arouses opposition to the expanded use of involuntary outpatient commitment. Such requirements also would involve the outpatient providers directly in the planning of the treatment. Some of the most vocal critics of involuntary outpatient commitment have been clinicians at outpatient facilities who have feared they would be inundated with uncooperative patients who would not benefit from any treatment available at the facility, but for whom the facility would be held responsible.

By requiring that a treatment plan be presented to the hearing officer before outpatient commitment may be ordered, judges would be able to make better informed decisions and outpatient clinicians would be able to exercise appropriate control over which patients are committed to them and under what treatment conditions. The patient should also be provided with a copy of the treatment plan so that he/she will be aware of the conditions with which he/she will be expected to comply. A plan for involuntary outpatient commitment should also take into consideration any reasonably possible alternative treatments preferred by the person, as potentially expressed in an advance directive. For example, New York's Assisted Outpatient Treatment law specifies: "If the subject of the petition has executed a health care proxy, the appointed physician shall consider any directions included in such proxy in developing the written treatment plan (24)."

If outpatient treatment is to be ordered on release from inpatient treatment, information sharing between inpatient and outpatient treatment staffs should be authorized and not be prohibited by any regulations governing confidentiality.

Length of Treatment

Since the patients for whom involuntary outpatient commitment is most effective generally suffer from chronic or recurring disorders, it is important that the statutes allow for continued extensions of commitment, based on specified grounds to be demonstrated at regularly scheduled hearings. Brief, time-limited periods of involuntary outpatient commitment are unlikely to be effective with these patients; the conditions which required the initial commitment order are quite likely to continue for significant periods of time. As noted above, the North Carolina and New York experiences indicates that benefits of mandatory outpatient treatment are realized when patients participate in the program for an extended period of time (180 days) (16, 24). During all hearings on extensions of commitment, the court must find, on the basis of clear and convincing evidence, that the patient continues to meet all criteria for involuntary outpatient commitment; otherwise, the patient must be released from the court order.

Response to Non-adherence

Formulating reasonable procedures for enforcing adherence to an involuntary outpatient commitment plan is a challenging task. The treating clinician should attempt to obtain the patient's voluntary adherence with the treatment plan. After reasonable effort is exerted, however, if the patient remains substantially non-adherent, the statute must contain a mechanism for some intervention to promote adherence. One option is to include in the commitment order an explicit authorization for law enforcement officers to transport a non-adherent patient for further evaluation upon receiving notice from the responsible clinician. The patient would be transported to the outpatient facility for a short period of time for evaluation, where it can be hoped that the patient will be persuaded to accept the prescribed treatment without requiring another hearing. This is the statutory scheme in several jurisdictions, including the District of Columbia and Utah. Alternatively, the law could provide that police custody may be asserted only on the authorization of a judicial officer, upon a reliable and adequate showing of non-adherence by the responsible clinician. This

is the strategy employed by Georgia and North Carolina, where the treating clinician can petition the court for an order authorizing a peace officer to take the patient to the treating facility or the nearest emergency room for evaluation. In New York City, a Citywide Assistance Team (CAT) is deployed to transport the patient to a hospital emergency room for evaluation.

In sum, it is important for involuntary outpatient commitment statutes to ensure that the treatment orders empower and mandate a crisis team such as a CAT or law enforcement officers to transport non-adherent persons for evaluation upon notification from the treatment providers. In addition, law enforcement officers should be carefully educated about the need for an expedient response to non-adherence in order to forestall their resistance to involvement. Law enforcement acting on these court orders may benefit from training on trauma-informed approaches as well as strategies for intervention and de-escalation of individuals with mental illness.

Beyond whether this function of law enforcement transport is provided for by statute, however, the statute must also authorize treatment providers to petition the court for a supplemental commitment hearing in the event of substantial non-adherence. At that hearing, the court should have three options: it could continue the involuntary outpatient commitment if the patient continues to meet all the statutory criteria and the court finds that it remains appropriate (with any modifications necessary to the treatment plan, as discussed and developed by the patient and his treatment team); it could order involuntary admission to the hospital if the patient meets inpatient commitment criteria; or it could discharge the patient from involuntary outpatient commitment.

The statute should also specify what liability protections are afforded clinicians involved either in seeking an order or treating a patient under involuntary outpatient commitment. Outpatient clinicians should not be subject to greater liability for treating patients under involuntary outpatient commitment. Fears of increased liability could generate inappropriate pressures and further discourage clinicians from agreeing to accept patients under judicial mandates.

If involuntary outpatient commitment is to be ordered, solutions to administrative problems -- including political, financial and legal barriers to the transfer of and accountability for patients between facilities and providers, and the continuity of their care -- must be explicitly provided in any enabling legislation or regulations. Such provisions may be necessary because different facilities and providers may be funded and/or operated by different state, county or private entities. In addition, the spread of public and private managed care plans may provide unique financial barriers to implementation of involuntary outpatient commitment. For example, payment for an involuntary outpatient commitment plan might not be fully authorized under managed care utilization review that requires medical necessity criteria are met and under some privatization schemes where the authority and responsibility for involuntary outpatient commitment may be unclear and should be addressed in any enabling legislation or regulations. Separate from the financial considerations the capacity to transfer information between facilities and providers should be unimpeded. Statutory changes may be required to overcome existing regulations designed to protect patient privacy by preventing disclosures of information without explicit voluntary consent.

The Issue of Involuntary Medication

Since involuntary outpatient commitment often works most effectively with patients who do well on psychotropic medications but repeatedly are non-adherent, the initial hearing should determine the role of medications as part of the treatment plan. Successful involuntary outpatient commitment programs need some legal authority to promote treatment adherence. Statutes generally do not authorize forced medication without a separate legal determination of involuntary medication. All techniques short of force should be

used to promote adherence. For example, the judge or hearing officer should make it clear that (if it is so decided) taking medications will be expected of the patient, and the taking of prescribed medication should be specified as one of the patient's obligations in the court order. If the patient does not adhere to court-ordered medication, that fact should be sufficient evidence of lack of adherence with the treatment plan for the patient to be taken to the outpatient treatment facility for re-evaluation. Once at the facility, the medication could again be offered to the patient, even if it would not be involuntarily administered if refused. It is likely that the prospect of repeated involuntary visits to the treatment facility would result in medication adherence for many patients. Moreover, a study in North Carolina indicates that, in spite of the fact that the statute does not authorize the involuntary administration of medication, most patients do believe that mandatory outpatient treatment requires medication adherence (32).

In summary, psychotropic medication is an essential part of treatment for most patients who are appropriate for involuntary outpatient commitment. The expectation that a patient take such medication should be clearly stated in the patient's treatment plan, and proactive measures should be taken to promote adherence. However, the involuntary administration of medication should not be authorized as a consequence of refusal to take medication as prescribed without subsequent review consistent with the state's process for authorizing involuntary administration of medication.

The Issue of Potential Racial Disparities

Several advocacy organizations, including the New York Lawyers for the Public Interest, have raised concerns that African Americans and other minorities are over-represented in programs such as NYS's AOT program (33). Whether this potential over-representation is unfair and represents racial discrimination rests, in part, on whether AOT is regarded as beneficial or detrimental to persons under court order. The concern over any potential over–representation of minorities in the program raises over-arching policy questions of whether AOT is regarded as a positive mechanism to improve access to services, outcomes for an under-served population and as a less restrictive alternative to involuntary hospitalization, or as a program without benefit that subjects minorities to a further loss of civil liberties. As discussed previously rates of AOT by race shows about 34% of AOT recipients have been African-Americans who make up only 17% of the state's population. However, racial differences in rates of AOT largely mirror the rates of eligibility for AOT among different minority groups. The New York AOT evaluation report concluded: "We find no evidence that the AOT Program is disproportionately selecting African Americans for court orders, nor is there evidence of a disproportionate effect on other minority populations (24, 34)." The research on this issue is limited to a single jurisdiction. As a result, independent evaluation of involuntary outpatient commitment programs should be conducted at regular intervals and reported for public comment and legislative review, especially in view of concerns about its appropriate use. Among several outcomes that should be assessed is any evidence of disproportionate use of involuntary outpatient commitment among minority groups and disenfranchised groups, inadequate due process protections and the diversion of clinical resources from patients seeking treatment voluntarily. Any indications of findings in these areas should be followed by program improvement plans and corrective action.

Conclusions

Involuntary outpatient commitment has received increasing public attention, owing in large part to occasional, highly publicized incidents of violence by persons with severe mental disorders who are non-adherent with treatment, and to other difficulties posed by the 'revolving-door' patients who suffer from severe mental illnesses and who are difficult to engage in ongoing treatment. Over the past twenty

plus years, as discussed in this Resource Document, the body of scientific literature on the effects of involuntary outpatient commitment has grown considerably, and many jurisdictions have enacted or are considering enacting outpatient commitment statutes.

This Resource Document supports the view that involuntary outpatient commitment can be effective when systematically and effectively implemented, linked to intensive outpatient services and prescribed for extended periods of time. Clinical experience in a number of jurisdictions provides further support for these conclusions. Second, there is no evidence that a judicial order reduces or undermines the positive effects of enhanced treatment; the only question is whether it has additive effect - and the existing studies suggests that it does. Third, there is clear evidence that enacting and implementing involuntary outpatient commitment concentrates the attention and effort of the providers; that is, the judicial order may help to enhance the services by 'committing' providers to the patients' care. Finally, enacting involuntary outpatient commitment may also help to 'commit' legislatures to provide the funding needed to provide enhanced community services for all patients, whether or not they are subject to a commitment order. In a political context, involuntary outpatient commitment may provide the leverage for increased funding for community mental health services, and particularly for persons with severe mental illnesses.

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Position Statement on Patient Access to Electronic Mental Health Records
Draft September 15, 2015

Systems that provide patients with online access to their mental health records should implement appropriate procedures and safeguards. These include:

(a) methods for ensuring that treating psychiatrists in the system are notified when patients access their records,
(b) methods for ensuring that information likely to result in harm to the patient or others will not be disclosed,
(c) methods for ensuring that information provided in confidence by third parties will not be inadvertantly disclosed,
(d) methods for facilitating patients' comprehension of disclosed information, and
(e) methods for ensuring that current inpatients may only access their records in consultation with the attending psychiatrist.

Background

"Health records" refers to evaluations, progress notes, discharge summaries, and other clinical documentation that is created by health professionals for the purpose of evaluation and treatment for a specific patient. As established by law, patients have a right to access their health records.[1]

Health care systems, including the Veterans Administration health care system, have begun to allow patients to access their treatment records online. This development has raised concerns.

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[1] The HIPAA Privacy Rule provides an exception to patients' right to access for "psychotherapy notes." As defined by the Rule, psychotherapy notes are those notes made by mental health professionals documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. To qualify as psychotherapy notes, the documentation must exclude information regarding medication prescription and monitoring, counseling session start and stop times, the modalities of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. HIPAA-defined psychotherapy notes are not equivalent to psychotherapy progress notes - they are akin to process notes. State laws may grant patients the right to greater access; psychiatrists should familiarize themselves with the laws of their jurisdiction.

In the past, patients' access to their medical information required physical access to a paper record. Typically, patient access would occur following a request to an individual psychiatrist or, in institutional settings, the medical records department. Medical records departments generally have followed the practice of obtaining the treating psychiatrist's approval prior allowing patients access. In many settings, the treating psychiatrist or a colleague would be present or available while the patient reviewed their information. These procedures provided an opportunity for the psychiatrist to review the available records, to restrict access to information as appropriate, and to be available to address questions, concerns, or emotional reactions that may arise.

The establishment of electronic medical records in some medical care systems has led to the availability of online access to personal medical records.

Patient access to information may benefit the therapeutic process in a number of ways:

- Online access provides a written source of information to patients about their care that can serve as valuable aid to memory. Patients can review the directions and other information from prior visits. This may lead to improvements in patient education and compliance.
- Access to the records provides an opportunity for patients to review documentation for accuracy and completeness.
- Ready patient access to records may promote active patient engagement in treatment. In reviewing the records, patients may gain a greater understanding of the information their psychiatrists have conveyed to them. The documentation may provide additional perspectives regarding their diagnoses, treatments, and treatment options. As a result, patients may have questions to discuss with their psychiatrists. Such discussions are important therapeutic opportunities that provide the psychiatrist with insight into their patients' hopes, fears, and concerns about their illness, treatment, and prognosis.
- Patients may use online access to facilitate the transfer of information from a past treatment episode to a new treating clinician. This may be an important as a means of providing continuity of care. Also, in emergencies, online access may be a means of conveying critical information.
- Online access to past records may be valuable to patients who have become estranged from care. Patients who review past treatment records may gain insight that will prompt them to seek ongoing care.

However, there are potential problems with online access to psychiatric records that require safeguards. These safeguards are discussed below:

(a) There should be methods for ensuring that treating psychiatrists in the system are notified when patients access their records

Electronic medical record systems with online portals enable patients to access their medical records, in any location, and at any time. As a result, psychiatrists may not be aware that their patients have accessed records. In some cases, patients may be affected by what they have read; their attitude toward treating psychiatrists and treatment may be changed. In the absence of notification of patient access, psychiatrists may miss the opportunity to clarify misunderstandings. As a result, the therapeutic relationship may be adversely affected. Psychiatrists should be notified when their patients access records.

(b) There must be methods for ensuring that information likely to result in harm to the patient or others will not be disclosed

Some patients may have extremely negative reactions to the recorded information to such an extent that their life or safety, or the life or safety of someone else, may be endangered. Medical records systems that permit online patient access should allow for this sort of sensitive information to be protected from viewing.

(c) There should be methods for ensuring that information provided in confidence by third parties will not be inadvertantly disclosed

Patients may get inappropriate access to information. For example, a family member or other party may have given the psychiatrist information regarding the patient under the promise of confidentiality. Record systems that are accessible to patients should have the capability of blocking this information from viewing.

(d) There should be methods for facilitating patients' comprehension of disclosed information

Patients who access records may be confused by what they read or misinterpret documentation. Confusion may be lessened if the patient has ready access to online sources of information regarding psychiatric terminology and abbreviations commonly used in medical records. However, they may be no adequate substitute for a psychiatrist's explanation of the clinical notes and related documentation. The treating psychiatrists, of course, will be the best guides for their patients. Treating psychiatrists can explain their intents in writing the documentation and how they employed medical terminology and abbreviations in context. Systems should include information about abbreviations and terms. As previously discussed above, treating psychiatrists should be notified so that they can follow up with their patients to address any questions.

(e) There should be methods for ensuring that current inpatients may only access their records in consultation with the attending psychiatrist

In some settings, it may be possible for inpatients to access their records during the course of hospitalization. Given the probability that psychiatric inpatients are acutely ill, and that the information accessed will include recent notes by psychiatrists, nurses, and other staff that may be disturbing to patients during acutely symptomatic periods, immediate access should not be routinely granted. As psychiatrists and other treatment staff are readily available, access should be granted by clinical discretion and, when deemed necessary, under the supervision of treatment providers. In cases in which there are disputes about access, resolution via mechanisms such as patients' ombudsmen, offices of patients' rights, or similar bodies should be available.

Documentation

If safeguards are not in place to prevent inappropriate access to information, clinicians may intentionally restrict the scope and detail of documentation to that which is minimally necessary. As a result, allied caregivers and subsequent treating psychiatrists may not have access to a rich record of treatment. This unintended outcome may be prevented by ensuring that electronic health records provide a mechanism to maintain highly sensitive information in a domain that is not generally accessible to patients through online access. Documenters need to be sensitive about language and clinical descriptions within their documentation. Additional education about patient-sensitive documentation may be necessary.

Developed by the Workgroup on Access to Mental Health Records, Council on Psychiatry and Law. Grace Lee, MD (Chair), Elizabeth Ford, MD, Mark Komrad, MD, Steven Daviss, MD, Andrea Stolar, MD, Jenny Boyer, MD, Richard Milone, MD, and Brenda Jensen, MD.

Position Statement on Trial and Sentencing of Juveniles in the Criminal Justice System

Juvenile justice systems in the United States are undergoing substantial reform based on impressive advances in neurobehavioral understanding of adolescent development and on strong evidence regarding the effectiveness of developmentally grounded interventions. This body of knowledge has been summarized in a landmark report of the National Research Council (2013) and referenced by the Supreme Court in important decisions banning the juvenile death penalty (*Roper v. Simmons*, 2005) and severely restricting sentences of life without parole (*Graham v. Florida*, 2010; *Miller v. Alabama*, 2012). Despite these developments, statutes in many states permit or even require adolescents charged with crimes to be tried in criminal courts as adults, thereby becoming exposed to substantial terms of imprisonment

It is the position of the American Psychiatric Association that juvenile courts should have exclusive original jurisdiction in all cases in which individuals less than age 18 have been charged with a criminal offense. The law should presume that the youth will remain within the jurisdiction of the juvenile court unless the prosecution presents a clear and convincing case for transferring the case to the criminal court. Transfer should be permitted only if a youth is older than 14 at the time of the offense, has been charged with a violent crime, and the juvenile court finds, based on individualized consideration of all of the circumstances, that the youth poses a significant risk of further offending and has demonstrated that he or she is not amenable to treatment with the range of clinically appropriate services that should be available to the juvenile justice system.

Background:

Juvenile transfer laws, also known as waiver or certification laws, transfer an individual less than age 18 and charged with an offense from the juvenile court system to the adult criminal justice system for trial and sentencing. There are three main transfer mechanisms: (1) judicial waiver laws that permit or mandate judges to decide, in accordance with statutory criteria, whether a youth should be removed from juvenile court jurisdiction and tried in adult court; (2) concurrent jurisdiction laws that authorize prosecutors to file a case in criminal court; and (3) statutory exclusion laws that grant criminal courts original jurisdiction over juveniles who meet defined criteria (e.g. specific crime type committed by a youth of a particular age). Transfer laws of all types expanded significantly during the 1980s and 1990s and played a significant role in placing increasing numbers of youth in the adult criminal justice system (Hockenberry and Puzzanchera 2014).

The vast majority of adolescents with antisocial behavior desist from criminal behavior as they enter adulthood. Even serious juvenile offenders demonstrate an increasing ability to control

impulses, suppress aggression, consider the impact of their behavior on others, take personal responsibility for their actions, and resist the influence of peers between the ages of 14 and 25. (Steinberg, Cauffman, and Monahan 2015). Multi-faceted community interventions, both residential and non-residential, available to juvenile courts have been shown to reduce reoffending and to prodeuce remarkably large economic returns relative to their costs (National Research Council, 2013).

Potentially detrimental effects of transfer include a longer or harsher sentence than may have been experienced by the juvenile if maintained in the juvenile justice system, physical, sexual, or psychological victimization from adult inmates or correctional officers, and harmful disruptions in the youth's developmental progress and to the process of forming identity and a responsible, law-abiding person (Mulvey and Schubert 2012). In addition, many juveniles who are tried in adult court will have a higher recidivism rate when compared to similarly matched juveniles adjudicated in the juvenile justice system (National Research Council, 2013; Schubert et al 2010). Finally, transfer for less serious crimes may result in stigma combined with the substantial economic cost of housing juveniles with adult offenders.

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Position Statement on Adjudication of Youths as Adults in the Criminal Justice System

Approved by the Board of Trustees, December 2005
Approved by the Assembly, November 2005

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

The ostensible goals of transfer, or waiver, to the criminal justice system include: (1) deterrence of youth from committing crimes, (2) reduction in recidivism among youth who are transferred, and (3) improvement of public safety. However, instead of accomplishing their intended goals, waivers have seriously disrupted the lives of youth, and their families, especially those from minority communities. The federal government, in concert with states, should review and develop a strategy to reform current transfer/waiver practices. The general goals of such reform must be: to reduce the number of youth inappropriately transferred to the criminal justice system who could be better served by the juvenile justice system, to provide rehabilitation services that support the development of youth as valued members of society, and to ensure community safety. Reform should specifically include:

1. a moratorium on the expansion of eligibility criteria for transfer.
2. limiting transfer only to judicial discretion (or sole authority by judge).
3. an elimination of transfers for nonviolent offenders.
4. an elimination of transfer of first-time offenders.
5. the development of specialized facilities for transferred youth. Such facilities would include small living units that are secure and safe; programming that addresses the developmental, educational, health, mental health, religious, and other special needs of these youth; and
6. adequately staffed with qualified workers to ensure safety and specialized programming (Council of Juvenile Correctional Administrators, 2005).

Executive Summary

The Council on Psychosomatic Medicine (CPM) focuses on psychiatric care of persons who are medically ill and/or pregnant and works at the interface of psychiatry with all other medical, obstetrical and surgical specialties. It recognizes that integration of biopsychosocial care is vital to the well-being and healing of patients and that full membership in the house of medicine is essential for our profession.

The Council is mission-driven and prioritizes activities around the updated charge set forth by the APA Board of trustees in 2015. Since the May meeting, Council members have strengthened working relationships with the Council on Healthcare Systems and Financing and its' Workgroup on Integrated Care; the Council on Advocacy and Government Relations; the Council on Psychiatry and the Law; the Council on Geriatrc Psychiatry; and the Academy of Psychosomatic Medicine. The Council recently completed a report, *Dissemination of Integrated Care within Adult Primary Care Settings: the Collaborative Care Model,* requested by the Council on Healthcare Systems and Financing, on the roles and responsibilities of psychiatrists; continues to submit abstracts for psychiatric and primary medical meetings for sessions designed to address the educational needs of psychiatrists who treat patients with complex comorbidities; and is currently encouraging the development of resource documents on member areas of expertise, (eg bariatric surgery). Finally, the Council continues to advocate for the enhancement of training in psychosomatic medicine and recruitment of residents into fellowship.

Action Item Update

- Action Item 8K, 8.K.1:
  Will the Joint Reference Committee recommend that the Board of Trustees approve the completed report on identification of the roles and responsibilities of psychiatrists:
  Dissemination of Integrated Care within Adult Primary Care Settings: the Collaborative Care Model

Referral Updates

- Position statement development: Emergency Department Boarding of Individuals with Psychiatric Disorders (Item 6.13). Kim Nordstrom, MD, lead author, completed the draft position statement. The Council reviewed the document, suggested revisions and it was revised. The position statement is being reviewed by Council on Healthcare Systems & Financing, Council on Advocacy and Government Relations and Council on Psychiatry and the Law and awaiting revisions.
- Revision of Position Statement: Principles of End-of-Life Care for Psychiatry. (Item 8.E.3) The CPM and the Council on Geriatric Psychiatry have created a small work group to collaborate on re-drafting the position statement.

Attachments: (for Joint Reference Committee Report)

- Dissemination of Integrated Care within Adult Primary Care Settings: the Collaborative Care Model.
- Minutes of Meetings of the Council

MINUTES: Council on Psychosomatic Medicine APA September Component Meeting 2015
Friday, September 11, 9:00 am – 5:00 pm Hilton Crystal City, Blue Ridge Room, First Floor

Members Attending: Dave Gitlin, MD (chair); Linda Worley, MD (vice-chair); Madeleine Becker,MD; Philip Bialer, MD; Robert Boland, MD; Jim Bourgeouis, MD; Catherine Crone, MD; Barbara Koscis, MD; Cristina Montalvo, MD; Larry McGlynn, MD; Sara Nash, MD; Melanie Schwartz, MD; Peter Shapiro, MD; Erik Vanderlip, MD; Thomas Wise, MD; RFM Members: Carrie Cunningham, MD (Public Psychiatry Fellow); Danielle Hairston, MD (APA/SAMHSA Fellow); Rubiahna Vaughn, MD (APA/SAMHSA Fellow); **Members Excused:** Sanjeev Sockalingam, MD (was out of the country and submitted materials to be discussed in advance); and Yadira Alonso, MD; **Guests:** Renee Binder, MD; Maria Oquendo, MD; Saule Levin, MD; Steve Koh, MD; James Rundell, MD; Kim Nordstrom, MD (by phone); Jay Shore, MD; Andrew Saxon, MD; Ranna Parekh, MD; Tristan Gorrindo, MD; Daena Petersen, MD (Fellow who participated on HIV work group). **APA Staff Liaison**: Karen Sanders

Welcome

- Dr. Gitlin opened the meeting with introductions, conflict of interest disclosures, and an overview of meeting objectives. No conflicts of interest were reported.
- Dr. Gitlin briefed the group on a breakfast meeting of Council Chairs convened by Drs. Binder and Oquendo. Emphasis of the meeting was to encourage collaboration between and among councils. Council chairs in attendance provided a brief summary of current activity and priority areas.
- The charge of the Council was reviewed. The chair discussed the two phases of council work, reponse to actions and providing expertise. He also emphasized joint projects with other councils such Medical Education. A goal for the group is to enhance communication between psychiatrists and our colleagues in medicine.

Approval of May Minutes

- May minutes were approved after one correction.

Visits by President/President Elect

- Renee Binder, MD, APA President reviewed her initiatives including, ethics, mental health and the criminal justice system and telepsychiatry. She provided an overview of the future of psychiatry emphasizing new practice models such as integrated care while some psychiatrists will continue private practice all cash practices. She pointed out that fellow appointments to the Council are highly competitive and consequently those selected should be quite proud as they are the best and the brightest in the field. She encouraged the fellows to take on special projects and closed by thanking the Council members for their volunteer work.
- Maria Oquendo, MD, APA President-Elect spoke about her desire to increase the diversity of the organization and to train new leadership.

Other Visitors

- Jay Shore, MD, discussed his APA telepsychiatry work group. He raised many issues e.g. working within collaborative care models, licensure across states, rural and urban use, etc.
- Steve Koh, MD, Chair APA Scientific Program Committee. Dr Koh reviewed where the profession is going and how the annual meeting fits into the future of psychiatry. The CPM suggested creating an Invited Session for the authors of *Dissemination of Integrated Care Within Adult Primary Care Settings: the Collaborative Care Model*.
- Saul Levin, MD, CEO Medical Director, expressed his strong support for the work of the Council and the APM and asked how he can best help.. The fellows shared their views that the name

"Psychosomatic Medicine" is off putting and "no one knows what it means." They shared that it was a deterrant for medical students and residents entering the field. They also shared their views that the cases seen in the field are the "cool" ones and are the ones that convinced them that they wouldn't have to give up being a physician when they decided to enter the field of psychiatry. They felt this is a vital message to refine for the future. Dr. Levin strongly agreed that the name Psychosomatic Medicine was problematic and offered the support of the APA including consultation with the communications and branding arm of the APA when the time is right. The Council communicated that it will be essential for the APA to support the a name change when going to the ABPN.

Council Work Plan Initiatives

Action Items

- Identify the Roles and Responsibilities of Psychiatrists (Item 8. K; 8.K.1) The Council reviewed, made editorial suggestions and completed the report: *Dissemination of Integrated Care within Adult Primary Care Settings: the Collaborative Care Model*. It was sent to the Council for Healthcare Systems & Financing for review and was approved. The report is going to the JRC for approval. Additionally the Council discussed possible internal and external communications plans. External targets should include payers, the Kennedy Forum, and primary care associations.

Referral Updates

- Emergency Department Boarding of Individuals with Psychiatric Disorder (Item 6.13). The draft position statement was reviewed by Kim Nordstrom, MD, primary author. The background paper is complete. Members of the Council expressed concern that the position statement may overly emphasize the national issue of limited access to psychiatry and the need for careful wording. Another suggestion was to include language addressing the boarding of patients with mental health diagnoses on medical floors. These changes were made. The next step is review by Council on Healthcare Systems & Financing, Council on Advocacy and Government Relations and Council on Psychiatry and the Law.
- Revision of Position Statement: Principles of End-of-Life Care for Psychiatry. (Item 8.E.3) CPM and the Council on Geriatric Psychiatry have created a small work group to re-draft this position statement. Dr Buxton & Dr Bialer volunteered to be members of the work group.

Other Business

- Action Paper review of Psychiatric Bed Registries. The CPM did not support this Action Paper. The ED Boarding position statement will address the overarching issue of access and should include the Action Paper authors' concerns. Dr Gitlin communicated with the authors.
- A Bariatric Surgery resource document is under development by Dr Sockalingam. Obesity management is a second issue embedded with bariatric surgery. Additional volunteers were requested.
- Practice Guidelines Comments: The Draft Guideline on the Use of Antipsychotics to Treat Agitation and Psychosis in Patients with Dementia is open for comments through 9/19/2015. Dr Bourgeois and Dr Boland reviewed draft comments expressing concerns limiting access to antipsychotics for individuals who have been on them for a lifetime. Suggestions and revisions were made and submitted.
- HIV Steering Committee, led by Dr Glynn. The Committee reviewed three draft position papers. Specific suggestions were provided and revisions will be incorporated.
    - PS on HIV Infection Screening, suggested following CDC recommendations;
    - PS on HIV Stigma and Discrimination, a profound issue, CPM supports this statement;

    - PS on HIV and Criminalization, a controversial issue, can result in people not seeking treatment.
- ABPN Letter on re-certification for general psychiatry and subspecialies. After discussion by the Council the following comments were sent to Dr Gorrindo: the Council agrees that re-certification in general psychiatry should be an intrinsic part of recertification in the subspecialty and that this should be part of a single exam coordinated by the ABPN not by the candidate trying to coordinate two separate examinations. This exam would contain some items pertinent to updates in the general practice of psychiatry in addition to questions focused on the field of psychosomatic medicine.
- Psychiatrists Undertaking Freedom from Smoking (PUFFS):Presentation by Dr Saxon on the APA strategic plan for addressing tobacco use disorders in our patients. He is reaching out to the council as potential champions and future educational partners.

Relationships with Allied Organizations

Dr. Gitlin urged members to think about leveraging the partnership between APA and APM.

- Academy of Psychosomatic Medicine (APM). Dr. Crone, president APM, updated the group on APM initiatives emphasizing continued collaborations between APM & APA. She discussed potential strategies to address concerns about dues for both organizations. Dr Crone will request the Scientific Program Committee review APM's annual meeting content to identify Invited Speakers for APA's 2016 annual meeting.

Fellow Recruitment and Retention

- New fellows were welcomed to the Council and actively participated in the day's discussions.
- Recruitment into Psychosomatic Fellowships- Dr. Bialer reported last year 64 out of 93 slots were filled in the Match.
- A name change was suggested for psychosomatic medicine to improve perception and desirability of the subspeciality by medical students and residents. Dr. Gitlin and Dr Crone provided history on the topic and will re-examine this option through convening a group of leaders. Dr Levin and the APA will be supportive of APM desires on the issue.

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DISSEMINATION OF INTEGRATED CARE WITHIN ADULT PRIMARY CARE SETTINGS

THE COLLABORATIVE CARE MODEL

AMERICAN PSYCHIATRIC ASSOCIATION
ACADEMY OF PSYCHOSOMATIC MEDICINE

I. EXECUTIVE SUMMARY

The integration of behavioral health and general medical services has been the focus of intensive resources, planning and education efforts for at least a decade. Significant, high-quality scientific health services research spanning three decades has identified one model, in particular, as being effective and efficient in delivering improved outcomes for a population of patients with behavioral health disorders seen in primary care settings, while also controlling costs and improving access and satisfaction with care. Known as the Collaborative Care Model, it separates itself from other attempts to integrate behavioral health services through its wide adaptation and steady reliance on consistent principles of chronic care delivery, as well as attention to accountability and quality improvement.

Over time, through many large-scale adaptations encompassing thousands of patients, expert consensus has identified four essential elements of Collaborative Care. These include the provision of care that is 1) team-driven, 2) population-focused, 3) measurement-guided and 4) evidence-based. A Collaborative Care team is multidisciplinary, shares roles and tasks, and together is responsible for the health outcomes of their patients. As a whole, the team is focused on the entirety of their patient population, regardless of the patient's current level of engagement in treatment. The team is equipped with tools to help manage their population of patients efficiently, often conceptualized as a disease registry. Together, this team utilizes measurement-guided patient-centered outcomes to guide the delivery of evidence-based care in order to achieve "treat-to-target" clinical goals for each patient. These core processes, in aggregate, allow each team to be held accountable to the care they provide, and improve upon their processes of care to achieve better outcomes in cost savings, satisfaction, access to care and health for the patients and systems they serve.

Each of these core elements can be adapted to a variety of community settings, and this report highlights the background, eligibility requirements, adaptation of the essential elements, accountability and quality improvement efforts in five of the largest Collaborative Care implementations to date from the persons directly involved in their implementation. Lessons learned from these early adopter programs provide invaluable insights for systems seeking quality evidence-based "integrated care" solutions.

The American Psychiatric Association and the Academy of Psychosomatic Medicine, jointly represented in authorship of this report, are dedicated to advancing the scientific understanding of evidence-based integrated care by outlining the current state of knowledge in this complex field and advocating for productive dialogue surrounding these models through the publication of this report.

ACKNOWLEDGEMENTS, DISCLOSURES

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Disclosures

James Rundell, MD is a paid consultant for Quartet, LLC. A company providing informatics services to health care plans to facilitate integrated care in their networks.

The remaining contributors report no relevant financial disclosures.

Acknowledgements

The workgroup members wish to express sincere thanks to the Academy of Psychosomatic Medicine and staff at the American Psychiatric Association for their instrumental support throughout the creation of this manuscript.

This report is dedicated in loving memory to the spirit and passion of Dr. Wayne Katon, whose body of scientific evidence and character lives on.

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II. WORKGROUP BACKGROUND

A. Formation of Workgroup

At the American Psychiatric Association (APA) September Components meeting of 2014, several committees identified the need for APA policy and guidance for membership defining evidence-based standards of Integrated Care models and showcasing emblematic programs of robust Collaborative Care implementation. The Council of Psychosomatic Medicine (PSM), under the guidance of Dr. David Gitlin, and the Academy of Psychosomatic Medicine (APM), under the guidance of then President Linda Worley, convened a workgroup chaired by Drs. Rundell and Vanderlip to examine existing models and assist interested organizations with defining evidence-based integrated care implementations. Both organizations were concerned that emerging policy documents and implementation recommendations were often not sufficiently evidence-driven. It is important to address the increasing national interest in integrated care model dissemination through the best available data and experience.

B. Membership of Workgroup

Following further discussions, the Workgroup membership was specifically selected to represent several large-scale integrated care implementations nationally. This included psychiatric and non-psychiatric leadership from the following:

1) The University of Washington Advancing Integrated Mental Health Solutions (AIMS) Center (Marc Avery, MD, John Fortney, PhD)

2) The Veterans Health Affairs (VA) population (James Rundell, MD and John Fortney, PhD)

3) Active military/Department of Defense (Charles Engel, MD MPH)

4) The Minnesota DIAMOND (Depression Initiative Across Minnesota—Offering New Directions) project (Mark Williams, MD)

5) An Academic/University-Based Health System – The University of California, Davis (David Liu, MD)

Carol Alter, MD, provided additional representation from the Academy of Psychosomatic Medicine and APA Council on Healthcare Systems and Financing. Consultants providing oversight and guidance also included APA staff from the Office of HIV Psychiatry (Ian Hedges) and the Office of the CEO and Medical Director (Kristin Kroeger), as well as Lori Raney, MD, Chair of the APA Workgroup on Integrated Care. Drs. Gitlin and Crone were representatives from the APA PSM Council and the APM.

C. Charge of Workgroup

Beginning February 2015 the Workgroup convened a series of teleconferences. During the first teleconference, the group discussed the charge of the Workgroup and expected product and timeline of development. Issues discussed at length included the scope of the Workgroup report and how to conduct the review of evidence-based literature on integrated care models. At the conclusion of the first teleconference, there was considerable interest in producing a report that highlighted the importance of primary care integration through the Collaborative Care model. Drs. Rundell and Vanderlip reformatted the Workgroup charge to be inclusive of a range of implementations, while calling for consistency in definitions to be used in integrated care discussions and use of a common language commonly used when addressing essential components of Collaborative Care models. At the conclusion of the second teleconference call, an outline for the report was developed based on workgroup discussions and review of the literature. The workgroup elected to keep this report focused on integrated care models for mental health and primary care, though it is important to acknowledge that there is impressive evidence for the effectiveness of integrating mental health services with specialty medical-surgical care

(Sharpe et al 2014) and integrating medical and preventive services into specialty care of the seriously mentally ill (Druss et al 2000, 2002, 2010).

The workgroup's final charge was to produce a working set of principles defining evidence-based integrated care implementation based on review of published literature and expert consensus when sufficient evidence could not drive a recommendation. Adaptations of these principles through in-vivo implementations are highlighted. This product is intended to facilitate standardization of educational materials and messaging for APA and APM membership as well as policy-makers, external and allied organizations, health system partners, payers and the general public.

III. SUMMARY OF EVIDENCE FOR INTEGRATED CARE

The notion of integrated care encompasses a broad spectrum of health services interventions intended to blend primary care services with traditional mental health services. Integrating mental health into primary care settings, as well as the blending of primary and preventive medicine into traditional mental health settings represents a more holistic approach to treatment than the traditional consultative and referral models. Bringing mental health services to primary care normalizes and de-stigmatizes treatment for behavioral health disorders, simultaneously increasing access for patients by making evidence-based mental health services available in their regular primary care clinics. The delivery of primary care services to mental health settings can also overcome barriers to receiving medical and preventive care, offering increased convenience and familiarity with services. Merging mental health services within primary care services is more studied than the reverse; the science around effective health services delivery is greater for these models.

For models integrating mental health into primary care, mental health providers can impact the care of more patients than in the specialty mental health referral sector. Integrated mental health providers take on more consultative and team-based roles and focus on helping primary care providers treat mental health disorders, leveraging their skills and expertise to reach more patients in need. In addition, integrated care encounters are typically briefer and more problem-focused than traditional specialty mental health encounters.

The terminology around integrated care models is somewhat inconsistent and confusing. The terms "Integrated Care" and "Collaborative Care" have often been used interchangeably, while at other times these terms reflect subtle but important differences in approach. For this report, we define Collaborative Care as the embodiment of the model originally developed by Katon and colleagues at the University of Washington, demonstrated to be clinically effective in randomized control trials (W. Katon et al. 1995; W. Katon et al. 1996). Collaborative Care is a specific type of integrated care that operationalizes the principles of the chronic care model (E. Wagner 2001) to improve access to evidence based mental health treatments for primary care patients.

There is expert consensus that all effective Collaborative Care models share four core elements: 1) team-driven, 2) population-focused, 3) measurement-guided and 4) evidence-based. These four elements, when combined, can allow for a fifth guiding principal to emerge; accountability and quality improvement. Table 1 reviews the core elements of Collaborative Care implementation. Collaborative Care is *team-driven*, led by a Primary Care Provider (PCP) with support from a Care Manager (CM) and consultation from a Psychiatrist who provides treatment recommendations for patients who are not achieving clinical goals. Other mental health professionals can contribute well to the Collaborative Care Model. Collaborative Care is *population-focused*, using a registry to monitor treatment engagement and response to care. Collaborative Care is *measurement-guided* with a consistent dedication to patient-reported outcomes, and utilizes *evidence-based* approaches to achieve those outcomes.
Additionally, Collaborative Care is *patient-centered* with proactive outreach to engage, activate, promote self-management and treatment adherence, and coordinate services.

Table 1: Essential Elements of Collaborative Care

Element	Definition
Team-Driven	A multidisciplinary group of healthcare delivery professionals providing care in a coordinated fashion and empowered to work at the top of their professional training.
Population-Focused	The Collaborative Care Team is responsible for the provision of care and health outcomes of a defined population of patients
Measurement-Guided	The team uses systematic, disease-specific, patient-reported outcome measures (e.g., symptom rating scales) to drive clinical decision-making.
Evidence-Based	The team adapts scientifically proven treatments within an individual clinical context to achieve improved health outcomes.

Because of these principles, Collaborative Care has demonstrated cost-effectiveness, significant improvements in clinical outcomes and high levels of satisfaction in providers and patients in diverse community settings. It is *practice-tested* with sustained adoption in hundreds of clinics across the country. By aggregating patient reported outcomes across providers and clinics, Collaborative Care is also *accountable* to payers and amenable to continuous *quality improvement*. Collaborative Care has consistently demonstrated the capacity to deliver improved clinical, cost and quality outcomes, including better satisfaction and access to services than traditional models of care delivery.

The Cochrane Collaborative conducted a meta analysis of 79 randomized controlled trials comparing Collaborative Care to usual care for primary care patients with depression and anxiety finding small to medium effect sizes for short and long-term clinical outcomes (Archer et al. 2012). The clinical improvement associated with Collaborative Care is meaningful to patients and providers. In randomized trials, compared to usual care, Collaborative Care doubles depression treatment response rates(Unutzer 2002). Quality improvement data from real world implementation of Collaborative Care programs suggests that similar outcomes can be achieved in a variety of settings (Rubenstein et al. 2010; Unützer et al. 2012; J. Fortney et al. 2012).

Because Collaborative Care is a multi-faceted intervention with core elements, there is not strong evidence about the relative contribution of each core element. However, because there has been variation in some intervention components across randomized controlled trials, it is possible to empirically examine the contribution of some components using meta–analysis techniques. Using data from multiple randomized controlled trials, one Collaborative Care intervention component stands out as being highly predictive of clinical outcomes. Having regularly scheduled care manager supervision by a psychiatrist (i.e., conducting weekly patient caseload reviews) was significantly correlated with improved outcomes (Bower et al. 2006; S Gilbody, Bower, and Fletcher 2006). Thus, having specialty mental health providers on the team most likely contributes to the clinical effectiveness of Collaborative Care. In addition, evidence from meta-analyses suggests that skill sets brought by nurse care managers in those settings studied, especially those with past mental health service delivery experience, generate better clinical outcomes than care managers from other disciplines (Bower et al. 2006; S Gilbody, Bower, and Fletcher 2006; Thota et al. 2012). Another meta-analysis examined whether it matters if the members of the Collaborative Care team are physically co-located with one another. The authors concluded that there is robust empirical evidence for the effectiveness of Collaborative Care regardless of the degree of physical co-location. In fact, several studies have shown that a centralized mental health team can effectively support multiple remote primary care providers (G. E. Simon et al. 2004; G. E. Simon et al. 2011; J. C. Fortney et al. 2007; J. C. Fortney et al. 2013; Dietrich et al. 2004; J. C. Fortney et al. 2015).

This review synthesizes the core elements of the Collaborative Care model through expert consensus based on lived experience with wide-scale implementations involving thousands of patients. The core elements of Collaborative Care were re-confirmed from the initial findings of an interdisciplinary national summit on integrated care in 2011 at the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington. As dissemination efforts grow around integrated care, it is hoped that this analysis brings attention to the Collaborative Care model and highlights the effective implementation of quality integrated-care through defining and rationalizing the essential components of Collaborative Care.

IV. ESSENTIAL ELEMENTS OF THE COLLABORATIVE CARE MODEL

A. Team-Driven Care

A multidisciplinary group of healthcare delivery professionals providing care in a coordinated fashion and empowered to work at the top of their professional training.

1. Definition:

Team-based Collaborative Care for mental disorders in primary care is operationalized within the chronic care model framework articulated by Wagner and colleagues (E. H. Wagner, Austin, and Von Korff 1996). Team based care is defined as a multidisciplinary group of care delivery professionals (e.g., office and support staff, nurses, care managers, primary care providers and appropriate specialists) providing and supporting care and implementing and revising the treatment plan. Broadly speaking, mental health practitioners potentially relevant to the Collaborative Care model for mental health conditions in primary care may include a psychiatric nurse practitioner, social worker, licensed counselor or therapist, psychologist, or psychiatrist. This may be contrasted with medical model approaches involving varying degrees of "physician as treatment team". In that model, the physician fulfills most health care delivery and patient treatment roles.

2. Components:

Collaborative Care uses behavioral or general medical Care Managers to track the well-being and care of a population and uses psychiatrists to provide consultation to Care Managers and PCPs and, in some settings, direct consultative care to patients (Unutzer 2002). Most studies of Collaborative Care management have relied on three main members of the health care team. These are: (a) the primary care provider (PCP); (b) a Care Manager (CM); (c) a consulting psychiatrist (**Figure 1**). The PCP oversees the overall patient care plan and is the ultimate decision maker for the clinical team.

Figure 1: Team Diagram of Collaborative Care Model (aims.uw.edu**)**

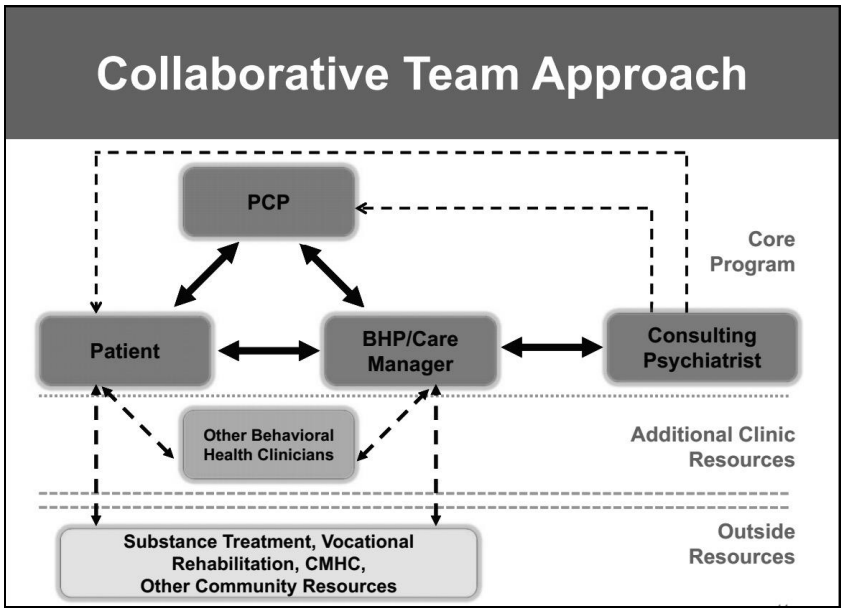


Figure 1: Dashed lines indicate less frequent methods of communication; bold lines indicate more frequent methods of communication.

The CM is the lynchpin member of the care team, linking the team to the patient and to each other. Accomplishing this often involves the use of the telephone, measurement-based clinical outcome metrics (e.g., Patient Health Questionnaire 9, PHQ-9, for depression) and health information/electronic medical record technologies such as registries, alerts and reminders. CMs also work to keep patients engaged in their care, assess treatment adherence, and explore treatment preferences. This information is then communicated to the team by available means (e.g., in-person, telephone, practice team meetings). The CM often prepares relevant clinical information to help ensure that periodic caseload review is accomplished efficiently when team-members including the psychiatric consultant are present.

The consulting psychiatrist reviews the CM's caseload at routine intervals; a task often facilitated by using some or all of the health information technologies previously noted. Recommendations are formulated (e.g., medication or dosing changes, addition or discontinuation of psychosocial interventions and referral to alternative behavioral health services or assessments) for the treatment team, particularly the primary care clinician and the CM with regard to the need to change or maintain individual patient treatment plans. Section VI reviews the advantage of psychiatric consultation to the Collaborative Care team. The facilitated caseload review and consultative role of the psychiatrist allows for individualized case-by-case feedback to the PCP, a form of learning that most closely approximates adult learning styles and may be superior to didactic seminars or algorithmic flowcharts.

Other members of the Collaborative Care team may include a primary care based psychologist or social worker for the purpose of patient assessment, enhancing access to evidence-based psychotherapies and urgent assessment of a patient's potential to harm themselves or others. A nurse or mental health specialist may be appropriate in the CM role, and teams may employ other members to help patients implement their own self-management plan such as peers or community health workers. Often, CMs have training, skills, and experience in managing patients with other chronic illnesses (e.g., diabetes, cardiovascular disease), and permit simultaneous care management of patients with multiple co-morbidities. Of note, meta-analyses of Collaborative Care studies for depression link characteristics of the CM to improved patient outcomes; specifically greater mental health expertise (S Gilbody, Bower, and Fletcher 2006; Bower et al. 2006) and nursing backgrounds (Thota et al. 2012).

3. Rationale:

The goal within Wagner and colleagues' notion of team-based care is, "to promote a systematic, planned approach to care" for chronic health conditions. The advantage to this approach is its capacity for efficiency and effectiveness through: (a) productive and planned patient and provider interactions; (b) informed, activated patients and their partners; and (c) a prepared, proactive clinical team. More specifically, as the elements of team care have been employed within research trials, the rationale for team-driven care is to match the skills of team members to specific tasks designed to maximize quality of care and produce timely and measureable patient status improvements. Many – perhaps most – patients with anxiety and depressive disorders do not improve in response to the first treatment, and a sizable proportion never adhere to the treatment plan long enough to lead to

reasonable expectations of improvement. Regularly collecting valid status measurements facilitates proactive adjustment of the treatment plan when indicated, the provision of feasible self-management strategies for affected patients, and keeping patients fully engaged in their care over time. This requires diverse skill sets possessed by no single member of the treatment team. The team-driven approach also allows for internal accountability and follow-up, checks and balances, and may help protect members from burnout and turnover when managing challenging clinical scenarios (Helfrich et al. 2014).

4. Narrative Description/Case Study: *Introduction to "the team".*

The following section serves to facilitate better understanding of the Collaborative Care team through a clinical example.

John J. is a 48 year-old white male visiting his primary care, Dr. Stevens, for a follow-up visit for managing his hypertension. During the visit, John's PHQ-9 score is taken and found to be 16, in the moderate range for Major Depression. John has been treated in the past for depression with Dr. Stevens 12 months ago, and remains on fluoxetine 20 mg daily, to which he had a fair initial response. This is John's first PHQ-9, part of the new Collaborative Care protocol instituted by Dr. Steven's clinic.

Dr. Stevens discusses the test result briefly with John during their clinic appointment, and introduces him to Ms. Cook, a Care Manager/Behavioral Health Specialist with the clinic's Collaborative Care team. Ms. Cook is immediately available in the clinic to meet patients coming and going from appointments at the request of the PCP or other clinic staff. John agrees to speak with Ms. Cook after the appointment, and Ms. Cook runs through a few patient screens for behavioral health and substance use conditions that are often co-morbid with Major Depression. John screens negatively for alcohol use or a history of mania. Ms. Cook discovers that John has recently moved out of his house and he and his wife are separating. He is staying with a friend in town, and it has been hard for him to make it to work consistently. He often goes to bed late and sleeps in, missing his alarm in the morning and eventually calls in sick. Ms. Cook shares some of this initial information with Dr. Stevens after their appointment, and Dr. Stevens increases John's fluoxetine to 40 mg daily. She also engages him in a behavioral activation strategy to improve his mood that includes getting together with his friend Joe over the weekend.

Three days later Ms. Cook has her weekly meeting with Dr. Brown, the consulting psychiatrist. They discuss John, the new addition to Ms. Cook's caseload. Dr. Brown acknowledges the PHQ-9 score and the fluoxetine increase, and reminds Ms. Cook of additional brief intervention techniques she has reviewed in the past with other patients. Five weeks later, during their caseload review, Dr. Brown notices John's PHQ9 score is unchanged. Ms. Cook notes that he stopped taking the fluoxetine the week before because of some ongoing jitteriness. Dr. Brown recommends switching to sertraline instead, and Ms. Cook conveys the recommendation to Dr. Stevens by flagging him in the electronic health record. Dr. Stevens reviews John's other meds the following day and writes a prescription for sertraline after Ms. Cook has called John to discuss the recommendations of the consulting psychiatrist. John agrees to try the sertraline. Ms. Cook reviews the side effects with John and offers her contact information in addition to Dr. Stevens' office if he has any problems with the medication. Dr. Stevens phones Dr. Brown and asks about the titration schedule of sertraline and starting dosage to confirm his management is appropriate. They agree to continue with increases in this medication with a target PHQ-9 of <5 if possible.

By constant communication and sharing tasks, the Collaborative Care team can work at their optimum level of efficiency and competence and share in the management of patients in a coordinated fashion.

B. Population-Focused Care

Healthcare costs as a percentage of the US gross domestic product are unsustainable. Consequently, it is clear that models of reimbursement and care delivery designed around efficacy of service delivery to an individual need to be counterbalanced by attention to the population. Collaborative Care models are a nexus for balancing population and individual health, but must incorporate principles of population management to be successful.

1. Definition:

The Collaborative Care Team is responsible for the provision of care and health outcomes of a defined population of patients.

When implemented through the lens of Collaborative Care models, three traditional components of population health (D. Kindig and Stoddart 2003; D. A. Kindig 2007) can be modified as follows:

(a) *Health outcomes and distribution within a population* – by reviewing a registry list of patients each week in systematic case review, the Collaborative Care team can sort patients who need more attention regardless of their level of clinical engagement. Patients who have been receiving care coordination resources for some time without demonstrating interest in engaging can also be identified, allowing refocusing of health resources to other patients or intensification of outreach efforts.

(b) *Patterns of determinants of these outcomes* – individual clinicians are accustomed to treating patients one at a time. Aggregating data on larger groups of patients allows for identifying trends in delivery system gaps – e.g. lack of social services, addiction screening, presence of co-morbid conditions such as chronic pain, financial limitations to medications etc. - are more easily identified and overcome.

(c) *Relevant policies and interventions* – Aggregated data and population management facilitates the systematic advocacy for improved legislative policy and system-wide interventions that are an essential component of population health (e.g. the way opiates are managed in a practice or the lack of alternatives for mentally ill patients in emergency settings needing housing or inpatient beds).

2. Components:

(a) Monitoring population outcomes

Population-based care requires effective data collection and outcome monitoring. This data typically includes symptom measures (e.g. PHQ-9), process measures (e.g. access), satisfaction measures, and cost measures (e.g. Emergency Department utilization). A first step in population management is generally to try to reach consensus on measures that are relevant for a given practice. Standardizing the measures used and setting up a way to compare practices or sites on population outcomes is an important first step. When possible, screening tools can generally also be used to monitor outcomes. A second step in population management is to block time in the schedule to consult

with those most able to react to the data with resources and authority to address systemic barriers that are discovered. When the data reveals that non evidence-based practice is occurring, a population management approach offers a way to provide information to a provider to show how he/she is not conforming to standard practice and offer support or training. Variation in outcomes should lead to exploration of important differences between treatment locations or patient populations and to teach those implementing changes about ways to adjust the approach to improve outcomes. Those involved in working with population health data need to be both at the administrative level and practice levels.

One example of a practice-based data review is in the systematic caseload review in Collaborative Care. The caseload review process requires real-time input from the consultative team of, at minimum, the psychiatrist and the CM, and population review time is protected at consistent intervals (e.g., once weekly). The psychiatrist is usually providing advice and guidance to the CM regarding the caseload of patients. This periodic "check in" allows the team the capacity to review a list of patients' health data and sort by severity to see which patients are in need of more attention, or by length of treatment to see who may have reached maximum benefit. It also allows for the identification of patients lost to follow-up and in need of more proactive management.

(b) Patient-centered services

In the management of a population, it becomes more important to address problems effectively and early than to wait for them to declare themselves in an office. In the Improving Mood Promoting Access to Collaborative Care (Unutzer 2002) model of Collaborative Care for example, a care manager continues to gather information on patients utilizing whatever means are necessary (e.g., home visits, phone calls, emails, text messages or spontaneous clinical encounters), allowing the psychiatrist to provide input to that patient's treatment team when a patient is not improving as expected and is not engaging in traditional means. There is a higher threshold for discharging the patient from care in this model, partly because there are more options available, and partly as this is an essential element of population-focused care. A patient who "no-shows" for an appointment represents an opportunity to explore more creative avenues of engagement to prevent further worsening of chronic illnesses. In addition, by being imbedded in primary care, the care coordinator has additional opportunities to connect with patients when they arrive for immunizations, a refills of hypertensive medication, etc., allowing care to be tailored to the individual in the settings most convenient to them and their lives.

(c) Raising the capacity of specialty and primary care through stepped care

A goal of population-based care within the Collaborative Care model is to raise the capacity of the primary care system to manage behavioral health conditions. A significant portion of the work of the psychiatrist in integrated care settings is indirect, involving curbside consultations with primary care colleagues, teaching nurse care coordinators about mental health issues, and providing suggestions in the patient's record to the primary care provider based on the latest evidence, with enough background to do case-based teaching (Raney 2015a). Rather than requiring a patient to attend specialty behavioral health appointments and perpetual co-management, the goal is to make sure the patient gets what he/she needs regardless of which healthcare door he/she enters and to titrate the intensity of services to the degree of patient complexity and response to treatment. Patients with less complex disorders are managed peripherally as outcomes improve. The specialist eventually intensifies treatment for complex or treatment resistant cases via more direct consultation and

management. Known as "stepped care", this is an essential component of population-based care and ensures that limited specialty resources are applied judiciously to the portions of the population most in need. Utilizing this tactic opens more face-to-face time in the specialist provider schedule for more complex and difficult to treat patients, improving access to specialty care.

(d) Attending to social and environmental issues

Any effort to manage populations of patients and improve their outcomes will eventually run into social and environmental contributors to behavioral health disorders – homelessness, poverty, lack of insurance, crime, lack of safety in the home, obesity, lack of exercise, etc… Any of these can make a significant impact on the potential for patients to develop, maintain, and recover from mental disorders. A psychiatrist working within a Collaborative Care model managing the population of the care team can more easily identify systematic barriers to care, advocate for social work resources in primary care clinics, encourage wellness programs to include those with mental health issues, and link the primary care system with community supports and resources.

3. Rationale

Collaborative Care Models offer unique opportunities for psychiatrists to impact populations and use skills critical to population management. Projected psychiatric workforce shortages are already significant and will continue to grow, demanding judicious use of scarce specialist resources (P. Wang et al. 2005; Swartz 2011; Thomas et al. 2009). Given that there will continue to be ongoing shortages in access to specialty mental healthcare, systems that proactively identify populations at risk and track their outcomes across time will allow for more rapid triage of clinical presentations to appropriate levels of consultation and preservation of limited resources.

Adherence to follow-up and medication therapy for behavioral health conditions is notoriously poor (P. S. Wang et al. 2005; Bogner 2013; Velligan et al. 2010). Through the use of population-based registries to track outcomes and make follow-up recommendations to modify treatment plans, persons failing to remain engaged with care or adherent to therapies can be more easily identified and strategies to engage them employed with increasing levels of creativity and intensity (stepped care). Consequently, population-focused management is an essential feature of Collaborative Care models and may contribute largely to their efficacy in treatment adherence (Lin et al. 2004; Lin et al. 2012). An important aspect of population-focused management is the ability to apply evidence-based recommendations with sometimes relatively limited clinical information. This is made possible by systematic management by a trusted team of colleagues performing longitudinal evaluation (Cerimele et al. 2014). The failure to implement a quality population-based registry of cases severely weakens the capacity for this vital systematic follow-up. Population management thus offers a way to spread limited psychiatric resources over a larger population, to implement and monitor evidence-based strategies more broadly, to engage patients who are inefficiently using the healthcare system and to learn from outcomes of groups of patients at multiple sites to inform better care delivery and advocate for improved care models within the greater community.

4. Case Study

The following section serves to illustrate population-based care through the ongoing Collaborative Care team clinical example.

Five weeks after his last appointment, John remains depressed. He did not return Dr. Steven's last call regarding some recent lab results, and no-showed one appointment. During their weekly caseload review, John is 8th on Ms. Cook's list of 58 patients when sorted by PHQ-9 score severity which leads to a case review. Their registry of patients also has flagged John's PHQ-9 as overdue and above their target. As she and Dr. Brown are reviewing all the patients, they review John's score and with the information in the registry are able to quickly recall his latest treatment plan, including the sertraline recommendations. Dr. Stevens did write the prescription, but Ms. Cook is unsure what happened after that. She attempted to call John about one week after the sertraline was prescribed and left him a message that wasn't returned. Ms. Cook and Dr. Brown agree that John needs increased outreach given his recent depression and lack of engagement, and Ms. Cook takes on this task over the next week. They then move on to Sue after spending about 5 minutes discussing John.

Through the course of an hour, Dr. Brown and Ms. Cook review all of the patients in the caseload who are still not at target (on this particular day this was 22 patients of the 58 in the registry), rapidly triaging clinical scenarios with Dr. Brown offering treatment suggestions or follow-up suggestions for those with unmet clinical needs. They allocate time and effort through an agreed-upon order; 1) new patients 2) follow-up patients not yet at target or not improving 3) patients not engaging in care 4) patients in remission, saving two or three complex patients for consistent check-in as time allows every week. Sometimes they do not discuss patients in remission unless certain problems arise. They review patients for possible discharge from the program who have met their clinical goals for three months with minimal care management (their program's discharge criteria) so as to open up more slots on Ms. Cook's caseload for new referrals, since 60 is her maximum. In this particular caseload review session, they identify two patients with more complicated personality traits and co-morbid substance use disorders for referral to the local Community Mental Health Center (CMHC) for more intensive treatment. They identify one patient in need of housing and benefits assistance from the clinic social worker. The two referral patients will remain on Ms. Cook's caseload under consultation from Dr. Brown and management by Dr. Stevens until they make their first CMHC appointments. Dr. Brown makes a note to call the CMHC administrator to work out an easier referral process from their clinic.

The following day, Ms. Cook writes a letter from the clinic to John offering assistance, and begins to call more frequently. Three days later, John calls back and he discloses that he never picked up the sertraline, and was not sure he was worth the attention of the team. He reports that he didn't want to feel like a failure again or let anyone down. John's PHQ-9 over the phone is 18, and Ms. Cook screens John for suicidal ideation, which is negative. She provides some education around depressive symptoms, the role of the team and their desire to help him feel better. John agrees to pick up the sertraline from the pharmacy and check-in before the weekend with Ms. Cook to report on how he's tolerating it.

Population-based care allows the Collaborative Care team to focus efforts on persons not improving or engaging well with care and rapidly link patients to other clinical or community-based resources as necessary.

C. Measurement-Guided Care

One of the core elements of Collaborative Care is Measurement-Guided or Measurement-Based Care (MBC). This is also known as "treat-to-target" care. Because the proactive longitudinal follow-up of patients by the care manager involves repeated assessments of symptom severity, the Collaborative Care team can use this information to determine whether patients have experienced a treatment response. Because MBC facilitates the recognition of patients who are deteriorating or not improving as expected, it prompts the care team to adjust the treatment plan thereby reducing clinical inertia – the failure to modify treatment regimens when outcomes are not met. Clinical inertia has been identified as a significant barrier to receipt of optimal treatment and chronic disease outcomes

(Schmittdiel et al. 2008). In the Collaborative Care model, these patient-reported outcomes and MBC are critical to the weekly case reviews conducted by the care manager and consulting psychiatrist.

1. Definitions

The team uses systematic, disease-specific, patient-reported outcome measures (e.g., symptom rating scales) to drive clinical decision-making.

MBC has been defined as the "enhanced precision and consistency in disease assessment, tracking, and treatment to achieve optimal outcomes" (Harding et al. 2011). MBC involves the systematic use of disease-specific, patient-reported outcome measures (i.e., symptom rating scales) to drive clinical decision-making. Symptom rating scales, such as the nine item PHQ-9 for depression (Arroll and Goodyear-Smith 2010), are brief structured instruments that patients use to report their perceptions about the frequency and/or severity of the psychiatric symptoms they are experiencing. MBC seeks to optimize the accuracy and efficiency of symptom assessment in order to facilitate the recognition of patients who are not responding to treatment. MBC also facilitates the use of treatment guidelines and algorithms which specify clinical decision nodes based on whether the patient is experiencing a full, partial or no response to treatment (Unützer and Park 2012). As such, it is a key component to Evidence-Based care. In addition, patients who regularly complete self-reported rating scales are likely to become more knowledgeable about their disorders, attuned to their symptoms, and cognizant of the warning signs of relapse or reoccurrence, thus enabling them to better self-manage their illness (Valenstein et al. 2009).

2. Components

Not all approaches to MBC are effective. A Cochrane review of depression screening (i.e., annual assessment of symptoms) found that patients with depression randomized to depression screening do not have better outcomes than patients randomized to no depression screening (Simon Gilbody, Sheldon, and House 2008). In addition, *patient-reported* outcome measures should be used for MBC rather than *clinicians' ratings* of their patients' symptoms, which are often biased and fail to detect deterioration (Hatfield et al. 2009). For MBC to be effective there is also good evidence that the patient-reported outcomes must be collected frequently and incorporated into multiple clinical encounters over time, including caseload reviews (Schmidt et al. 2006; Slade et al. 2006; Fihn et al. 2004).

For the patient-reported outcome measures to be clinically actionable (i.e., able to inform clinical decision making), the symptom rating scale data must be current, interpretable and easily available during the clinical encounter. If the symptom severity data are outdated or presented to the provider outside the context of the clinical encounter, this is not actionable and is not considered to be MBC. In addition to being current, interpretable, available and used by the provider during the clinical encounter, the instruments used to measure symptom severity must be reliable (i.e., consistent across repeated measurements when there is no change in symptom severity) and sensitive to change (i.e., able to detect clinically meaningful changes in severity) (Smith et al. 1997; Kerr et al. 2001). **Table 2** outlines the key principles of MBC.

Table 2: Key Principles of Measurement-Based Care

Six Components of Effective Measurement

1. **Measurement alone is not enough; outcomes must be incorporated into the clinical encounter**
2. **Patient-reported outcomes are more accurate than clinician-reported outcomes**
3. **Measures must be collected frequently to accurately assess the most recent clinical state**
4. **Measures must be tightly correlated to the illness state and are typically diagnostic specific**
5. **Instruments must be reliable and sensitive to change**
6. **Methods must be relatively simple to implement and low-cost**

3. Rationale

While the relative contribution of MBC to the overall effectiveness of Collaborative Care has not been established empirically, MBC on its own is one of the most widely studied elements of Collaborative Care. Virtually all randomized controlled trials with frequent and timely feedback of patient-reported symptoms to the provider during clinical encounters have found that it significantly improves outcomes (Harmon et al. 2007; Hawkins et al. 2006; Murphy, Rashleigh, and Timulak 2012; Reese, Norsworthy, and Rowlands 2009; Reese et al. 2010; W. Simon et al. 2012; Slade et al. 2006; Whipple et al. 2003; Lambert et al. 2002; Bickman et al. 2011; Brodey et al. 2005; Knaup et al. 2009; Krägeloh et al. 2015). A meta-analysis of nearly 300 therapists and 6,000 patients, found that only 22% of patients randomized to usual care experienced symptom improvement compared to 38% of patients randomized to MBC group (Shimokawa, Lambert, and Smart 2010). Based on these findings, it is highly likely that MBC contributes to the overall effectiveness of Collaborative Care. Moreover, in an implementation study of MBC with over 3000 patients, 100% of psychiatrists rated the symptom rating scales as helpful for monitoring response to treatment (Sachs et al. 2003).

MBC can also facilitate communication across providers working within the context of Collaborative Care. For example, the patient-reported symptom severity scores collected by care managers are shared with the primary care provider and consulting psychiatrist to focus the team based care on treat-to-target goals (Unützer et al. 2012). In addition, patients have positive perceptions of symptom rating scales and reported that they helped them increase their understanding of their illness and better express themselves to their provider (Dowrick et al. 2009). Finally, MBC will soon be required by health plans and accreditation agencies. For example, the National Committee for Quality Assurance (NCQA) has proposed depression symptom monitoring with the PHQ-9 and response/remission rates as health plan performance measures for the 2016 Healthcare Effectiveness

Data and Information Set ("National Committee for Quality Assurance: Healthcare Effectiveness Data and Information Set (HEDIS)" 2013).

4. Case Study

The following section serves to illustrate Measurement-Based Care through the ongoing Collaborative Care team clinical example.

John, the patient, calls Ms. Cook, the Care Manager, on Friday and reports that he picked up the sertraline and is taking it without side effects, but doesn't feel much different after two days. Ms. Cook reassures John that this is not unusual, and that he needs to stick with the medication for 4-6 weeks at the right dose sometimes before his mood may change. They make a plan to check in once a week.

In four weeks, John's PHQ-9 score has gone from an 18 to a 15, and he is tolerating the sertraline without any problems. Dr. Brown, the consulting psychiatrist, recommends they titrate the dose to a higher level and continue to monitor John's response. Dr. Stevens, the PCP, writes a new prescription for John, Ms. Cook confirms that he picks it up at the pharmacy and takes it, and after another 4 weeks his PHQ-9 is 13. John reports that he is feeling better and has applied for a new job. He and his wife are fighting less, and they are talking about having him move back in. In spite of these gains, however, Ms. Cook discusses John's remaining symptoms of prominent guilt and negative self-worth, poor quality sleep, energy and concentration coupled to overeating; all of which contribute to his current score. They formulate a plan to begin more regular exercise. Because his PHQ-9 is still above 5, Dr. Brown's advice is to continue to titrate the sertraline to the maximum daily dosage, noting his steady improvements.

Four weeks later, John's PHQ-9 score is 5. He reports that he feels like his old self again, has moved back in with his wife, is exercising more regularly now and starting to lose some excess weight.

The use of patient-reported outcomes and standardized measures can provide for valuable patient education experiences, attention to ongoing symptomatology in the context of sub-threshold clinical improvement, and facilitate more robust treatment response.

D. Evidence-Based Care

Evidence-Based Care utilizes principles of decision support connected to Measurement-Based outcomes to help facilitate the efficiency of the Collaborative Care team in population management.

1. Definition

> The team adapts scientifically proven treatments within an individual clinical context to achieve improved health outcomes.

Evidence-based care refers to the application of proven treatments within an individual clinical context to achieve Measurement-Based Care outcomes. Evidence-Based care is defined by Sackett and colleagues as the "conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al. 1996). Evidence-based care incorporates data from systematic research into the clinical decision-making process while tailoring general disease management strategies to the individual.

2. Components

Several components of Evidence-Based Care emerge within the context of Collaborative Care.

Identification of modifiable Measurement-Based Care outcomes is possible.

There must be a clinical scenario that is definable which allows for the application of existing systematic research data. This clinical scenario must have measurable outcomes that, when achieved, directly result in improved quality of life and individual functioning. While this may seem obvious, many clinical implementations of integrated care choose to focus on outcome measures for which there are no definable evidence-based treatments available. Abstract clinical measures such as quality of life, inpatient hospitalization or generalized risk scores are enticing to include but often offer little guidance to healthcare personnel lacking a proven evidence-base for treating complexity. Such scores often represent down-stream end-points that encompass a more complex mix of biological, sociological and psychological risk. This is in contrast to successful Collaborative Care interventions that select clinically definable and measurable outcomes such as the Patient Health Questionnaire-9 (PHQ-9) or Hemoglobin A1c that are directly related to clinical illness severity.

Evidence-Based treatments exist.

Evidence-Based Care presupposes that treatments exist for the clinical scenario in question and that the treatments are efficacious, reliable and proven to improve outcomes and quality of life. Ideally, these treatments are relatively inexpensive and well-tolerated. Furthermore, the treatments should be as "tightly linked" to the outcome measured as possible, so that treatment intensification efforts are accurately reflected in outcomes and severity of illness is quantified (Kerr et al. 2001; Selby 2009).

Collaborative Care teams must have confidence in the dose of treatments offered so that failure to achieve a clinical outcome after the application of treatment is more easily dichotomized to poor treatment adherence/delivery or failure of response. This confidence is offered through the reliance on existing clinical evidence, allowing for some increased degree of predictability in response. An example is treatment for Major Depressive Disorder. Through a robust evidence base, clinicians can be relatively confident that evidence-based treatment with pharmacotherapy and/or psychotherapy is effective in achieving remission of depressive symptoms for approximately 60-70% of patients. Psychotherapeutic interventions employed for depression care in the IMPACT model include Problem Solving Therapy and Behavioral Activation – two Evidence-Based approaches to depression management in primary care (Linde et al. 2015). Given this evidence-based expectation, Collaborative Care teams can more readily identify underlying causes for lack of clinical improvement. Evidence-Based Care allows clinical teams to be confident in their treatment efforts while also providing for judicious use of limited resources to maximize efficacy.

Standardized, stepped care algorithms can be employed.

Evidence-Based Care is most effective when treatment algorithms are standardized and levels of treatment intensification are commonly accepted among practitioners as a standard of care. This "stepped care" approach allows for a more rapid application of a treatment intensity framework for individual patients and facilitates the caseload review process and population management. Whenever possible, this should be driven by evidence and is often assimilated in guidelines for clinical management. One essential element of the Collaborative Care model is the presence of treatment guidelines, education materials for patients, clinicians and care managers, and ongoing trainings offered to ensure that the treatment team is delivering the most up-to-date therapies. One advantage of the Collaborative Care Model is the ability to disseminate Evidence-Based Treatments rapidly through a population-based approach and systematic quality improvement.

Diabetes is an excellent example of this approach. The Hemoglobin A1c value and the current therapies identify the level of treatment intensification necessary and are amenable to well-standardized algorithmic approaches. For example, an individual naïve to treatment with a Hemoglobin A1c of 10.1% with Type 2 Diabetes should receive both metformin and insulin therapy from the beginning of treatment to achieve the total reduction in A1c necessary – metformin alone will likely be insufficient ("7. Approaches to Glycemic Treatment" 2014). This knowledge is culled from the accumulated evidence-base in diabetes and is reflected in current diabetes guidelines.

3. Rationale

While the practice of Evidence-Based care extends back several decades, the application of this within Collaborative Care stems from the original Chronic Care Model which was formulated originally around diabetes care (E.

H. Wagner, Austin, and Von Korff 1996). An essential element of any chronic illness management is the use of clinical decision supports to guide treatment intensification and improve outcomes. Clinical decision supports are simply the application of systematic research evidence to individual cases when possible, and aid clinicians in rapidly assessing a clinical scenario and applying treatments with predictable chances of success. Population-based care, rapid assessment and treatment intensification are not possible for clinical scenarios for which there is no commonly accepted evidence-base for treatment. Having standard guidelines also allows for shared agreement and buy-in amongst consultants and primary practitioners in chronic illness management. The Collaborative Care team can provide the algorithmic, population-focused management advice which can be counterbalanced by the primary care provider and care manager's patient-level experience and input, overcoming barriers in clinical inertia and failure of treatment intensification commonly encountered in chronic illness management (Lin et al. 2012; Schmittdiel et al. 2008).

4. Narrative Description/Case Study:

The following section serves to illustrate Evidence-Based Care through the ongoing Collaborative Care team clinical example.

Two months after John achieved early remission from his Depression, Ms. Cook calls him for a routine check-in. He notes that he stopped taking the sertraline for a couple of weeks right after their last conversation, and had a relapse of some of his symptoms. His PHQ-9 score has jumped from 5 to 13, and John is feeling embarrassed and shameful. He resumed his sertraline at 200 mg about a month ago, but still struggles with energy and has stopped his workout routine. Dr. Brown suggests that they augment the sertraline with bupropion, and Dr. Stevens writes the prescription for John.

One month later, John's PHQ-9 score is 10, and Ms. Cook engages him with Behavioral Activation focused on his exercise regimen again. They discuss the cycle of inaction, guilt and depression, and John agrees to experiment with a different workout regimen and assess his mood. Dr. Stevens automatically adjusts his bupropion to a higher level since he is tolerating it well, and one month later John's PHQ-9 score is 4.

This clinical scenario depicts the use of treatment algorithms for depression care. After a relapse and partial response to sertraline at maximum dosage, Dr. Brown employed evidence from the Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study (Rush et al. 2006) to augment with bupropion, and Dr. Stevens recognized the algorithmic step and ensured that John was prescribed an appropriate dosage. Additionally, Ms. Cook employed a psychotherapy technique proven to be effective in the management of depression in primary care, Behavioral Activation therapy (Linde et al. 2015). Through consistent application of evidence-based care, John was able to achieve remission of his depressive symptoms after his relapse.

V. ACCOUNTABILITY, QUALITY IMPROVEMENT AND MEASUREMENT

Successful implementation and ongoing maintenance of a Collaborative Care program requires many new system processes to achieve each of the four essential elements. Often, these processes are complex and include different clinical roles, workflows, and team makeup. There may also be increased demands on the system; including new or different training, communications, information technology, facility needs, and others. A systematic, quality improvement framework is thus required in order to assure that all of these processes are coordinated and effective.

A. Definitions

Two aspects of accountability and quality improvement surface repeatedly in Collaborative Care implementations, and include:

(a) Performance Measurement: The process of evaluating how well organizations are managed and the value they deliver for customers and other stakeholders (Moullin 2002).

(b) Pay-for-Performance / Value Based Purchasing: The process of paying providers to meet quality goals (Rosenthal et al. 2004; Rosenthal et al. 2005).

B. Rationale and Key Elements

The improvement seen in clinical outcomes derived from Collaborative Care is thought to be achieved via the four core structural elements of the model: care that is (a) team-driven, (b) population-focused, (c) measurement-guided, and (d) evidence-based. As important as these elements are to achieving better clinical outcomes, they also in sum create a framework for transparent accountability at multiple levels and with various participants – including the patient and clinical providers. Patient Reported Outcomes Measures (PROMs) – structured self-report patient outcome measures – are being increasingly utilized by payers and accreditors to hold provider entities accountable for the health outcomes of populations served. For example, the National Council of Quality Assurance (http://www.ncqa.org) has included screening (and soon to include remission rate measurement) for depression as measured by the PHQ-9 as one of the measures for comparing health care plan performance levels in their 2015/2016 HEDIS measures for comparing health plan performance.

The use of PROMs creates new opportunities to demonstrate the value of Collaborative Care models to patients and provider teams themselves. Through the use of self-reported measures individual patients can, together with their clinician, review data and determine whether clinical goals are met or whether care plans need to be adjusted. The clinician and patient together can use clinical outcomes data to help discern which clinical modalities and methods are most effective. This empowers the patient towards the maximal amount of self-management in his or her own care. Clinicians, in turn, are able to periodically review their caseloads in order to assess which patients are not improving as expected, or whether a change in care or treatment strategy is indicated. This is important, because clinicians often are unable to make this determination using clinical judgment alone (Hatfield et al. 2009). In effect, patients and their clinicians become "agents of quality assurance" for

their own care and practices (respectively). The same process can occur at the clinical team level, clinical program level, agency level etc… Data can be "rolled up" to display caseload, practice, or population summary reports for the purposes of practice monitoring, professional development, and program improvement.

Clinical outcomes measures like the PHQ-9 may serve as the primary clinical outcome measure for a program. However, for ongoing program success, programs should consider secondary process measures as well. Though one might think that the process of care is not relevant as long as the expected outcomes are achieved, expert consensus is that the means of achieving clinical goals are important. This is partially because the use of patient outcomes measures alone has not been associated with improved outcomes (Simon Gilbody, Sheldon, and House 2008). However, it also appears that use of process measures are important to help guide clinicians and leaders in assuring the necessary steps that are required for programmatic success, such as screening rates, access rates, financial stewardship, and service timeliness. Without attention to the processes, there can be an erosion of fidelity to the core processes required to achieve clinical outcomes, and ultimately an erosion of the expected outcomes themselves. Thus, a mixture of process and clinical-outcome measurements is required.

By utilizing this data in the context of caseload consultation, the Collaborative Care psychiatric consultant is in an optimal position for assuring fidelity with the Collaborative Care core processes. Throughout his/her medical school and residency training, the psychiatrist is trained to evaluate using a differential diagnosis, oversee, and suggest changes to patient care plans. The psychiatric consultant draws on this expertise in order to give education, guidance, and care recommendations for individual patients. Collaborative Care experts believe that the benefits of the model arise not only from WHAT services are offered, but also HOW that care is coordinated, and WHEN the services are given. Thus, the psychiatric consultant is often called upon to provide team leadership around the roles, functions, workflows and other processes in the delivery of Collaborative Care.

Evidence-based, accountable care occurs only with intention. In a constantly changing environment of care, a structured and continuous quality improvement strategy is critical for initial and ongoing success. Programs that fail to create a system for ongoing process improvement are especially vulnerable to drifting back into non-collaborative and non-evidence based patterns of care. From the outset, programs should have a plan for periodically monitoring their success in achieving the target population's intended clinical outcomes as well as monitoring fidelity to the clinical model. These reassessments allow teams and leaders to make necessary changes to the vision and action plan, and to review the process of bringing on new staff. These also make for a great opportunity to celebrate clinical successes and re-energize teams (UW AIMS Center 2015). This ongoing quality improvement process touches all levels and functions of an organization. Fortunately, a number of practice change models and methods exist, such as the Institute for Healthcare Improvement Collaborative Model (IHI 2003).

C. Narrative Description/Case Study: Measures for Quality Improvement

The following section serves to illustrate Accountability and Quality Improvement through the ongoing Collaborative Care team clinical example.

Ms. Cook, the care manager, checks in with the clinic supervisor for the Collaborative Care program who helps to oversee the performance of all the Care Managers in the program. At Ms. Cook's last check-in about three months ago, her rates of depression remission or response as measured by a PHQ-9 of less than 5 or greater than 50% reduction from original PHQ-9 score, respectively, for patients enrolled at least 6 months in the program were on par with her colleagues at the same clinic – around 45%. However, this quarter her rates have dropped to about 30%. The clinical supervisor and she review her caseload turnover, which is also about the same as the other care managers, as is the severity of her patients based on her average initial PHQ-9 score. One notable exception is the number of patients discussed during the weekly caseload review process with Dr. Brown, which has dropped considerably. Ms. Cook notes that they rarely get through all the caseload now, as opposed to the beginning of their work together, sometimes discussing only 4 or 5 patients in an hour leaving little time to consider others who still have uncontrolled symptoms but don't seem as complicated. She considers one case recently, John, who suffered a relapse in his depression after she hadn't made contact in about 5 weeks.

Ms. Cook talked with another care manager in her clinic who managed to maintain his response rate consistently around 55% and discovered that the other care manager made it a point to check in with everyone in some capacity (phone, in-person, email, etc…) at least once every two weeks until their remission had lasted three months. She sets up a rotating schedule to call all her patients over the course of two weeks at a minimum regardless of their status (though sometimes more). She will also share the process and outcome results with Dr. Brown to help focus their caseload review process, ensuring that all of the caseload is considered at standard intervals.

Paying attention to both process and outcome measures can help to ensure that vital elements of Collaborative Care implementation, including population-based care (as shown above), are thoroughly implemented and ongoing monitoring is available to protect against programmatic drift.

VI. UNIQUE ATTRIBUTES OF PSYCHIATRISTS IN THE COLLABORATIVE CARE MODEL

Psychiatrists have integral roles on several levels to ensure success in Collaborative Care Models (Raney 2015a). Psychiatrists provide an effective combination of knowledge and skills for the Collaborative Care environment, given their background in medical and behavioral health fields as well as scientific and clinical authority to provide definitive recommendations in complex diagnoses and treatment regimens that involve both psychopharmacology and psychotherapy. Psychiatrists also offer leadership and accountability in caseload consultation, population management, medico-legal liability and triage of potential clinical crises.

1. Training in both Medicine and Behavioral Health

The most common reasons for psychiatric consultation in Collaborative Care are diagnostic clarification and psychopharmacologic recommendations (Norfleet, Ratzliff, and Chan 2015; Raney 2015a). The psychiatrist on the team has the breadth and depth to clarify how psychiatric symptoms present within the primary care setting and the medical conditions that may mimic them. This background in psychiatric care of medically ill persons is gained during residency training rotations, followed by clinical experience or further training related to psychiatry in medical settings. Psychiatrists in collaborative care settings bring knowledge of latest evidence based pharmacological and non-pharmacological treatments, comfort in managing patients with medical illnesses, understand principles of handling drug-drug interactions, and bring skills in working with multi-disciplinary medical care teams.

Psychiatric diagnoses most commonly encountered in Collaborative Care programs include depressive disorders, anxiety disorders, bipolar disorder, personality disorders, substance use disorders, and somatic symptom disorders (Norfleet, Ratzliff, and Chan 2015). Although the most robust evidence base for Collaborative Care models are in depression and anxiety, patients within primary care clinics present with a variety of primary conditions or co-morbid behavioral health concerns, many of which can also be managed in the Collaborative Care framework. Furthermore, psychiatrists maintain proficiency in medical communication that may otherwise limit the adoption of some treatment recommendations by a PCP. Such experience and training may overcome barriers to implementation such as PCP engagement. Similar to primary care physicians, consultant psychiatrists within Collaborative Care should be "generalists" – willing to adapt practice styles and scope, as able, to the demands of the clinical situation and needs of their colleagues

(Raney 2015a).

2. Educating others in applying evidence-based practice

Medication recommendations are a frequent request for Collaborative Care psychiatrists; discussing the rationale for a particular recommended treatment is often helpful for ensuring implementation, adherence, and education of the patient and team members. For example, a written recommendation for a specific antidepressant may include an explanation of why that particular one was chosen. These collegial and informative communications are invaluable in gaining "buy-in" from PCPs, which often helps to shore up institutional support through positive PCP feedback. Furthermore, psychiatrists have the skill set necessary to evaluate the evidence-base across all treatment paradigms and operationalize Evidence-Based care within given clinical contexts. Through repeated consultation around specific patient scenarios, the psychiatric consultant is able to build the capacity of the PCP to confidently and competently treat a variety of psychiatric disorders.

3. Collaboration, Consultation and Partnership with Primary Care

Working with PCPs in a collaborative model requires they understand the psychiatric consultant's role in assisting and supporting their management of psychiatric illness they may consider to be beyond their scope of expertise. Working as a team targeting outcomes, while having the patients remain under the PCP's care, requires significant trust from the PCP that you are available and employed in their best interest. Although this type of support from psychiatry will likely be seen as new (and unexpected) to most PCPs, an emphasis on trust building is essential for a successful partnership. This process may begin with a face-to-face meeting, perhaps during downtime at the primary care clinic, where introductions are made and the Collaborative Care model described. These opportunities may be reinforced with future meetings during which the psychiatrist provides the PCP with algorithms for diagnosis and treatment of common mental illnesses, such as depression and anxiety. Additionally, these meetings provide an opportunity to elicit feedback from the PCPs, which enhances the perception that this is indeed collaboration. It is important for the PCP to have access to the psychiatrist for questions, which may be informal "curbsides", or even urgent questions. Skills in providing informal consultation are crucial to the relationship and require some time to master (Raney 2015b). Contact by HIPAA compliant electronic messages, cell-phone calls, and pages are often encouraged as opportunities to communicate and obtain consultation.

Indeed, one advantage of psychiatrist participation in Collaborative Care models is more ready access to emergent or urgent consultation and advice for urgent or life-threatening clinical situations which otherwise would not have been available. With the longitudinal nature of the consultant team's relationship, patterns in behavior that may differ and point to alternative diagnoses allow for novel clinical evaluation methods that also were not previously available, and more rapid triage of more complex situations to an appropriate level of care (i.e. an initial presentation of bipolar disorder as depression with no known history of mania converts to hypomania which may have previously been lost to follow-up).

4. Team Leadership, Vision and Accountability

By virtue of their extended training and expertise in managing complex situations, psychiatrists are often called upon to provide guidance, leadership and accountability to the Collaborative Care team, though it should be noted that each member of the team is treated with equal respect and mutual admiration. The cultures of primary care and behavioral health differ in many ways and the psychiatrist, trained in both worlds of general medicine and psychiatry, can help mitigate problems that may occur as these cultures come together in the Collaborative Care model.

Psychiatrists possessing skills in population management who review all patients in a particular caseload in accordance with clinical severity are ensuring the team is held responsible to the provision of evidence-based care across the population. Their consultant relationship helps to guarantee that they remain appropriately distant from clinical situations allowing for objectivity, creativity and momentum to overcome clinical inertia. This distance is in contrast to the expected closeness of the care manager and the PCP, and provides an essential checks and balances system when implemented correctly.

5. Medico-Legal Liability

When participating as a member of a Collaborative Care team, care is taken to clarify malpractice liability risks. Current literature and case law suggest the relative risk of curbside consultation is minimal, and that the medico-legal risk to a psychiatrist for providing organized advice on a patient not physically seen (indirect consultation, the most frequent role in this model) is less than for providing direct care; the patient is under the principal care of another provider (Olick and Bergus). During systematic caseload review, it is helpful to record team discussions to help track treatment history and follow-up, with the added statement in the team note explaining that the patient was not directly seen. Furthermore, as the expectation remains that the patient continues under the direct care of the PCP, who may or may not choose to take the recommendation offered, the clarification that "treatment plan recommendations provided in the course of this consultation should not supplant clinical judgment and are offered through data derived from the care manager without direct patient consultation" could be included in all communications. Ready access to a specialist with expertise in both diagnosis and management helps to alleviate medico-legal concerns that inevitably arise when managing behavioral health disorders in the community.

VII. IN-VIVO IMPLEMENTATIONS OF COLLABORATIVE CARE MODELS

Introduction

Implementation of Collaborative Care requires extensive systematic change on multiple levels that span from the provider workflows and task shifting traditional roles, to payment and reimbursement reform. As such, bringing the CC model to scale is difficult. This section attempts to provide practices, health systems and policy-makers with actual implementation examples, highlighting each program's history, methods of implementation of the four essential elements, attention to accountability, funding mechanism(s) and lessons learned. Attempts were made to draw broadly across services and payer types.

A. Washington State Mental Health Integration Program (MHIP)

1. Background & History

The Washington State Mental Health Integration Program (MHIP) was created in 2007 in partnership between the Community Health Plan of Washington (CHPW, a not-for-profit health plan), Seattle-King County Department of Public Health, and the AIMS (Advancing Integrated Mental Health Solutions) Center at the University of Washington. The program was initially piloted in two of Washington State's most populous counties. Program data from the first years of 2008 and 2009 showed that, compared to counties without MHIP, the target population in MHIP counties had 17% fewer inpatient medical admissions and smaller increases in inpatient psychiatric costs (21% vs. 167%) over the review period. Compared to those that did not receive services, health plan enrollees who received MHIP services had a larger decrease in number of arrests (24% decline in MHIP clients), a smaller increase in those living in homeless shelters or outdoors (50% vs. 100%), and a smaller increase in days spent in state hospitals (33% vs. 500%) (Joesch 2011). Partially because of these positive results, the MHIP program was expanded statewide in 2009. During the first 14 months of statewide implementation, the state saved an estimated $11.2 million in hospital costs alone

(*Community Health Centers: Behavioral Health Integration* 2013). The program has now been in continuous operation for over eight years, and has served over 45,000 patients in more than 150 community health centers.

2. Program Description

The program was initially patterned after the IMPACT program developed by the University of Washington (Unutzer 2002). Like the IMPACT model, the MHIP program incorporates core components of team-based care, use of a clinical Behavioral Health (BH) care manager, and use of a psychiatric caseload consultant. In addition to the PHQ-9, patients were also screened for anxiety and substance use conditions. Over time, additional screening tools have been incorporated into the care model, including symptom rating scales, functional rating scales, and important medical markers, such as glycosylated hemoglobin (Hemoglobin A1c, HBA1c) and LDL Cholesterol.

Appropriate and eligible patients are identified via standardized screening (such as the PHQ9) or via referral by the primary care provider. Whenever possible, "warm handoff" referrals are utilized, connecting the BH care manager immediately to the patient. The BH care manager also has a primary role of coordination of referrals and care transitions – including referral to specialty mental health when indicated, once patients are enrolled in the MHIP program.

3. Adaptation of Essential Collaborative Care Elements

(a) Team-Driven and Evidence-Based Care

The MHIP program emphasizes a team-based care model, as depicted in **Figure 1**. In this model, the patient and primary care privider are joined by the BH care manager and the psychiatric consultant in the care of MHIP patient. In many clinics, Behavioral Health (BH) care managers work alongside the primary care team – whereas in smaller clinics a BH care manager may work at another location but serve clients at the smaller clinic.

The BH Care Manager serves a central role in MHIP care team – coordinating care, managing referrals and transitions, and assisting in medication reconciliation. The BH care manager also plays the important role of providing brief, evidence based treatments. BH care managers receive ongoing training in these practices via live trainings and recorded webinars.

The psychiatric consultant provides regular (usually weekly), caseload reviews with the care manager for the purpose of ensuring population review for the assigned caseload. During the consultations, the psychiatrist assists with diagnosis and formulation, and makes recommendations regarding medications, psychotherapy and patient management. Recommendations are documented in a caseload review note that is forwarded to the primary care provider. The consultant remains available throughout the week by telephone to assist the care team in the event of additional questions. The psychiatric consultants are often available either in-person or by tele-psychiatry for direct patient care consultations for more complex clinical questions or concerns.

(b) Population-Focused Care and Measurement-Guided Care

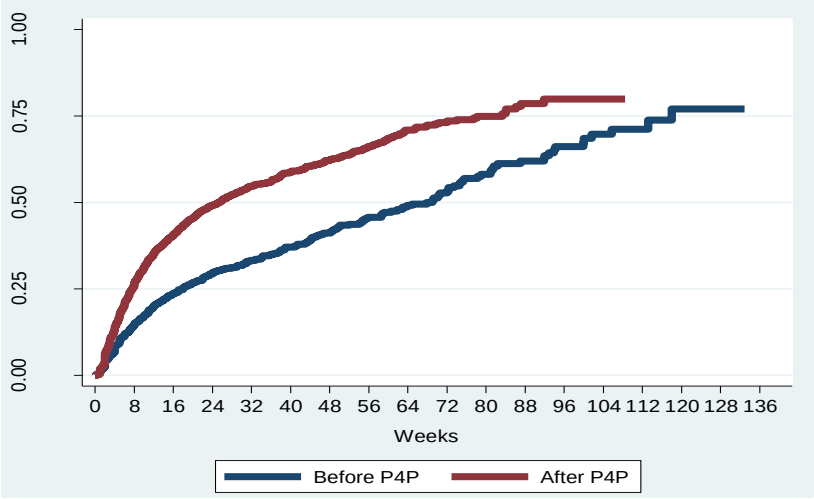
A web-based tracking system, described by the AIMS Center (Unützer et al. 2002) is utilized to help support systematic outcome tracking and quality improvement. The MHIP registry captures clinical diagnoses assigned by clinicians working with patients and clinical outcomes using validated clinical rating scales such as the PHQ-9 (Patient Health Questionnaire) for depression (Arroll and Goodyear-Smith 2010). This information is gathered for all participants at an initial assessment and at each subsequent contact with a BH care manager. The care registry displays individual and caseload summary data to the BH care manager who in turn utilizes this information to make care decisions. A key emphasis is review of patients who are not improving; with an aim of adjusting the care plan as needed.

4. Quality Improvement and Accountability

Initial experience with this program showed high levels of variation between programs as measured by PHQ-9 and GAD-7 population-level outcomes. To help address this variation – real-time clinical reports were created and embedded into the care registry tool. These reports contained several key clinical indicators – including timely follow up of patients, tracking medication lists, and the provision of psychiatric consultation for patients who were not improving. The care managers and consulting psychiatrists were trained in how to utilize this data when making care plans and prioritizing services. For instance, the timely follow up measure was often utilized to determine whether a patient might benefit from an outreach call.

These measures were further reinforced financially – approximately 5% of their annual reimbursement per measure was tied to achieving each one of these quality measures, a procedure known as "pay for performance." As shown in **Figure 2**, the implementation of these quality measures successfully improved overall care by demonstrating a 50% shorter time to achieve a 50% reduction PHQ-9 score (or achieving a score less than 10). Though this study was not able to separate the effects of providing the real time feedback from pay for performance stimulus, but it is likely that both were factors in improving outcomes (Unützer et al. 2012).

FIGURE 2: Pay-for-performance-based quality improvement dramatically reduces median time to depression improvement in a state-wide Collaborative Care program.



5. Funding

The program was initially funded by the state legislature and administered by the not-for-profit Community Health Plan of Washington (CHPW) for the General Assistance Unemployable (GAU) recipients in two of Washington State's most populous counties. Shortly thereafter, the program received additional funding for veterans and their families, underinsured, older adults, and pregnant and new mothers under voter-approved levy funds, and administered by the Seattle-King County Department of Public Health. The program was further expanded to statewide in 2009 under similar funding arrangements based on the demonstrated early success mentioned above. In 2014 the Medicaid expansion resulted in termination of the GAU program as these recipients became eligible for Medicaid. The program was continued as a treatment option for patients who selected CHPW as their Medicaid insurance carrier.

6. Lessons Learned

a. Primary Care centered Collaborative Care is possible in a high-needs safety net population.

Prior to the initiation of this program, there was little recorded experience on the effectiveness of providing primary care integration services to safety net populations. The Joesch report (Joesch 2011) showed early evidence that Collaborative Care can demonstrate quick and demonstrable population improvements and system cost savings. This encouraging data suggested that Collaborative Care programs can be effective in safety net populations in both bending the cost curve AND improving clinical outcomes.

b. Systematic uses of process and outcomes measures that are built into clinician workflows are important for program success.

As reported in the accountability section above, the incorporation of a combination of both real-time process and clinical outcome measures that are built into the BH care managers' workflows had a dramatic impact on clinical outcomes: reducing the time to depression remission for half of the overall patient population by as much as 50% (Unützer et al. 2012).

c. Ongoing workforce development, training, and support are critical for program success.

For such a large program, it was a challenge to find and train a clinical workforce of over 100 BH care managers and approximately 20 part-time psychiatric consultants. Once the initial roll-out process was complete the challenge of program sustainability became apparent. Use of recorded web-based training helped, but training needs remains an ongoing challenge. Furthermore, as the program expands, it continues to draw clinicians from an already strained mental health clinician resource pool. Training efforts for current and new clinicians are ongoing – but more needs to be done to consider the "pipeline" for new clinicians (BH care managers and consulting psychiatrists) who are considering a career in Collaborative Care. A discussion of workforce training is offered in the new directions section.

B. Depression Initiative Across Minnesota, Offering a New Direction (DIAMOND)

1. Background and History

The Depression Initiative Across Minnesota, Offering a New Direction (DIAMOND) project was initially conceived in 2006 at the Institute for Clinical Systems Improvement (ICSI), a non-profit quality improvement organization representing more than 60 hospitals, medical groups, and health plans primarily in Minnesota. As a neutral convening group, ICSI was able to pull together a steering committee that involved not only care providers, but also insurance representatives, patients, employers, and regulatory groups for the state to look for common ground on the gulf between what was available in the literature regarding the treatment of depression and what was happening in the state.

At the time a meta-analysis (S Gilbody, Bower, and Fletcher 2006) of 37 randomized controlled trials supported care coordination for depression as being superior to practice as usual. ICSI contacted Jürgen Unützer, M.D., one of the architects of the IMPACT model for the management of depression as an expert consultant and then reached out to member organizations in the state to seek interest and capacity for changes in their delivery system. The participation of insurance groups in the design of DIAMOND allowed the opportunity to link practice change with payment redesign and practices across the state were offered the chance to have expert help in system redesign along with the promise of a new source of reimbursement for care coordination of depression in adult patients.

Interested medical groups were screened for readiness for change and those deemed capable were assigned a place in a staggered implementation plan of five 'waves' in which a group of primary care clinics worked on learning and implementing over six months. Those participants in earlier segments were then a part of the training group for the next wave, with over 80 primary care clinics receiving training by the end of implementation. Each participating clinic was required to submit data on response (fifty percent improvement) and remission (subthreshold clinical score) based on the PHQ-9 through an online registry and ICSI returned data to each clinic to show them how they were doing compared to other sites transparently, allowing clinics to contact each other to find out what was working best or to overcome common barriers. As a quality improvement project, there was no overall grant funding for DIAMOND; however, the HealthPartners Research Foundation received funding to follow and study the implementation using a stepped wedge study design with repeated cross-sections of patients across clinic settings (Crain et al. 2013).

2. Program Description

Eligible patients were 18 or older. They had to be in a primary care provider's panel, with a PHQ-9 of 10 or more, and they could not have an entry diagnosis of bipolar disorder. These patients were identified by the involved clinics through electronic means or upon the patient's arrival into the clinic to see their primary care provider. Once identified, the primary care provider was asked to decide if the patient was likely to have major depression or dysthymia; with prior training of primary care

providers on diagnosis . Each clinic found it had to be proactive to ensure the easy availability of the primary measure (PHQ-9) in both case identification and monitoring of outcomes.

The way in which patients entered the care coordination program evolved over time as word of the availability of this option spread and early success was noted. Initially, the majority of patients came directly from the primary care provider to the care manager via a "warm handoff", found to be far more successful than contacting patients by phone for screening. Over time, as popularity grew, entry into DIAMOND became independent of a specific primary care provider needing to authorize the referral, allowing any primary care provider to refer another provider's patients when cross-covering. In addition, patients would contact the clinic asking for the program after hearing about it from a family member or neighbor, and referrals became more common from psychiatric clinics, hospitals, and emergency rooms. Those referrals from outside the primary care clinic were required to be reviewed to make sure each patient indeed had a primary care provider, as this was an integral part of the model.

3. Adaptation of Collaborative Care Essential Elements

(a) Team-Driven Care

The team involved in this model included the patient, his/her primary care provider, a care manager/care coordinator, and a consulting psychiatrist. Clinics were required to identify and block off time in the schedule of a care manager/care coordinator who was trained in the DIAMOND model by ICSI and charged with management of their whole population of depressed patients. The depression care manager role was often a new one to primary care clinics at the time, and efforts were made to defend that role as unique to avoid a care manager being pulled into multiple other tasks. The care manager was most often an RN, but LPNs and social workers were also employed and could also be effective care managers. Behavioral activation and motivational interviewing were identified as important skills in this role, and a caseload of up to 100 patients per full time care manager was possible although it was common to see caseloads of 50-80.

DIAMOND required psychiatrists to work in their capacity within the Collaborative Care model – a role unfamiliar to many. Data on each patient, presented during the caseload review, was collected by the care coordinator to enrich the process and increase the chances of the psychiatrist making meaningful recommendations without directly seeing patients. In addition, any patient not improving would be reviewed, and with the aid of the registry, the psychiatrist could focus on those patients most in need of attention versus just those who the care manager remembered at the meeting. Availability outside this care review meeting was also important for an occasional call by the care manager or by the primary care provider. The primary care provider wrote all prescriptions.

(b) Population-Focused Care

The program utilized a registry to manage the population of patients enrolled. Registry functionality was employed to attend to an entire list of patients in weekly systematic case reviews where a psychiatrist could sort all the data on patients by severity of symptoms or length of stay

and thus make sure patients with the most needs were not forgotten and patients not improving were not approached repeatedly in the same way. It also included the ability to generate reports on the population of affected patients to review with various audiences – for example, reviewing with a primary care provider all of his/her patients, or generating reports on patients' progress for the director of a clinic or for those responsible for a group of clinics.

ICSI offered any participating group access to a registry specifically tailored for DIAMOND that was housed at the University of Washington. Some clinics used that registry, while others were given specifications based on that registry to develop their own registry. Included in those specifications was a list of consistent measures that needed to be sent to ICSI on a regular basis for quality comparisons. The registry offered a place to enter clinical data if it was not already a part of the EMR. In addition, care managers could track which patients needed a follow-up call, where to reach a patient on a given day, and how many times they might have reached out to a given patient and left a message. Finally, the registry offered real time access to administrative data to compare how care managers were doing at several clinics, and to track useful data such as admission by primary care provider, response rates by clinic, etc.

ICSI designers felt that relapse prevention was critical to the success of DIAMOND. A number of important activities related to relapse prevention were integrated into the DIAMOND model: meeting with a patient after he or she has gone into remission, reminding the patient that depression is a recurring illness, reviewing the earliest signs of an impending depressive episode, reviewing behavioral activation activities, education on the importance of adherence to medications, documenting which therapy approaches were most helpful for that individual, and creating an action plan for relapse. The expectation within DIAMOND was that patients would be enrolled until reaching remission (defined as two PHQ-9 results under 5 separated by at least six weeks). At that point they were discharged. If the patient was not in remission by 12 months of participation, the expectation was that they would be discharged unless there was an obvious reason why more time in care management might be productive (e.g. a patient who just left an abusive partner towards the end of the year). The overall goal of the DIAMOND program was to get as many patients into remission as possible.

(c) Measurement-Guided Care

A screening and monitoring instrument allows case finding and treat-to-target planning and discussions to occur. Significant work was then required by each clinic to elaborate a method to distribute, collect, and record the PHQ-9 in a way that allowed for both patient care and outcome monitoring for the clinic. The PHQ-9 was chosen as the common tool, and the success of DIAMOND led to the larger adoption of this tool by Minnesota Community Measurement – a nonprofit organization charged with monitoring health outcomes for primary care across the state. Depression was the first mental health condition included in mandatory outcomes for primary care (and outpatient psychiatric specialty care) clinics for transparent comparison of outcomes on the Internet (http://www.mnhealthscores.org/).

In addition to the PHQ-9, each new patient entering DIAMOND was screened for anxiety (often using the Generalized Anxiety Disorders-7, GAD-7 (Spitzer et al. 2006), alcohol misuse (often using the Alcohol Use Disorders Identification Test (AUDIT)(Frank et al. 2008; Gual et al.

2002)), and for bipolar history (often using the Mood Disorders Questionnaire (MDQ)(Hirschfeld 2000)). While the PHQ-9 was required to do the model, the tools for these other comorbidities were offered as recommendations, allowing a clinic to pick a similar tool if preferred. Clinics could also add extra screening tools and questions for the care manager to ask before each intake to enhance the psychiatrist's ability to make a meaningful initial suggestion to the primary care provider of a new patient.

(d) Evidence-Based Care

The model being implemented in DIAMOND was based on IMPACT and was chosen because of the amount of evidence in published literature supporting both efficacy and effectiveness. In addition, by having a psychiatrist review panels of patients and provide feedback on approaches to groups of primary care providers, there was an opportunity to encourage the use of evidence-based approaches to depression. Each note to a primary care provider was a potential teaching opportunity. A guideline built for primary care from ICSI for depression was a reference source as it was adapted for this setting and updated each year. Care managers were each provided with access to this guideline and were encouraged to use it as a reference point in answering questions from patients or providers when appropriate.

4. Quality Improvement and Accountability

The implementation strategy for DIAMOND was that used in the Breakthrough series model of practice change. As described in the background above, practices were screened for readiness to implement this model. Those ready tended to have the capacity to implement both the PHQ-9 and a consulting psychiatrist, as well as the resources to hire a care manager/care coordinator. They also needed buy-in by both those in the clinic and by leadership. Finally, they needed a champion at the intervention site and IT support.

Practices selected for the study sent a team to be trained by ICSI. The team included the care manager/coordinator, a primary care champion, a psychiatry consulting provider, and desk and nursing staff from the participating clinic. IT support was also encouraged to attend these meetings as needed. Plan Do Study Act (PDSA) cycles were used to adapt aspects of the model to a given setting, and outcomes were tracked at each site and compared in a transparent way with all participating clinics, both within and outside a given medical group. A healthy competition ensued and was encouraged.

After introducing this model to many clinics, those trained in an earlier 'wave' of training were recruited to teach their colleagues in a later wave. Nuances about how to implement aspects of the model were often uncovered through the use of those actually doing the work as trainers. ICSI provided feedback to all the clinics and to leadership at all the sites on progress in recruitment, panel sizes, response rates, and remission rates.

5. Funding

The steering committee for DIAMOND included both providers of care and insurance representatives as members. It was clear from the start that both groups felt there was significant room to improve processes and outcomes in the state for adult patients with depression. Healthcare

providers were willing to make significant changes but felt that they needed reassurance that this new model brought with it a new source of financing for non-direct care activities. Six large insurance groups within the state agreed to work with their organizations to create a new payment model to help sustain the changes.

In order to clarify a target amount for payment, ICSI was able to survey participating DIAMOND sites about the time involved in creating DIAMOND (committee meetings, the care manager's schedule, time blocked in the psychiatrist's schedule, etc.) and time spent in caseload review and supervision. By pooling and de-identifying this data, a range of costs per month was available to participating medical groups in their negotiating with the insurance groups. The payers offered a monthly bundled reimbursement meant to cover both the work of the care manager and the non-direct patient care activities of the consulting psychiatrist. Primary care providers involved in the care of these patients continued to bill as they had previously. Anti-trust laws prevented direct conversations about how much a given medical group was planning to bill and this was left as a negotiation. All insurance groups involved agreed upon a single billing code initiated by ICSI-participating clinics representing a standard set of bundled services. Insurance groups agreed that one year was reasonable as a period of payment for an enrollee. After that, a practice needed to appeal to continue billing for DIAMOND services for a given patient.

6. Lessons Learned

(a) Care coordination for depression can be successfully implemented in a wide variety of settings for improving depression outcomes – cost reduction may or may not follow.

DIAMOND sites consistently outperformed other primary care sites on six and twelve-month response and remission rates as measured by the PHQ-9 and reported on Minnesota Healthscores during the implementation process. Pre-post comparisons done at given sites (Williams et al. 2011) also showed significant improvement in clinical outcomes. Neither of these comparisons was as rigorous as one would find in a randomized trial however, and during implementation it was clear that there was wide variability in outcomes by site, even within a medical group. It was also common to see a given clinic reach a certain level of outcome and remain there.

Finally, DIAMOND was not designed to reduce utilization in emergency departments and hospitals. Improving depression, it was argued, should naturally lead to reduced utilization of acute services and most certainly it did in some patients, however, limited data exists from DIAMOND about cost reductions. Cost reduction (i.e., changes in utilization) in few patients is difficult to generalize when some depressed patients are not using many services at all. In addition, those patients using the Emergency Department or hospital may need a different type of intervention involving social services or home visits if that is the primary outcome needed to support continuation of care coordination.

(b) Implementation science approaches are critical to successfully starting, improving upon and sustaining care coordination models.

Care coordination models are disruptive in that they require changes in all aspects of a primary care clinic—the checking in and rooming of patients, management of phone calls and triage, changes

in nursing roles, building the way in which a specialist (psychiatrist) integrates into the primary care workflow, and evolving the approach by the primary care provider to patients with depression. Simply providing such a model to a clinic without helping that clinic through the changes is like providing a chronic smoker with a pamphlet on the dangers of smoking and expecting that to be enough. Successful implementation has been studied and organizations making such changes can benefit from attention to implementation science (Whitebird et al. 2014).

The implementation teams had data comparing outcomes between sites within and outside of their own medical groups. This comparison data was very helpful in creating some healthy competition to recruit more patients and to be better at capturing follow-up data. However, reasons for variation remained elusive. Practice sites had varying success at making collection and submission of their outcome data a priority within their institution to allow for analysis of site differences, and once a program was implemented and early results were in, it was easy to focus on the next site for implementation. In starting an implementation of Collaborative Care, the team should expect and plan for variation in outcomes. In a large health care system, a central team that is able to do small tests of changes that could impact outcomes at a few sites may help all the teams in knowing where to focus their efforts.

(c) Aligning incentives – pay attention to startup costs and payer mix

The bundled payment offered to clinics implementing DIAMOND was very helpful in both getting medical groups to participate (psychiatric time was covered as was the cost of the care coordinators salary), and in sustaining the model once it started. In addition, having a financial part of the model led to more structure in the length of treatment and definitions around discharge, as these were tied to payment. There was significant cost to each organization to start up DIAMOND (i.e., the cost of hiring a care coordinator, creating an electronic registry, including the PHQ-9 in the workflow, and meetings with involved clinics to explore and plan). The organizational cost of implementing a change was never covered by the new reimbursement for DIAMOND. This cost is not a minor issue in a time when primary care practices were struggling to break even financially. In addition, the variety of sources of payment for services delivered to patients coming into primary care made it less likely that clinics could continue a model reimbursing for only a part of their eligible population. The bundled payment system worked fairly well in clinics where the majority of patients were covered by one or a few plans but in DIAMOND clinics with a large percentage of government payers, the program had trouble being sustained.

(d) Care managers need support and ongoing training

A clear preference for RNs in the role of care manager was present from the start. However, sites using individuals from other backgrounds such as LPNs and social workers had comparable outcomes. Sites using non-nurses were able to save on costs but had to find ways to back up these care managers with nursing support. It was widely noted by those involved in the project that the personal qualities and the institutional support of the care manager may have made more of a difference in outcomes than professional degree. Sites with dedicated care managers did better than sites in which a care manager was asked to take on several roles. Training of care managers is important but it is also clear that the role involves ongoing skill development in motivational interviewing. Weekly visits with psychiatrists have educational value as well.

(e) Psychiatrists need to learn new skills to do this model effectively

Psychiatrists were not all comfortable with this new role; structured training and peer support/mentoring were helpful. Psychiatrists need to be comfortable trusting their colleagues in primary care. Fears about lawsuits were addressed and this model was compared to any curbside support given in electronic consults where the primary responsibility remained with the primary care provider. Primary care practices often had trouble finding psychiatric support, especially in rural areas, and access to psychiatric services was noted to be an overall stressor for primary care. A general rule-of-thumb suggestion born of experience with the model over time was to contract with a psychiatrist for 2 hours per week per full time care manager for caseload supervision. When a primary care site had two care managers, this was more efficient for the psychiatrist who might then be able to block off a half-day and reduce travel time. Psychiatrists with some responsibility for the overall outcomes and processes in the primary care clinics where they were consulting tended to enjoy the role and contributed more to improved outcomes than when simply contracting for the time.

C. Re-Engineering Systems of Primary Care Treatment of PTSD and Depression in the Military (RESPECT-MIL)

1. Background and History

The RESPECT-Mil program (Re-Engineering Systems of Primary Care Treatment of PTSD and Depression in the Military) is an Army-wide, Collaborative Care initiative aimed at improving the primary care system's capacity to identify and effectively treat service members with depression and PTSD within the Military Health System (MHS) (Wong et al. 2015). The Military Health System, with an annual budget over 55 billion dollars, is responsible for the provision of health care to roughly 10 million beneficiaries who receive care in over 300 military treatment facilities worldwide, making it among the largest and most diverse health systems in existence (CBO: Congressional Budget Office 2014).

The initiation of RESPECT-Mil in January 2007 was in response to a clearly demonstrated MHS need: during many years of armed conflict in Iraq and Afghanistan deploying some 2.6 million men and women in uniform, data emerged regarding high rates of PTSD, depression, and other mental health conditions as well as low rates of specialty mental health service use among those affected (Hoge et al, 2004; Tanielian et al, 2008). Indeed, of the nearly 20% of service members returning from deployment with PTSD or depression, fewer than a fourth received mental health care from a specialist, in part due to stigma and the potential for occupational repercussions when these problems come to light (Hoge et al. 2004; Tanielian and Jaycox 2008).

Collaborative Care is an evidence-based approach to these challenges. RESPECT-Mil adapted a Collaborative Care model previously tested for depression by adding PTSD (Dietrich et al. 2004; Oxman et al. 2002). With the assistance of an original team of MacArthur Foundation funded investigators, a 2005-2006 demonstration project with feasibility assessment was completed at a busy primary care clinic serving the medical needs of the 82nd Airborne Division. The study found high primary care provider satisfaction with and acceptance of the RESPECT-Mil approach, and two-thirds to three-fourths of service members reported clinically significant improvements in their psychiatric

status (C. C. Engel et al. 2008). The success of this demonstration led to large-scale implementation at the direction of the US Army Surgeon General (Surgeon General 2013).

RESPECT-Mil has served as the precursor to the currently existing Collaborative Care Patient-Centered Medical Home (PCMH) model now implemented for all beneficiaries across Army, Navy and Air Force primary care clinics. Before transitioning to the second-generation MHS PCMH approach, RESPECT-Mil was implemented for over 3.5 million visits in 94 primary care clinics located at 39 installations and 8 time zones worldwide. In addition, RESPECT-Mil led to the first large multisite randomized controlled trial of a health care delivery intervention in the MHS, the STEPS-UP Trial (STepped Enhancement of PTSD Services Using Primary Care), a trial evaluating Collaborative Care implementation approaches for PTSD and depression (C. C. Engel et al. 2014; C. Engel et al. 2015). This trial is nearing completion at this time.

2. Program Description

All service member visits to participating primary care clinics are routinely screened for PTSD using the four-item Primary Care PTSD screen (Prins et al. 2004) and for depression using a yes/no 2 item PHQ-2 (Kurt Kroenke, Spitzer, and Williams 2003). Patients screening positive (PC-PTSD ≥2 or PHQ-2 ≥ 1) are given the PTSD Checklist (PCL)(Blanchard et al. 1996), PHQ-9, and single item PHQ question assessing symptom-related functional status difficulties (K Kroenke, Spitzer, and Williams 2001). Primary Care clinicians were trained in these measures, given guidance on how to use them, and afforded ultimate discretion as to what constitutes a positive diagnosis. All usual patient referral options were available (e.g., watchful waiting, routine primary care treatment and follow-up, emergency department, specialty care referrals, inpatient hospitalization). Clinicians had the additional option of enlisting the help of a RESPECT-Mil "care facilitator", a registered nurse (RN) who kept patients fully engaged in care, tracked treatment adherence, assessed symptom status at a minimum of every 2 weeks and every 4 weeks thereafter, and entered relevant data into a decision support system for tracking of symptom improvement.

3. Essential Elements of Collaborative Care

(a) Team-Driven Care

The military health system used an approach to team care that involves primary care clinic office support staff, primary care nurses, the primary care clinician, a nurse trained in care management of depression and PTSD, and a consulting psychiatrist. Clinic support staff was trained to initiate a waiting room screen for depression and PTSD. Clinic nurses reviewed the initial screening with the patient at the time of assessing vital signs (actual clinic flow was adapted with different clinics in consultation with a health system implementation team). If the initial screen was positive, patients were asked to complete a validated hard copy "diagnostic aid" and the clinician reviewed the result briefly with the patient. The clinician asked any necessary follow-up questions. Based on patient responses, referral to specialty care or to the clinic-based Collaborative Care manager was made. If the referral was to the care manager, he or she followed up with the patient, usually by phone but sometimes in person, at regular intervals to assess patient symptom severity using the same measures used at the index primary care visit. In addition, assessments of treatment side effects and adherence were assessed and captured in a health information technology platform that created registries. The

consulting psychiatrist met with nurse care managers weekly to review patients' status, discuss treatment plans, and recommend any treatment plan changes to the primary care clinician as appropriate using the electronic health record.

(b) Population-Focused Care

A web-based PTSD and depression decision support tool was used to generate real-time symptom registries at the care facilitator level for measurement-based treatment planning. Care facilitators assessed patient symptoms at regular intervals (within 2 weeks after the index visit and at least every 4 weeks thereafter). Registries were used to identify patients whose symptoms were not improving so that their treatment plan could be intensified or otherwise modified. The registry also identified patients by level of treatment engagement; efforts were made to ensure that patients at risk of falling out of treatment or who had already fallen out of treatment were identified and efforts were made to better engage or reengage them. Efforts to adjust treatment plans and improve engagement were reviewed by the psychiatrist with the care facilitators using the real-time electronic registry.

(c) Measurement-Guided Care

The RN care facilitators tracked symptoms in the patients they were monitoring, assessing them using validated symptom and functional status assessment tools, and entering results into the online decision support tool. Resulting registries were generated and used to inform weekly reviews of care facilitator caseloads by the installation's RESPECT-Mil psychiatrist.

Improvement of 5 points on either PCL or PHQ-9 was considered minimally significant clinical improvement. Less than a 5-point improvement more than 8 weeks after the most recent treatment change prompted an automated flag and triggered reassessment of that patient's treatment regimen. Changes in regimen included the addition of a new medication or discontinuation of existing therapies, changes in medication dosing, addition of psychotherapy or changes in psychotherapy frequency, modality or provider.

(d) Evidence-based Care

All RESPECT-Mil program practices were codified in manuals (http://www.pdhealth.mil/respect-mil.asp). Screens and ongoing patient status indicators were published, standardized measures (e.g., PHQ-2/9, PC-PTSD, PCL). Manuals for primary care providers, behavioral health specialists, and care facilitators provided guidance with regard to stepped psychopharmacologic treatment. In the second generation RESPECT-Mil approach assessed in the STEPS-UP Trial, stepped psychosocial interventions were added. These included care facilitator engagement strategies, nurse assisted online CBT self-management, telephone CBT with a clinical psychologist, primary care clinic-based therapy with a social worker or psychologist and specialty clinic-based psychotherapy services (*see Engel et al, 2014 for more detailed summary of the evidence-base for these modalities*).

4. Quality Improvement

RESPECT-Mil program quality improvement efforts were driven and sustained based on a carefully crafted worldwide structure and accountability (Belsher et al. 2014). Each implementing

installation (i.e., a single Army Post, on average covering about 3 primary care clinics each up to 7-8) assigned both a primary care and behavioral health champion. The latter was a psychiatrist that provided weekly caseload supervision for all care facilitators. The former was a primary care provider responsible for monitoring and overseeing that installation's RESPECT-Mil quality metrics.

Overall RESPECT-Mil quality improvement assessment, reporting, and metrics were driven by the "R-MIT" (RESPECT-Mil Implementation Team). The R-MIT was a multidisciplinary group (psychiatrist, psychologist, social worker, nursing, statistician, database manager/programmer, health informatics specialist, administrative support, and expert part-time consultants) located in Silver Spring Maryland. R-MIT staff (a) completed two day trainings for new champions; (b) performed at least monthly 30 minute telephone consultations with each RESPECT-Mil installation team (champions, care facilitators, and administrative assistants) to strategize around implementation challenges; (c) executed one site visit per year for each implementing installation with in- and out-briefs for facility commanders and delivery of a written installation visit report; (d) distributed RESPECT-Mil semi-annual installation report cards summarizing key clinical metrics and comparing them to grand mean program performance and providing site performance rankings. Data for these reports were gleaned from installation data reports, aggregate electronic health record reports, and outcomes data from the online clinical decision support tool used by care facilitators and their psychiatrist supervisors.

5. Funding

Program personnel (1 GS10 equivalent RN care facilitator and 1 GS5 administrative assistant equivalent per 10,000 military personnel in participating clinic catchment area; 5,000 minimum for funding of one of each) were funded through Army Medical Command Behavioral Health funding under Medical Command Operations Order. With the transition to the PCMH, program resourcing was driven in part by a Department of Defense Instruction and budgeting guidance and each military service's derivative policies.

6. Lessons Learned

The lessons learned implementing RESPECT-Mil have been broad and myriad. Only a few are summarized briefly here.

(a) Collaborative Care is feasible to successfully implement and maintain quality control of in a worldwide context.

RESPECT-Mil was a major operation by any standard.

(b) Central assistance aids high fidelity implementation.

There were many examples in which installations, clinics, and individual care facilitators identified, corrected and conquered complex local challenges with the assistance of the R-MIT. By training, talking with, visiting, and inspecting data from implementing installations, the R-MIT became the historical repository for lessons addressing specific challenges that arose again and again. Central assistance is also important for supplementing the scarce mental health resources in many rural settings

through the use of web-based self-management, phone-based CBT, and remote care facilitation services.

(c) The use of an electronic decision support system facilitated timely changes in the treatment plans of patients for whom treatment is likely to have otherwise remained unchanged and ineffective.

The process and outcomes data from this system, populated with data collected by care facilitators during phone follow-up contacts, was also readily used in aggregate to monitor installation, clinic, and care facilitator performance.

(d) Routine actionable performance reports with high installation/organizational visibility resulted in observable responses, particularly from under-performing installation programs.

In most cases, installation efforts to avoid poor performance (more than efforts to be viewed as a high performing installation) drove program performance in the direction of greater overall fidelity with time. This fostered and sustained a culture of performance improvement.

(e) Installation site visits were essential for insuring that high-level policies achieved intended objectives and for identifying unintended effects early and correcting them.

They also insured that RESPECT-Mil implementers considered the first hand views of the entire health care team (e.g., unit clerks, medics, nurses, administrators, records personnel, primary care physicians and mid-level providers, mental health specialists from all disciplines). These views were always informative.

(f) The use of the macro-level central assistance program organizational model not only facilitated program implementation and quality improvement efforts; it led to the recent successful completion of a large multisite randomized effectiveness trial of a second-generation Collaborative Care method (C. Engel et al. 2015).

D. Veterans Health Administration

1. Background and History

As the American health care system moves toward integrated and Collaborative Care, Patient Centered Medical Homes, outcome-based models of healthcare funding, and accountable care organizations, the experience of the nation's most extensive Collaborative Care implementation, the Veterans Health Administration's (VHA's) Patient Aligned Care Team (PACT) model is relevant and important. The VHA is in the process of implementing Primary Care-Mental Health Integration (PC-MHI) in over 7,000 primary care clinics (Reid and Wagner 2014).

The VHA cares for over 5.3 million primary care patients; more than half of that care is provided in Community-Based Outpatient Clinics (CBOCs) (Schectman and Stark 2014). There is a single patient electronic record system used organization-wide. Twenty percent of VHA patients receive mental health services (Post and Van Stone 2008). In 2010, the VHA began to augment primary care teams to ensure at least four full-time health care professionals per panel of primary care patients, including mental health professionals, nutritionists, and clinical pharmacy specialists. Organization-wide metrics provide accountability and visibility for opportunities to standardize and improve access and care.

PC-MHI in the VHA blends two models of integrated care: 1) the Collaborative Care model (referred to as care management) and 2) the Behavioral Health consultant model (referred to as co-located care) (Dundon and Dollar 2011). All VA Medical Centers and CBOCs with more than 5,000 patients are required to implement both models. The requirement for a blended model is based on the evidence base of the Collaborative Care, and the need for co-located mental health specialists to provide immediate access for patients. Collaborative Care is designed to support primary care providers prescribing of psychotropic medications, and includes proactive longitudinal follow-up and brief behavioral health interventions. Collaborative Care services are usually provided over the telephone, often by staff who are not independently licensed, but who are supervised by a psychiatrist or psychiatric advance practice nurse. Co-located Behavioral Health Consultants conduct curbside consultations with primary care providers and participate in interdisciplinary team huddles.

2. Program Description

Most patients in the VHA with depression are treated in primary care; therefore, collaboration between primary care and mental health care providers is essential for optimizing treatment (VHA: Veterans Health Administration 2008). Most patients are introduced to the Behavioral Health Consultant via a "warm handoff" from the primary care provider to the PC-MHI provider operating an open access clinic (i.e., no appointment necessary). In some programs, referrals are made using the VHA's CPRS (computerized patient record system) electronic consultation function (VHA: Veterans Health Administration 2008). The decision to make an electronic referral or warm handoff is based on the clinical experience and level of concern of the referring primary care provider. No specific referral criteria have been operationalized. Licensed independent mental health providers conduct focused assessments and deliver brief interventions, usually face-to-face in the primary care clinic. Some PC-MHI encounters are scheduled solely for the purpose of delivering mental health treatment while others are conducted as part of the primary care encounter.

3. Adaptation of Collaborative Care Essential Elements

(a) Team-Driven Care

The Department of Veterans Affairs has a detailed staffing formula that prescribes full time equivalent assignments of Behavioral Health Providers (BHPs) to primary care clinics, based on enrollment population. Case identification, triage, evaluation/consultation, follow-up, case management, psycho-education, medication management, and coordination of patients needing longer-

term or more intensive mental health specialty services are targeted to all primary care panels across the national VHA health system.

VHA PC-MHI program staffing varies among facilities, and facilities vary in size, but a 2010 PC-MHI evaluation survey (Wray et al. 2012) and a VHA operations manual (Dundon and Dollar 2011) reported the following system-wide average full time equivalent employees by provider type per facility, revealing of relative provider mix for a clinic accommodating approximately 3,000 to 4,000 veterans:

Table 3: Characteristics of Full-Time Equivalent (FTE) Staff per Clinic in VHA Integrated Care Implementations

Staff Title	FTE
Psychiatrists	0.54
PhD level psychologists	1.11
Mental health nurses	0.69
Masters of social work	0.62
Prescribing mid-level providers	0.40
Mental health administrative support	0.31
Mental health technicians	0.23
Doctoral level pharmacists	0.11
Masters level counselors/therapists	0.04
Primary care physician	3.00

(b) Population-Focused Care

Implementation of the PACT model is monitored through standard metrics that are shared nation-wide. Data can be viewed for the entire health system, for regions, for facilities, for panels, and for individual providers. Standard metrics are related to panel management, patient engagement, patient satisfaction, access, continuity, staff satisfaction, care coordination, and clinical improvement (Schectman and Stark 2014). Clinics vary in their commitment to dedicated time for teams to participate in team population health activities through registry review and team discussion. Partial determinants of degree of implementation of the PACT/Collaborative Care model in the VHA include physical presence of mental health professionals in the primary care clinic, availability of space in the primary care clinic, and availability of financial resources (Chang et al. 2013).

The information technology support needs for the optimal practice of population health are substantial (VHA: Veterans Health Administration 2008). The IT system should ideally facilitate the ability to track a panel of patients, identify next steps in clinical care, provide decision support at point-of-care for medication dosing and other clinical treatment decisions, enable patients to enter patient-reported symptoms, provide secure messaging for team members, and provide outcome feedback to care providers and teams.

The VA utilizes a current software platform to accomplish many of these needs. The Behavioral Health Lab (BHL) Software Package is an informatics tool to facilitate the delivery of measurement-based behavioral health care. The software provides a mechanism for collecting patient reported outcome data, tracking patients over time, monitoring patients' symptoms and generating

patient and program level outcome data. The program level data include predefined reports but data is also easily exportable for use locally. The software program has the capacity to provide decision support for initial or baseline interviews. The software creates patient focused reports for any visit that tracks treatment progress and progress notes for clinical records. The BHL interfaces with the VA's electronic health record and could be used with other health systems. The interface capacity enhances the user experience by populating BHL with patient demographic information and pushing patient reports from BHL into the existing VA EMR system. Additionally, BHL structured assessment data are pushed to the Mental Health Assistant which populates the data in the National Data Warehouse.

(c) Measurement-Guided Care

Because the VHA is a large system of care, the preponderance of research has focused on implementation success of PC-MHI and access-relevant metrics such as wait-time for behavioral health services (Hankin et al. 1999). There is a relative paucity of data at this time related to outcomes attributable to measurement-based treatment to target and clinical outcomes.

The most robust outcome data to date within VHA come from a depression treatment initiative, Translating Initiatives for Depression into Effective Solutions (TIDES) Project (VHA: Veterans Health Administration 2008). TIDES has been implemented in several VHA regions and aims to improve care for depressed veterans by implementing depression Collaborative Care models through evidence-based care guidelines. Support for treating to 50% response and full remission was provided in implementation expectations for the sites participating in the model. Initial data from the TIDES program from 1,000 patients enrolled in the program revealed that the model resulted in very high levels of medication adherence (85%) and follow-up visits (95%). Remission rates at six months were 62% among primary care patients and 40% among the more severely ill veterans referred to mental health specialty treatment (Rubenstein et al. 2010).

(d) Evidence-Based Care

The VHA maintains an extensive set of evidence-based practice guidelines, regularly updated by expert panels, in collaboration with the Department of Defense. Adherence to practice guidelines is part of VHA providers' quality and performance improvement program, both as individuals and as groups. In many facilities performance pay (bonuses) are partly determined by review of adherence to aspects of evidence-based practice guidelines. The guidelines are readily available in the CPRS system. Critical reminders from evidence-based guidelines are incorporated into "push" clinical reminders upon opening of patient records. For example, if metabolic monitoring for antipsychotic medication is due, a "reminder due" message is evident on the front page of the electronic medical record.

Psychotherapists in the VHA PC-MHI program receive training in brief evidence-based psychotherapies, including problem solving therapy, and adaptations of cognitive-behavioral based therapies. Designated evidence-based therapy coordinators ensure fidelity to the manualized conduct of psychotherapy via periodic review of case records.

4. Accountability and Quality Improvement

National VHA evaluation and local program data have demonstrated that PC-MHI has increased the likelihood of receiving care defined by evidence-based practice guidelines, and enhanced treatment engagement for patients referred on to VHA specialty mental health services (Pomerantz et al. 2014). The increase in access to care resulting from the widespread implementation of PC-MHI has led to significant and substantial increases in the rates of detection, diagnosis and treatment of depression, anxiety, PTSD and substance use disorders (VHA: Veterans Health Administration 2008; Zivin et al. 2010). The VHA has nationally standardized staff training and patient educational materials, created centrally using evidence-based methods and materials curated by content experts. With almost 5 million PC-MHI encounters to date, VHA's experience is that Collaborative Care can be successfully implemented at scale.

The VHA Primary Care Research in Substance Abuse and Mental Health for Elderly (PRISM-E) randomized controlled trial demonstrated that VHA patients were significantly more likely to engage in mental health services that were integrated with primary care than to follow through on traditional referrals to specialty services. For example, depressed patients in integrated care had 2.86 higher odds of having at least one contact with a mental health specialist than those in referral care (Bartels et al. 2004).

5. Funding

VHA funding mechanisms facilitated relatively easy realignment of resources and population-wide implementation of PC-MHI. Workload tracking is based largely on patient resource utilization and behavioral health provider (BHP) workload documentation. BHP workload is captured using CPT codes for PC-MHI-relevant encounter types (Dundon and Dollar 2011):

a) Initial consult visit
b) Follow-up visit
c) Treatment adherence enhancement visit
d) Relapse prevention visit
e) Behavioral Medicine visit
f) Psycho-educational group visit
g) Conjoint (BHP and PCP joint visit) consultation
h) Telephone consultation
i) Unscheduled staff or patient- initiated contact for immediate problem-focused intervention

Several clinical services are not provided or staffed for in PC-MHI, including:

a) Outpatient psychotherapy requiring more than six visits
b) Intensive outpatient services
c) Psychological or neuropsychological testing
d) Patients already in treatment with a specialty mental health provider, service, or program

6. Lessons Learned

(a) Depression is not the only condition

Nationally, the most frequent PC-MHI diagnoses are, in order of frequency, major depressive disorder, other depression, PTSD, anxiety disorder, alcohol use disorder, drug use disorder, bipolar disorder, schizophrenia, and personality disorder (Wray et al. 2012). While over 95% of PC-MHI programs addressed depression and anxiety disorders in 2012, 83% addressed PTSD, 55% alcohol dependence, 53% bipolar disorder, and 46% schizophrenia (Wray et al. 2012).

(b) Transformation to population health is evolutionary

Clinical care teams can preserve clinician-patient relationships and therapeutic alliances when they are high-functioning teams emphasizing good communication and shared decision-making (Reid and Wagner 2014). In the evolution of PC-MHI toward true team care and population management, a challenging stage is when there is co-location but not totally integrative team care. VHA PACTs are in various stages of transformation; effective leadership and organizational commitment are necessary for evolution to true integrated team care and population health. The degree of evolution toward a pure Collaborative Care or population health model has also been shown to be dependent on the presence of psychiatrists or psychologists in the primary care clinic, greater financial sufficiency, and greater space availability (Chang et al. 2013). To date, there is insufficient data to conclude whether or not VHA efforts to promote self-management, robust care coordination, and healthy behavior change have resulted in population health improvements (Reid and Wagner 2014).

(c) System engagement is related to ease and degree of Collaborative Care implementation.

Reid and Wagner (Reid and Wagner 2014) identified eight large-scale changes that must be implemented and sustained to achieve PC-MHI in a population health program like the VHA:

1. Engaging leadership in meaningful change
2. Deploying evidence-based quality improvement and change strategies
3. Empaneling patients to establish care accountabilities
4. Shifting to team-based rather than clinician-directed care
5. Promoting patient-centered care interactions
6. Deploying strategies to enhance chronic, preventive, and acute care
7. Ensuring access of patients to their care teams
8. Establishing effective care coordination strategies

(d) Leadership provides a critical fuel for Collaborative Care implementation

The differences between PC-MHI programs and traditional mental health in the VHA are dramatic and require a culture shift for all stakeholders, from primary care providers to behavioral health providers, and leadership at all levels. VHA research has shown that if leaders do not allocate resources, support providers, identify clinical change champions, or define job duties, implementation of Collaborative Care, or even co-located care, is likely to be hindered (Guerrero et al. 2015; Chang et al. 2013). National VHA leadership has implemented organization-wide training and emphasis on new skills that must be learned to effectively implement PC-MHI, including cultural competency, motivational interviewing, communication skills such as active listening, and use of tele-health and home-tele-health technology.

E. University of California Davis Health System

1. Background and History

The University of California-Davis Health System (UCDHS)'s "Depression Care Management" pilot projects (2011 and 2012), through a Pay-For-Performance Initiative, led to the development of the Care Coordination Program (CCP) in 2013 that utilizes the Collaborative Care model for behavioral health and disease management. The goal of the CCP is to improve interdisciplinary collaboration within the UC Davis Primary Care Network (PCN), as many patients have limited access to in-person psychiatry consultations when PCPs request specialty mental health care. PCPs now refer patients to the CCP to target mental health outcomes through care management, PCP education initiatives, and electronic consultations with psychiatrists. The education initiatives within the CCP have contributed to the program's popularity and "buy-in" from PCPs and Health System administration.

2. Program Description

The UCDHS CCP targets mental health outcomes within each PCN through care management, PCP education initiatives, and electronic consultation using referrals to Care Managers (Licensed Clinical Social Workers - LCSWs and Nurses). The most common referrals are for depression, diabetes, obesity and smoking cessation. There are an increasing number of referrals for patients with behavioral health resources to support patients with co-morbid psychiatric and medical disorders. The PCP places these referrals through an order-set within the Electronic Medical Record (EMR), briefly detailing the consultation question(s), with the only exclusion criteria at this moment being child and adolescent patients. The Care Managers receive the referrals and then work closely with the patients, PCPs and psychiatrists to improve medical and psychiatric outcomes.

3. Adaptation of Collaborative Care Essential Elements

(a) Team-Driven Care

The Care Coordination team consists of a Psychiatrist, Care Managers (LCSW and nurse) and a clinical pharmacist. Upon receiving a referral, the Care Manager contacts the patient by telephone to assess for specific needs. The assessments include inquiry into medication adherence, clinical outcomes data (e.g. PHQ-9 or GAD-7), side effects, risk assessment and resources available. The Care Coordination team meets weekly to "round" on active patients. Each member of the team fully engaged to influence and guides the treatment approach. The Psychiatrist leads the team in data review, diagnostic clarification, and opportunities to improve outcomes through treatment adjustment or resource referrals.

The assessments and recommendations from the team meetings are recorded into EMR and, to ensure continuity of care between the Care Coordination team and the PCP, the psychiatrists often follow-up with a communication through the EMR to the PCP, particularly if there are recommendations for medication adjustment. These communications allow an opportunity for teaching, which may include the rationale for a particular diagnosis and explanation of the treatment recommendations. In addition to weekly care coordination team meetings, PCPs frequently contact the psychiatrists for brief communications and "curbside" consultations. Case Managers have access to psychiatrists' pagers and mobile numbers to ensure real-time assistance with urgent questions. These

personal communications add to PCP satisfaction, making it easier to garner PCP and administrative support for the Collaborative Care model. Psychiatry involvement within the Care Coordination Program has been rated very highly by both PCPs and care managers.

(b) Population-Focused Care

Each Case Manager has a caseload of approximately 100 patients, while weekly team meetings normally cover 10-14 patients over a 2-hour session. Case Managers guide the weekly team meetings through presentation of patients in whom the Case Manager identifies a question regarding mental health. Practically, this means new referrals from PCPs or follow-ups from discussions during a previous team meeting. As such, there is no registry component consistently utilized to guide care.

(c) Measurement-Guided Care

PHQ-9 and GAD-7 assessments are easily accessible within the EMR as a drop-down menu, and PCPs are strongly encouraged to assess for depression and anxiety using these brief assessment tools for each patient they refer for mental health care. The Care Manager incorporates the PHQ-9 and the GAD-7 into the patient presentation during the CCP meetings. Measurement-based care, including a "treat-to-target" philosophy, is frequently used in CCP team meetings.

(d) Evidence-Based Care

Initial telephone encounters from Care Managers include motivational interviewing, brief supportive therapy, and elements of Cognitive Behavioral Therapy, including Behavioral Activation. Manuals for Care Management to standardize some evidence-based practices are currently under development, and monthly in-services delivered by the psychiatric consultants with Care Management staff are provided on behavioral health topics such as depression and anxiety disorders in the medically ill, personality disorders, eating disorders and others.

4. Accountability and Quality Improvement

Initial quality improvement (QI) analyses have demonstrated reductions in healthcare utilization for patients enrolled in CCP along with cost reductions as well (*unpublished work, UCDHS Care Coordination Value Analysis, November 2014*). As the CCP evolves and is refined, ongoing QI will be crucial in determining the optimal patient population to target (choosing the "right" type of patients), metrics for evaluating treatment teams and outcomes of physician education.

5. Funding

UCDHS has significantly invested in the Collaborative Care model. Beginning in 2010, the successful UCDHS "Depression Care Management" project through two consecutive Pay-For-Performance pilot grants brought a psychiatrist into a select number of UC Davis Primary Care Network (PCN) clinics for Lunch & Learn sessions. In 2013, the continuing positive feedback motivated the UCDHS to fund the Care Coordination Program (CCP) within all 17 of the PCNs. The services of this program were funded through the Department of Health Management and Education who support the salaries of the Care Managers (initially four LCSWs and five nurses) in addition to 0.1 FTE of two psychiatrists supported by the UCD Department of Psychiatry and Behavioral Sciences.

Additionally, a Psychosomatic Medicine Fellow maintained their own treatment team for the 2014-2015 academic year in periodic meetings with protected time.

Because of the acceptance and success of the CCP, the University of California Davis Health System has recently been awarded separate grants to be conducted within the CCP framework. One award is to evaluate asynchronous and synchronous telepsychiatry (AHRQ funded RO1 study) consultations at two PCNs and the other is to evaluate asynchronous telepsychiatry (internal Practice Management Board Innovations Grant) consultations for Medicare patients within two PCNs.

6. Lessons Learned

(a) Importance of care managers

The importance of Care Managers cannot be overstated, as they engage in a continuous process of refining their skills of bridging information between the PCP, patient, and Psychiatrist. A good fit for the Care Manager role is one who possesses skills in rapid diagnostic assessment, efficient presentations, excellent communication skills (particularly when shifting between patients, PCPs, Psychiatrists and team meetings) and ability to deliver evidence-based brief interventions. They also have extensive knowledge of local resources, particularly important because of the high percentage of referred patients covered through Medicare and Medicaid programs, which offer limited options for access to mental health services.

(b) Local champions and attention to stakeholders

Primary care and other local champions for integrated care exhibit a sincerely held belief in integration and have an ability to tactfully engage and navigate the varying partners important to integration success, including human resources staff, physicians, nursing leadership, mental health leadership, social work leadership and system administrators and information technology experts. These champions explore innovative ways for systems improvement such as creative funding sources for innovations including telepsychiatry for under-served areas. Because of strong across-the-board buy in, the CCP teams were able to offset the large behavioral health needs encountered by PCP turnover, at times, through shared coordination and communication, improved access to consultations and support, and expert evaluation and triage services that would have otherwise been lacking. As a result of obtaining crucial administrative support and meeting the stakeholders' needs first, the CCP program has achieved greater success.

VIII. TABLE 4. IN-VIVO COLLABORATIVE CARE MODEL IMPLEMENTATION CHARACTERISTICS

	Population	Eligibility	Referral Mechanism	Funding	
				Initial	Sustained
MHIP	Initial: Uninsured in 2 WA state counties; Current: Contracted Behavioral Health Benefit of a non-profit Medicaid Vendor	Adults with behavioral health needs receiving benefits from designated Medicaid vendor	Uniform screening in Primary Care; Primary Care referral for Behavioral Health; Warm Handoffs	State Legislative Action; Levy Funds; Defined proportion of CM revenue tied to performance	Non-profit Medicaid Vendor Benefit
DIAMOND	Adults with eligible private health insurance plans	Adults with PHQ-9 score ≥ 10; Negative Bipolar Screen; Benefits through 1 of 6 private insurers	Primary Care Screening for Those eligible; Warm Handoffs; Specialty Referrals Required Assignment of PCP	Multi-payer (N=6), private; Pooled-data allowed for range of PMPM available to clinical systems on an individually negotiated rate; individuals are eligible for 12 mos of PMPM	Not applicable
RESPECT-Mil	Active-duty military	Adults with Positive Screen on either 4-Item PTSD Screener in Primary care (Prins 2003; PC-PTSD ≥2) or PHQ-2 (≥1); followed by Positive PCL and PHQ-9	PCP option for referral to Care Manager with RESPECT-Mil or traditional care mechanisms	Salaried; 1 equivalent RN care facilitator and 1 administrative assistant equivalent per 10,000 military personnel in participating clinic catchment area; 5,000 minimum for funding of one of each	Transitioned to PCMH funding at discretion of DoD, folded into PCMH payment methodologies

Veterans Health Administration PACT	Adult Veterans	Behavioral health disorder; at discretion of primary care physician (their comfort level, access)	Warm-handoff to Care Manager in primary care setting primarily, EMR order referral secondarily	Salaried; CPT codes generated for BH services to track process outcomes and volume of services provided	Not applicable
UC Davis Coordinated Care Teams	Adult persons with Primary Care within UC Davis Primary Care Network (PCN)	Behavioral health disorder; at discretion of primary care physician (their comfort level, access)	Electronic order entry in EMR	Grant-supported "pay for performance" pilot Lunch and Learns with psychiatrists in primary care	California Department of Health Education and Management (salaried Care Managers), UCDHS Department of Psychiatry FTE Psychiatric Faculty, Psychosomatic Medicine Fellow; Two new grants, an R01 and internal funding for ongoing telepsychiatry efforts

IX. TABLE 5. IN-VIVO COLLABORATIVE CARE MODEL ADAPTATION OF ESSENTIAL ELEMENTS

	Team	Population Health			Measurement Based Care Outcomes	Evidence Based Care	
		Caseload	Registry	Caseload, Supervision		Training	Algorithms
MHIP	PCP, Care Manager/Behavioral Health	40-100 per Care Manager	Real-time MHITS, Web-Based	Protected time, typically weekly, for	PHQ-9, GAD-7, AUDIT, MDQ, DAST[1]	Systematic and ongoing training	System-wide, published

	Specialist, Psychiatrist Consultant		Registry, separate from EMR; tracks clinical outcomes and lapses in care	Consulting Psychiatrist and Care Manager		support for Care Managers and Psychiatric Consultants	algorithms; common medications used and educational materials for PCPs
DIAMOND	PCP, Care Manager/Behavioral Health Specialist, Psychiatrist Consultant	100 per Care Manager, 50-80 common	Real-time Web-Based Registry, Managed by 3rd Party Implementation Support	Weekly as allowed with Care Manager, Psychiatrist	PHQ-9, GAD-7, AUDIT, MDQ	Ongoing modeling, backup of non-nursing trained Care Managers by nurses was helpful	None
RESPECT-	PCP, PCP clinic nurses, PCP office staff, PCP Depression and PTSD Nurse, Consulting Psychiatrist	50-80 per Care Manager	Real-time web-based PTSD and Depression registry; Capacity to target persons lapsing in care; triage worsening clinical outcomes	Protected with PTSD/Depression NCM and consulting psychiatrist weekly	PHQ-9, PCL	RESPECT-Mil Implementation Team; On-boarding orientations, monthly support calls and once-yearly on-site visitations with report cards	Standardized algorithms were in place for PTSD/Depression and distributed to all team-based participants

Veterans Health Administration PACT	At least one co-located Behavioral Health Clinician with each Primary Care clinic; PACT staffing averages 0.5 FTE Psychiatrist per primary care clinic, 1.11 FTE psychologist, and 0.69 mental health nursing equivalent (Care Management)	Not defined.	Behavioral Health Lab (BHL) Software System allows for patient-level behavioral health tracking and monitoring, clinical decision support and program-level performance monitoring.	Variable across clinic implementation site; dependent upon physical co-location, space and funding availability	No consistent program-wide clinical outcomes; Depression outcomes measured for TIDES program	Nationally curated trainings and patient-education materials for various behavioral health conditions	Centrally supported algorithms available through on-line resources for review
UC Davis Coordinated Care Teams	Psychiatrist, Care Manager (LCSW and a Nurse), Pharmacist	100 per care manager	None consistently utilized	Weekly; physically-present team-members discuss 12-14 patients selected for review by CM	PHQ-9, GAD-7 embedded within EMR system for easy review during caseload supervision	Nurses and LCSW trained on EB Psychosocial Interventions	Psychiatrists "curbside" with PCPs regarding stepwise approach to management of common disorders

[1]PHQ-9: Patient Health Questionnaire 9-Item (K Kroenke, Spitzer, and Williams 2001), GAD-7: Generalized Anxiety Disorder 7-Item (Spitzer et al. 2006), AUDIT: Alcohol Use Disorders Identification Test (Frank et al. 2008), MDQ: Mood Disorders Questionnaire (Hirschfeld 2000), DAST: Drug Abuse Screening Test (Skinner 1982).

IX. FUTURE DIRECTIONS

Collaborative Care models represent a compelling solution for multiple challenges faced by healthcare systems seeking to integrate behavioral health with primary care services. Robust implementations have consistently demonstrated the capacity to achieve the "triple aim" of systematic reform efforts (W. J. Katon and Unützer 2013)-- improving the experience of care, improving the health of populations, and reducing per capita costs of health care. While much has been achieved, further efforts are necessary to realize the promise of behavioral health integration. The following recommendations highlight areas in need of additional research and development. **Table 6** lists the summary recommendations as noted in **bold** in the text.

A. Use of consistent language and terminology when referring to integrated care implementations

At present, there is marked variability in regards to the terminology of "integrated care". Terms like "collaborative care", "coordinated care", "co-located care" are often used interchangeably, leading to challenges in defining a common core standard of integrated care models and comparison of implementations. The skillsets and training backgrounds of personnel involved in "integrated care" also varies highly, yet many persons with widely varying backgrounds may be referred to as the "mental health specialist", "behavioral health practitioner" or "care manager" – in addition to a number of other terms.

To be sure, the Collaborative Care Model requires a multidisciplinary team for implementation and is adaptable in a variety of settings with different degrees of workforce resources. Utilizing more standardized terms can help systems to advance their "integrated care" programs toward more evidence-based approaches through clearer understanding of the meaning of "Collaborative Care".

Recommendations:

Develop a standardized glossary of evidence-based "integrated care" terminology in partnership with other essential allied organizations.

B. Ongoing emphasis on psychiatric physician workforce training and development

The American Psychiatric Association (2014) has enumerated several core competencies needed by psychiatrists who participate in integrated care models:

1. Familiarity with models of healthcare payment
2. Knowledge of electronic medical records and registries
3. Operational familiarity with quality and performance metrics
4. Ability to participate in team-based approaches to care under physician oversight
5. Skill in providing caseload supervision and decision support to care managers or ongoing evaluation and follow-up visits with a psychiatrist
6. Knowledge of principles of population management
7. Ability to communicate with professionals in a variety of medical, social services, and administrative disciplines

Integrated behavioral health is growing rapidly, and there are limited training resources on this topic. The University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center (http://aims.uw.edu/resource-library/psychiatry-resident-training-collaborative-care, 2015a) has developed a clinical rotation curriculum for Psychiatry residents that introduces a senior resident to the role of the psychiatric consultant in a Collaborative Care team. Fellowship opportunities and post-graduate training experiences are now also offered for psychiatrists interested in furthering their skillset in Collaborative Care at the AIMS Center as well. The Collaborative Care faculty psychiatrist provides weekly caseload supervision and individual case reviews of four to six patients weekly. Residents participate in interdisciplinary care team meetings. Content of the teaching includes introduction to the theory and practice of Collaborative Care teams, case finding, differential diagnosis, case formulation, treating to target, team building, workflows and quality improvement. A recently released report from the American Psychiatric Association Council on Medical Education and Lifelong Learning details training requirements and current experiences linked to ACGME milestones competencies for Collaborative Care models (Summers et al. 2014).

There are also effective modules for training psychiatrists transitioning into integrated behavioral care roles in the principles and practice of Collaborative Care. For example, the AIMS Center (UW AIMS Center 2015) and the Center for Integrated Health Solutions, supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), have structured training programs psychiatrists can take advantage of to prepare for work in Collaborative Care. The AIMS Center/SAMHSA's program (Ratzliff et al. 2012) has modules that include building an integrated care team, principles of psychiatric consulting in primary care, behavioral interventions and referrals in primary care, medical patients with psychiatric illness, the evidence base for Collaborative Care, roles for a psychiatrist in team-based care, and making the case for integrated behavioral health in primary care. The American Psychiatric Association has course offerings in Collaborative Care at annual scientific meetings coupled to in-depth reading materials (Raney 2015c). In addition, the APA will soon have available online training modules available for CME credit.

Recommendations

Further expand training opportunities within graduate medical education on evidence-based models of integrated care in collaboration with the American Board of Psychiatry and Neurology (ABPN).

Expand Continuing Medical Education (CME) opportunities for physicians, especially online courses paired with CME credit.

Incentivize ongoing training and standardization through a professional certification program.

C. System-wide implementation support with focus on accountability, quality improvement and the use of information technology

Review of existing large-scale Collaborative Care demonstrations reveals several consistent types of resources necessary for quality implementations. These include the need for ongoing training of healthcare team members to provide Evidence-Based Care (EBC); consistent use of disease registries to allow for population-focused team efforts, individual team-member accountability and patient-level follow-up; and standardized treatment manuals to facilitate stepped-care and EBC. Furthermore, whole-team accountability and quality improvement can be operationalized on the frame of these core components, which guards against inevitable programmatic drift without a structured measurement system.

Measurement of individual patient health outcomes via a registry is an essential tool to achieve successful outcomes, and is often one of the last components to be implemented within "integrated care" models, if it is included at all. Because healthcare information technology is still relatively nascent, current registries often exist in parallel to Electronic Medical Record (EMR) systems, creating cumbersome duplicative workflows and reporting

mechanisms for Care Managers, physicians and other team members. Consequently, this is a rate-limiting step to full-scale evidence-based Collaborative Care implementation.

Once registry functionality is firmly embedded, Collaborative Care teams can more accurately measure their outcomes, clinical implementations can be seen in aggregate, and effective performance measures can be established which drive improvements in patient health and program efficiency.

Recommendations

Develop standard minimum functional criteria for disease registries and Information Technology in Collaborative Care.

Advocate for the inclusion of these minimal criteria in existing EMR platforms or at the level of Health Information Exchanges.

Develop common team-based performance benchmarks for use in Collaborative Care implementation.

Design a "road-map" to Collaborative Care implementation to assist systems invested in evidence-based integrated care delivery.

D. Standardized and coordinated training for all healthcare personnel involved in Collaborative Care Model implementation, including Primary Care and Care Management Associations

In-vivo implementations of Collaborative Care require steadfast attention to workforce training for all team-based personnel. Because there is considerable regional diversity in background and qualifications for Collaborative Care healthcare providers and care managers, a clear training curriculum that expands upon the roles of the Primary Care Physician as well as the Care Manager is necessary, and should align with existing training programs available to integrated care psychiatrists.

Recommendations

Partner with allied behavioral health organizations (Psychology, Social Work, Advance Practice Nursing, Professional Counselors etc…), care management and primary care (American Association of Family Practitioners, American College of Physicians, American Academy of Pediatrics etc…) to develop interdisciplinary training programs focusing on the respective roles within the Collaborative Care Model.

Partner with allied organizations responsible for the training of future behavioral health, care management and primary care practitioners to develop opportunities to formally incorporate Collaborative Care earlier in the professional curriculum.

E. Development of standardized measures to assess process outcomes related to essential core elements of Collaborative Care

A core feature of accountability and quality improvement is the capacity to measure processes of care. When clinical outcomes are sub-par, this allows for identification and correction of possible sources of under-implementation. Given the definable essential elements of Collaborative Care, process measures may be derived that approximate these elements and guide more robust implementation.

Recommendations

Support the development of process measures that align with the four essential elements of Collaborative Care.

Coordinate with national and regional entities, including payer and provider stakeholders, to disseminate a common set of process measures for Collaborative Care.

F. Support for testing and refining definitions and implementations of essential core elements through ongoing process improvement

The essential elements of Collaborative Care require ongoing testing, validation and refinement. Additionally, they should be associated with individual clinical outcomes and system-wide outcomes, costs of care and satisfaction in care delivery. It may be arbitrary to segregate each of the elements, but attention to them as independent entities may lead to increased awareness and fidelity to research-level implementations and outcomes.

Recommendations

The APA and APM should work in a coordinated fashion to support ongoing scientific research into the effectiveness of each of the essential elements of Collaborative Care in aggregate and individually, exploring opportunities to add or subtract essential elements as necessary to streamline implementation, effectiveness and efficiency of Collaborative Care models.

The APA and APM should support for further implementation research that runs in parallel to the effectiveness of the core elements.

G. Advocacy for payment mechanisms that align with the essential elements of effective integrated care and are tied to performance-based incentives

Payment reform has proven to be a significant barrier to wider implementation of Collaborative Care Models. Significant task-shifting and time commitments are required for team-members, all of which require practitioners to work outside of their typical reimbursable scope of duties. As such, healthcare providers are at risk for engaging in Collaborative Care models unless reimbursement strategies are in place. In-vivo demonstrations in this report illustrate the breadth of payer systems willing to invest in the Collaborative Care model provided the implementation is true to the essential core elements of Collaborative Care.

Systems working within full-scale Collaborative Care offer a realistic option to operationalize clinical pay-for-performance incentives for healthcare providers that have been proven to improve efficiency in care. Consequently, Collaborative Care is an enticing platform of services delivery for "integrated care" models from the payer perspective, but the myriad of terms and non-evidence-based implementations serves to confuse payer stakeholders and threatens to halt momentum for integration of behavioral health and primary care.

Recommendations

APA and APM should create opportunities to educate public and private payer stakeholders on the essential elements of Collaborative Care models.

APA and APM should develop resources for members to educate local and state payers of health services on essential elements of Collaborative Care models.

APA and APM should support efforts to continue to research the cost-savings and added value of Collaborative Care model implementation in real-world settings.

H. Advocacy for state and federal-level policy favoring implementation of evidence-based integrated care

A significant portion of mental health services are provided through state-level Medicaid programs which have yet to consistently recognize or implement through payment mechanisms the substantial evidence-base for Collaborative Care programs. State innovation is often driven by Federal incentive programs that offset the financial risk for program start-up, workforce training and investment in overhead such as Information Technology supports. Public and private payer entities rarely are recognized or rewarded for their contributions to innovation in payment.

Recommendation

Develop advocacy platforms directed at state and federal agencies that foster the incorporation of Collaborative Care models into the existing menu of reimbursable services.

Partner with allied medical and non-medical stakeholders in advocacy measures calling on funders to recognize, through adoption of alternative payment mechanisms, the potential value of Collaborative Care models in healthcare reform efforts.

Develop recognition programs for stakeholders investing in Collaborative Care models to foster competition and positively reward innovation.

I. Partnering with medical groups and organizations to increase healthcare providers' awareness of Collaborative Care.

Medical groups representing primary and specialty care are logical partners in educating healthcare providers about the evidence base that supports the advantages of Collaborative Care. Penetrance and acceptance of Collaborative Care can be facilitated by awareness of the triple-aim benefits of Collaborative Care and advantages for improving access and outcomes among medical-surgical populations that can benefit from the model. Residency training programs across a spectrum of physician and other provider specialties could benefit from exposure to Collaborative Care models during required psychiatry or mental health content.

Recommendation

Partner with allied medical stakeholders in increasing healthcare provider awareness of Collaborative Care models and the evidence that supports their outcomes.

Consult with medical and other healthcare professional organizations regarding inclusion of Collaborative Care training during required psychiatry or other mental health rotations or content.

J. Leveraging of technology to improve Collaborative Care outcomes.

One of the challenges of dissemination of Collaborative Care is that many geographic areas and many smaller primary care clinics do not have or do not have access to local mental health providers who can be on-site, even part time. Telemedicine-based Collaborative Care virtually co-locates and integrates mental health providers into primary care settings. Virtual care offers the possibility of relieving mismatches in mental health care needs and available resources. There have been few comparisons of outcomes of patients assigned to practice-based and telemedicine-based Collaborative Care (Fortney et al 2012, Hilty and Yellowlees 2015), but early evidence is that outcomes are as good or better. A significant barrier remains securing a payment model in the fee-for-service environment that facilitates the non-patient contact elements of Collaborative Care, such as registry management and case supervision.

Recommendation

Advocate for outcomes research related to elements predictive of optimal implementation of telemedicine-based Collaborative Care.

Include virtual clinical models when advocating for payment models that align with the core elements of Collaborative Care.

Table 6: List of Workgroup Recommendations, Future Directions

Education and Training
Develop a standardized glossary of evidence-based "integrated care" terminology in partnership with other essential allied organizations.
Further expand training opportunities within graduate medical education on evidence-based models of integrated care in collaboration with the American Board of Psychiatry and Neurology (ABPN).
Expand Continuing Medical Education (CME) opportunities for physicians, especially online courses paired with CME credit.
Partner with allied behavioral health organizations (Psychology, Social Work, Advance Practice Nursing, Professional Counselors etc…), care management and primary care (American Association of Family Practitioners, American College of Physicians, American Academy of Pediatrics etc…) to develop within-field continuing education training programs focusing on the respective roles within the Collaborative Care Model.
Partner with allied organizations responsible for the training of future behavioral health, care management and primary care practitioners to develop opportunities to formally incorporate Collaborative Care earlier in the professional curriculum.
Partner with allied medical stakeholders in increasing healthcare provider awareness of Collaborative Care models and the evidence that supports their outcomes.
Incentivize ongoing training and standardization through a professional certification program.
Implementation Support
Develop standard minimum functional criteria for disease registries and Information Technology in Collaborative Care.
Advocate for the inclusion of these minimal criteria in existing EMR platforms or at the level of Health Information Exchanges.

Develop common team-based performance benchmarks for use in Collaborative Care implementation.
Design a "road-map" to Collaborative Care implementation to assist systems invested in evidence-based integrated care delivery.
Support the development of process measures that align with the four essential elements of Collaborative Care.
Coordinate with national and regional entities, including payer and provider stakeholders, to disseminate a common set of process measures for Collaborative Care.
Advocate for outcomes research related to elements predictive of optimal implementation of telemedicine-based Collaborative Care.
The APA and APM should support for further implementation research that runs in parallel to the effectiveness of the core elements.
The APA and APM should work in a coordinated fashion to support ongoing scientific research into the effectiveness of each of the essential elements of Collaborative Care in aggregate and individually, exploring opportunities to add, subtract or redefine the essential elements as necessary to streamline implementation, effectiveness and efficiency of Collaborative Care models.
Payment Reform
APA and APM should create opportunities to educate public and private payer stakeholders on the essential elements of Collaborative Care models.
APA and APM should develop resources for members to educate local and state payers of health services on essential elements of Collaborative Care models.
APA and APM should support efforts to continue to research the cost-savings and added value of Collaborative Care model implementation in real-world settings.
Develop advocacy platforms directed at state and federal agencies that foster the incorporation of Collaborative Care models into the existing menu of reimbursable services.
Partner with allied medical and non-medical stakeholders in advocacy measures calling on funders to recognize, through adoption of alternative payment mechanisms, the potential value of Collaborative Care models in healthcare reform efforts.
Develop recognition programs for payers investing in Collaborative Care models to foster competition and positively reward innovation.
Include virtual clinical models when advocating for payment models that align with the core elements of Collaborative Care.

*The above recommendations are divided into three categories: education and training, implementation support and payment reform.

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Item JRC #8.L
Joint Reference Committee
October 2015

Executive Summary

Action Items

Will the Joint Reference Committee recommend to the Board of Trustees that additional unnecessary interventions in psychiatry be determined under the premise that a new ABIM Foundation Choosing Wisely list will be developed?

- See ABIM Foundation Choosing Wisely material, Attachment #1
- See original APA Choosing Wisely List, Attachment #2

The Council wishes to inform the Joint Reference Committee about the recommendations or edits of the following positions statements that were assigned to the Council Quality Care:

Will the Joint Reference Committee recommend to the Assembly that the Position Statement on The Right to Privacy be referred to the Council on Psychiatry and the Law and the Council on Advocacy and Government Relations?

- See Attachment #3

Will the Joint Reference Committee accept the revisions to the Position Statement on College and University Mental Health, and recommend the updated statement be approved by the Assembly?

- Please see red-lined edits, Attachment #4

Will the Joint Reference Committee recommend to the Assembly that the current version of the Position Statement on Infectious Disease Epidemics Including H1N1 be retired?

- Please see Attachment #5

Will the JRC support the request of the Council and recommend to the Assembly that if retirement of the Position Statement on Infectious Disease Epidemics Including H1N1 is approved, to support the development of a new statement reflective of vaccines in general?

- Please see Attachment #5

Will the Joint Reference Committee recommend to the Assembly that the Position Statement on Posttraumatic Stress Disorder and Traumatic Brain Injury be retained as currently written?

- Please see Attachment #6

Referral Updates

In response to the request that the Council on Quality Care provide their opinion on the issue of Timely Reimbursement for Psychiatric Treatment (ASMMAY1512.G) and address the appropriate scope or universe to implement this paper and if legislation might be needed.

- The Council on Quality Care yields to the opinion of the Council on Health Systems and Finance that this paper be sent back to the author for further clarification including a definition of the problem that is being addressed. It was noted that there are state laws currently in place that dictate allowable turnaround times for claims payment. How this proposal would interact with those laws is unclear. CHSF further recommends, given this, and the paper's request for legislation, that this be refer to CAGR for input as well.

- Per the Council on Health Systems and Finance recommendations, and the opinion of the Council on Quality Care, the Council on Quality Care request to be removed from this assignment at present time, as the group agreed, this is not currently a quality issue.

In response to the request that the Council on Quality Care provide their opinion to the Council on Minority Mental Health and Health Disparities on the Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault (ASMMAY1512.H).

- The Council on Quality Care recommends working with outside groups that assist with victim advocacy.

In response to the request that the Council on Quality Care provide their opinion to the Council on Medical Education and Lifelong Learning on the issue of Promoting Military Cultural Knowledge among Psychiatrists (ASMMAY1512.M).

- The Council on Quality Care agreed that the question, "Have you or someone close to you served in the military?" as part of the clinical evaluation, is a good question to ask as related to quality care, but that it will be important to develop educational materials to assist psychiatrists in what to do with the information they elicit from this question.

Meeting Minutes

- See the minutes of the meeting of the Council on Quality Care, Attachment #7

APA Document Reference No. 910007

The Right to Privacy
POSITION STATEMENT

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

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

This statement was proposed by the Committee on Gay, Lesbian, and Bisexual Issues[1] *of the Council on National Affairs..*

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

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

The American Psychiatric Association is a national medical specialty society, founded in 1844, whose 36,500 physician members specialize in the diagnosis and treatment of mental and emotional illnesses including substance use disorders.

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Position Statement on College and University Mental Health

Approved by the Board of Trustees, December 2005
Approved by the Assembly, November 2005

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

A Presidential Task Force on Mental Health on College Campuses was appointed by the American Psychiatric Association (APA) in 2005. An earlier group, the 1972 APA Task Force on College Mental Health, issued a statement focusing on the need for psychiatrists working in college settings to understand the special nature of work in colleges. While we agree with the general thrust of these comments, changes in both psychiatric practice and the college student population necessitate a new policy statement:

The need for mental health services on college and university campuses is increasing. More students enter college already taking psychiatric medications and most colleges report increases in medications being prescribed at their mental health services. Further, most colleges report seeing increases in students with binge drinking, substance abuse, and severe psychopathology. Suicide is the second leading cause of death in college students. Going to college is often very stressful for late adolescents when faced with more intensive grade pressure, separation from parents and friends, and the continuing formation of one's identity. In addition, several disorders begin during late adolescence and early treatment is necessary.

There are institutional benefits to providing excellent mental health care on college and university campuses. Data show that treatment for mental health problems results in higher rates of student retention and graduation.

It is the position of the APA that all colleges and universities should:

1. have an established arrangement for timely access to necessary and appropriate psychiatric services for all students in need of mental health services. Such arrangements may include employed and/or consult- ing psychiatrists, as well as referral arrangements with local private practitioners. Arrangements should be in place for care to be coordinated in an appropriate manner. When students are refer- red out of their student health systems, care should be taken to minimize the risk of confidentiality breeches and professional ethical conflicts.
2.
3. ensure that psychiatrists have authority commensurate with their education and training ~~responsibilit~~y. This should include significant participation in assessment and treatment planning for students served in college and university mental health settings.
4. ~~assure that the treating psychiatrist role is clearly separated from the role of psychiatrist as practitioners,~~ hospitals, university health services and/or community mental health centers. ~~When students are referred out of their student health systems, care should be taken to minimize the risk of confidentiality breeches and professional ethical conflicts.~~
5. offer health insurance coverage programs to students that provide comprehensive coverage for mental health, including substance abuse treatment, and is with parity to insurance benefits for physical illness..-
6. provide students, parents and staff with easily accessible and culturally sensitive orientation information and ongoing education regarding wellness, general health, and mental health issues (including information about accessing emergency services). This should include problems associated with re-entry of students who have had to interrupt their education.
7. educate student health personnel about recognition of mental health problems.
8. have comprehensive suicide risk reduction and substance abuse prevention programs.
9. establish clinically informed policies that are responsive to and consistent with the ADA (Americans with Disabilities Act).
10. work with psychiatric residency training programs to increase educational opportunities in college and university mental health services. Consideration should be given to the establishment of post-graduate fellowship programs in college psychiatry.
11. work to educate the public as to the challenges and risks related to the college years, in partnership with the appropriate agencies (such as NIMH, NIDA, SAMSA).
12. work toward de-stigmatization of psychiatric illness and raising awareness among college students and faculty that psychiatric illness is common and effective prevention programs and treatments are available. ~~helping young people and their families make thoughtful choices about college.~~
13. support the expansion of research endeavors around college mental health issues and exploration of factors relating to prevention and resiliency.

Prepared by the Task Force on College Mental Health, May, 2005; revised by the Council on Children, Adolescents & Their Families, September 2005; and revised by the Joint Reference Committee, October 2005

Position Statement on Infectious Disease Epidemics Including H1N1

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

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

Developed by the Council on Research and Quality Care.

ISSUE: As the nation faces the onset of seasonal flu season and H1N1 continues to spread the APA acknowledges the increasing impact this will continue to make on the community. Many populations are vulnerable due to their situation, disease or socioeconomic position. Additionally individuals in schools and institutions are at additional risk due to their close proximity with each other.

POSITION STATEMENT:

With the infectious diseases such as H1N1 APA strongly supports:

1. Increased collaboration between psychiatry and primary care and public health to foster adherence, behavioral and medical interventions including psychiatric care for those exposed and infected.
2. Active and rapid planning for the special needs of vulnerable populations. In particular care and outreach is critically important for children; child and adult psychiatric patients, particularly those with chronic mental illnesses; those infected with HIV; schools; pregnant women; and the elderly.

The APA encourages psychiatrists and others to stay informed of the CDC guidelines and the vaccine recommendations in the statement.

Position Statement on Posttraumatic Stress Disorder and Traumatic Brain Injury

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

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

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

Developed by the Council on Research and Quality Care and revised by the Joint Reference Committee.

Council on Quality Care
September 10, 9AM-5PM
Richmond, Lobby Level
Hilton Crystal City, Virginia

I. Opening/Introductions: Grayson Norquist, M.D., Chair
Council Members in Attendance: Norquist, Young, Yager, Dalack, Altchuler, Zima, Beherens, Isles-Shih, Halverson, Vasan, Vo, Kidd

Council Members Absent: Pincus, Wilner, Kathol

Invited Guest Attendance: Anzia, Daviss Martin, Fochtmann, Shore, Pierce (via teleconference), Stephanie Demian (AACAP)

Administration Attendance: Wang, Kroeger, Kanefield, Shugarman, Mosciki, Daviss, Tatro, Duffy

A. Conflict of Interest/Disclosure Statements, *Attachment #1*
B. Appointment Recommendations
Three council member spots will open following the May 2016 Annual Meeting, the group was asked to share appointment recommendations with Ms. Shugarman and Dr. Norquist ASAP.

II. Minutes from last meeting
A. May 19, 2015 Annual Meeting, *Attachment #2*
Minutes approved.

III. Remarks
A. Dr. Levin
Thanked Council members by acknowledging participants active involvement and how the group's efforts will help mold the future of psychiatry. Efforts in the coming year will include determining a method to increase the pace and volume of the development of practice guidelines. The work that this group does, similar to other Council's, is cross-cutting within the association, as such, internal APA administration has made an increased effort to improve department interface. The Advocacy Policy Team, which meets regularly, is an internal effort to remove the organizational silos.

B. Dr. Binder
Identified members of the Council as those setting the standards for the future practice of psychiatry. Dr. Binder invited the group to consider the other councils or their reporting components in the development of products (e.g. practice guidelines).

A report from the APA Registry Workgroup, by Dr. Dalack was presented during the July 2015 BOT Meeting. In addition to Dr. Dalack's report, presentations were provided by representatives from the Council on Medical Specialty Societies (CMSS), the American Academy of Neurology (AAN), and the American Academy of Ophthalmology (AAO). The take away from this meeting was the acknowledgement of this being a huge project, that carries a hefty expense, and will eventually and probably generate money (though, not immediately). While there was resistance displayed by the BOT for psychiatry to take on this endeavor, Dr. Binder emphasized that "this is something that needs to happen." As a result of these presentations, the BOT determined the next step will include the development of a business plan (now referred to as a business case), which would answer some of the following questions: what could a society-led registry cost, what diagnoses do we focus on, how do we start, should we decide to move forward? Dr. Binder also shared that the Association would work with a consulting firm to develop the business case.

Discussion included how a society-led registry could be very relevant to the Council as a vehicle to display where standards in practice do and don't exist and what practice variations affect outcomes. This could have value to the Council on Research as a low cost or no cost resource for research.
Adding to Dr. Binder's remarks, Dr. Wang informed the Council of a new project headed up by the Department of Research called the CMS Enclave Virtual Research Data Center (VRDC) Project. The group learned that it will allow users to evaluate the impact of policy, payment, practices, and how changes in policy affect outcomes. It will be the responsibility of the various councils to pose the right questions to get the best use out of these data.

ACTION Item: ID questions/policy questions for CMS data search

IV. Reporting Component Updates

A. Steering Committee on Practice Guidelines, **Update provided by Dr. Fochtmann.**

a. **Practice Guidelines on Psychiatric Evaluations of Adults, third edition**

The full guidelines were published on PsychiatryOnline as an online book and in print on August 1, 2015. An executive summary of the guidelines was also published in August. A number of promotional, marketing and social media efforts began in August after the publication was released. In addition, Dr. Fochtmann will be leading a symposium on the guidelines at the 2016 Annual Meeting.

The guidelines were submitted and approved for inclusion by AHRQ's National Guideline Clearinghouse.

Staff has met with the Education Department to discuss the development of educational products to complement the new guidelines. Since much of the guideline content is of particular interest to students and residents, staff plans to reach out to ADMSEP, AADPRT, and the Association for Academic Psychiatry to collaborate on the development of learning tools for these populations. The development of PIPs will be discussed for the two areas in which practice gaps were identified, assessment of suicide risk and assessment of risk for aggressive

behaviors.

Staff is exploring the development of complementary tools to improve accessibility of the guidelines for psychiatrists, other clinicians, patients, the public, and other interested stakeholders (e.g., media, insurance companies). Staff anticipates creating unique guideline summaries for various audiences, broken down by module, for publication on psychiatry.org. Staff is also exploring the possibility of creating brief podcasts that would highlight the main points of the new guidelines and any major differences between the second and third editions.

Staff will be reaching out to Guideline Central to explore the development of quick reference guides and mobile- and web-based apps. Guideline Central works with 30+ medical specialty associations to develop these types of products exclusively. Guideline Central seeks external funding for product development, and they would be created at no cost to APA yet would create an additional revenue stream through royalty income.

b. Draft guideline on the use of antipsychotics to treat agitation and psychosis in patients with dementia

The draft guideline on the use antipsychotics to treat agitation and psychosis in patients with dementia was open for public comment on July 31, 2015. The link to view and comment on the draft was widely disseminated to stakeholders both internal and external to APA, and was highlighted in Psychiatric News Update as well as APA President Dr. Binder's column in Psychiatric News. The Committee has reached out directly to the Council on Geriatric Psychiatry to solicit their feedback, and will reach out to Assembly leadership in order to address any potential major concerns prior to the November 2015 Assembly meeting and vote. The public comment period ends on September 19, 2015, at which time the Guideline Writing Group will review the feedback and make changes as necessary.

c. Future Guideline Development

Many of the Committee's short- and long-term goals (≤ 1 year and ≥ 2-3 years) are contingent upon the anticipated hiring of a methodologist and writer for FY 2016. (These positions have been added to the 2016 budget and are pending approval by the BOT in December). Even with additional personnel, staff still would not have the capability to conduct its own systematic reviews for broad topics. For the short-term, the Committee still needs to rely on systematic reviews that have recently been, or will soon be, completed by AHRQ, especially for topics for which the body of literature is prohibitively large.

Moving forward, the Committee plans to develop guidelines under two models: 1) guidelines that address 3-4 clinical questions require extensive literature searches, and take up to 3 years to complete, and 2) guidelines that address 1 clinical question, have a more narrow literature base, and would take an estimated 12-16 months to complete. By adopting this approach, the Committee hopes to have a continuous pipeline of guidelines that are in development at any given time. The

Committee will also consider the development of other documents (e.g., practice advisories) that address topics that would not necessarily warrant a full guideline due to lack of evidence, but are nonetheless viewed as timely and critical for the field. The Committee has decided to discontinue the development of guideline watches so that resources may be channeled into both revising outdated guidelines and developing new ones.

Taking the above into consideration, the Committee is finalizing a queue of future guidelines from the following list:

1. Practice Guideline on the Use of Pharmacotherapy for Adults with Alcohol –Use Disorders
2. Practice Guideline on the Use of Antidepressants to Treat Depression during Pregnancy and the Postpartum Period
3. Practice Guideline on Bipolar Disorder
4. Practice Guideline on the Pharmacologic Treatment for Delirium
5. Practice Guideline on the Treatment of Binge Eating Disorder
6. Practice Guideline on Borderline Personality Disorder
7. Practice Guideline on the Treatment of Schizophrenia in Adults

Topics 1, 2 and 5: All have systematic reviews that were completed by AHRQ in 2014 and an in-process report of the US Preventive Services Task Force on depression screening in pregnant and postpartum women also includes substantial review of the evidence for antidepressant efficacy and harms. The guideline development process for these topics will begin with the identification of non-psychiatrists writing group members and reaching out to the APA Research Division about an expert survey.

Topics 3 and 7: These topics were nominated to AHRQ by APA. It was originally anticipated that the bipolar disorder review would be completed in early 2015. However, it has been delayed several times by AHRQ , with completion now anticipated in early 2016. SCPG will have plans in place to start guideline development immediately upon the completion of this review. Topic 7 was recently accepted by AHRQ, and guideline development will begin once that review is complete.

Topics 3 and 4: These topics have been identified as ones from our prior practice guidelines that require updating and are of importance to the field. The clinical specificity (1 question vs. 3-4) of the topics is such that staff, along with consultants and volunteers, will attempt to undertake the systematic review themselves. This will also serve as a litmus test for the feasibility of independently conducting some systematic reviews moving forward.

d. Status of NLM grant-funded research on the application of principles of medical informatics to guideline development and publication

The NLM funding has completed its final year of no-cost extensions and a final progress report is being prepared for submission to NLM. The survey on clinical information needs of psychiatrists will lead to several publications on the characteristics of psychiatrists that influence use information resources, the types

of informational resources that psychiatrists use and the types of questions that arise in the course of clinical care and result in accessing of information resources.

The grant also included development of a "gold standard" set of 20,000 abstracts from PubMed, PsycInfo and Cochrane Database that were screened for relevance to psychiatric practice guideline topics. Each reference is being screened twice with a final determination by a third individual if the initial ratings are discordant. Screeners were trained and had good inter-rater reliability before embarking on the "gold standard" reference screening task. The screening portion of the project is now nearing completion; the "gold standard" set of references will be used to develop machine learning algorithms to streamline future screening of references for guideline inclusion.

e. Next Steps

Within the next 3 years, the Committee hopes to have an infrastructure in place that will allow APA to undertake all of its own systematic reviews, whether this is accomplished through the use of outside vendors or consultants or by increasing staff resources. This would allow the Committee to end its reliance on AHRQ and their development queue, and drive guideline development based on APA's own topic prioritization rather than that of external bodies. Input from the Council on Quality Care, APA governance and membership and the profession as a whole will continue to be important in identifying topics of importance to drive timely and relevant guideline development.

The Council was interested in learning the process used to determine a guideline topic. Clarification was made that the Steering Committee on Practice Guidelines look at which previously developed guidelines are least current, in addition to referencing a survey completed by the Assembly and the SCPG. Consideration of existing AHRQ systematic reviews, and feasibility based on current volume of literature is also assessed.

Some voiced that other guideline developers identify topics utilizing a multi-stakeholder perspective that is not driven only by what AHRQ has available (because what is available isn't always timely for practice). It was agreed that more consideration should be placed on the clinicians who will utilize these guidelines.

Other points of discussion included the need to establish clinical validity of established measures of process and outcomes and a need for development of performance improvement guidelines. There was also discussion about having a separate development effort for guidelines in areas where evidence doesn't exist.

B. Committee on Mental Health Information Technology (CMHIT), update provided by Committee Chair, Dr. Steve Daviss

Members continue to request advice on which EHR is best to use. The CMHIT determined it would be beneficial for those who have utilized specific products to share their experience. While the Committee is in the process of developing a list of criteria that include features for what would make a good EHR, it has determined that the next step for the Committee is to develop a rating scale to define if an EHR meets the criteria

list. This prevents the APA from having to endorse a specific product, but allows members to provide feedback on a product. This rating system will model the work of the Workgroup on Software Applications and is scheduled to start mid-2016.

Further discussion among the Council suggested it would be beneficial to have a central location to access assessments for use with larger EHRs (e.g. Epic, Cerner) as well as sample templates.

ACTION item: Dr. Daviss recommended the development of an action paper to present to the Assembly this October that will set up an ad hoc feasibility workgroup to develop an electronic clinical decision support tool that would be licensed to IT vendors (EHR, registries, HIE, etc) and other interested entities. The Council supported Dr. Daviss move ahead on this action paper.

C. Workgroup Mental Health and Psychiatric Apps, update provided by Dr. Steve Chen
The work group has been busy since the May 2015 meeting; at which time the Council approved the workgroup's plan to start their work. This group is tasked with determining a method for rating software applications for use by psychiatrists. Currently, two methods for rating have been identified: 1) workflow created by the internal APA website staff or 2) member managed. It is anticipated that the demand for reviews will be made by clinicians and patients.

It was requested that during the workgroup's next update, they provide a progress report and goals with a strategy for their work. Slides will also be shared that provide more detail on the two methods for review.

D. Workgroup on Patient Safety, Update provided
The Workgroup, chaired by Dr. Geetha Jayaram, provided a written report to update the Council its accomplishments since May 2015.

"A. I have been on the Technical Expert Panel for CMS and they have discussed 2 topics of importance thus far:

1. Diabetes in patients on antipsychotics and the lack of a protocol to systematically assess, instruct and intervene with patients regarding self - care, exercise, proper nutrition and other preventative measures. Many areas of compliance, enforcement of measures and differences in levels of autonomy and paternalism toward patients was discussed. Feedback was provided about the importance of these assessments, but the absence of scientific trials to inform what needs to be done was emphasized.

2. The assessment and containment of violence and aggression on inpatient units, staffing problems, and lack of uniformity in screening patients was discussed. We all shared our own work and publications on the matter. Further topics are to be discussed in an ongoing manner.

B. Yad and I have been reviewing the 244 page guidelines sent to us by Sam regarding Patient Safety. The topics are of general interest to us but do not focus on the needs of psychiatric patients, particularly aggression and violence and suicide prevention. Infection, pressure ulcers and the like are not central to psychiatric care. Falls are a focus in the elderly and in particular groups of patients such as post ECT patients. Transitions and hand offs between and among institutions and med reconciliation are rather

general in scope and need fine tuning for psychiatry.

C. Dr. Jayaram has published the first book on Patient safety through Oxford University Press and the flier is attached.

D. Drs. Jabbarpour and Jayaram will be co -authoring a Focus issue dedicated to Patient Safety in the upcoming months.

E. Presentations for the upcoming APA meeting are being planned."

E. Workgroup on Standards and Survey Procedures

A discussion about efforts at the federal level regarding surveys and the potential move by the federal government to take on more survey/accreditation responsibilities was led by Council member, Steve Altchuler. The Council raised concern about this move by the federal government and its implications for future surveys. The group agreed that Dr. Altchuler develop a potential action paper on the subject. The plan is to bring this back for the discussion at the next Council meeting. Discussion also included developing a relationship between the APA Department of Government Relations and The Joint Commission Department of Government Relations.

F. Workgroup on Registries, update provided by Dr. Dalack

Dr. Dalack summarized the presentation of the work completed by the Workgroup on Registries provided to the BOT in July. He explained that the decision of the BOT was to have APA administration and members work together with a consulting firm to develop a business case. The plan and work of the consultants and this core group will be presented at the December 2015 BOT meeting.

G. Psychotherapy Caucus

It was recommended we ask the group to propose some specific efforts that would raise the profile of psychotherapy in psychiatry. Discussion among the Council members included whether the group should address questions like, should there be an APA message of retaining psychotherapy in the practice of psychiatry? What kind of psychotherapy should psychiatrists get trained in? The Council will ask the Caucus to outline one and three year goals.

H. Committee on Performance Measurement; updated provided by Dr. Karen Pierce (via teleconference),

Dr. Pierce summarized the first phone call of the committee, which took place on Friday, August 28, 2015. She explained that this is the organization's effort to become proactive in the quality measurement space. The committee will work to identify key stakeholders for clinical expertise, measurement expertise, and funding sources.

Ms. Shugarman asked the Council to consider how they may use their connections with individuals who are involved with different agencies to get the APA to the table at an early stage to inform the measure development process (agencies include, but are not limited to: CMS, SAMHSA, ASPE, NCQA). Members were asked to provide Ms. Shugarman with contact information, if available.

Some members of the Council expressed frustration with the outcomes measures that do exist, specifically PHQ-9. The psychiatric symptoms of this measure are very narrow to the exclusion of certain diagnoses (e.g. bipolar disorder, anxiety disorder). A question posed to the Committee: is there some way to have more multi-dimensional measures? Dr. Pierce agreed to bring this issue back to the Committee for further discussion.

V. Discussion: Review/Edits of position statements

A. Over the next several weeks, the Council will work to edit the statements identified as those needing updating.

VI. Discussion: JRC Actions

A. Timely Reimbursement for Psychiatric Treatment (ASMMAY1512.G)
The Council on Quality Care agreed that this is not a quality issue at present time and recommends the JRC remove the Council on Quality Care and refer this back to the Council on Health Systems and Finance.

B. Removing Barriers to Providing Compassionate Care to Victims of Sexual Assault (ASMMAY1512.H)
The Council on Quality Care recommends working with outside groups that assist with victim advocacy.

C. Promoting Military Cultural Knowledge among Psychiatrists (ASMMAY1512.M)
The Council on Quality Care agreed that the question, "Have you or someone close to you served in the military?" as part of the clinical evaluation, is a good question to ask as related to quality care, but that it will be important to develop educational materials to assist psychiatrists in what to do with the information they elicit from this question.

VII. Update: BOT appointed Workgroup on Telepsychiatry; Jay Shore, M.D.

The Work Group on Telepsychiatry was convened by Dr. Binder in order to address psychiatrists' ever-expanding role in the practice of telemedicine. Dr. Jay Shore, Chair, and the group had their inaugural call in March 2015 and, since then, has held a monthly conference call in order to further define the group's priorities and establish a timeline for a series of deliverables which include:

1) Create a resource/guide/toolkit for APA members that provides an orientation to telepsychiatry including guidance on its use in clinic settings.
2) Support and facilitate APA meeting content and programs in telepsychiatry (2015 IPS and 2016 Annual Meeting).
3) Develop policy and advocacy recommendations for telepsychiatry for APA policy and advocacy efforts.

Because this effort is very closely linked to ethics, the group queried the idea of recreating what already exists in the field of telemedicine. It was recommended to Dr. Shore that the Workgroup apply preexisting telemedicine standards to psychiatry where appropriate. Some voiced concern that if the APA doesn't develop the guidelines specifically for telepsychiatry, then another society will. Some agreed this might be a good opportunity for collaboration with outside stakeholder groups through joint guidelines.

VIII. Update: Ad Hoc Workgroup on Health Care Reform, Update provided by Ms. Shugarman

Ms. Shugarman reviewed a table that included the recommendations made by the Workgroup that

were to be acted upon by the Council. Ms. Shugarman was pleased to report that the majority of the recommendations the Council was responsible for have been completed or are ongoing efforts. One area that is yet to be addressed is the "creation of a CME activity that is designed for members on quality measurement in practice so that members can receive enhanced expert teaching in quality and performance measurement both at the practice and broader service levels." Dr. Altchuler referenced the Greenbelt training, a preexisting quality improvement methodology. He suggested making this already existing education method available. The group agreed that there is not a reason the training must be specific to psychiatry.

The group concluded their discussion on this report by requesting Dr. Martin request the Ad Hoc Workgroup meet to provide continued updates and summaries to the components that helped with their work.

IX. New Business

A. Discussion: Choosing Wisely Campaign

Dr. Norquist posed to the group that it should be proactive to develop a new list of practices that psychiatrists should not do. Perhaps we could identify over-utilized, but unnecessary treatments (i.e. how can we look to cut down on patient harm and financial expense). The group spent some time discussing this.

ACTION Item: It was agreed that this would be an opportune time to collaborate with the Council on Research and other councils to further examine whether there is a need for this kind of new list and what might be on it.

B. Discussion: Formulary Limitations

APA has a position that medication formularies should not be limited. However, payers are limiting formularies. The problem is these payers note that without the evidence to justify the addition of a new medication to a formulary (i.e., added clinical benefit) they don't see a need to increase the cost for treatment. There was discussion among the Council about the need for more evidence on the effectiveness of various medications and the utility of certain medications for specific populations. It was felt that without more information such as this, the payers would continue to restrict their formularies. The Council decided it would be helpful to work with the Council on Research to develop data to help support the limitation of formularies.

C. Future Activities (General Discussion on priorities/strategic planning)

a. Dr. Norquist explained that in the coming year we will have quarterly Council teleconferences. This will help move the efforts forward, rather than relying on the Fall and Spring meetings to advance the work. He will also ask the reporting components to focus on their goals and strategies for one and three years. He is asking that the reporting components generate a list of specific products they intend to produce. The intent is to be proactive and product oriented with clear deliverables.

b. Dr. Duffy addressed the group in an effort to welcome the Council as partners in testing DSM 5 measurement tools. Dr. Duffy stated that she will provide, to the group, which measures she is considering.

COUNCIL ON RESEARCH
REPORT TO THE JOINT REFERENCE COMMITTEE

Executive Summary

Since the Council's face-to-face gathering at the 2015 Annual Meeting, the group has been working on the following issues: 1) revising the APA position statement on atypical antipsychotic use for potential revisions and adherence to reformatting requirements; 2) development of a letter to APA leadership (Drs. Levin and Binder) regarding high priority research areas of importance to APA research, advocacy, and communication; 3) continuing work within their respective workgroups and committees on manuscript development; and 4) continuing collaboration with APA Administration in generating feedback in response to multiple requests for comments from various bodies on specific mental health initiatives (e.g., NIH Strategic Framework; NIMH Youth Mental Health Research Network, CHADD letter regarding formulary restrictions for ADHD medication).

The Council will hold their next in-person meeting at the 2016 APA Annual Meeting.

The Council brings the following Action Item:

Action Item 1: Will the Joint Reference Committee recommend that the Assembly vote to approve the revised Position Statement on Atypical Antipsychotic Medications?

- See Attachment 1 for revised and reformatted position statement.
- The statement is still relevant, but the Council is recommending that this statement be revised slightly for language and clarity. It also has been reformatted so that it conforms to the latest APA position statement formatting guidelines.

Referral Updates

The Council wishes to provide an update on the following Joint Reference Committee referral:

Referral Item Number: JRCOCT148.G.22
Title: Current Health Services Literature on Integrated Care Models
Action: Will the Joint Reference Committee refer the request from the Council on Healthcare Systems and Financing to the Office of Research to review the current health services literature on integrated care models, including physician-led and non-physician-led models, and summarize and organize this review in such a way that it can be used by APA administrative staff and members for integrated care education and advocacy?
Response: The Division of Research has completed its compilation of the literature, which is included here as Attachment 2. A more detailed report based on the literature review is under development.

Attachments

Attachment 1: Revised and Reformatted Position Statement on Atypical Antipsychotic Medications

Attachment 2: Articles on the 93 Integrated Care Programs Reviewed for this Referral.

Attachment 3: Draft Minutes from the Council on Research's 2015 Meeting of the September Components

Attachment 1

TITLE:
Position Statement on Atypical / Second Generation Antipsychotic Medications
~~Approved by the Board of Trustees, September 2009~~
~~Approved by the Assembly, May 2009~~

BACKGROUND:
Atypical antipsychotic medications, also called second-generation antipsychotics, are 5-HT2A/D2 receptor antagonists. They are classified as "atypical" based on their ability to diminish psychotic symptoms while producing minimal extrapyramidal side effects (EPS), including tardive dyskinesia , as compared to "typical" antipsychotics (Meltzer 2013). This may be clinically important given that EPS can contribute to medication discontinuation. Atypical antipsychotic medications include clozapine and those discovered afterwards, such as asenapine, olanzapine, quetiapine, risperidone, lurasidone, aripiprazole, and ziprasidone.

Atypical antipsychotics are FDA approved for the following disorders: schizophrenia, bipolar disorders, as an adjunct to antidepressant therapy for major depressive disorder (only quetiapine XR, aripiprazole, and olanzapine/fluoxetine in combination); and irritability associated with autism spectrum disorder (only risperidone and aripiprazole) (Maher & Theodore, 2012; Maglione et al., 2011). Clozapine is sometimes termed the "gold standard" of atypical antipsychotic drugs due to its superior efficacy in reducing positive symptoms of treatment-resistant schizophrenia (Meltzer 2013). In fact, it is the only medication currently approved for treatment-resistant schizophrenia. Compared to other antipsychotics, clozapine also has demonstrated superiority in reducing aggression and violence associated with psychosis; decreasing psychotic symptoms in Parkinson's disease; reducing risk of tardive dyskinesia; and lowering risk of suicide in schizophrenia or schizoaffective disorder (Meltzer 2013). However, clozapine does carry additional side-effects, including agranulocytosis, enhanced bone marrow suppression, hyperlipidemia, type II diabetes and the associated metabolic syndrome, motor and myoclonic seizures, and myocarditis (Meltzer 2013).

As noted above, atypical antipsychotics may be beneficial over typical antipsychotics in producing fewer EPS, including tardive dyskinesia, akathisia, and Parkinsonianism (Meltzer 2013). Despite their benefits, some atypical antipsychotics—particularly olanzapine, clozapine, quetiapine, and risperidone—can increase the risk of metabolic dysregulation and lead to weight gain, glucose intolerance, and hyperlipidemia (Meltzer 2013; Maglione et al., 2011). However, certain typical antipsychotics carry these same metabolic risks, and both classes of medications should be accompanied by routine monitoring of patients' weight and lipid profiles (Meltzer 2013). Other side effects associated with certain atypical antipsychotics include EPS, fatigue, and sedation.

Atypical antipsychotics have been used to treat schizophrenia and bipolar disorders in children and adolescents in the short-term, while long-term safety trials are still needed (Caccia 2013). Children appear to experience the same adverse event profiles seen in nonelderly adult populations, including agranulocytosis and neutropenia with clozapine, weight gain, hyperlipidemia, and glucose dysregulation (Caccia 2013). In older populations, atypical antipsychotic medications have been used to successfully treat schizophrenia; psychotic disorders; bipolar disorders; and unipolar depression with psychotic symptoms (Gareri et al., 2014). These medications should be used for these indications cautiously and at lowest effective dosages due to the potential for significant adverse events in geriatric patients, including increased risk of mortality, stroke, and EPS (Maglione et al., 2011; Gareri et al). For these reasons, off-label use of antipsychotics should especially be used with caution in elderly patients with dementia. In order to ensure that antipsychotics are used in a time-limited period in elderly patients with dementia, careful monitoring and periodic review by a psychiatrist is recommended.

Several areas have been identified as important targets for future research (Maglione et al., 2011), including more studies on minimum effective dosages; additional off-label clinical trials on medications beyond those most commonly studied thus far (i.e., risperidone, olanzapine, and quetiapine); efficacy trials and adverse events associated with newer atypical antipsychotics (e.g., asenopine, iloperidone,lurasidone, paliperidone); and more data on gender-, racial-, and ethnic-related variations in treatment efficacy and outcomes associated with atypical antipsychotic use.

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ISSUE:
Certain atypical antipsychotics appear to be associated with metabolic and cardiovascular side effects. Baseline metabolic function should be assessed at the start of medication therapy and periodically during the duration of treatment.

Atypical antipsychotics should be used with caution and on an appropriate basis in elderly patients with dementia. In order to ensure that antipsychotics are used in a time-limited period in elderly patients with dementia, careful monitoring and periodic review by a psychiatrist is recommended.

STATEMENT:
Given the current state of knowledge, including randomized controlled trials and observational studies, it is our opinion that the ~~new~~ second generation of antipsychotic medications ~~(except clozapine) need~~ should continue to be made available as first-line treatments for appropriate individuals throughout all systems of care. Clozapine is the exception, given its side-effect profile. However, ~~Similarly,~~ clozapine ~~needs to~~ should be

made available for individuals with treatment refractory psychotic disorders. Access to these medications needs to be made available in all systems of health care and by all public and private insurers, including all jails, prisons, and youth services facilities.

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Attachment 2

Articles on the 93 Integrated Care Programs Reviewed for this Referral.

1. Adler DA, Bungay KM, Wilson IB, Pei Y, Supran S, Peckham E, et al. The impact of a pharmacist intervention on 6-month outcomes in depressed primary care patients. *General Hospital Psychiatry* 2004;**26**(3):199–209.

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† This guide provides information on the Cherokee Health System and can be accessible at: www.hpoe.org/integratingbehavio

Attachment 3

Draft Minutes
Council on Research
2015 September Components Meeting
Hilton Crystal City; Arlington, VA
September 9, 2015; 9:30 a.m. – 12:30 p.m.

Member Attendance:
X Linda Carpenter, M.D
X Dwight Evans, M.D.
O Michael First, M.D. (excused absence)
X Joyce Johnson, D.O.
O Ned Kalin, M.D. (excused absence)
X John Krystal, M.D
X Glenn Martin, M.D.
X William McDonald, M.D.
O Charles Nemeroff, M.D., Ph.D. (excused absence)
X John Oldham, M.D.
/Daniel Pine, M.D.
X James Potash, M.D., M.P.H. (via conference line; excused absence)
X Rajiv Radhakrishnan, M.D.
O Carolyn Rodriguez, M.D., Ph.D. (excused absence)
X Anup Sharma, M.D., Ph.D.
X Jerome Taylor, M.D.
O Mauricio Tohen, M.D., Dr. P.H., MBA (excused absence)
X Alik Widge, M.D., Ph.D.

APA Administration Attendance:
/Alison Bondurant, M.A.
X Diana Clarke, Ph.D., M.Sc.
/Farifteh Duffy, Ph.D.
X Ricardo Juarez
/Kristin Kroeger
X Emily Kuhl, Ph.D.
/Saul Levin, M.D.
/Nicole Lewis
X Eve Mościcki, Sc.D., M.P.H.
/Maria Oquendo, M.D. (via conference line)
/Ranna Parekh, M.D.
X Philip Wang, M.D., Dr. P.H.

Note:
X - attendance for the full meeting
/ - partial attendance of the meeting
O - absence from the meeting

1. Opening Session

The meeting opened with Dr. Evans asking everyone to introduce themselves and declare any financial conflicts of interest.

The minutes from the 2015 Annual Meeting were unanimously approved.

2. Update from Dr. Maria Oquendo

Dr. Oquendo briefly spoke with the Council on a few issues of importance. First, she noted that, in the future, the APA Board of Trustees (BOT) will be requesting input (e.g., reviews of statements, suggestions for citations, etc.) from the Council on various informational issues so as to help the APA maintain a high level of public credibility. Dr. Evans agreed, noting previous attempts to increase collaboration between APA, the American College of Neuropsychopharmacology (ACNP), and the Society for Neuroscience (SNP) to increase advocacy and outreach efforts on mental health issues, such as funding. He expressed hope that perhaps such an initiative could be revisited, potentially helping to increase APA's communication efforts and credibility. Dr. Oquendo also noted that the APA's Corporate Communications and Public Affairs (CCPA) has undergone some changes and has been developing new and exciting marketing and communications initiatives. Drs. Oldham and Potash both agreed that the revitalization of CCPA is important and useful.

3. Council Updates
(These updates took place throughout different portions of the Council's agenda. This information is presented here sequentially for continuity.)

- APA Patient Registry

In the absence of Gregory Dalack, M.D., of the APA Patient Registry Workgroup, the update on the APA Patient Registry was provided by Kristin Kroeger, APA Chief of Policy, Programs, & Partnerships. At the BOT meeting in July, Dr. Dalack presented the Workgroup's report on registries, and the BOT voted to move forward with creation of a business case. Internally, APA Administration will work with a consultant to begin developing this, and it will include such information as the type of registry to be developed, a SWOT analysis on risks and opportunities, a cost analysis, identification of potential vendors, the overall timeline, and potential partners with whom the APA might want to collaborate in developing this. The consultant also will help the APA gather information about member readiness. The business case will be presented to the BOT in December.

Dr. Wang summarized some of the potential research opportunities and uses of the registry if the BOT approves further development and it is up and running including the possibility to serve as an important resource for data mining for things such as new diagnostic clusters, new classifiers, and quickly identifying patients with certain genotypes or phenotypes for participation in clinical trials. Dr. Wang and Ms. Kroeger emphasized the importance of ensuring that a potential registry provides member benefits, such as the ability

of the registry to facilitate reporting requirements for quality and Part IV Maintenance of Certification. Dr. Potash asked whether any additional thought had been given to whether the registry will cover just major depressive disorder or whether it will more broadly encompass all diagnoses or perhaps just common diagnoses. Ms. Kroeger stated that a decision had not been reached on that but would be examined as part of the business case. Dr. Johnson stated that should the APA decide to look for federal partners, she could assist with that.

Dr. McDonald suggested looking at neuromodulation as a possible platform of the registry, as electroconvulsive therapy (ECT) providers would likely be very interested in the creation and use of a registry. Similarly, Dr. Krystal noted that people who have already adopted ketamine as an intervention might be highly interested in a registry to help clarify outcomes, safety issues, and tolerance.

- Committee on Research Training

In the absence of Charles Nemeroff, M.D., Ph.D., Dr. Mościcki provided the update on research training. The Committee received a slightly smaller number of applications for the 2015 Research Colloquium for Young Investigators (n=30), which took place in May. The program was well-received by both the investigators and the mentors. The Committee is discussing ways to boost the application rate, such as better clarifying to academic institutions that multiple nominees from the same department are permitted. They also are considering marketing efforts, such as posting flyers at conferences and placing ads in the *American Journal of Psychiatry* and *Psychiatric News*. Drs. Krystal and Oquendo both emphasized the value and importance of the Colloquium, particularly given how those who have participated as investigators have remarked on the impact it had on their research career.

In April, the APA submitted an application to the National Institute on Minority Health and Health Disparities for support for the 2016 Research Colloquium for Young Investigators, which unfortunately did not receive a fundable score. The APA is currently looking elsewhere for support, including the American Psychiatric Association Foundation and possibly from the National Institute on Drug Abuse (NIDA). Dr. Krystal suggesting revising the topic labeled "psychiatric treatment" to "psychiatric treatment and services" so as to appeal to a broader range of applicants and possibly increase interest. He also noted that if funding was being sought from NIDA, it might be worthwhile to also speak with the National Institutes on Alcohol and Alcoholism to gauge their interest in supporting this with NIDA as a joint initiative. Dr. Krystal suggested the journal *Biological Psychiatry* might be amenable to providing free advertising for the Colloquium to help generate more interest.

Discussion then turned to the near-parallel timing of the APA Annual Meeting with that of the Society of Biological Psychiatry (SOBP) and how that could potentially be leveraged to increase participation and interest in the Colloquium. Drs. Krystal and Pine expressed hope that, with new APA leadership and new leadership in the Division of Research, opportunities to collaborate with SOBP would be considered. Dr. Pine suggested reaching out to Stephen Strakowski, M.D., and Maggie Peterson, M.B.A., both of SOBP. Dr. Krystal suggested that, if grant funding could not be secured, perhaps SOBP and ACNP would be interested in jointly underwriting the Colloquium with the APA (for roughly $17,000 apiece). Dr. Evans agreed that this was an idea worth pursuing.

- APA Minority Fellowships

Dr. Parekh thanked the Council for their mentorship of APA Minority Fellows and encouraged their continued participation with future fellows. Ms. Bondurant noted that the APA Division of Diversity and Health Equity (DDHE) is working closely alongside CCPA to develop an integrated marketing program to extend their reach to new fellows. This year, DDHE selected 13 recipients for the Research Scholars Award, which grants $2,500 to each investigator and $500 to each of their respective mentors. The Psychiatric Research Award, which is $45,000, was given to 2 applicants this year. Council members were encouraged to serve on the selection workgroup and/or refer colleagues to participate in the selection process.

Dr. Oldham remarked that, now that there is more stability in the Division of Research, he hopes this will be a good opportunity to build more bridges between the APA and its various components. Dr. Wang agreed and stated that working with the Council can help the Division of Research and the APA better address current challenges in psychiatric research training, such as how to recruit traditionally underrepresented populations who don't normally gravitate toward research careers and how to help trainees at low-resourced institutions who are interested in pursuing research. Dr. Wang expressed optimism that, in the near future, the Division of Research can perhaps serve as a data resource for young psychiatrists who don't otherwise have access to large secondary data sets. Dr. Potash suggested that perhaps an opportunity could be created such that trainees gain short-term experience in-house at the Division of Research, giving them the chance to receive hands-on, direct supervision in data analysis and methodology. Dr. Wang agreed and re-emphasized the importance of the Division of Research acquiring data sources, such as through the Centers for Medicare & Medicaid Services (CMS).

- Committees on Research Awards and Health Services Research

Dr. Kuhl provided the group with updates on the various research awards. In the absence of a Director in the Division of Research at the time of the awards, it was decided that the Health Services Awards would not be give this year. However, Carolyn Robinowitz, M.D., will be receiving the Judd Marmor Award at IPS: The Mental Health Services Conference this October.

- Task Force to Revise the Practice of Electroconvulsive Therapy

Dr. McDonald reported that he, Holly Lisanby, M.D., and Laura Fochtmann, M.D., met with John McDuffie, Editorial Director of Books with American Psychiatric Publishing, to finalize editing for their book, *Guidelines and Recommendations for Electroconvulsive Therapy*. The final draft of the book should be completed by October 1, and copyedits should be complete by January 1, 2016. The book is scheduled for release in June 2016.

- Committee on Psychiatric Dimensions of Disaster

Dr. Johnson, Committee member, presented the disasters update in place of Robert Ursano, M.D., newly appointed chair of the Committee. She reported that the Committee is refining their section of the APA website to ensure content is accurate and thorough. Although it is primarily geared toward psychiatrists and mental health professionals, they are planning on adding a section on coping with disasters for the general public. She also noted that APA's new blog has facilitated recent discussions on disasters, including how to

talk to children about disasters, reflections on Hurricane Katrina, and the recent shooting of 2 television journalists in Roanoke, VA. Dr. Krystal suggested the disasters website include links to the VA National Center for PTSD, which is replete with disaster training and education materials. Dr. Johnson thanked Dr. Krystal for this suggestion and said the Committee would consider adding the VA as well as other federal resources, like the Centers for Disease Control and Prevention. Dr. Evans added that some of the references on the webpage are very dated (e.g., going back to 1995) and should be updated.

The Committee is currently reviewing an action paper on the impact of global climate change on mental health, which they will send to the Council on Minority Mental Health and Health Disparities. South Carolina Psychiatric Association President Rachel Houchins, M.D., has requested that the Eric Lindemann Grant be awarded to support the recovery of the city of Charleston following the Emanuel African Methodist Episcopal Church shooting on June 17. Finally, the Committee is moving forward with the nomination of Dr. Kathleen Clegg, of the Ohio Psychiatric Physicians Association (OPPA), for the 2016 Bruno Lima Award in Disaster Psychiatry, with support from the OPPA President Dr. Steven Jewell.

- Diagnostic and Treatment Markers Workgroup

Dr. McDonald provided the Workgroup update in the absence of Dr. Nemeroff. He informed the Council that the Workgroup's meta-analysis on ketamine will be published in the *American Journal of Psychiatry* shortly.

The Workgroup currently has 5 manuscripts in development. The Workgroup is currently reviewing one paper from Mauricio Tohen, M.D., Dr.P.H., on biomarker predictors of treatment response associated with bipolar disorder. Drs. Carpenter and McDonald are continuing their work reviewing a manuscript on guidelines for rTMS for depression, the latest iteration of which required extensive revisions. Dr. Potash's paper about genetic predictors of antidepressant response now has been split into 2 manuscripts. The first, on biomarker predictors of antidepressant treatment response, is largely complete, and a draft will be circulated soon. The second is on genetic and brain imaging predictors of response to antidepressant treatment and is currently still in development. He and Dr. Widge will get together to clarify the status of the paper. Finally, a fifth paper, which Dr. Carpenter is helping develop along with former Council resident fellow Brent Nelson, M.D., will review electric stimulation devices.

- Caucus on Complementary and Alternative Medicine

Dr. Carpenter reported that she continues to work with the Caucus on a review paper on SAMe. There are several drafts being circulated and edited, and a final draft should be ready for Dr. Nemeroff's review in the very near future.

4. Meeting with Dr. Saul Levin

Dr. Levin arrived with Nicole Lewis. He thanked the Council for their ongoing efforts. Dr. Levin formally introduced Dr. Wang, the recently hired Director of the Division of the Research. He also expressed gratitude to the members of the Council who served as resources during the selection process and whose input was greatly valued. Dr. Wang thanked Dr. Levin for the opportunity to serve as the Director of the Division of Research and expressed excitement about the ways in which the APA can potentially change the practice and

science of psychiatry (e.g., through development of a potential patient registry and through improving research training). He stated that he is looking forward to working with the Council on these initiatives. Dr. Levin reiterated that the APA is looking for additional funding for the Research Colloquium and is open to the Council's ideas about exploring joint support from ACNP and SOBP. He also emphasized Dr. Oquendo's earlier remarks about the importance of the Council weighing in on statements and other informational issues to ensure the APA remains science-driven and that we are communicating messages to the public that are credible and current.

Dr. Evans again noted that previous efforts to join forces with ACNP and SFN to increase advocacy and outreach for mental health funding should be revisited, and that he hopes that will be a future target for APA Administration. Dr. Levin agreed and added that Rodger Currie, Chief of Government Affairs, and his Department of Government Relations has been actively working with leaders on Capitol Hill to increase federal funding, such as through that of the NIH BRAIN Initiative. Dr. Levin also discussed recent meetings with the CEO of Research!America to re-engage them in funding for mental and substance use disorders.

Finally, Dr. Levin provided a brief update on activity related to *Diagnostic and Statistical Manual of Mental Disorders* (DSM), including the BOT's recent approval for the creation of 7 workgroups to determine the process for addressing errors and other needed revisions to DSM-5.

5. Additional Discussion Issues

- Update on Division of Research Report on Integrated Health Care Literature

Dr. Mościcki provided the Council with an overview of the request from the Joint Reference Committee (JRC) that the Division of Research provide a summary report on the status of the literature on integrated behavioral and general medical health care models. The goal of the report is to provide an update that will inform APA education and advocacy efforts to increase integrated approaches to mental health care and ensure psychiatrists have the skills and training needed to meet the demands of integrated care. Dr. Mościcki walked the Council through the process Division of Research Administration has taken to complete the review. Their draft report will be circulated to the Council for their input within the coming weeks. The final report is due to the JRC on October 2.

Dr. Evans wondered whether the literature truly could indicate whether or not onsite psychiatric involvement is an integral element to integrated care or whether offsite consultation is as effective. Dr. Wang cautioned that answering that question was challenging because of the lack of research specifically parsing out components of collaborative care and then randomizing participants to elements to determine which have an effect. However, the research does support the combination of three major components (a primary care physician, a care manager to coordinate care, and a psychiatric consultant) as effectively improving clinical and functional outcomes. Dr. Wang also noted that some of the models aren't implementable in the "real world" because there are no CPT codes for the psychiatric consultant, so psychiatrists in this role cannot get paid. Ms. Kroeger remarked that the APA is aware of this critical problem and is maintaining ongoing discussions with CMS about providing a CPT code for psychiatric consultants. Dr. Krystal suggested that, if possible, the report should provide some quantitative findings regarding cost-benefit and cost utility, as these are practical concerns in which most people will be interested.

- Request for Comments on the National Sleep Foundation Recommendations on Sleep Duration

The Council responded to the request from Dr. Levin for comments on the National Sleep Foundation's (NSF) recent revisions to recommendations for sleep duration. Leadership from NSF has asked Dr. Levin to consider signing a letter of endorsement reflecting the APA's support of NSF's revisions. He has asked the Council for their input as to whether or not the APA should sign the letter.

The Council agreed that there are 2 issues that need to be addressed before a recommendation on endorsement can be given. First, they would like APA leadership to consider whether there is any real value to endorsing these recommendations; that is, how does it benefit the APA to do so? Drs. Carpenter, Krystal, and Wang all noted some possible medical-legal consequences that could arise from publication of these recommendations, and thus the APA should consider the extent to which endorsing them could cause the APA to be pulled into public discussions on these medical-legal issues.

The second issue pertains to the nature of the request for the Council's review. The Council would like additional clarity as to what precisely they are reviewing the recommendations for in order to determine whether or not endorsement is justified. Are they reviewing for empirical rigor? Quality? Scope? Accuracy? Dr. McDonald noted that the recommendations seemed largely opinion-based and derived by consensus agreement rather than by rigorous scientific review. For instance, most of the recommendations appear to be based on patients' self-report of sleep habits, which have been repeatedly shown throughout the literature to be unreliable. Drs. Krystal, Carpenter, Evans, and others agreed with his concerns. The Council also agreed that experts in sleep medicine should review the documents first, with the Council then weighing in secondarily. They suggested reviews could come from Charles Reynolds, M.D.; Daniel Buysse, M.D.; Vaughn McCall, M.D.; and Andrew Krystal, M.D.

In sum, the Council first would like APA leadership to consider whether endorsement is truly necessary or even beneficial. If it is, they would like a more specific charge that spells out the nature of their review. Finally, reviews should first be completed by sleep medicine experts; then the Council will weigh in accordingly. Dr. Kuhl stated that she would convey the Council's concerns back to APA leadership and let the Council know how Dr. Levin would like to proceed.

- Review and Approval of Letter to APA Leadership on Research Priorities

Dr. Potash presented for the Council's review a letter to APA leadership (Drs. Levin and Binder) outlining areas of research on which they believe the APA should focus its advocacy efforts. The content of the letter was based on responses the Council generated at their May meeting as feedback to the NIH Blueprint. Dr. Potash presented the letter and reviewed the main areas of content.

The Council discussed ways to wordsmith the letter to improve its message. For example, Dr. Oldham noted that he would like to see psychotherapy included among the items pertaining to neuroscience that need more support. Many on the Council agreed, noting that talk therapy is cognitive science, as it affects the brain and behavior. Also, the draft letter mentions mental disorders and symptoms that broadly apply to many populations and are in need more study but focuses primarily on impulsivity. Dr. Oldham suggested adding

emotional dysregulation and borderline personality disorder, as they too represent broad concerns that impact other disorders.

Dr. Kuhl reported that she will summarize everyone's comments and distribute to the Council. Individuals will make their revisions in track changes and send to Dr. Potash to integrate. A revised version of the letter will then be distributed for the Council's further review.

- Federal posting of the notice of proposed rulemaking for the "Common Rule"

Dr. Martin notified the Council of the recent posting of the notice of proposed rulemaking on changes to the "Common Rule" for Protection of Human Subjects (available at http://www.gpo.gov/fdsys/pkg/FR-2015-09-08/pdf/2015-21756.pdf). The proposed changes have important implications for the informed consent process, such as mandating that informed consent forms are shorter and clearer. The Council was asked whether this was something they would be interested in reviewing and perhaps suggesting the APA submit feedback. The deadline for public comment is December 7. The Council agreed that this was worth reading and considering for feedback. Dr. Martin indicated he would send to the Council via email a link to the NPRM and a summary of the proposed changes.

- The Council, having completed its deliberations, adjourned, with its next meeting scheduled during the 2016 APA Annual Meeting in Atlanta, GA.