WWW.PSYCHNEWS.ORG | NEWSPAPER OF THE AMERICAN PSYCHIATRIC ASSOCIATION | VOLUME 50, NUMBER 5, MARCH 6, 2015

PSYCHIATRIC NEWS

The First and Last Word in Psychiatry

ISSN 0033-2704

APA 2015 ELECTION

Maria Oquendo, M.D. (right), will become president-elect of APA at the end of APA's annual meeting in May, when Renée Binder, M.D., becomes president. See story below and chart on page 38 for all election results.

Oquendo to Become APA's Next President-Elect

APA members have selected the current secretary as the next person in line to hold APA's highest elected leadership position.

BY CATHERINE BROWN

APA's voting members have selected Maria A. Oquendo, M.D., of New York City to become APA's next president-elect. Oquendo outpolled Barton J. Blinder, M.D., Ph.D., of Newport Beach, Calif., and Charles F. Reynolds III, M.D., of Pittsburgh.

Oquendo is residency training director at the New York State Psychiatric Institute, where she started as a community psychiatrist. She is professor and vice chair for education at Columbia University, conducting research on mood disorders and suicide. As APA secretary, she chairs APA's Conflict of Interest Committee. She formerly chaired APA's SAMHSA Fellowship Selection Committee and has a small private practice. Blinder is a clinical professor and past director of Eating Disorder Research in the Department of Psychiatry, University of California, Irvine, and is in the private practice of adult and child psychiatry. Reynolds is the UPMC Endowed Professor in Geriatric Psychiatry and director of the Aging Institute of UPMC and the University of Pittsburgh.

"I am honored and grateful to have been elected to lead APA," Oquendo told *Psychiatric News*. "This is an exciting time to practice psychiatry. Our knowledge base has grown exponentially in the last decades, and we still have the privilege of forming close therapeutic alliances with our patients and their families, offering relief for suffering. Yet, APA has much work to do."

Commenting on her goals as president, Oquendo said they "include securing an appropriate role for psychiatrists as health care reform is implemented while ensuring that the most severely mentally ill people receive care. At the same time, it is essential to secure adequate federal funding for education and research through advocacy, ensure equitable reimbursement for psychiatric care, and enhance collaboration with psychiatric subspecialties and primary care. These aims will require that APA provide effective representation of psychiatry to the public and government.

"Importantly, I believe APA can continue to strive for diversity at all levels of the organization including representation from women, minority psychiatrists, international medical graduates, and LGBT members. I hope to harness my experience in teaching and mentoring to engage our trainee members and early career psychiatrists. They are our future."

In the race for secretary, Altha J. Stewart, M.D., of Memphis emerged the winner over Rahn Kennedy Bailey, M.D., of Nashville.

For early career psychiatrist (ECP) trustee-at-large, Lama Bazzi, M.D., of Stony Brook, N.Y., outpolled Paul O'Leary, M.D., of Birmingham, Ala.

In the race for minority/underrepre-

see ***Election Results*** *on page 38*

President Signs Law Expanding MH Services For Veterans

APA and veterans groups are pleased as the Clay Hunt SAV Act becomes law.

BY AARON LEVIN

President Obama signed into law on February 12 the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, intended to reduce suicides and improve access to mental health care among veterans. The bill was passed unanimously by the House and Senate earlier this year after being held up on a technicality at the end of the last Congress.

"Too many of our troops and veterans are still struggling, recovering from injuries and mourning fallen comrades," said Obama in remarks at the signing ceremony in the East Room of the White House. "For many of them the war goes on, and we will not be satisfied until every man and woman in uniform gets the help they need to stay strong and healthy. It's not a sign of weakness to ask for help; it's a sign of strength."

The act was named for a U.S. Marine veteran of the Iraq and Afghanistan wars who died by suicide in 2011. Clay Hunt's mother and stepfather, Susan and Richard Selke, and his father and stepmother, Stacy and Dianne Hunt, attended the White House ceremony. The Selkes were especially active in advocating for passage of the law.

see ***Veterans*** *on page 40*

PERIODICALS: TIME SENSITIVE MATERIALS

INSIDE

PSYCHIATRIC NEWS

Psychiatric News, ISSN 0033-2704, is published biweekly on the first and third Friday of each month by the American Psychiatric Association, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Periodicals postage paid at Arlington, Va., and additional mailing offices. Postmaster: send address changes to *Psychiatric News,* APA, Suite 1825, 1000 Wilson Boulevard, Arlington, Va. 22209-3901. Online version: ISSN 1559-1255.

SUBSCRIPTIONS
U.S.: individual, $134. International: APA member, $182; nonmember, $201. Single issues: U.S., $24; international, $41. Institutional subscriptions are tier priced. For site licensing and pricing information, call (800) 368-5777 or email institutions@psych.org.

EDITORIAL OFFICES
Telephone: (703) 907-7860
E-mail: cbrown@psych.org
Web site: psychnews.org

ADVERTISING SALES
Frank Cox, Kathleen Harrison, Tim Wolfinger, Eamon Wood, Pharmaceutical Media Inc., 30 East 33rd Street, New York, N.Y. 10016; (212) 904-0379; fax: (212) 685-6126; twolfinger@pminy.com. Nonpharmaceutical and Classified advertising: ewood@pminy.com; (212) 907-0363

CHANGES OF ADDRESS
Call the APA Answer Center at (888) 35-PSYCH in the U.S. and Canada; in other countries, call (703) 907-7300.

CONTENTS

GOVERNMENT NEWS

PROFESSIONAL NEWS

EDUCATION & TRAINING

CLINICAL & RESEARCH NEWS

Departments

FROM THE PRESIDENT

The Mental Health Mission Of Rep. Tim Murphy

BY LLOYD I. SEDERER, M.D., AND PAUL SUMMERGRAD, M.D.

"Those with serious mental illness (SMI) do recover and can lead fulfilling lives, but an astounding 40 percent of the 10 million Americans with SMI are not in treatment. And, even when care is delivered, it is often delayed for more than two years after the illness first appears."

Is this a quote from one of our APA leaders? From the National Institute of Mental Health (NIMH)? From the chair of a department of psychiatry? From a major advocacy organization?

No. It is the opening paragraph of the webpage describing the Helping Families in Mental Health Crisis Act, which was first introduced in Congress in 2013 and is slated for reintroduction at press time. It's one reason the APA Board of Trustees, in December 2014, voted unanimously to "support the bill as the vehicle to achieve comprehensive mental health reform." The bill was written by U.S. Rep. Tim Murphy (R-Pa.), and its lead Democratic cosponsor is Rep. Eddie Bernice Johnson (D-Texas).

At APA's 2014 annual meeting, Rep. Murphy spoke to the APA Assembly. His speech received a prolonged, standing ovation: He had made clear his goals and his determination to serve people with SMI and their families, as well as his strong support for psychiatrists and evidence-based care.

Murphy is a clinical psychologist and a lieutenant commander in the Navy Reserve Medical Service Corps at Walter Reed National Military Medical Center, where he specializes in treating military personnel with posttraumatic stress disorder and traumatic brain injury. Rep. Johnson has her own hands-on experience with mental health care: Before entering Congress, she was the chief psychiatric nurse at the V.A. hospital in Dallas.

Rep. Murphy's experience in delivering frontline patient and family treatment and understanding the limitations of our mental health system are evident in his unflinching drive to improve services for people with mental illness in this country. It's no surprise that Rep. Johnson and scores of Democrats and Republicans have signed onto this effort. Rep. Murphy is a critical ally in our work as psychiatrists and for the mission of APA.

Like President Kennedy's Community Mental Health Act in 1963, over 50 years ago, the Helping Families in Mental Health Crisis Act is both comprehensive and focused on the urgent mental health needs of our time. Its core elements include the following:

- Driving evidence-based care.

- Making explicit that families, the greatest source of support for most people with any serious and persistent illness and ongoing functional impairment, can work with the clinicians serving a patient—now often constrained by misunderstandings of the privacy rule under the Health Insurance Portability and Accountability Act (HIPAA).

- Integrating primary care and behavioral health care.

- Expanding crisis training for law enforcement officers and supporting the use of mental health courts to help people with serious mental illness get treatment—not wind up in jails and prisons, where their conditions worsen and society is made no safer.

- Placing overall federal mental health policy under an assistant secretary for mental health and substance use disorders.

- Expanding the availability of mental health services in terms of both community mental health services and psychiatric hospital beds.

- Increasing research funding for psychiatric disorders and innovative programs to improve treatment for first-episode psychosis (for example, the program Recovery After an Initial Schizophrenia Episode (RAISE; see *Psychiatric News*, October 17, 2014).

When it comes to improving mental health in this country, multiple, coor-

see ***From the President*** *on page 31*

Lloyd Sederer, M.D., is medical director of the New York State Office of Mental Health and an adjunct professor at the Columbia/Mailman School of Public Health.

GOVERNMENT NEWS

GAO Calls for Better Coordination, Evaluation Of Federal Mental Health Programs

A critical House subcommittee hears testimony from the Government Accountability Office about the need to streamline federal mental health programs.

BY AARON LEVIN

Members of Congress excoriated two key federal health agencies at a February 11 hearing, complaining about poor coordination and evaluation of programs supporting people with serious mental illnesses.

The hearing by the House Energy and Commerce Subcommittee on Oversight and Investigations coincided with the release of a report requested by the subcommittee and issued by the Government Accountability Office (GAO). The report covered 112 government programs targeting mental illness but concentrated mainly on the 30 nonmilitary programs.

The GAO recommended that the Department of Health and Human Services (HHS) establish an interagency mechanism to coordinate the programs. It also called for HHS and the departments of Defense, Justice, and Veterans Affairs to determine when and how their programs should be evaluated.

Formal interagency coordination is lacking now, in part because the body established for that purpose, the Federal Executive Steering Committee for Mental Health, has not met since 2009, said Linda Kohn, Ph.D., the GAO's director of health care. HHS does have a Behavioral Health Coordinating Council, but it functions only within that department.

"We are concerned that the lack of coordination inhibits an understanding of the federal footprint in this area," Kohn told the subcommittee. "Coordination helps identify overlaps and gaps to maximize existing resources."

After reviewing the report, HHS and the Substance Abuse and Mental Health Services Administration (SAMHSA) rejected the recommendations, leading to harsh criticism by subcommittee chair Tim Murphy (R-Pa.).

"HHS is essentially saying there is no room for improvement," said Murphy in his opening remarks. "This is unbelievable. This is a clear example of unaccountable government—one that refuses to recognize its failings even when presented with constructive recommendations for improvement."

GAO encountered several problems in producing the report. For one thing, the agencies it contacted had difficulty simply identifying all relevant programs within their departments. A program aimed at reducing homelessness might serve some people with mental illness but might not be specifically targeted at them. Responses from the agencies thus varied in completeness because of differing standards.

Aaron Levin

GAO Director of Health Care Linda Kohn, Ph.D., comments on the GAO's report on federal mental health programs as HHS's Richard Frank, Ph.D., and SAMHSA's Pamela Hyde, J.D., listen.

In addition, there was no consensus among the participants on the definition of "serious mental illness." The GAO report referred to current or past-year presence of "a diagnosable, mental, behavioral, or emotional disorder [based on *DSM* criteria] … that resulted in serious functional impairment. …" Others on the panel suggested some definition incorporating a combination of diagnosis, functioning, and patient history, including trauma.

Also, only nine of the 30 nondefense programs had completed evaluations, leaving the agencies (and the GAO) in the dark about program effectiveness.

Officials from HHS and SAMHSA defended their agencies at the hearing.

The GAO report was remiss in not covering reimbursement programs such as Medicare, Medicaid, or the military health insurance program Tricare, noted Richard Frank, Ph.D., assistant secretary for planning and evaluation at HHS.

"The problem is that if you leave out Medicare and Medicaid, you're not seeing the whole picture," he said. Medicare and Medicaid together account for 40 percent of mental health spending compared with just 5 percent of expenditures by HHS and SAMHSA; 55 percent is covered by private insurance, he said.

Aaron Levin

Rep. Tim Murphy (R-Pa.) presides at the hearing on the GAO report. He is chair of the House Energy and Commerce Subcommittee on Oversight and Investigations. At right is ranking member Rep. Diana DeGette (D-Colo.).

Furthermore, the sort of coordination recommended in the GAO report was unneeded, said Frank: "HHS recognizes the need to coordinate at the agency, program, provider, and individual levels, but people with mental illness don't live their lives at program boundaries."

SAMHSA Administrator Pamela Hyde, J.D., went even further in defending her agency's performance.

"The recommendation was about a specific type of infrastructure that we think is not going to make a difference on the ground," she said. "One high-level federal coordinating body is not going to solve the problem."

Most subcommittee members appeared to disagree. Murphy, a clinical psychologist, is preparing comprehensive mental health legislation that would include a high-ranking coordinator within HHS (see page 11).

"I hope there are ways we can work through these issues and concerns on a bipartisan basis," added ranking committee member Diana DeGette (D-Colo.). "We should work together to put the lessons learned in our oversight hearings into practice." PN

The House of Representatives' webcast "Federal Efforts on Mental Health: Why Greater HHS Leadership Is Needed" is posted at http://energycommerce.house.gov/hearing/federal-efforts-mental-health-why-greater-hhs-leadership-needed. The GAO report, "HHS Leadership Needed to Coordinate Federal Efforts Related to Serious Mental Illness," is posted at http://www.gao.gov/products/GAO-15-113.

Join With APA to 'Give Back'

In its sixth year, "APA Gives Back" provides an opportunity for APA, its members, and other annual meeting attendees to support a community organization in the host city of the annual meeting. This year's recipient is Covenant House Toronto. Covenant House serves as a crisis-intervention center and provides residential, nonresidential, and community support services, including a pastoral ministry, a runaway prevention program, meals, assessment and referrals, counseling, health care, and housing help. A family practice doctor and psychiatrist are on site. For more information, visit www.covenanthousetoronto.ca.

Contributions may be made when you register for the annual meeting at http://annualmeeting.psychiatry.org/registration. APA will match the amount contributed. To date, the APA Gives Back program has donated $67,177 to local groups in annual meeting host cities.

APA Protests Exclusion of Psychiatry From Primary Care Designation in ACOs

APA says the method used by the Obama administration for designating primary care providers could negatively affect access to care in ACOs for "dually eligible" individuals and others with serious mental illness.

BY MARK MORAN

APA wants the government to reconsider its method for assignment of patients to primary care providers within accountable care organizations (ACOs) under the Medicare Shared Savings Program and to include psychiatrists among those physicians designated as primary care physicians.

The Shared Savings Program is designed to facilitate coordination and cooperation among clinicians; eligible physicians and hospitals participate in the program by creating or participating in an ACO.

In a February 6 letter to the Centers for Medicare and Medicaid Services (CMS) Administrator Marilyn Tavenner, APA CEO and Medical Director Saul Levin, M.D., M.P.A., said psychiatry is frequently the point of first contact for persons with undiagnosed conditions.

"Many patients will present with nonpsychiatric disorders that become manifest through psychiatric symptoms," Levin wrote. "Differential diagnosis is a core skill and function of the specialty. The psychiatrist generally establishes a treatment plan for all presenting medical conditions and assumes the role of care manager/supervisor with the required team of health care professionals. This includes provision of care for mental health/substance use disorders as well as medical comorbidities. … Simply put, psychiatrists are often responsible for ensuring that patients are properly diagnosed and triaged and for securing all needed services even if they do not provide all of them themselves."

More broadly, Levin expressed APA's concern about how the administration's methodology for designating primary care will affect where people with serious mental illness—and especially "dual-eligible" individuals who qualify for both Medicare and Medicaid—are treated.

Levin said the administration needs to "carefully examine how the assignment rules affect accountability for beneficiaries with mental health and substance use disorders." He added that the methodology currently used by the administration "could have a negative and avoidable impact on access to appropriate care coordination for disabled and elderly beneficiaries with psychiatric disorders who often suffer from multiple co-occurring medical conditions."

Levin's letter was in response to a December 8, 2014, proposed rule by CMS designating certain physicians as primary care providers on the basis of a two-step assignment process by which Medicare beneficiaries are assigned to an ACO.

The first step in this process assigns a beneficiary to an ACO if the beneficiary receives the plurality of his or her primary care services from internists, general practitioners, family practitioners, or geriatric medicine practitioners within the ACO (or from a physician in a federally qualified health center or rural health clinic included in the attestation provided by the ACO as part of its application).

Beneficiaries not assigned in the first step are assigned to an ACO in a second step if they receive a plurality of primary care services from specialist physicians and certain nonphysician practitioners within the ACO.

But in the December 8 proposed rule, CMS excluded psychiatry from consideration in the second step of the assignment process. The proposed rule is part of an ongoing effort by the government to reform the way physicians are reimbursed in public programs; last month, CMS announced it will accelerate the movement toward "value-based payment" of physicians (see box).

The administration apparently excluded psychiatry from among physicians designated as primary care providers in the second step of the assignment process on the basis of several criteria. These include recommendations by CMS medical officers about the services typically performed by physicians and nonphysicians, the number of services

*see **ACOs** on page 41*

CMS Sets Timeline for Value-Based Payment

In a meeting in January with consumers, insurers, clinicians, and business leaders, Health and Human Services (HHS) Secretary Sylvia M. Burwell said the administration is laying out a timeline to move the Medicare program, and the health care system at large, toward "value-based payment," that is, reimbursing physicians based on the quality rather than the quantity of care they give patients.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as accountable care organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.

"We believe these goals can drive transformative change, help us manage and track progress, and create accountability for measurable improvement," Burwell said in a statement.

The Affordable Care Act establishes a value payment modifier that rewards or penalizes a physician or group of physicians based on the "value" of service provided, as calculated by a formula that includes quality and cost of care. In 2017, CMS will apply the value-based payment modifier, based on 2015 reporting, to all physicians regardless of group size—including solo practitioners.

All participating physicians will be subject to three sets of rewards or penalties: "meaningful use" of electronic health records, performance on quality measures in the Physician Quality Reporting System (PQRS), and the value-based modifier—which includes performance on the PQRS as part of its formula (*Psychiatric News,* December 5, 2014).

In comments in response to the 2015 Medicare Fee Schedule, released by CMS last December, APA CEO and Medical Director Saul Levin, M.D., M.P.A., especially expressed concern about the dearth of quality measures in the PQRS applicable to psychiatry (see page 12).

"[M]any psychiatrists are trying to comply with the PQRS system, but are shut out or are automatically triggering the measure applicability verification (MAV) process because they cannot find enough relevant measures to include in their reporting. …," Levin wrote in his December comments. "Consequently, psychiatric physicians may be unable to meet the PQRS reporting requirements and be subject to the downward adjustment that has repercussions for other programs as well. ..."

GOVERNMENT NEWS

CMS Will Work With Stakeholders To Amend Meaningful Use Criteria

Changes under consideration include reducing the program's complexity and shortening this year's EHR reporting period from a full year to just 90 days. Among APA's concerns is that there are too few quality measures relevant for meaningful use in psychiatry.

BY MARK MORAN

The Centers for Medicare and Medicaid Services (CMS) is vowing to engage with stakeholders to update and improve "meaningful use" criteria for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs this year.

In a January 26 blog on the CMS website, Patrick Conway, M.D., CMS deputy administrator for innovation, said changes under consideration include reducing the program's complexity and shortening the EHR reporting period in 2015 from a full year to just 90 days.

"These intended changes would help to reduce the reporting burden on providers, while supporting the long-term goals of the program.

"The new rule, expected this spring, would be intended to be responsive to provider concerns about software implementation, information exchange readiness, and other related concerns in 2015," Conway wrote. "It would also be intended to propose changes reflective of developments in the industry and progress toward program goals achieved since the program began in 2011."

Specifically, Conway said the administration proposes to do the following:

- Realign hospital EHR reporting periods with the calendar year to allow eligible hospitals more time to incorporate 2014-edition software into their workflows and to better align with other CMS quality programs.

- Modify other aspects of the program to match long-term goals, reduce complexity, and lessen providers' reporting burdens.

- Shorten the EHR reporting period in 2015 to 90 days to accommodate these changes.

"To clarify, we are working on multiple tracks right now to realign the program to reflect the progress toward program goals and be responsive to stakeholder input," he said.

Conway added that the proposals are separate from the forthcoming Stage 3 proposed rule expected to be released sometime this month. CMS intends to limit the scope of the Stage 3 proposed rule to the requirements and criteria for meaningful use in 2017 and subsequent years.

The announcement comes in response to concerns expressed by the AMA and other medical organizations, including APA.

"The AMA welcomes the Centers for Medicare and Medicaid Services' announcement of plans to address some of the issues we have raised with the Meaningful Use program through rulemaking aimed at requirements for meeting Meaningful Use in 2015," AMA President Steven Sack, M.D., said in a statement.

"We are eager to see the proposed rule as we have been working with CMS and the Office of the National Coordinator for Health IT (ONC) offering solutions to improve the incentive program for quite some time.

"We hope the new rule will be issued expediently to provide the flexibility needed to allow more physicians to successfully participate in the Meaningful Use program and better align Meaningful Use with other quality reporting

*see **CMS** on facing page*

Morehouse Is Home to New Center For Mental Health Policy and Research

A focus on mental health equity will characterize a new center for policy and research at Atlanta's Morehouse School of Medicine.

BY AARON LEVIN

Former U.S. Rep. Patrick Kennedy and former U.S. Surgeon General David Satcher, M.D., last month announced the formation of the Kennedy Center for Mental Health Policy and Research at the Morehouse School of Medicine in Atlanta. The center will be part of the Satcher Health Leadership Institute and will collaborate with the Kennedy Forum, a think tank founded by Kennedy and dedicated to furthering research into neuroscience and mental health.

"The center will increase the visibility of mental health policy issues and solutions among the public, policymakers, and the community," said Morehouse President and Dean Valerie Montgomery Rice, M.D., at a press conference in Washington, D.C. "It will address not just health disparities but ways of achieving health equity by discovering and promoting best practices in the treatment of mental illness and addiction."

David Hathcox

Poll results show that most Americans are ready for major changes in the U.S. mental health system, said former U.S. Rep. Patrick Kennedy (D-Mass.) and former U.S. Surgeon General David Satcher, M.D., in Washington, D.C., as they announced formation of the Kennedy Center for Mental Health Policy and Research at the Morehouse School of Medicine in Atlanta.

"Both Patrick Kennedy and David Satcher are extraordinary leaders, and we look forward to continuing to work closely with them," said APA President Paul Summergrad, M.D., who attended the event.

Besides urging more research into neuroscience, Kennedy emphasized the core need to fully implement and enforce mental health parity to ensure that patients are getting the care to which they are entitled under the law.

"The promise is there, but the practice is not," he said. "We need full disclosure and transparency by insurance companies to be able to compare mental health and physical health benefits."

Kennedy also reiterated the treatment needs of veterans, most of whom do not go to Veterans Health Administration facilities for mental health care.

"Veterans are covered by their employers' insurance, so parity is important to them," he said.

Yet another way to overcome the artificial division between physical and mental health is to integrate care, a practice now being tested at Atlanta's Grady Memorial Hospital, said Satcher, whose 1999 report on mental health was a landmark in the field.

"We volunteered to take over mental health services in the emergency room and improved the care of patients by reducing waiting times by 80 percent, use of restraints by 70 percent, and costs by 40 percent," said Satcher. "At Grady, we treat people as whole persons and respond to their needs, whatever they may be."

While Grady serves an inner-city population in Atlanta, the vision of "community" at the new Kennedy Center will be much more expansive, said Rice. "Our community will not have borders and won't be defined by race, ethnicity, or ZIP code."

The announcement came in the context of a national public-opinion survey of 800 registered voters commissioned by the Kennedy Forum. The survey reported that 66 percent of Americans believe that mental health conditions are a "very serious" problem in the United States. About 71 percent also said they would support "radical" or "significant" changes to the mental health system, an idea that received bipartisan support: 64 percent of Republicans and 76 percent of Democrats agreed. PN

More information on the Kennedy Center for Mental Health Policy and Research at the Morehouse School of Medicine is posted at http://www.msm.edu/Administration/MarketingandCommunications/SOTUInMentalHealthAndAddiction.php.

CMS

continued from facing page

programs such as the Physician Quality Reporting System (PQRS) and the Value-Based Modifier (VBM). …"

In general, a physician will be considered a meaningful EHR user during an EHR reporting period in a payment year if he or she uses certified EHR technology to capture, exchange, and report specific quality measures.

APA has addressed confidentiality concerns as well as concerns about a dearth of quality measures relevant to meaningful use by psychiatrists.

In a December 30, 2014, letter to CMS in response to the 2015 Medicare fee schedule released that month, APA CEO and Medical Director Saul Levin, M.D., M.P.A., said many psychiatrists are trying to comply with the PQRS system but are shut out or are automatically triggering the measure applicability verification process because they cannot find enough relevant measures to include in their reporting.

"CMS must ensure a sufficient number of appropriate measures are available for all physicians regardless of specialty," wrote Levin.

"APA has analyzed the available measures and finds that only 10 of the measures that could possibly be reported by psychiatrists can be reported via the claims-based process for 2015. In 2014, there were four specific psychiatric-focused measures available for claims-based reporting. In 2015, these four measures may be reported only through an EHR. Psychiatry generally has a low adoption rate for EHR technology due to the confidentiality and stigmatization around mental health. Consequently, psychiatric physicians may be unable to meet the PQRS reporting requirements and be subject to the downward adjustment that has repercussions for other programs as well."

In comments to *Psychiatric News,* Steve Daviss, M.D., chair of the APA Committee on Mental Health Information Technology, especially emphasized the confidentiality concerns around electronic health records as they currently exist. He said EHRs generally lack the capability of properly handling HIPAA-defined "psychotherapy" notes that carry a greater degree of privacy protections than other parts of the electronic records.

"Because of the stigma and sensitivity of mental health- and addiction-related information, psychiatrists need EHRs that can maintain the privacy protections built into HIPAA," he said.

He added that another reason that psychiatry has such a low EHR adoption rate is that psychiatrists are concerned about the general lack of "granular control" that patients have over who has access to more sensitive portions of their records, which are sometimes shared across health information exchanges (HIEs). Most HIEs require all-or-nothing consent for practitioners to access their records, he said.

"Patients should be able to enjoy the care coordination benefits provided by EHRs and HIEs while maintaining control over who can access more sensitive parts of their records. Unfortunately, having these protections in place is not a meaningful use requirement within electronic medical records." PN

A complete list of PQRS measures for all reporting mechanisms is posted at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html. A summary of the key provisions in the 2015 Medicare Physician Fee Schedule Final Rule, including information on the PQRS reporting system, is posted on APA's website at http://www.psychiatry.org/practice/managing-a-practice/medicare.

PSYCHIATRY & INTEGRATED CARE

Integrated Psychosocial Care for Cancer Patients

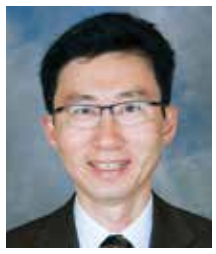
BY JESSE FANN, M.D., M.P.H.

This month, Dr. Jesse Fann reflects on his experience with collaborative psychosocial oncology care. After more than two decades of clinical work and research in psycho-oncology, he has developed a keen appreciation for the challenges and opportunities related to improving the lives of cancer patients, and he knows how gratifying it can be for a psychiatrist to work as a member of an integrated psycho-oncology team.
—Jürgen Unützer, M.D., M.P.H.

Over 14 million Americans, or 4 percent of the population, are living with a cancer diagnosis. Each year, over 1.6 million people are diagnosed with cancer. Nearly 1 in 2 males and more than 1 in 3 females will be diagnosed with cancer during their lifetime. Fortunately, in most cases, cancer can be managed as a curable or "chronic" condition. Attention has increasingly turned to improving not just survivors' length of life but their quality of life.

Cancer care has become more complex with the advent of personalized treatment regimens and complex health care systems. Meanwhile, we have new quality standards and guidelines that mandate universal screening and provision of comprehensive psychosocial care integrated into routine care. This convergence requires integrated systems of psychosocial care that are cost-effective and adaptable to diverse cancer care systems. While screening patients for distress has received primary focus, it is the subsequent steps—what to do with the information to best benefit patients—that pose the most challenges. Research in oncology has confirmed findings in other medical settings that screening without an integrated system to ensure appropriate triage, treatment, and follow-up is not likely to be cost-effective in improving outcomes.

A framework for an integrated psychosocial model was presented in the 2008 Institute of Medicine report "Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs" and emphasizes five key components: (1) identification of patients with psychosocial health needs; (2) care planning to address these needs; (3) mechanisms to link patients with psychosocial health services; (4) support of illness self-management; and (5) follow-up on care delivery.



While referral to community mental health providers remains an important option, many patient- , provider- , and system-level advantages exist for providing "in house" psychosocial oncology services when possible. For example, patients typically prefer to receive centralized health care, especially during intensive cancer treatment; providers benefit from comprehensive health records during complex treatment regimens; and care can be better coordinated within a single institution.

Jesse Fann, M.D., M.P.H., is a professor of psychiatry and behavioral sciences and an adjunct professor of epidemiology and rehabilitation medicine at the University of Washington. He is director of psychiatry and psychology at the Seattle Cancer Care Alliance and affiliate investigator at the Fred Hutchinson Cancer Research Center. Jürgen Unützer, M.D., M.P.H., is an internationally recognized psychiatrist and health services researcher. He is a professor and chair of psychiatry and behavioral sciences at the University of Washington School of Medicine, where he directs the Division of Integrated Care and Public Health and the AIMS Center, dedicated to "advancing integrated mental health solutions."

These advantages, however, weigh against the costs of providing psychosocial care that is potentially resource-intensive and often not revenue-producing.

A viable solution is the application of integrated collaborative care principles to the cancer setting. There is growing evidence that this is convenient for patients, reduces the stigma associated with treatment for mental disorders, builds on existing multidisciplinary systems and relationships, and improves outcomes. At least six published randomized, controlled trials have illustrated successful application of the collaborative care model, compared with usual care, among patients with cancer, including low-income racial and ethnic-minority patients. The role of the care manager can be filled by nurses, psychologists, or social workers. The unique components of these studies highlight the model's flexibility and adaptability.

The Indiana Cancer Pain and Depression (INCPAD) trial used telehealth technologies to provide care management for depression and pain in 16 community-based oncology clinics. INCPAD demonstrated the viability of using telehealth and remote collaborative care teams to increase the reach of psychosocial oncology care for patients with multiple conditions. Most recently, multicenter studies in the United Kingdom, known as Symptom Management Research Trials (SMaRT) Oncology-2 and -3, were conducted in a large, pragmatic, cost-effectiveness trial and in a trial of patients with lung cancer. Both showed robust advantages of collaborative care over usual care

*see **Integrated Care** on page 18*

Integrated Care

continued from page 17

for depression as well as an array of other important cancer-related outcomes, such as anxiety, pain, fatigue, functioning, and quality of life.

Ultimately, innovation and flexibility will be required to develop effective adaptations and enhancements to the collaborative care approach to meet the needs of diverse oncology settings, identify optimal reimbursement mechanisms, overcome institutional resistance and inertia, and ensure sustainability.

Technology can improve the provision of psychosocial care by addressing the identification of patient needs as well as the provision of information, coordination of care, and psychosocial support while potentially reducing cost.

One of the barriers to the implementation of collaborative care in cancer settings, particularly in rural and remote areas, is the lack of psychiatrists and other psychosocial specialists, particularly those experienced in treating cancer patients. Thus, the potential utility of telemedicine/telemental health and videoteleconferencing technology, coupled with task shifting and task sharing, in the context of the collaborative psychosocial oncology care model warrants further exploration. Having an option for community or home-based treatment might also add efficiency, acceptability, and reach. For example, potential barriers to implementation like patient reluctance to enroll and low patient appointment attendance could be overcome with a community-based

approach. Home-based collaborative care might be especially beneficial to patients with comorbidities that make clinic attendance difficult.

From our experience implementing collaborative psychosocial oncology care at the Seattle Cancer Care Alliance, we have found that collaborative care has many inherent advantages. First, oncology care by nature embraces a culture of multidisciplinary collaboration. Second, collaborative care encompasses measurement-based care, the foundation of current oncology practice. Third, collaborative care has a history of working closely with primary providers, a core component of the growing emphasis on smooth transitions to survivorship care in oncology. Fourth, collaborative care integrates well with the principles of many quality-improvement programs being embraced by health care systems, such as Lean Management and Patients Are First. Finally, the Affordable Care Act and the mental health parity law have created opportunities to provide mental health care to a larger number of patients.

Despite the cumulative evidence in favor of collaborative psychosocial oncology care, we need further implementation and dissemination research in diverse clinical settings that pays attention to implementation outcomes such as fidelity, penetration, sustainability, uptake, and costs as well as service outcomes such as efficiency, equity, patient-centeredness, and timeliness. Finally, we need ongoing exploration of sustainable payment structures for collaborative psychosocial oncology care programs. PN

RESIDENTS' FORUM

What Studies Do We All Need to Know?

BY ISH BHALLA, M.D.

As a junior psychiatry resident at Yale, I sometimes feel overwhelmed by the abundance of journal articles and papers at our disposal. I often hear more senior residents and attendings cite various landmark studies that guide our current standards of care. It is daunting for me to wade through the academic literature to find these famous papers while also keeping up with new evidence.

I eventually saw the need for a centralized publication that provides a basic evidence-based foundation for residents and early career psychiatrists. To tackle this issue, I decided to write a proposal for a book called *50 Studies Every Psychiatrist Should Know*. The book would provide value in two ways: selecting 50 of the most important studies and critically evaluating each using a defined approach.

My first step was to find a mentor. I approached my associate program director, Dr. Vinod Srihari, who has a special interest in the dissemination of evidence-based practice to trainees. After I explained

Ish Bhalla, M.D., is a PGY-2 psychiatry resident at Yale University.

my idea, he agreed to join the project.

In our first meetings, we decided how to segment the book and formed a plan to enlist the help of our department's expert clinical and research faculty whose career interests aligned with each of the subsections. These educators would help choose the studies and eventually coauthor chapters. I was interested to observe Dr. Srihari's thought process for recommending faculty to fill this role. He carefully considered broad issues such as the political impact of his selection and seniority in the department as well as practical issues such as willingness to work with residents and ability to respond quickly to emails. This process involved querying department leadership for nominations for potential candidates.

I was admittedly intimidated to electronically approach these senior faculty members as a second-year resident, especially when asking them for so much of their time. I was pleasantly surprised at the reception of my initial contact email. As expected, a few of these individuals were slow to respond. It felt awkward to electronically nudge them every now and then. Dr. Srihari encouraged me to actually wait outside the office of one senior professor with the inkling that he might be missing my emails. He joked that it is harder to turn down a physical being than to passively reject participation by not responding to a message. I still remember running into this professor in the hallway and pitching him the idea on the short walk to his office. We ended up having a rich conversation on the topic, and soon thereafter he sent me several studies to consider.

Also interesting was the different way in which each adviser chose to craft his or her list of studies even though I sent every nominee the same prompt.

One of our advisers who is an associate fellowship director asked herself what she would like all entering fellows to have read by their first day in the program: "If you know nothing else, know this." A vigilant faculty expert suggested including a study that cautions psychiatrists about big pharmaceutical companies' influence on clinical practice.

More research-oriented physician-scientists selected studies that have promise for future investigation or those with less clinical applicability that have not yet been translated to a human population.

Of course, some of this heterogeneity comes from the nature of the particular topic, but my sense is that the bulk can be attributed to varying opinions of competent experts regarding what every psychiatrist should know. I negotiated with the authors to include only studies that affect providers' impressions and decisions at the bedside. We wanted to be conservative and assemble a list based not only on the most novel and innovative ideas of today but one that would stand the test of time.

Assembling this list of studies as a resident was both challenging and rewarding. Finding a strong, respected mentor-advocate was instrumental in negotiating the politics of a large academic department. It was quite satisfying to balance the years of specialized expertise of senior faculty with the basic question we have as junior trainees: What studies do I need to know? PN

Mentoring for Residents

These are among the mentoring opportunities available at APA's 2015 annual meeting in Toronto.

MONDAY, MAY 18
7 a.m.-8:30 a.m.
Meet the Experts Sunny Side Up Breakfast
Upper Canada Room, 18th Floor, Fairmont Royal York

TUESDAY, MAY 19
7 a.m.-8:30 a.m.
Early Research Career Breakfast
Salon B, Convention Floor, Fairmont Royal York

PROFESSIONAL NEWS

APF Launches Program to Support Emotional Health in the Workplace

A program known as ICU follows three core tenets: (1) Identify the signs of distress. (2) Connect with the person experiencing distress. (3) Understand the way forward together.

BY NICK ZAGORSKI

While we may see lots of colleagues during the course of a normal workday, do we really "see" them? In an age where people often have more profound conversations over their smartphones than face to face, detachment and nonchalance can creep into workplace interactions.

But in that indifference, we might be missing some hints of emotional turmoil and opportunities for support. A coworker who looks down might just be having a bad day, or that mood might indicate deeper distress. Either way, investing just a little time to provide assistance can go a long way.

To enable workplaces to foster a culture that will encourage such emotional investment, the American Psychiatric Foundation (APF) and its Partnership for Workplace Mental Health have unveiled a program known as ICU.

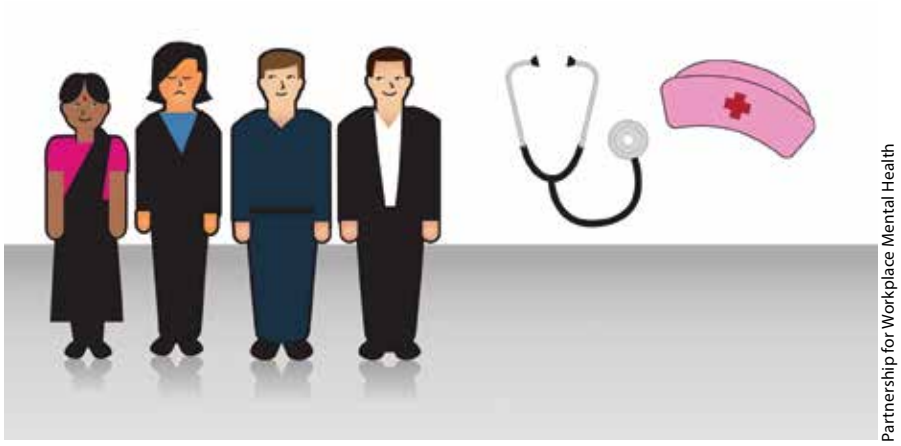
ICU—initially developed by DuPont in 2011 and generously donated by the company to the partnership—is an awareness campaign designed to decrease the stigma associated with discussions of mental and emotional health. The acronym corresponds to the three core steps of the program: (1) Identify the signs of distress. (2) Connect with the person experiencing distress. (3) Understand the way forward together.

And analogous to intensive care units at hospitals, the ICU, or I See You, program envisions an environment wherein people are vigilant and responsive to psychological injury or illness. ICU does not require clinical know-how of mental health diagnoses; rather it focuses on encouraging employees to lend an ear when they observe a peer in distress and help "move forward together."

"In today's world of increasing levels of stress and demands on workers, creating a culture of support is all the more crucial," said Paul Heck, M.Ed., L.P.C., global manager of employee assistance and work/life services at DuPont and a member of the partnership's advisory council. "The ICU program gives permission for a sense of normalcy around emotional distress."

Clare Miller, director of the Partnership for Workplace Mental Health, offered a similar take. "There is a lot of worry about getting too personal and overstepping boundaries," she said. "But ICU gives permission for you to be human."

APF and the partnership learned about the program—and the many accolades it had received worldwide—through the association with Heck, who realized the partnership, which serves as the employer outreach arm of the APF, was in a great position to disseminate ICU to many other workplaces. In turn, the partnership could promote a product stamped with DuPont's imprimatur, providing additional credibility to prospective takers.



Partnership for Workplace Mental Health

The ICU product centers on a short video explaining how employees can confidently—and appropriately—connect with distressed peers who may need support. Other components include an implementation guide, a slide presentation, and templates for a flier and email message.

"We wanted a program that would feel like it was living at your company," said Mary Claire Kraft, a program manager for the Partnership for Workplace Mental Health. "So we adapted the ICU into a white-label product; anyone can easily tailor the templates with their

*see **APF** on page 40*

VIEWPOINTS

Listening to Patients With an Open Mind

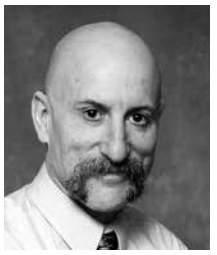
BY JEFFREY GELLER, M.D., M.P.H.

Roger Redstone is a 55-year-old single man who has lived his entire life within easy commuting distance of the state hospital in which he has been an inpatient for 10 months on his third state hospital admission (one before age 18, one for eight years' duration).

During his admission, no one has observed Mr. Redstone reading a newspaper, magazine, or book; no one has seen him attending to the news on radio or television.

Mr. Redstone's diagnoses using *DSM-5* criteria are schizoaffective disorder, mixed personality disorder, and unknown substance use disorder, moderate. Neuropsychological testing showed borderline IQ and a high score for psychopathy (30 on PCL-R).

Mr. Redstone, after eight months of severely problematic behavior in the hospital—thought to be a combination of willful behaviors reflecting his psychopathy and impulse-driven behaviors out of his control—changed dramatically after an increase in his dose of fluphenazine decanoate. Prior to Wednesday, November 5, 2014, he had had many weeks without any of his prior intrusive, crude, dangerous behaviors. Mr. Redstone was scheduled to be discharged within a few weeks.



On November 5, Mr. Redstone lost control, regressing to his earlier presentation. I met with him the next day, and the following conversation ensued:

JG *"What happened? You were doing so well."*

RR "I'm going to lose my SSI/SSDI. I'll be homeless. I'll have nothing to eat. What will I do? This is awful." Mr. Redstone was frantic.

JG *"What are you talking about? Did something happen?"*

RR "I'm in trouble. I won't make it."

JG *"Let's slow down. Why do you think all this is going to happen to you?"*

RR "The election yesterday!"

JG *"What about the election?"*

RR "The governor."

Mr. Redstone told me that the person who was elected governor would cut out all funds for people like him.

I informed him that anything the governor-elect might do would not occur for some time and that the impact on him would be very little, as he was mostly in federal, not state, programs.

With this information, Mr. Redstone settled, used the self-soothing skills he had learned during this hospitalization, and the blip in progression toward discharge was over.

I bring this vignette to your attention because it is another example of our frequent misperceptions of what individuals with serious, chronic mental illness are capable of or what they are attending to. Mr. Redstone could not tell me how he knew who was elected governor, and even more puzzling, how he knew the political views and expected social policies of the governor-elect.

Perhaps I should not have been surprised. In 1992, I did a survey about what inpatients at the same hospital knew about Operation Desert Storm.

The patients were well informed, to the surprise of many. We learned at that time not to jump to conclusions about patients' answers without asking them what they meant when they gave what on first hearing sounded like a delusion. One question on the survey was, "Do you know what Jordan is?" Many indicated it was a country in the Middle East. One patient said, "It's where I buy my underwear." Sounds like psychosis. But the interviewer asked, "What do you mean?" The patient responded, "You know, Jordan Marsh." Jordan Marsh was a department store in Massachusetts, often referred to as "Jordans." PN

Jeffrey Geller, M.D., M.P.H., is a professor of psychiatry and director of public sector psychiatry at the University of Massachusetts Medical School. He is also APA's Area 1 Trustee.

Lay *DSM* Guide Describes Trauma, Dissociative, Somatic Disorders

Descriptions of somatic disorders may be especially helpful to older patients who experience anxiety about general medical conditions. This is the third installment of a series on the new layperson's guide to *DSM-5*.

BY MARK MORAN

A new layperson's guide to the *DSM-5* to be published in May by American Psychiatric Publishing will help patients, families, and the general public understand mental illnesses that affect people of all ages with symptoms that may cross several categories of disorders.

The book, titled *Understanding Mental Disorders: Your Guide to DSM-5*, covers the mental disorders in *DSM-5* in clear, concise language. While it is intended for patients and their families, it will also be useful for other members of the public with an interest in psychiatric illness and how it might be affecting the people around them or for whom they are responsible—teachers, administrators, coaches, employers, and clergy, among others, will find it useful.

Like the clinicians' version of *DSM-5* released in 2013, the new guide is arranged roughly along developmental lines, reflecting a "lifespan" approach to mental illness. (See previous issues of *Psychiatric News* for descriptions of the chapters on disorders that start in childhood, schizophrenia and other psychotic disorders, bipolar disorders, depressive disorders, anxiety disorders, and obsessive-compulsive disorders.)

The seventh through ninth chapters cover trauma and stress disorders, dissociative disorders, and somatic-symptom disorders—illnesses that cross the lifespan and include symptoms that may present in ways similar to other disorders.

"In the area of the trauma-related disorders and dissociative disorders, *Understanding Mental Disorders: Your Guide to DSM-5* offers a valuable resource for patients and families to gain an understanding of their many nuances," said Susan Schultz, M.D., one of a six-member panel of editorial advisers who oversaw the writing and editing of the guide. "Because these categories of disorders are often seen in individuals who are also suffering other concurrent disorders, they can be especially challenging to sort out by the lay public. Persons with trauma-related illnesses or dissociative disorders commonly are also suffering from problems with mood, anxiety, and substance use, which can create difficulty in achieving the right diagnoses and care.

"This guide offers information that may permit readers to navigate to the right treatment despite suffering puzzling symptoms that seem to span many categories," Schultz told *Psychiatric News*.

The new book's description of traumatic disorders offers a sample of the straightforward, easy-to-understand language used throughout: "A traumatic event is something horrible that people have lived through or seen. It upsets, scares, and disturbs those who survive or learn about the event. *Stress* is a common experience and involves feeling tense or pressured. For some, major stress can lead to feeling overwhelmed and unable to cope."

Check Out the Guide

While you are at APA's 2015 annual meeting, be sure to stop by the American Psychiatric Publishing Bookstore and page through *Understanding Mental Disorders: Your Guide to DSM-5*. This is the essential resource on mental illness you've been needing to recommend to patients, families, and community members.

APA members get a 20% discount on all APP purchases; resident-fellow members get a 25% discount.

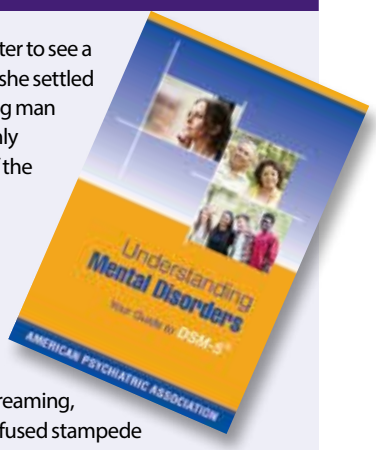
Many chapters of *Understanding Mental Disorders: Your Guide to DSM-5* include an illustrative patient story, based on a real-life clinical vignette, with names and other identifying information altered. For an example, see "Mary's and Robert's Stories" the box describing two patients who experienced the same traumatic event but had different reactions.

Dissociative disorders, which can be especially bewildering to patients, are described like this: "Dissociative disorders cause problems in people's normal sense of awareness and affect their sense of identity, memory, or consciousness. Dissociation is a change in awareness that alters a person's sense of identity or self. It affects the person's ability to connect memories and perceptions. Dissociative disorders … involve severe changes in a person's mental state, and some can cause big gaps in memory. They can become an unhealthy way for the person to avoid reality."

In comments to *Psychiatric News*, Schultz—who is president of the American Association for Geriatric Psychiatry and director of the Iowa Geriatric Education Center as well as codirector of the Center on Aging and Aging Mind and Brain Initiative—noted that changes to the chapter on

see **DSM *Guide*** *on page 41*

Mary's and Robert's Stories



Mary went to a theater to see a movie premiere. As she settled into her seat, a young man in a ski mask suddenly appeared in front of the screen. Holding an assault rifle, he fired into the crowd. She saw many people get shot, including the woman sitting next to her. People all around began screaming, and there was a confused stampede for the exit door. Terrified, she somehow fought her way to the exit. She escaped, uninjured, to the parking lot, just as police cars arrived. Robert was in the same movie theater at the same time. He too feared for his life. Hiding behind a row of seats, he was able to crawl to the aisle and quickly sprint to the exit. Although covered in blood, he escaped without physical injury.

Two days later, both Mary and Robert considered themselves "nervous wrecks."

Mary—Two Weeks Later

Mary was feeling and behaving like her normal self within two weeks. Although reminders of the shooting sometimes led to a brief panic or physical reaction, they did not dominate her waking hours. She no longer had nightmares. She knew that she would never forget what happened in that movie theater, but for the most part, her life was returning to normal.

Robert—Two Weeks Later

Robert had not recovered two weeks later. He felt unable to express his feelings and to have pleasant or positive feelings. He jumped at the slightest sound and was unable to focus on his work, and he had nightmares. He tried to avoid any reminders of the shootings but still remembered the sound of gunfire, the screams, and the sticky feel of the blood pouring out of his neighbor's chest and onto him as he hid behind the seats. He felt disconnected from his surroundings and from himself. He viewed his life as having been changed by this trauma.

Planning to Attend APA's 2015 Annual Meeting? Be Sure You Know Travel Requirements

With the 2015 APA annual meeting being held in Toronto, Canada, there are several travel considerations of which members attending the meeting should be aware.

All travelers to Canada, including those from the United States, must present a valid travel document showing proof of citizenship, such as a passport, birth certificate, or permanent resident card, upon entry to Canada. They must also satisfy an immigration officer that they have "ties, such as a job, home, financial assets, and family, that will take [them] back to [their] country of origin." Permanent residents of the United States who are not citizens should carry their Resident Alien Card. Those traveling with a child under age 18 need the same type of documentation of citizenship status for the child.

Some visitors, depending on country of origin, may also need a medical exam and a letter of invitation from the organizer of the event they are attending in Canada. Visitors from many countries will need a visa to enter Canada. Information about visas, including requirements and locations worldwide for applying for a Canadian visa, is posted at www.cic.gc.ca/english/information/offices/vac.asp. Don't wait until just before the meeting to begin the visa application process! Travelers are also advised that their passport should have six months' validity from the date of entry.

Canada cautions that "if you are a foreign student, temporary worker in the U.S., or visitor in the U.S. who wants to return to the U.S. after visiting Canada, you may encounter difficulties entering Canada without your passport or a Canadian Temporary Resident Visa (TRV). Because your status in the U.S. does not confer any status in Canada, or necessarily give you the right to re-enter the U.S., you should check with an office of the U.S. Immigration and Naturalization Service before leaving the U.S. to make sure you have all the necessary papers to return to the U.S." Information is posted at www.cbp.gov/travel/international-visitors.

Upon returning to the United States, the U.S. government says that all travelers must present a valid passport, though other forms of identification may be acceptable, depending on the traveler's circumstances. Legal residents must present a valid, nonexpired Green Card. Information is posted at www.getyouhome.gov.

White House Unveils Details Of Precision Medicine Initiative

President Obama envisions the creation of a national research cohort to understand health and disease as well as expand the opportunities for research and application of the genetic markers of disease.

BY NICK ZAGORSKI

Following up on statements made during his State of the Union address, President Obama unveiled an investment of $215 million in his FY 2016 budget toward his Precision Medicine Initiative. The lion's share of this funding would go to the National Institutes of Health (NIH), particularly the National Cancer Institute, with the aims of developing a national research cohort of a million volunteers and expanding research into the genetic markers of cancer.

In a perspective published in the *New England Journal of Medicine*, the directors of these two entities, Francis Collins, M.D., Ph.D., and Harold Varmus, M.D., respectively, noted that while the near-term focus is cancer, in the long run the initiative would "generate knowledge applicable to the whole range of health and disease." (See more in infographic at right.)

Given the challenges involved in prescribing psychiatric medications, a federal focus on precision medicine—defined as getting the right treatment at the right time to the right person—should be welcome news for research on mental illness. But how much would such research benefit from this new initiative?

Bruce Cuthbert, Ph.D., director of the Division of Adult Translational Research at the National Institute of Mental Health (NIMH), acknowledged that mental illness might not reap the same rewards as other diseases.

"Genetic signatures are not as strongly influential for psychiatric illness as they are for disorders like cancer, diabetes, or cystic fibrosis," he told *Psychiatric News*. "For mental health, so much risk comes from the surrounding environment and life experiences, which is known as the exposome."

That's not to say the White House initiative lacks value. Cuthbert noted that NIMH leadership is pleased with the announcement and on board with this new drive.

After all, given the prevalence of mental comorbidities among people with a chronic disease like cancer or diabetes, any improvements in the care of these patients and their outcomes will indirectly improve the mental health of millions of people.

This initiative also aligns with NIMH's strategic goals, particularly in regard to its version of precision medicine—the Research Domain Criteria (RDoC) project.

The goal of RDoC is to reshape how research looks at mental illness by focusing on deficits in specific neural pathways, such as reward circuitry or working memory, instead of traditional diagnoses and their diagnostic criteria (*Psychiatric News*, May 2010). In turn, that better neurobiological understanding could lead to more targeted treatments.

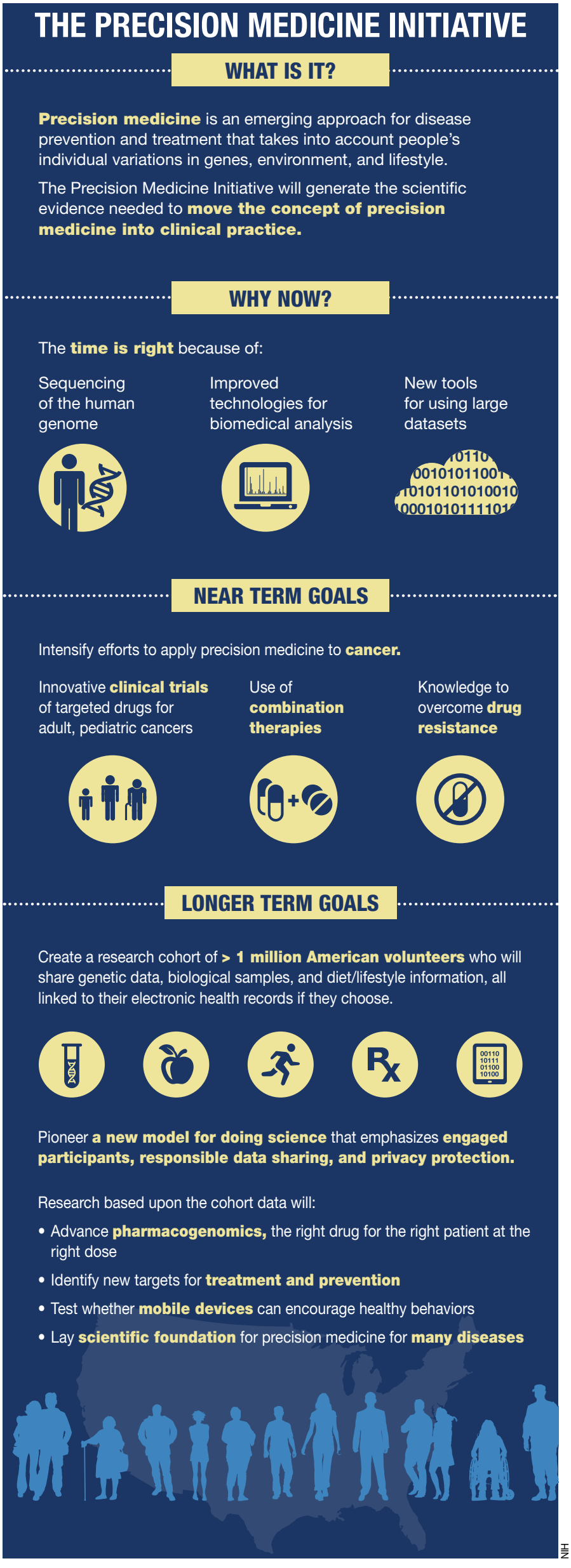
For example, anhedonia (an inability to experience pleasure) cuts across mood, anxiety, and affective disorders, but not every depressed individual presents with this condition. But if researchers uncover the mechanisms in the

*see **Initiative** on page 38*

New Public-Private Partnership Aims to Bring Precision Medicine to Psychiatry

As part of a partnership among a health care provider, a pharmacy-services provider, and an academic institution, NHS Human Services is leading a 28-month research project to improve outcomes and reduce side effects of psychiatric medications. NHS will collaborate with CareKinesis Inc., a medication-therapy management services provider; Coriell Life Sciences, a pharmacogenomics testing vendor; and the Department of Human Genetics at the University of Pittsburgh, which will provide expertise in genetic testing and genetic counseling. The project, funded by a $350,000 grant from the Polk Foundation, will be a large-scale attempt at pharmacogenomics. The group will tailor personalized-medication regimens for study volunteers based on their genetic profiles. Volunteers will be selected from a pool of adults with mental illness served by NHS in Pennsylvania's Allegheny, Beaver, Dauphin, and Lehigh counties.

More information is posted at http://www.nhsonline.org/news-and-events/articles/company/383-study-on-medication-related-problems.html.



Pediatrics Academy Urges More Screening for MH Problems

More consistent screening in physicians' offices, plus better integrated care, would help children with mental health or emotional problems, says the American Academy of Pediatrics.

BY AARON LEVIN

Developmental screening is a regular part of comprehensive pediatric care, but physicians should routinely expand on that model to include the mental health of their young patients, according to a new clinical report issued by the American Academy of Pediatrics.

"Behavioral and emotional problems and concerns in children and adolescents are not being reliably identified or treated in the U.S. health system," wrote Carol Weitzman, M.D., a professor of pediatrics and director of the Developmental-Behavioral Pediatrics Program at the Yale School of Medicine, and Lynn Wegner, M.D., an assistant professor at the University of North Carolina School of Medicine, in the February *Pediatrics.*

Developmental and behavioral problems often overlap to some extent, they noted: "Studies have revealed that children with cognitive, language, and social impairments and developmental disabilities, in general, are far more likely to manifest behavioral and emotional problems."

Identifying those symptoms is critical for pediatricians, given that more than 1 in 3 children will be diagnosed with an impulse-control, behavioral, anxiety, or mood disorder by age 16, they added. At the same time, "fewer than 1 in 8 children with identified mental health problems receives treatment."

However, despite a widespread understanding among pediatricians of the value and need for screening, many do not feel confident in managing children's mental health problems. They often say they don't have the time or they are concerned about barriers to referral, such as long wait times and too few providers.

"Pediatricians don't go into pediatrics to be mental health professionals," said Gregory Fritz, M.D., a professor and director of the Division of Child and Adolescent Psychiatry at the Warren Alpert Medical School of Brown University. "They are not trained to do this work, but two years out of residency, once they see it in their practices, they say they wish they'd had more didactics on mental health diagnosis and treatment."

Mental health screening is not as systematic as it should be, especially when pediatricians get busy or a child's problems are ones they are less familiar with, said Fritz, who was not involved with the clinical report.

However, better training and increased use of available standardized screening instruments might help, suggested Weitzman and Wegner.

So could collaborative models of care, they suggested. Such approaches might include placing mental health practitioners in the same clinic or using paradigms like the Massachusetts Child Psychiatry Access Project, which offers near-real-time phone consults to pediatricians. That program has been adapted in at least 30 other states, building the capacity of pediatricians, said Fritz.

michaeljung/Shutterstock

Much of the work the report proposes—such as following up on referrals and consulting with psychiatrists or counselors—takes up physician or staff time, only some of which is covered by CPT codes.

"The question is, how do pediatricians find time to screen and interpret results, and how do they get reimbursed for it?" said Fritz, president-elect of the American Academy of Child and Adolescent Psychiatry (AACAP). "Adding an unremunerated service is not an incentive, given the challenging economics of pediatrics."

AACAP and APA are also working to remove financial barriers to getting children into care, such as rules against patients' seeing two doctors on one day, requirements for face-to-face contacts, or not reimbursing for non-*DSM*-level conditions.

"I've been working at the boundaries of pediatrics and child psychiatry for 30 years, and this is a very exciting time," said Fritz. "I've never been so encouraged about the spirit of cooperation and the recognition and interest within primary care of the importance of children's mental health problems." PN

An abstract of "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" is posted at http://pediatrics.aappublications.org/content/135/2/384.abstract.

Mobile App for Evaluating Traumatic Brain Injury Gets FDA Approval

The ability to quickly diagnose traumatic brain injury will soon be only a few taps away.

BY VABREN WATTS

A new app will soon be available to help clinicians diagnose traumatic brain injury in as little as five minutes in almost any setting, including combat.

The app, called the Defense Automated Neurobehavioral Assessment (DANA), runs on multiple mobile platforms and was recently granted Food and Drug Administration (FDA) approval. "It's like a brain thermometer," stated Lt. Col. Chessley Atchison, a program manager for the Combat Casualty Care Research Program of the U.S. Army Medical Research and Materiel Command (USAMRMC). "And once we get it right, we're going to put it fairly far forward in the field."

Shutter_M/Shutterstock

According to the USAMRMC, DANA operates much like a video game. Service members will undergo a baseline series of on-screen exercises during which both speed and accuracy are recorded. Those who may have had a serious head injury will then participate in a series of both cognitive efficiency tests and self-administered questionnaires. Afterward, a clinician will review the results, comparing them with the results of the baseline exercises. The combination of the app's cognitive and psychological components allows for insight into the prevalence of symptoms related to both traumatic brain injury and post-traumatic stress disorder, USAMRMC said in a press statement.

USAMRMC stated that once DANA is fully validated for battlefield use, it may be used to help assess fitness for duty. The app is currently being tested on tablet devices. PN

ANNUAL MEETING

Deymos.HR/Shutterstock

Deymos.HR/Shutterstock

Niagara Falls and Other Delights Just Short Drive From Toronto

The Butterfly Conservatory is a serene, meditative stop in Niagara Park after experiencing the awe-inspiring power of the famous falls.

BY MARK MORAN

"All trembling, I reached the Falls of Niagara, and oh, what a scene!" wrote the naturalist John James Audubon. "My blood shudders still ... at the grandeur of the Creator's power; and I gazed motionless on this new display of the irresistible force of one of His elements."

The falls continue to make visitors shudder, and they are just a short drive for APA members and their families visiting Toronto in May for this year's annual meeting. Here are a few suggestions for special ways to take in one of the Seven Forgotten Wonders of the World and surrounding areas.

REGISTER NOW!
MAY 16-20, TORONTO

Information on APA's annual meeting can be accessed at APA's Web site at http://annualmeeting.psychiatry.org/.

Member Registration: Go to http://annualmeeting.psychiatry.org/registration/individual-registration-information and click on "Member Registration."

Nonmember Registration: Go to above URL and click on "Nonmember Registration."

Low advance registration rates are now in effect, so register now!

Hornblower Niagara Cruises is a thrilling way to experience the drama and power of the cascading torrent. As a passenger, you will get as close as possible to the breathtaking flow. Within the Niagara Great Gorge, the cruise travels past the American Falls and Bridal Veil Falls and into Horseshoe Falls.

Bryan Busovicki/Shutterstock

Skylon Tower is located in the heart of the Niagara Falls hotel, dining, and entertainment district. Just steps from the falls, the Skylon Tower offers Niagara Falls attractions, dining, entertainment, and shopping. It has two levels of dining, both 775 feet above the falls—the Revolving Dining Room Restaurant and the more affordable Summit Suite Buffet Dining Room. The Ride-to-the-Top and indoor/outdoor observation decks are favorite attractions at Skylon, and the 3D/4D movie "Legends of Niagara Falls" is another family-friendly attraction.

Journey Behind the Falls is an attraction that takes visitors to a protected space behind the falls where they can see 2,800 cubic meters of water thundering over the brink every second, traveling 65 kilometers an hour. Visitors can take an elevator down 45 meters (150 feet) through bedrock to tunnels leading to the Cataract Portal and Great Falls Portal, one-third of the way behind the massive sheet of water. From there visitors walk on to the upper and lower observation decks at the foot of the falls.

After experiencing the falls, you may be ready for something restful and meditative. Try the **Butterfly Conservatory** on the grounds of the Niagara Parks Botanical Gardens, 10 minutes north of the falls. The conservancy features more than 2,000 colorful tropical butterflies flitting among lush, exotic blossoms and greenery. Paths wind through the rainforest setting, past a pond and waterfall and the Emergence window, where butterflies leave their pupae and prepare to take their first flight. The self-guided walking tour of the Butterfly Conservatory begins with a short video presentation that is closed-captioned for the hearing impaired. PN

Tickets for these and related attractions can be purchased online. See box for website addresses.

More Information

Hornblower Niagara Cruises
5920 Niagara Parkway
Niagara Falls, Ontario
(905) NIAGARA
www.niagaracruises.com

Skylon Tower
5200 Robinson Street,
Niagara Falls, Ontario
(888) 9SKYLON; (905) 356-2651
www. skylon.com

Journey Behind the Falls
(877) 642-7275; (905) 356-2241
www.niagaraparks.com/

Butterfly Conservatory
(877) 642-7275; (905) 356-2241
www.niagaraparks.com/niagara-falls-attractions/butterfly-conservancy.html

APA's Education Council Issues Report On Need for Integrated Care Training

Educational programs in psychiatry need to further develop their ability to train students, residents, and psychiatrists to practice in integrated care models.

BY MARK MORAN

Integrated, or collaborative, care is the future of health care delivery, and physicians and physicians-to-be at all levels of training and professional life need to be trained in emerging models of collaboration with primary care and other specialties.

That's the conclusion of a comprehensive report by APA's Council on Medical Education and Lifelong Learning that was published online in *Academic Psychiatry* this month, with specific recommendations for undergraduate, graduate, and continuing medical education (see box). The report, "Training Psychiatrists for Integrated Behavioral Healthcare," also offers perspectives on future directions for interprofessional and interspecialty training.

The report, which was presented at the December 2014 meeting of the APA Board of Trustees, had its genesis two years ago in discussions among council members when Richard Summers, M.D., became chair of the council.

"We identified the emerging integrated care models as really important in terms of overall system change and therefore important to the world of education, because practitioners were going to need to develop a new set of skills, new ways of collaborating, new knowledge, and new cultural values to be able to practice in these new models," Summers told *Psychiatric News.*

The report emphasizes that the nature of integrated care models is evolving and that integrated care will likely take different forms in different parts of the country and different systems of care and practice settings—public, private, small-group, and large organized systems of care. The report also stresses that models for reimbursement of collaborative care—which will be especially fateful for the success or failure of integrated care and for psychiatric participation—have not been realized on a systemwide scale.

"We anticipate building excitement and enthusiasm around these new models and developing psychiatrists who are both competent and confident in the provision of these new models of care," the council report states. "We recognize that our conclusions and specific recommendations reflect the view from 2014 and know that we will learn much from greater experience with integrated care models and educating students and practitioners for these roles. These recommendations will surely need to be updated with that additional experience."

Richard Summers, M.D.

Richard Summers, M.D., says the report of APA's Council on Education and Lifelong Learning is designed to help drive interest and innovation in education around integrated care.

Summers told *Psychiatric News* that the evolving and still-to-be-determined nature of collaborative care presents what he called a "chicken and egg" problem for educators. "The reimbursement reform that will support these models hasn't happened yet nationally, though everyone expects it to happen," he said. "So should we train people for working in a model that isn't quite reimbursable yet" or wait for the models to evolve more fully?

"We decided our goal should be to drive interest and innovation in education around integrated care," Summers said. "We want to get people excited and provide some specific recommendations and examples of best practices for educators so they can begin to implement some models for integrated care training in their own settings."

The 36-page report addresses undergraduate, graduate, and continuing medical education as well as training for interprofessional and interspecialty collaboration; for each category, the council provides data on the extent of current training and examples of best practices.

"Interspecialty and interprofessional collaboration will need to be a priority across the continuum of medical education," the report states. "The integrated care model rests on collaboration among health care professionals, cross-fertilization of medical knowledge across specialties, shared technology platforms, and new approaches to collecting empirical data. Education about collaboration and collaboration in education will surely improve these essential components of care."

Council Offers Recommendations for Teaching Integration

In a report presented to APA's Board of Trustees last December, the Council on Medical Education and Lifelong Learning outlined specific recommendations for undergraduate, graduate, and continuing medical education on integrated care. Highlights appear below; the entire list appears in the council's report, posted at http://www.psychiatry.org/File%20Library/Network/CMELL/CMELL_ICReport_2232015.pdf.

Undergraduate Medical Education

- Promote a view of medical care, including integrated behavioral health care, as a collaborative, interspecialty, and interdisciplinary enterprise through the creation of didactic content and early preclinical exposure to role models and care systems.
- Engage medical students in a range of activities designed to improve interprofessional and interdisciplinary communication, beginning in the preclinical years, to promote the development of interpersonal and teamwork skills. This should include didactics that emphasize cross-system understanding of pathology, interdisciplinary collaboration, and collaborative service delivery.
- Develop integrated care clinical experiences as part of the psychiatry clerkship, when possible, utilizing effective teaching sites where residents, fellows, and attending psychiatrists experienced in integrated care are working.
- Support innovation in rotation design, especially in settings offering integrated behavioral health, and study the educational outcomes of these experiences. Programs should consider the potential for longitudinal educational experiences, which by their nature involve interdisciplinary and interspecialty collaborative experiences.
- Include the psychiatrist's role in integrated behavioral health care in discussions about physician career choice in recruitment activities.

Graduate Medical Education

- Develop a comprehensive, four-year, developmental sequence of educational experiences to prepare residents to provide psychiatric care in integrated settings.
- Create a didactic experience in integrated care, probably in PGY-3 or PGY-4. A minimal educational experience for a residency would probably be a didactic experience in the later years of the residency.
- Engage residents in a range of activities designed to improve interprofessional and interdisciplinary communication, including didactics that emphasize cross-system understanding of pathology, shared clinical case conferences and grand rounds, and collaborative service delivery.
- Provide clinical experience in recognition and management of common medical conditions, metabolic side effects of psychopharmacologic treatments, causes of early mortality in patients with psychiatric illness, motivational interviewing, lifestyle interventions such as smoking cessation, and techniques for psychiatrists to ensure adequate primary medical care for their patients.
- Plan clinical experiences for residents and fellows that arise organically out of existing integrated care settings, rather than attempting to graft rotations for trainees onto clinical services that are functioning without behavioral health input. Co-location, improved primary care, and telemedicine settings may be more available in some institutions currently, while collaborative practice models are less prevalent but expanding.

Continuing Medical Education

- Develop tools that help practitioners assess whether they have the knowledge to be successful in the new health care environment.
- Focus on the components of integrated care that are knowledge- and skills-based, such as supporting evidence base, screening tools, and registry technology.
- Develop materials across the range of integrated behavioral health care including providing consultation in the primary care setting and addressing the health status of the seriously mentally ill population.

EDUCATION & TRAINING

Within undergraduate medical education, a survey of members of the Association of Directors of Medical Student Education in Psychiatry showed that clinical rotations that give medical students exposure to integrated care are relatively rare; where they do exist, the rotations tend to be in Veterans Administration (VA) settings, federally qualified health centers, and other primary care clinics and to involve traditional psychiatric consultation with primary care providers.

"Exposure to integrated care for medical students is just the beginning," the report concludes. "There are many exciting opportunities for modeling interspecialty collaboration, developing team participation skills, and incorporating a population-based framework for understanding illness and care. As the health care system changes to reflect these new values, and clinical services are increasingly organized along these lines, the clinical educational opportunities for medical students will surely improve."

In May and June 2014, the American Association of Directors of Psychiatric Residency Training (AADPRT) Integrated Care Task Force conducted a survey on integrated care education.

There were 88 respondents: 52 general psychiatry program directors and 36 child and adolescent program directors. Seventy-eight percent of general psychiatry program directors and 72 percent of child and adolescent psychiatry (CAP) program directors stated that they offered one or more integrated care rotations. Of these, 65 percent of general psychiatry rotations and 40 percent of CAP rotations were elective.

The most common type of integrated care rotation was psychiatric consultation within a primary care clinic, while the least common was provision of both primary care and psychiatric care by psychiatry residents. In general psychiatry residency programs, rotations were most commonly offered in VA settings, followed by other primary care clinics, while the most common sites for CAP rotations were federally qualified health centers. Forty-three percent of programs also offered didactics about integrated care.

Claudia Reardon, M.D, who co-wrote the section on residency education, emphasized in an interview with *Psychiatric News* that the new Accreditation Council for Graduate Medical Education "milestones" for psychiatry, which went into effect last July, provide benchmarks that residents are expected to meet by the time they graduate and include those that are uniquely suited for accomplishment in integrated care settings.

For example, under the domain of "systems-based practice," the milestones state that "residents should be able to provide integrated care for psychiatric patients through collaboration with other physicians."

(For more comprehensive coverage of the Milestone Project, see *Psychiatric News,* August 28, 2013.)

"Integrated care is coming close to being a requirement" for residency programs, Reardon said, noting that resident performance against the milestones will be critical in the evaluation and reaccreditation of programs: "Programs are seeing the imperative to offer these kinds of experiences. Many of these rotations at this point are elective and are offered to senior residents who have honed the skills required to practice in integrated care."

Claudia Reardon, M.D., notes that some ACGME milestones call for trainees to demonstrate ability to collaborate with other specialties in integrated care.

Reardon is associate residency training director in general psychiatry at the University of Wisconsin and chair of the AADPRT Integrated Care Task Force.

"Beyond that, it is becoming increasingly clear that the typical model of psychiatric care—an individual psychiatrist providing frequent, lengthy, one-on-one sessions—will certainly continue to be an important part of the package of psychiatric care but isn't going to be the whole story," she said. "Integrated care is a highly efficient way we can work with primary care colleagues to manage populations of patients." PN

The full text of the council's report, including recommendations for undergraduate, graduate, and continuing medical education, is posted at Xhttp://www.psychiatry.org/File%20Library/Network/CMELL/CMELL_ICReport_2232015.pdf. An audio interview with Richard Summers, M.D., about the report is posted at http://www.psychnews.org/update/audio/richard_summers.mp3.

Learn More About Practicing in Integrated Care

APA offers the following courses to help psychiatrists learn more about integrated care and common conditions that psychiatrists may encounter in integrated care settings. The courses can be accessed in the course catalog at APA's education portal, http://www.apaeducation.org. Both courses are free to APA members.

The Integration of Primary Care and Behavioral Health

This course focuses on the models of care, the evidence for these models, and funding issues around the integration of primary and behavioral health. It also discusses the value that is added to a health care system when psychiatric and behavioral health resources are included. As the health care system evolves, there will be greater accountability for outcomes, cost containment, and patient satisfaction (the "triple aim" of integrated care). Health care systems will seek psychiatric expertise to design systems of care to meet these goals. Psychiatrists need to be prepared for these changes to assist in well-informed and meaningful ways. Participants can earn up to 1.50 AMA PRA Category 1 credits.

Primary Care Updates for Psychiatrists

This course presents updates on the current treatments for health conditions commonly found in in populations with serious mental illness in public mental health settings. Case examples and an overview of preventive measures to reduce the risk of cardiovascular disease are presented. Hypertension, diabetes, obesity, smoking cessation, and dyslipidemia are reviewed along with the latest treatment recommendations and treatment algorithms. Cases are presented to demonstrate treatment options. The course is led by Lori Raney, M.D., chair of APA's Council for Healthcare Systems and Financing Workgroup on Integrated Care, with presentations by dual-boarded med-psych physicians in the field. Handouts providing a case for discussion are available for download. Participants can earn up to 4 AMA PRA Category 1 credits.

From the President

continued from page 11

dinated actions like these are greatly needed and long overdue.

Rep. Murphy's bill has drawn controversy over two of its features in particular. The first is its support for assisted outpatient treatment (AOT), also known as involuntary outpatient commitment. But Rep. Murphy has been clear that he, like a growing group of organizations and distinguished individuals working under the rubric of the Opening Closed Doors Alliance (http://scattergoodfoundation.org/consensus-project), recognize that AOT is a last resort when a life-saving intervention is needed to provide care for those who are at highest risk for suicide, medical complications, or chronic impairment. AOT also is dependent on a functioning, adequately resourced community mental health system. It's but one tool we need to help our patients.

The second is Rep. Murphy's view that the country needs a federal mental health agency led by, and with the stature of, a presidential appointee who is in the senior leadership of the U.S. Department of Health and Human Services (HHS): an assistant secretary for mental health and substance use disorders (see page 12). The assistant secretary would coordinate federal programs and ensure that community mental health services block-grant recipients apply evidence-based models of care developed by NIMH. The Murphy-Johnson bill also seeks to use HHS budgetary controls to require the provision of evidence-based services and to limit funding for programs that may advocate and litigate against psychiatric services.

These two aspects of the Helping Families in Mental Health Crisis Act, as well as the HIPAA provision, have drawn concerns and opposition. But good government requires the art of compromise—of finding common ground to do the right thing. With Rep. Murphy as this bill's author; a Congress whose two chambers are in political alignment; strong bipartisan support; and routine, high-profile public attention on the consequences of our failing mental health care system, the Murphy-Johnson bill stands a strong chance of becoming law.

As Winston Churchill liked to say, you will never reach your destination if you stop and throw stones at every dog that barks. There is no such thing as perfect legislation. We have a unique and rare opportunity to dramatically improve a system that desperately needs it. Rep. Murphy, supported by Rep. Johnson and a broad swath of Democrats and Republicans, is on a mission. We support that mission: Our nation cannot afford to wait another 50 years for legislation designed to fix so much of what ails our mental health system, a system that deprives far too many people of what they need to build lives of fulfilling relationships, work, and contributions. PN

Better Antipsychotic Adherence Could Save Governments Millions

The collective cost burden of schizophrenia in the United States is approximately $21 billion annually, but improved disease management could make a substantial dent in these expenses.

BY VABREN WATTS

The Centers for Medicare and Medicaid Services is the largest payer for mental health services in the United States, with schizophrenia-associated costs accounting for a large burden of such spending—making the disorder a major target for disease-management intervention.

Findings from an analysis conducted by the RAND Corporation on the potential net savings to state budgets from interventions to improve adherence to antipsychotic drugs in patients with schizophrenia were published January 2 in *Psychiatric Services in Advance.*

"Antipsychotic medications are effective in controlling disturbing symptoms of schizophrenia, including hallucinations and paranoid delusions, and adequate adherence has been shown to reduce the risk of hospitalization, the costliest form of health care," coauthor Soeren Mattke, M.D., M.P.H, a senior scientist at RAND, told *Psychiatric News.*

According to the study, schizophrenia accounts for approximately 1.5 percent to 3 percent of the total Medicaid spending for mental health care, in addition to being costly in other areas outside of direct health care. The authors cited a recent study showing that 46 percent of a sample population with schizophrenia had at least one interaction with the justice system as either a perpetrator or a victim of a crime within a given year.

"The associated costs to the states of these interactions are substantial," the researchers noted, "as evidenced by an average annual cost of $1,881 per person [in 2013], which includes only the cost of arresting and incarcerating the perpetrators but not the cost of providing forensic inpatient care." They added that interventions to increase adherence to antipsychotic medication in people with schizophrenia have been shown to reduce costs and improve outcomes.

Oko Laa/Shutterstock

In the current study, the researchers conducted a literature review to investigate schizophrenia-related financial burdens incurred by states in 2013, including direct costs for mental health care to Medicaid programs and the criminal justice system.

The analysis estimated annual schizophrenia-related spending of $21.4 billion by state Medicaid programs and criminal justice systems. The bulk of spending was attributed to direct health care costs—$16.9 billion, or 79 percent—with the remaining $4.6 billion related to spending in the criminal justice system. Of the estimated direct health care costs, psychiatric outpatient treatment accounted for 43.5 percent of the expenditures, while inpatient treatment and prescription drugs accounted, respectively, for 40.7 percent and 15.2 percent. Annual cost to state budgets ranged from $33.1 million in Idaho up to $3.29 billion in California.

Based on the financial model used, the researchers found that improvements in interventions for antipsychotic adherence would yield annual net savings up to $3.28 billion for state budgets and net savings of $1,580 per patient per year. Most of these savings would come from lower hospitalization rates and would require total expenditure for prescription drugs by states to increase by 18.3 percent.

"It's important for legislators to understand that money can be saved to state budgets if access to antipsychotics is made less burdensome for patients," Mattke stated. He said that interventions to increase adherence could include medication-management programs, such as counseling by pharmacists or advance-practice nurses, or cognitive adaptive training, which attempts to change patients' behaviors by modifying their home environment through alarms, checklists, and electronic medication monitoring that remind patients to take their medications. Mattke also cited a more "straightforward" intervention—long-acting injectable antipsychotics, which help ensure patients' adherence from 30 to 90 days, depending on the extent of a medication's activity.

"We have to rethink the cost for better health care management of schizophrenia on the state level rather than in silos such as budgets allocated to inpatient care and outpatient [care] … and really think of the total financial burden caused by untreated schizophrenia and mental illness," Mattke emphasized. "Hopefully, data presented in this study will create a dialogue on how we can optimize spending that will both benefit patients and state finances." PN

An abstract of "Improving Antipsychotic Adherence Among Patients With Schizophrenia: Savings for States" is posted at http://psychiatryonline.org/doi/full/10.1176/appi.ps.201400506.

bikeriderlondon/Shutterstock

PTSD Linked to Increased Risk For Type 2 Diabetes in Women

PTSD treatment should be expanded to address behaviors that could lead to increased weight gain and type 2 diabetes in women, advise researchers.

BY VABREN WATTS

Women with the highest number of posttraumatic stress disorder (PTSD) symptoms may have a twofold increased risk of developing type 2 diabetes compared with women without PTSD, according to a study published in *JAMA Psychiatry.*

Researchers from the Harvard School of Public Health and the Mailman School of Public Health at Columbia University analyzed data from a large-scale longitudinal study to examine whether an association exists between PTSD and the incidence of type 2 diabetes in women.

"One in nine American women will suffer from PTSD at some point in their lives," Karestan Koenen, Ph.D., the study's senior author and a professor of epidemiology at Columbia, told *Psychiatric News.* "Understanding the physical health consequences of the disorder is critical."

According to Koenen and colleagues, the current study was prompted by previous research suggesting that trauma and PTSD have profound effects on mental health as well as on physical health, which includes inflammation and endocrine dysfunction. The researchers noted that while previous studies have shown a correlation between PTSD and type 2 diabetes, the majority of the populations examined were military members or men.

"We wanted to see whether PTSD was associated with new onset of type 2 diabetes in a civilian sample of women," Koenen explained. "We also wanted to know whether health behaviors like diet, smoking habits, and exercise might explain why women with PTSD could be at higher risk of type 2 diabetes."

After gathering health information from nearly 50,000 women as part of the Nurses' Health Study, Koenen and colleagues analyzed data from annual follow-ups extending over 22 years. Participants were aged 24 to 42 at study enrollment.

The analysis showed that PTSD symptoms were associated with the

see ***PTSD*** *on page 38*

CLINICAL & RESEARCH NEWS

SAMHSA Releases Guidance for Initiating Medication Treatment for Opioid Overdose

Overdose deaths due to opioid prescription painkillers have quadrupled in the United States since 1999, but a new publication hopes to reduce that tragic number.

BY VABREN WATTS

Arisha Singh/Shutterstock

As rates for opiate use disorder—including use of prescription painkillers and heroin—continue to rise in the United States, researchers, federal health agencies, and pharmaceutical manufacturers are focusing on pharmacotherapies that could help some individuals access treatment for the disorder in medical office settings rather than in specialized opioid treatment centers.

To this end, the Substance Abuse and Mental Health Services Administration has published the guidance "Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide." It provides a summary of the key differences between extended-release injectable naltrexone (naltrexone-ERI), methadone, and buprenorphine.

"Medication-assisted treatment for opioid dependence is clearly well researched and has great safety and efficacy," Petros Levounis, M.D., chair of the Department of Psychiatry at Rutgers New Jersey Medical School, said in an interview with *Psychiatric News*. "Yet, few psychiatrists and other physicians seem to be using these pharmacotherapies to treat opioid use disorder. The guidance is very necessary to spread the word about treatment options for opiate addiction."

According to the 2013 National Survey on Drug Use and Health, approximately 4.5 million people in the United States reported nonmedical use of prescription pain relievers in the prior month, and 289,000 reported use of heroin in the prior month. Despite the dimensions of the problem, the guidance noted, nearly 80 percent of people with an opioid use disorder do not receive treatment because of limited treatment capacity, financial obstacles, stigma associated with being enrolled in a treatment program, and other barriers to care.

The guidance offers a step-by-step process for treating people with opioid use disorder, from assessing patients' need for treatment to deciding when it is safe for patients to discontinue treatment. The guidance highlights the importance of documenting the patient's substance use history, including alcohol and other drugs of abuse, as well as the history of comorbid general medical and psychiatric conditions to best prioritize and coordinate treatment management. It also stressed the importance of evaluating the patient's degree of motivation for behavior change and readiness to participate in treatment.

As it relates to medication options, the guidance highlights key distinctions among the medications approved by the Food and Drug Administration for treating opioid use disorder, such as the pharmacological category in which each one is classified.

For example, "Unlike methadone and buprenorphine, extended-release injectable naltrexone [an opioid antagonist] has no potential for abuse and diversion and requires once-a-month dosing,

see ***Overdose*** *on facing page*

FDA Approves First Drug for Binge-Eating Disorder

Vyvanse was approved under the FDA's priority review program because of the limited treatment options available for this disorder.

BY VABREN WATTS

In midwinter, Vyvanse—a medication originally approved for attention-deficit/hyperactivity disorder (ADHD)—became the first medication to be approved by the Food and Drug Administration (FDA) to treat binge-eating disorder.

"Binge eating can cause serious health problems and difficulties with work, home, and social life," said FDA Division of Psychiatry Products Director Mitchell Mathis, M.D. "The approval of Vyvanse provides physicians and patients with an effective option to help curb episodes of binge eating."

Vyvanse was first approved in 2007 as a once-daily medication for ADHD in patients aged 6 and older. It is a Schedule II controlled substance because it has high potential for abuse and dependence. The active ingredient is lisdexamfetamine dimesylate.

According to the Agency for Healthcare Research and Quality, binge-eating disorder affects up to 2.5 percent of the population and has been recognized as a psychiatric disorder in *DSM-5*—the first time ever for such recognition in the *Diagnostic and Statistical Manual of Mental Disorders.*

"Cognitive-behavioral therapy is effective for treating patients with binge-eating disorder," said Johns Hopkins Eating Disorders Program Director Angela Guarda, M.D., told *Psychiatric News.* "However, access to expert therapists trained in cognitive-behavioral therapy for binge-eating disorder is often limited, so there is a clear need for other effective treatments."

The drug was reviewed under the FDA's priority review program, which expedites the review process of drugs that are intended to treat serious conditions for which limited therapy options are available.

The FDA approved Vyvanse based on

continued on facing page

Lightspring/Shutterstock

FROM THE EXPERTS

Behavioral Addictions: Helping Patients to Engage in Treatment

BY MICHAEL ASCHER, M.D.

While traditionally the term "addiction" was confined to substance use disorders, extreme behaviors are now being recognized as "behavioral addictions" and attracting attention for their relevant social impact. This group includes sex, love, gambling, food, work, Internet use, and compulsive buying. Unlike with other behavioral addictions where research remains in its infancy, research in pathological gambling and substance use disorders suggests a strong neurobiological link based on biochemical, functional, neuroimaging, and genetic studies. A research work group of the *DSM* reclassified gambling disorder, making it the first (and only) behavioral addiction in *DSM*. "Internet gaming disorder" is a "condition for further study" and listed in Section 3 of *DSM-5*.

Like substance use disorders, the addiction model can be helpful in understanding behaviors that can hijack the pleasure-reward circuitry in the brain, resulting in compulsive engagement, loss of control, cravings, withdrawal, tolerance, and negative consequences (financial, interpersonal, legal, and so on) for the individual. Additionally, many of our patients may present with subclinical behavior that can be both personally and professionally damaging.

Behavioral addictions can have calamitous effects on both the individual and families. Patients who suffer from behavioral addictions can experience myriad emotions including shame, guilt, fear, irritability, sadness, and anxiety. To complicate matters, when patients present for treatment for a behavioral addiction, the only outcome for which they are often initially hoping is a decrease in negative consequences associated with the behavior, and not extinction or modification of the behavior itself.

It can be difficult for clinicians to discern and assess when excessive behavioral patterns require psychiatric intervention or whether presenting problems fall within the realm of normative behavior. Moreover, behavioral addictions can present in a wide range of subtle and complex patterns, and individuals are likely to fluctuate between the line of pathology and habit. Tracking and monitoring symptoms over time is critical for establishing patterns of use and documenting ongoing consequences.

Unfortunately, inquiring about many of these behaviors is not part of the standard psychiatric assessment, and most individuals do not normally seek treatment for behavioral addictions. The importance of asking the right questions and creating a space of nonjudgment is crucial. Without an investment in building the therapeutic alliance, clinicians can fail to gather all the pieces necessary to understand the full clinical picture of their patients.

It can help to build the therapeutic alliance by exploring the concept of ambivalence with our patients. After eliciting the behavior, clinicians should explicitly tell the patient that ambivalence is a normal part of the motivation and change process.

While medications can help to alleviate some symptoms associated with behavioral addictions and other co-occurring disorders, psychotherapy (both individual and group) often provides the best outcome. Psychiatrists are therefore in the position to provide psychoeducation to patients about the benefits of establishing a relationship with their therapist to explore more fully the problem and the function of the behavior. Explaining to patients that the behavior does not define them but is a symptom of an unmet need or underlying issue can be helpful in decreasing shame. Maintaining an empathic but hopeful stance that they can live a happier and more meaningful life if they engage in treatment can increase the likelihood that they will gather the intrinsic resolve to address the problem through treatment, which may include medications, therapy, or 12-step facilitations. The importance of maintaining an open, curious, flexible approach is paramount to building the therapeutic alliance and leading to improved treatment outcomes. PN

Michael Ascher, M.D., is a clinical associate in psychiatry at the University of Pennsylvania Perelman School of Medicine. He is the coeditor of *The Behavioral Addictions*, published by American Psychiatric Publishing. APA members can order the book at discount at http://www.appi.org/SearchCenter/Pages/default.aspx?k=Ascher.

data generated from two clinical trials with 724 adults with moderate to severe binge-eating disorder. The results showed that participants taking Vyvanse experienced a decrease in the number of binge-eating days per week and had fewer obsessive-compulsive binge-eating behaviors compared with those taking placebo.

Adverse reactions reported by individuals taking Vyvanse included insomnia, increased heart rate, and anxiety. Results from one of the two studies—published in the January 14 *JAMA Psychiatry*—showed that 85 percent of participants taking the medication experienced some form of adverse reactions, compared with 59 in the placebo group.

Vyvanse's medication guide notes the risks associated with the medication's use, such as increased risk of psychotic or manic symptoms, including for individuals without a history of psychotic illness. The FDA emphasized that Vyvanse is not approved or recommended for weight loss.

"Because of the high rates of psychiatric and medical comorbidities associated in populations of people with binge-eating disorder, it is important to monitor the use of Vyvanse going forward," said Guarda. "Long-term follow-up will be very important, with much focus on rates of remission and cessation of binge eating in patients treated with this agent."

Vyvanse is marketed by Shire U.S. Inc. PN

An abstract of "Efficacy and Safety of Lisdexamfetamine for Treatment of Adults With Moderate to Severe Binge-Eating Disorder" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=2089519.

Got a Question For APA's Leaders?

All APA voting members are invited to attend APA's Annual Business Meeting and Annual Forum at the 2015 annual meeting in Toronto. The Annual Business Meeting informs members about the state of the Association and its activities and accomplishments over the past year. At the Annual Forum, APA voting members are invited to ask questions of and share comments with APA leaders.

SUNDAY, MAY 17
12:30 p.m.-1:30 p.m.
Annual Business Meeting and Annual Forum
Room 106, Toronto Convention Centre

Overdose

continued from facing page

which should be desirable to providers and some patients," Joseph Liberto, M.D., associate chief of staff for education and academic affairs at the Veterans Administration of Maryland Health Care Center and a member of the expert panel that developed the new guidance, told *Psychiatric News*.

In addition, Liberto, who is also an associate professor of psychiatry at the University of Maryland School of Medicine, stated that naltrexone-ERI can be prescribed by anyone licensed to prescribe medications, including physicians, nurse practitioners, and physician assistants without specialized board certification or specialized training—which is currently required for administering methadone, an opioid agonist. "Its availability therefore holds the promise of increasing access for people with opioid use disorder who have, up to now, gone untreated."

Maryland Treatment Centers Medical Director Marc Fishman, M.D., who also served on the guidance-development panel and is an assistant professor of psychiatry at Johns Hopkins Hospital, told *Psychiatric News* that though buprenorphine, a partial opioid agonist, is still considered "the first-line treatment" for opioid use disorder by most physicians, it's a relief to have more options available to treat patients with opioid addiction.

"Pharmacotherapies vary from person to person," Fishman noted. "Whether the prevention medication be naltrexone, buprenorphine, or methadone, medication-assisted treatment should be the standard of care as an opportunity for treatment modality for every patient with opioid addiction."

As for Levounis, he said that health care professionals must continue to spread the word that evidence-based interventions for opioid use disorder are available and should be used to treat some patients with the disorder. "The tables and information in the guidance that compared the different treatment options were very helpful. I think that psychiatrists and primary care physicians, as well as patients, will benefit from what is presented in the document." PN

"Clinical Use of Extended–Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide" is posted at http://store.samhsa.gov/shin/content//SMA14-4892/SMA14-4892.pdf.

MED CHECK

BY VABREN WATTS

European Drug Agency Calls for Suspension of Some Generics

In midwinter, the European Medicine Agency (EMA) accused India-based drugmaker GVK Bioscience of falsifying clinical-trials data for approximately 700 generic drugs—which included the antipsychotic ***quetiapine,*** commonly used antidepressants ***escitalopram*** and ***venlafaxine,*** and the anxiolytic ***clonazepam.***

According to the EMA, the recommendation is based on findings from an inspection that raised concerns about electrocardiogram-generated data from studies conducted at GVK's Hyderabad site dating back at least five years. The agency stated in a press release that the "systematic nature [of the studies], the extended period of time during which they took place, and the number of members of staff involved cast doubt on the integrity of the way trials were performed at the site generally and on the reliability of data generated at that site." EMA did not recommend suspension of Hyderabad-produced generics that contained additional clinical-trials data that were generated and provided by sources outside of GVK.

Because the EMA has expressed doubts about the integrity of trials performed at the Hyderabad site, GVK said in a statement that it has suspended studies being conducted there with plans to redo all the studies in question at another GVK facility. However, the company has denied any wrongdoing.

Ex-FDA Official Testifies Against Johnson & Johnson In Risperdal Case

Johnson & Johnson (J&J) knew that its atypical antipsychotic ***Risperdal*** could either "probably or very likely" have caused breast development in boys years before it was marketed to children, testified David Kessler, M.D., J.D., former commissioner of the Food and Drug Administration, in a Philadelphia court in late January.

According to Kessler, a 2001 clinical trial funded by J&J showed that 3.8 percent of young male participants given Risperdal developed breasts, a condition known as gynecomastia. In 2006, the company added a warning about the side effect to the drug's official label. This "certainly was a red flag," he stated.

Under oath, Kessler reported that in years leading to the drug's approved use in children, J&J encouraged physicians to prescribe Risperdal through "off-label" marketing with trinkets such as children's Lego-like blocks in bright colors adorned with the Risperdal logo.

Kessler's testimony backed two Alabama parents who sued on behalf of their son, who had been taking the antipsychotic for five years before the drug was FDA-approved for use in children with autism spectrum disorder, according to the *Philadelphia Inquirer.* Their son, now age 20, claims that Risperdal caused him to grow breasts and accused J&J of hiding the risk.

In a statement, Robyn Frenze, a spokeswoman for J&J subsidiary Janssen Pharmaceuticals, said that Risperdal "has improved the lives of countless children and adults throughout the world … and it continues to improve patients' quality of life today." The company claims that it properly warned patients and their doctors about Risperdal's risks and did not mishandle marketing of the drug.

In 2013, J&J agreed to pay $2.2 billion to settle federal and state allegations that it marketed Risperdal for off-label uses in children and the elderly. The U.S. Department of Justice deemed this one of the largest health-care frauds in history (*Psychiatric News,* December 13, 2013).

Actavis, Richter Won't Give Up On New Schizophrenia Drug

The phrase "dust yourself off and try again" may be applied to the pharmaceutical companies Actavis and Gedeon Richter regarding their new antipsychotic ***cariprazine.***

Fourteen months after the dopamine D_3 and dopamine D_2 receptor partial agonist was rejected, Actavis has gathered new phase 3 data to demonstrate the effectiveness of its "blockbuster" hopeful in the treatment of schizophrenia.

For a double-blind study, Actavis recruited 200 patients with schizophrenia who were given 3 mg to 9 mg a day of cariprazine or placebo. The results showed that individuals taking cariprazine were 55 percent less likely to relapse within a 20-week period than patients in the placebo cohort. The most commonly reported adverse events included nasopharyngitis, tremors, back pain, and increased creatine phosphokinase in blood.

The Food and Drug Administration approved a new drug application resubmission for cariprazine submitted by Actavis in January.

FDA Approves New Formula for Zohydro ER

Last year's Food and Drug Administration (FDA) approval of ***Zohydro ER*** generated outrage from advocates and officials from several states who proclaimed that marketing of the hydrocodone-based painkiller would merely add to the nation's high rates for opioid addiction—forcing makers of the controversial drug to take action.

Last month, Zogenix, manufacturer of Zohydro ER, announced that it had received a green light from the FDA for a new formulation of the painkiller through the use of BeadTek, a technology that transforms the drug into a viscous gel when crushed and dissolved in liquids or solvents. The new formulation, Zogenix claims, will maintain the efficacy and pharmacokinetic profile of the original formula if used as intended.

"While we are very pleased with the outcomes from our safe-use initiatives, implemented with the introduction of Zohydro ER last year, we believe moving forward with this formulation change at the earliest possible time is a responsible action for us to take," said Stephen Farr, Ph.D., president of Zogenix.

Though the company plans to transition to Zohydro ER with BeadTek in the second quarter of this year, the FDA will not give Zogenix the nod for labeling the drug's abuse-deterrent properties until such is proven by additional studies. The new formulation will be available in strengths ranging from 10 mg to 50 mg.

Swiss Company, Janssen To Collaborate on Alzheimer's Vaccine

Switzerland-based pharmaceutical company AC Immune has announced that it will join forces with Janssen Pharmaceuticals to develop and commercialize anti-Tau vaccines for the treatment of Alzheimer's disease (AD) and other Tau protein–related neurodegenerative diseases.

Janssen and AC Immune will co-develop AC's lead therapeutic vaccine, ***ACI-35,*** now in a phase 1b clinical trial with AD patients. As of phase 2, Janssen will assume responsibility for the clinical development, manufacturing, and commercialization of the biologic.

ACI-35 functions by stimulating patients' immune system to produce antibodies against mutated Tau proteins—a hallmark of AD independent of amyloid-beta plaques. The vaccine is the first of its kind in clinical development that targets modified Tau-proteins associated with AD. PN

Election Results

continued from page 1

sented representative (M/UR) trustee, incumbent Gail Erlick Robinson, M.D., D.Psych., of Toronto won over Curley L. Bonds, M.D., of Los Angeles.

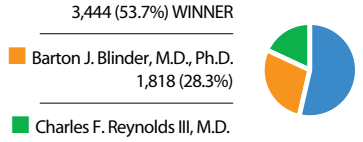
This year, three APA Areas elected trustees—Areas 1, 4, and 7. Retaining the position of Area 1 trustee is Jeffrey L. Geller, M.D., M.P.H., of Worcester, Mass. His opponent was Anthony J. Rothschild, M.D., also of Worcester, Mass. In Area 4, Ronald M. Burd, M.D., of Fargo, N.D., defeated Shastri "Swami" Swaminathan, M.D., of Chicago. In Area 7, incumbent Jeffrey Akaka, M.D., of Honolulu outpolled Stephen L. Brown, M.D., of Casper, Wyo., and Annette M. Matthews, M.D., of Portland, Ore.

Each year the Association's resident members elect a resident-fellow member trustee-elect, who the following year rotates into the position of resident-fellow member trustee. Stella Cai, M.D., a resident at the University of California, Irvine, won this year's race. Her opponents were Alicia A. Barnes, D.O., M.P.H., a resident at UMDMJ-Robert Wood Johnson Medical School in Camden, N.J., and Sarah Schmidhofer, M.D., a resident at Brown University.

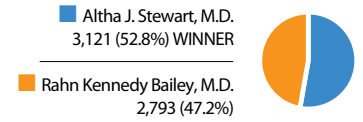
Election results were approved by the Tellers Committee in February, but the results will not be official until after the Board of Trustees reviews them at its meeting this month. All of the winning candidates will assume their positions on the Board at the close of the annual meeting in May. PN

Results of APA's 2015 Election

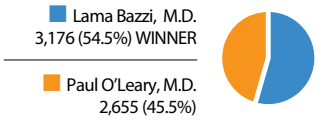
President-Elect*



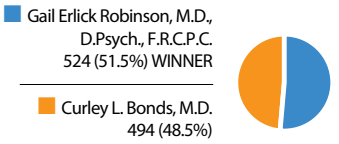
Secretary



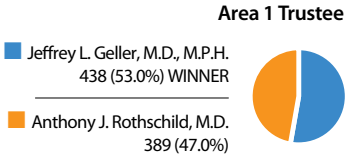
Early Career Psychiatrist Trustee-at-Large



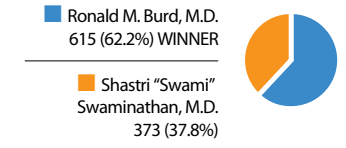
Minority/Underrepresented Representative Trustee



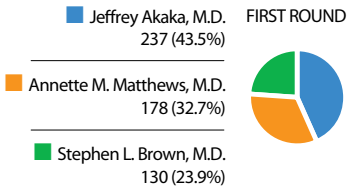
Area 1 Trustee



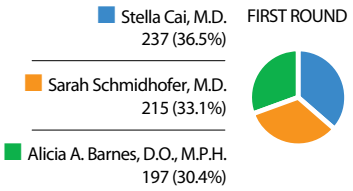
Area 4 Trustee



Area 7 Trustee*



Resident-Fellow Member Trustee-Elect*



* A majority vote (>50%) is necessary in a three-way contest. If a majority does not exist after tallying all first-choice votes, voters' second-choice votes for the candidate with the least amount of first-choice votes are tallied and added to the remaining candidates' tallies. This follows the procedure outlined for "Preferential Voting" in Sturgis' *The Standard Code of Parliamentary Procedure.*

Initiative

continued from page 24

reward circuitry that cause anhedonia, they might find a drug target that can help a wide range of people but not be needlessly used in others.

In this regard, Cuthbert believes that building a national research cohort that includes standard medical records along with genetic and lifestyle data would create an "information commons"—a concept first espoused by the Institute of Medicine in a 2011 report—that is critical in enabling researchers to rethink disease classification and develop more personalized treatments.

NIMH already has developed repositories like the National Database for Autism Research (http://ndar.nih.gov) to facilitate these goals, but the new NIH cohort would provide a huge boost in data. "With a large-enough database, we can identify the right grain size we need for a particular disease," Cuthbert said. "Effective treatment doesn't necessarily have to always be at the level of the individual; we might be able to find features shared among a larger population subgroup."

A national patient-powered research cohort will take a while to get up and running, so the benefits of that project are down the road. In the meantime, many researchers who work in the pharmacogenomics arena will likely applaud the $10 million that the Precision Medicine Initiative proposes for the Food and Drug Administration to ensure that the oversight of genomic applications does not stifle innovation and that the technology works and protects patient privacy. PN

More information about the Precision Medicine Initiative is posted at http://www.whitehouse.gov/blog/2015/01/30/precision-medicine-initiative-data-driven-treatments-unique-your-own-body.

PTSD

continued from page 33

development of type 2 diabetes in a "dose-response" fashion—the greater the number and severity of PTSD symptoms, the greater a woman's risk of developing type 2 diabetes. Of the approximately 2,000 women who reported the highest number of PTSD symptoms (six to seven symptoms) in any given year of the study, 12 percent developed type 2 diabetes, whereas fewer than 7 percent of the women who reported no trauma exposure had developed type 2 diabetes.

Data also showed that antidepressant use and elevated body mass index accounted for nearly half—34 percent and 14 percent, respectively—of the increased risk of type 2 diabetes in participants with PTSD. Smoking, diet quality, alcohol intake, and physical activity did not increase risk for type 2 diabetes in women with PTSD, according to the study.

Coauthor Andrea Roberts, Ph.D., a research associate in behavioral science at the Harvard School of Public Health, stated that "women with PTSD and the health professionals who care for them should be aware that these women are at greater risk for diabetes. As fewer than half of Americans with PTSD receive treatment, our study adds urgency to the effort to improve access to mental health care to address factors that [could potentially] contribute to diabetes and other chronic diseases."

Koenen told *Psychiatric News* that the research team is preparing to examine the biological mechanisms underlying the relationship between PTSD and type 2 diabetes and further examine the effect of antidepressant use on PTSD-related diabetes.

"Our health care system treats the brain and body as if they are separate," said Koenen. "This study reiterates that patients with PTSD need treatment that integrates mental and physical health."

The study was funded by the National Institutes of Health. PN

An abstract of "Posttraumatic Stress Disorder and Incidence of Type 2 Diabetes Mellitus in a Sample of Women: A 22-Year Longitudinal Study" is posted at http://archpsyc.jamanetwork.com/article.aspx?articleid=2088152.

Breaking News on Adolescent Drinking To Be Presented at APA's 2015 Annual Meeting

Adolescent drinking and its causes and consequences will be a focus of a panel presentation featuring the authors of two new research studies that the *American Journal of Psychiatry (AJP)* will release at APA's 2015 annual meeting in Toronto. The papers will be accompanied by an editorial by George Koob, Ph.D., director of the National Institute on Alcohol Abuse and Alcoholism. *AJP* Editor-in-Chief Robert Freedman, M.D., will host the presentation . The session will be held Monday, May 18, at 9 a.m. in Room 801B, Level 800, South Building, Toronto Convention Centre.

Jacquelyn Martin/Associated Press

President Obama signs the Clay Hunt SAV Act into law as First Lady Michelle Obama (right) and Clay Hunt's mother, Susan Selke (far left), look on. The law provides incentives for psychiatrists to work in the Veterans Health Administration.

Veterans

continued from page 1

APA strongly supported the legislation, noted CEO and Medical Director Saul Levin, M.D., M.P.A. He attended the ceremony with APA President Paul Summergrad, M.D.

"APA is proud to have worked alongside veterans groups like the Iraq and Afghanistan Veterans of America to push for this new law," said Levin. "We are committed to providing our veterans with the quality mental health care they deserve, and the Clay Hunt SAV Act is an important step forward in improving their access to care."

Among other things, the legislation will establish a pilot project encouraging more psychiatrists to choose a career with the Veterans Health Administration (VHA) by offering medical-school loan repayments on par with other government agencies and private practices. Current policy makes it difficult for the VHA to compete with employers that offer employment incentives, such as medical-school loan repayment.

The loan-repayment section of the Clay Hunt Act seeks to recruit at least 10 new psychiatrists each year over three years to fill vacant full-time positions in the VHA.

It also increases peer support and outreach for service members as they move into civilian life, extends eligibility for enrollment in mental health care services at the VHA by an additional year, and requires evaluation of mental health care and suicide-prevention practices.

"Today is a more hopeful day for America's veterans," Summergrad said after the signing ceremony. "The brave men and women who served our country have sacrificed so much for us, and the Clay Hunt SAV Act is one way we can begin to repay them by improving much-needed access to mental health care and to reduce the tragedy of veteran suicides." PN

Remarks by the president at the signing of the Clay Hunt SAV Act are posted at http://www.whitehouse.gov/the-press-office/2015/02/12/remarks-president-signing-clay-hunt-sav-act. The text of the law is posted at https://www.congress.gov/bill/113th-congress/house-bill/5059.

APF

continued from page 22

own branding and messaging." Several employers are already introducing ICU at their companies.

At the same time, acknowledging that time and resources are limited at many workplaces, the ICU program can also be used "as is" if needed.

In line with that, Kraft stressed that successfully implementing ICU does not require additional resources or infrastructure. "What ICU offers is a platform that reminds employees about benefits they already have but often go unused, such as their employee assistance program or other health and wellness services," she said.

ICU is the second major workplace initiative being offered through the Partnership; last year it launched Right Direction, a program to reduce the stigma and increase understanding of depression and encourage those who may need care to seek help (*Psychiatric News,* August 16, 2013). PN

The ICU video (which can be easily embedded) and other program documentation is posted at www.workplacementalhealth.org/ICU. More information about the Partnership for Workplace Mental Health, including details on ICU and Right Direction, can be found at www.workplacementalhealth.org.

ACOs

continued from page 13

provided by psychiatrists under codes included in the definition of primary care services (CPT codes 99201–99215, 99304–99340, 99341–99350), and a determination that psychiatrists are not typically the only physicians who a beneficiary sees.

In the letter to Tavenner, Levin questioned all three criteria. "We believe the decision to [exclude psychiatry] may have been based on common misperceptions rather than on how patients actually receive care, especially the care provided to dually eligible individuals with psychiatric and/or substance use disorders and medical comorbidities," he wrote.

He said there are a number of reasons why most people with serious mental illness would rather see their psychiatrist than a traditional primary care provider. For example, primary care physicians have been found to be uncomfortable providing care for those with serious mental disorders; people with cognitive deficits often have limited ability to navigate the health care system and access care in nonspecialty settings; and exacerbation or improvement of psychiatric disorders often affects behavior and the medical treatment of other systems of the body.

Regarding calculations of primary care service codes, Levin said APA has conducted its own rank-order claims analysis by volume and found that psychiatry consistently ranks higher than many of the specialties denominated as primary care by CMS. For example, he said a review of claims for codes 99211–99215 (Evaluation and Management–Established Patient) shows psychiatry ranked higher than many specialties that received designation under the second step of assignment.

Moreover, he said the highest-volume claim, CPT 99213, shows psychiatry ranked sixth in total volume, less than only cardiology among those specialties otherwise designated for second-step assignment.

For those codes designated as primary care services for nursing facility services, psychiatry ranks in the top five of volume, Levin pointed out.

Finally, Levin said a solid experiential base, predicated on numerous discussions with psychiatric physicians who provide care to individuals with serious mental illness in specialty-sector settings, indicates that these patients are very likely to see only their psychiatrist for all of their health care, medical and behavioral.

"The psychiatrist in turn performs most, if not all, of the core primary care functions … ," Levin wrote. "Derivative of this reality, system transformation in the mental health/substance abuse (MH/SA) specialty sectors has led to a number of care innovations that bring the requisite primary medical care to the specialty-sector sites as well as specialty psychiatric care to primary medical care settings that would otherwise be without the ability to address MH/SUD conditions." PN

Levin's letter to CMS is posted at http://www.psychiatry.org/File%20Library/Advocacy%20and%20Newsroom/final-APA-02.06.2015----ACO-Primary-Care-Denomination-Letter.pdf. Additionally, a summary of the 2015 fee schedule released by CMS in December, which outlines rules regarding value-based payment and physician quality reporting, is also on the APA website.

DSM Guide

continued from page 23

somatic disorders are particularly important to older adults needing mental health services who may be prone to experiencing anxiety about medical illnesses.

(Among the most important of those changes is the removal of the centrality of medically unexplained symptoms—a defining characteristic of these somatic disorders in *DSM-IV;* see *Psychiatric News,* March 1, 2013).

"This new guide provides a very useful opportunity to explain the substantial changes to the somatic disorders that were developed for *DSM-5*," Schultz said. "The new criteria for the somatic disorders offer a great advancement in our ability to characterize the complex patient who presents with primarily medical complaints or physical symptoms that are challenging to the clinician.The guide helps patients and families better understand these perplexing conditions that can be very distressing and lead to multiple visits to different medical specialties before they are accurately diagnosed." PN