ROLE OF PSYCHIATRY IN HEALTHCARE REFORM

A REPORT BY AMERICAN PSYCHIATRIC ASSOCIATION BOARD OF TRUSTEES WORK GROUP ON THE ROLE OF PSYCHIATRY IN HEALTHCARE REFORM

2014

THE WORK GROUP ON THE ROLE OF PSYCHIATRY IN HEALTHCARE REFORM

Paul Summergrad, M.D., Chair
Dr. Frances S. Arkin Professor and Chairman
Department of Psychiatry
Professor of Medicine
Tufts University School of Medicine
Psychiatrist-in-Chief, Tufts Medical Center
Chairman, Tufts Medical Center Physicians Organization
Boston, Massachusetts

Carol A. Bernstein, M.D.
Associate Professor of Psychiatry
Vice Chair for Education
Department of Psychiatry
NYU School of Medicine
New York, New York
Immediate Past President, APA

Peter F. Buckley, M.D.
Dean, Medical College of Georgia
Professor, Department of Psychiatry
Georgia Regents University
Augusta, Georgia

Robert Cabaj, M.D.
Public Psychiatry/Community Mental Health Administrator
San Francisco, California
Chair, APA Council of Advocacy and Government Relations

Frank deGruy III, M.D.
Woodward-Chisholm Professor and Chair
Department of Family Medicine
University of Colorado
Aurora, Colorado

Benjamin G. Druss, M.D., MPH
Rosalyn Carter Chair in Mental Health
Department of Health Policy & Management
Rollins School of Public Health
Emory University
Atlanta, Georgia

Anita S. Everett, M.D.
Section Director, Community Psychiatry
Johns Hopkins Bayview
Baltimore, Maryland
Trustee-at-Large, APA Board of Trustees
Former Chair, APA Council on Healthcare Systems and Financing

David Fassler, M.D.
Clinical Professor of Psychiatry,
University of Vermont
Clinical Director,
Otter Creek Associates
Director of Advocacy/Public Policy, Vermont Center for Children, Youth and Families
Burlington, Vermont
Treasurer, American Psychiatric Association

Patrice Harris, M.D.
Director of Health Services, Fulton County, Department of Health and Human Services
Clinical Associate Professor, Emory University
Department of Psychiatry/Behavioral Sciences
Atlanta, Georgia
Member, American Medical Association Board

Roger G. Kathol, M.D.
President, Cartesian Solutions, Inc.™
Burnsville, Minnesota

Wayne Katon, M.D.
Professor, Vice Chair, Director of Division of
Health Sciences and Psychiatric Epidemiology
University of Washington Medical School
Seattle, Washington

Grayson Norquist, M.D., M.S.P.H.
Chair, Department of Psychiatry and Human
Behavior, University of Mississippi Medical Center
Jackson, Mississippi

Edward Pontius, M.D.
Brunswick, Maine
Assembly Committee on Public and Community Psychiatry

WORK GROUP ON THE ROLE OF PSYCHIATRY IN HEALTHCARE REFORM
EXECUTIVE SUMMARY TO THE APA BOARD OF TRUSTEES

INTRODUCTION

Health reform, broadly stated, is a combination of market forces, health policy changes, and statutory/regulatory initiatives shaping health insurance markets, coverage, and the organization, delivery, and payment for healthcare services. Healthcare reform is not simply about what is codified in the Affordable Care Act (ACA). There are market forces and government budget forces -- at both state and federal levels -- that predate the ACA, and will persist going forward. The underlying reality is that healthcare costs are continuing to grow at an unsustainable pace and the fiscal pool that underwrites these expenditures is shrinking. How to reshape the trajectory of the healthcare costs has become the policy imperative for government, employers, and all payers. Untreated psychiatric and substance use disorders have a significant impact total healthcare costs. The implications of health reform for psychiatric practice are quite broad, although they will differentially impact APA members depending on their primary practice settings and choices regarding participation in emerging models of care and payment.

While the changes wrought by health reform are not fully predictable, they will, because of the underlying fiscal realities, be widespread and ongoing. It is likely that some aspects of psychiatric practice will remain relatively unchanged, even as reform initiatives change other aspects of practice significantly. We have approached our work focused on what changes in our current care systems are most likely to improve the quality of care and costs for patients with psychiatric, substance use, and medical illnesses. The work group believes that it is imperative for

us to remain focused on what is best for patients and their families. We are confident that this focus will provide an important guide both for our overall healthcare system and for the support of psychiatric practice.

There are a myriad of factors that shape the context in which psychiatry and its patients find themselves.

Psychiatric Practice and the Field: Psychiatry brings many formidable legacy issues into the emerging healthcare environment and the challenges it poses. Greater understanding of the impact of psychiatric illnesses and substance use disorders on total healthcare costs by the government, employers, and the public will be needed. Recognition that the key policy objectives and the initiatives of reform afford major opportunities for improved patient care and new options for practice is also essential. However, many psychiatrists operating in solo or small group private practices may be ill prepared for these transitions. It is critical that the APA act to ensure recognition of the significance of mental health and substance use disorder conditions and contribute to the leadership of health reform initiatives in these areas. It is also vital that we prepare the field internally for changes that are likely to occur.

The Triple Aim--Accountability for Patient Care and Cost: The key organizing principles underlying most current healthcare initiatives are embodied in the so-called Triple Aim of health reform: 1) patient-centeredness, i.e., better, evidence-based care for individuals; 2) cost effectiveness; and 3) improved population health. At its core, this embodies accountability for patient outcomes, efficient use of treatment resources, and the well-being of the community.

At the Policy Level: Key components of the policy calculus to achieve the Triple Aim include: 1) coverage expansion and insurance market redesign; 2) development and implementation of integrated care models; 3) adoption of patient care performance metrics (e.g., quality indicators, evidence-based clinical guidelines, etc.); and 4) development and adoption of payment methods that create provider incentives to achieve the patient care and

cost objectives. There are a large number of commercial, federal, and state government-driven initiatives underway.

At the Patient Level: We cannot know how the foregoing will affect practice and patient care at this point in time nor will these be the only factors affecting psychiatric care. Advances in science, new understandings of psychiatric illness, more effective treatment, and controlled trials of delivery reforms will all affect practice. Appropriate access to treatment for psychiatric and substance use disorders remains a formidable challenge and a healthcare-system-wide problem. Health reform advocates must cope with the reality that these conditions are highly prevalent and usually associated with high total healthcare costs. The intersection of health reform objectives, clinical practice, and patient care must be negotiated properly and become a primary focus while not losing support for existing evidence-based care models or the role of research in improving care and changing our fundamental understanding of these disorders.

At the System Level: The fragmentation, disarray, and defunding of the behavioral health delivery system continues. This reality has been well documented by two Presidential Commissions, the IOM, and other research entities. Attempts to address the serious challenges of access, integration of services, and quality have repeatedly failed to solve these problems. Although health reform was not designed specifically to change the behavioral health system, it offers significant new opportunities to transform care and treatment, i.e., through insuring many more individuals, including those with high rates of illness; paying for previously unreimbursed services; integrating care using new information technology; advancing and adopting underused evidence-based interventions. The Mental Health Parity and Addiction Equity Act (MHPAEA) provides significant potential leverage to enable transformation on an equitable basis for the populations with mental health and substance use disorders.

The potential afforded by these opportunities will not occur without leadership and sustained effort. Psychiatry has to assume a leadership role in these transformations. To date the APA has not fully embraced that role.

KEY FINDINGS AND RECOMMENDATIONS

Health reform is occurring now and will move forward rapidly with or without deliberate actions by organized psychiatry. There are definable opportunities and choices that will allow the APA to help shape the outcome. The Work Group believes there are significant actions that the APA should undertake.

The Work Group intends that the recommendations set forth here and in the reference document and the accompanying analysis by Milliman should be a starting point for discussion and action within the APA. It is our intention to highlight implications for the allocation and organization of resources within the APA.

This executive summary provides recommendations for key areas affected by health reform that the Work Group explored and on which it deliberated. Each section of the summary provides a brief background discussion and findings respecting the topic and then sets forth the recommendations.

- Contemporary Health Reform Efforts
- Integrated Care (IC): A Healthcare Reform Imperative
- The Financing of Psychiatric Care: Structure, Payment, and Administration
- Quality and Performance Measurement
- Health Information Technology (HIT)
- Workforce, Work Environment, and Medical Education and Training
- Research and the Mental Health Evidence Base
- APA as an Organization in a Health Reform Environment

In July 2011, the Board of Trustees voted to establish a Work Group on the Role of Psychiatry in Healthcare Reform. Paul Summergrad, M.D., was named chair by then APA president John Oldham, M.D. The Work Group was

charged to address a number of questions and issues, including:

1. What is the role of a psychiatrist in a primary-care led practice?
2. Who will care for the seriously mentally ill population?
3. The need to identify models (What is role of psychiatrists in an integrated care system?)
4. What is the political strategy allowing APA to be a "player" in development of policy"?
5. What is the best way to effectively educate members about new models of care?

The Work Group convened numerous times over the course of the last 18 months, and regular presentations and/or meetings were held with the Board of Trustees, the Assembly, and relevant councils and components for discussion -- and input. Extensive background reviews of key topic areas were undertaken and meetings and interviews were held with various experts.

CONTEMPORARY HEALTH REFORM EFFORTS

Background

As stated in the introduction, health reform is a combination of market forces and statutory/regulatory initiatives shaping health insurance markets and coverage for the organization and delivery of and payment for healthcare services. Healthcare reform is not simply what is codified in the Affordable Care Act (ACA). There are market forces and government budget forces in motion that predate the ACA, and will persist going forward. One must not forget that state deficits are heavily driven by medical spending.

The changes in the healthcare system have numerous implications and likely consequences for psychiatric care, ranging from performance metrics for patient care to alternative payment methodologies.

The primary underlying market reality is that healthcare costs continue to grow at an unsustainable pace and the fiscal pool, particularly at the state and federal levels that underwrites much of healthcare expenditures, is shrinking. How to reshape the trajectory of the healthcare costs has become the policy imperative for both commercial and public sector payers. Psychiatric and substance use conditions and their related medical co-morbidities are acknowledged to be significant cost drivers.

The initiatives to achieve this policy objective derive from a "consensus" assessment of the core problems with the current system:

- Present care delivery is uncoordinated
- Current payment methodologies are inefficient
- There is a lack of practitioner accountability
- There is an insufficient focus on the patient

Hence, the key principles guiding health reform efforts can be characterized by the Triple Aim:

- Better care for individuals – patient centeredness;
- Cost effectiveness; and
- Improved population health.

Key components of the policy calculus to achieve the Triple Aim include:

- Insurance coverage expansion and market redesign;
- Development of integrated care models; and
- Adoption of performance metrics and payment methods to align stakeholder incentives.

These developments, as reviewed below, are unfolding at federal and state levels and within the commercial sector.

The Affordable Care Act (ACA): The ACA represents the most significant regulatory reform of the United States healthcare system since the enactment of Medicare and Medicaid in 1965. The ACA's provisions further and/or

codify reform initiatives to facilitate better patient access and clinical and cost outcomes through:

1. Coverage expansion;
2. Insurance market redesign; and
3. Delivery system and payment reform.

These provisions and their implications for individuals suffering from mental health and substance use disorders are described in more detail below.

Coverage Expansion

The ACA's key reforms include a mandate for individuals to purchase health insurance and an expansion of Medicaid, aiming to increase access to health insurance coverage for Americans who were previously uninsured. The ACA incorporates coverage — by mandate — of mental health and substance use disorder services and extends the Mental Health Parity and Addiction Equity Act (MHPAEA) to new plans.

Insurance Market Redesign

The Individual Mandate: Beginning January 1, 2014, the ACA aims to improve access to health insurance coverage by requiring individuals and their dependents who are not covered by Medicare, Medicaid, an employer-sponsored health plan, or other private insurance to maintain a minimum level of health insurance coverage.

Insurance Exchanges, Medicaid, and Essential Health Benefits: To meet the individual mandate, the ACA requires the creation of an exchange program (American Health Benefit Exchanges) in each state to serve as a marketplace where individuals and small businesses can purchase health insurance. These exchanges are meant to decrease the cost of health insurance coverage through risk pooling and to make private health insurance more affordable. States have the choice to elect to create their own exchange (called a State Exchange) or allow the Department of Health and Human Services to establish a "federally-facilitated exchange" for them.

The ACA provides that health exchange plans (along with small group plans that are not self-insured and individual products offered outside of exchanges and Medicaid expansion plans described below) must offer an essential health benefits (EHB) package that includes mental health and substance use services.

The scope of EHB under the health plans is to be substantially equal to the scope of the benefits offered by a benchmark plan selected by the state.

Coverage for mental health and substance use disorders under health plans offered through Exchanges and Medicaid benchmark and benchmark equivalent plans and plan terms and conditions must comply with the Mental Health Parity and Addictions Equity Act of 2008 (MHPAEA).

Medicaid Expansion: Also, beginning January 1, 2014, the ACA aims to further improve access to health insurance coverage by expanding Medicaid eligibility to all individuals and families with incomes under 133 percent of the federal poverty level.

The Supreme Court held that states could not be forced to expand Medicaid to the newly eligible, therefore making such expansion optional for states. As of this writing, 24 states have elected to participate.

Issues with Expansion Provisions: Despite these key provisions, which expand insurance coverage in populations with high mental health needs and extend mental health parity requirements for individuals suffering from mental health and substance use disorders, there are a number of issues raised by these provisions that we should be concerned about.

There will still be coverage gaps: Despite the ACA's Medicaid expansion provisions, there will still be individuals who will remain uninsured after January 1, 2014.

In addition, other individuals will make a personal decision to remain uninsured and opt for the penalty for failing to elect coverage.

There will be numerous EHBs and state laws to track and analyze: States play a critical role as decision makers

under the ACA's healthcare exchanges for qualified plans and under Medicaid expansion. Decisions as to how healthcare reform will be operationalized will occur at both the state and federal levels. This will present special challenges because of the need to effectively interact with a potential of 50 different reform plans, and will have implications for the APA's role with state associations.

There is no defined scope of services requirement: The actual state mental health and substance use disorder services provided will be defined by what is in the benchmark plan selected by the state.

While MHPAEA applies to Medicaid non-managed care plans, it is not clear how MHPAEA's Interim Final Rule applies to Medicaid benefit and benefit equivalent plans.

The problems with compliance and enforcement issues regarding MHPAEA will still exist under coverage expansion plans unless more guidance is issued and states are made to enforce MHPAEA.

Delivery System and Payment Reform

Insurance Market Redesign: In addition to coverage expansion, the ACA requires comprehensive reforms to the private health insurance market that are aimed at improving access to coverage, protecting consumers from abusive insurance company practices, and improving the quality of care for health plans sold through and outside state exchanges.

Physician payment reform: It seems certain that any repeal of the Medicare Sustainable Growth Rate (SGR) will be tied to dramatic changes to Medicare physician payment that heavily emphasize quality improvements.

New Models of Care: The Centers for Medicare and Medicaid Services (CMS) and its Center for Medicare and Medicaid Innovation (CMMI) are tasked with implementing and/or exploring a vast range of care models and payment initiatives for the Medicare and Medicaid programs.

Purchasers, employers, and commercial payers: Market forces driven by current and anticipated resource

constraints are driving purchasers/employers and payers to restructure the delivery of and payment for care independent of federal/state statutory/regulatory initiatives.

*Managed behavioral health organizations (MBHOs): A*fter a long period of consolidation, MBHOs are focusing their efforts on expanding services. In tune with market forces and healthcare reform, MBHOs are engaged in developing wellness programs, identifying at-risk patients, and expanding the use of health information technology and integrated care.

Common denominators: The common health reform themes going forward in both the public and private sectors are:

1. New models of care delivery (with varying degrees of evidence to support them) are under development and/or being deployed.
2. The measuring and monitoring of care (quality and performance measures) will be increasingly codified.
3. Alternative payment methodologies will be developed and deployed.
4. Patient-centered principles of care.

<u>Health Reform Implications for Persons with Psychiatric Illnesses/Substance Use Disorders (SUD)</u>

The policy objectives of health reform are highly significant for all patients with psychiatric illnesses. For the purpose of this discussion, patients with primary medical conditions and comorbid psychiatric/SUD conditions and patients with primary psychiatric/SUD diagnoses and comorbid medical conditions represent two overlapping populations/categories and the principal treatment settings in which they are seen may differ as well. However, whether their disorder is primarily psychiatric or they have a psychiatric comorbidity to a primary medical condition, their care is fragmented and uncoordinated and they are generally high cost patients. Populations newly eligible for insurance coverage are known to have a high prevalence of mental health and substance use conditions. Mental

health conditions are a significant public health problem whether seen in the primary care or psychiatric sector. Multiple studies have shown patients with major depression, anxiety disorders, and substance use disorders have 50 to 100 percent higher total medical costs over a one-year period even after controlling for socio-demographic factors and chronic medical illnesses. In 2008, a study from the actuarial firm Milliman found that untreated mental disorders in patients with chronic medical conditions cost commercial insurers and Medicare between $130 billion and $350 billion annually in additional health related expenses.

What is significant is that both of these populations, with respect to their comorbid conditions, are in large measure undertreated or not treated at all. This under-/non-treatment of comorbidities, medical or psychiatric, has significant consequences for both clinical outcomes and the utilization of healthcare resources.

The serious and persistent mental illness (SPMI) population (including duals): Approximately 40 percent of the dual eligible population has both physical and mental conditions (as opposed to less than 20 percent of other Medicaid beneficiaries), and the vast majority of individuals with SPMI are part of the dual ranks. Approximately half of the dual eligible population aged 18-64 has at least one mental health or cognitive condition and these individuals have a much higher incidence of serious mental disorders than the general Medicare population. Treating these patients for their comorbid medical conditions is an especially daunting task in a fragmented system. Dual eligible demonstration projects are being launched or considered in many states. These state-level pilots vary significantly and will have a major impact on reshaping the care and practice environment.

Psychiatrists have a number of unique essential medical/clinical skills that are vital to meeting the clinical challenges in treating these multiply co-morbid populations whatever the setting, and treatment by psychiatrists has been demonstrated in research trials to positively

contribute to better patient outcomes and improved healthcare resource utilization.

Health reform implications for psychiatrists and their patients: Psychiatry has a central role and demonstrated effectiveness in the new patient care delivery and payment models. Psychiatry will, however, need to define new basic units of clinical care and/or management for reimbursement and better performance measures will be required to enable proper payment. Psychiatrists, working with other healthcare providers, will need to be ready to assume risk, enter into integrated gain-sharing arrangements, and work in and oversee primary care and other integrated settings for care. This will be particularly important in public settings that are further removed from many mainstream healthcare reform settings. Further elaboration of these multiple psychiatric roles will evolve parallel to the many demonstration projects, research efforts, and delivery reforms currently underway.

INTEGRATED CARE (IC): A HEALTHCARE REFORM IMPERATIVE

Background

Many view integration of medical and psychiatric care as a significant part of the solution to the challenges of rising healthcare costs, the lack of population and quality focus, and the excess morbidity and mortality among patients with psychiatric/SUD illness. Both the public and private sectors are actively involved in exploring various integrated care models. *Integrated care models* refers to various emerging models ranging from collaborative care to patient-centered medical homes to co-located care and accountable care organizations (ACOs). Even if none of the integrated models currently being discussed prevails, the volume and variety of the pilots underway in the public and private sectors suggests that elements of these models will play out in some way in the future. Whether today or tomorrow, the principles underlying integrated care will have an impact on the way psychiatry is practiced. Hence, this report's central emphasis on these evolving models of integrated care.

The Work Group recommends that psychiatrists must play a major role in formulating the integrated care solution. Psychiatrists' unique training with the most critically ill psychiatric and medical patients and their general medical, psychopharmacologic, and psychotherapeutic expertise have the potential to bring significant value to the healthcare reform imperative. Leadership and active participation by psychiatric physicians in integrating behavioral health and medical care, formally studying its effects, and overseeing key elements of care will be essential if these efforts to integrate services are to be effective and the best possible patient care is to be provided.

The Work Group's survey and review of the field yielded numerous primary findings that it believes should drive essential considerations for the APA. These findings form the basis for the Work Group's recommendations to the Board**.**

Findings

Lack of common language for integrated care, but core principles emerge. Integrated care has been defined differently in different studies, by different groups, and in different settings. The Agency for Healthcare Research and Quality (AHRQ) has begun the task of developing a lexicon for the field. In general, integrated care uses behavioral or general medical care managers to track the wellbeing and care of a population and uses psychiatrists to provide consultation to care managers and PCPs and, in some settings, direct consultative care to patients. The Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington has advanced the following "core principles of effective integrated behavioral healthcare":

- *Patient-centered care*. Primary care and behavioral health providers collaborate effectively using shared care plans.
- *Population-based care*. A care team shares a defined group of patients tracked in a registry. Practices track and reach out to patients who are not improving, and mental health specialists provide

caseload-focused consultation, not just ad hoc advice.

- *Measurement-based treatment to target*. Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are adjusted if patients are not improving as expected.
- *Evidence-based care*. Patients are offered treatments that research has shown to be effective in treating their target conditions.
- *Accountable care*. Providers are accountable and reimbursed for quality care and outcomes.

Based on the core principles and a survey of the field, five models of integrated care emerged. The impetus of healthcare reform, and the Affordable Care Act (ACA) specifically, played a role in the selection of the five models discussed below, as well as in the various models' potential impact in the public and private sectors.

1. Collaborative Care
2. Care Management
3. Co-location (e.g., patient-centered primary care based homes with psychiatric or other mental health provider presence) and reverse co-location (e.g., community mental health centers with psychiatric leadership and primary medical care services) or as more recently identified, bi-directional models
4. Medical Homes: patient-centered medical homes (PCMHs) and patient-centered behavioral health homes (PCBHHs) with a broad range of medical and psychiatric/behavioral care
5. Accountable Care Organizations (ACOs)

The evidence base is robust for some collaborative care models. Collaborative care models have been studied most extensively and rigorously (randomized controlled trials) for patients with comorbid depression, although

models are now being extended to patients with other co-morbidities including anxiety, substance use, and multiple medical co-morbidities. A meta-analysis of 37 trials showed that collaborative care compared with usual primary care was associated with a two-fold increase in antidepressant adherence, improvements in outcomes for depression that lasted up to two to five years, and increased patient satisfaction with depression care and primary care. [Thota AB, et al.]

Care/case/disease management models yield positive results. One study assessed the two-year outcomes, costs, and financial sustainability of a medical care management intervention for a CMHC and found that sustained improvements were obtained in the intervention group in the quality of primary care preventive services, the quality of cardio-metabolic care, and the mental health related quality of life. However, the program was not financially sustainable after the grant funding ended. [Druss] Data was collected on the Missouri Medicaid program participants in CMHCs and, overall, case management services were effective in reducing total healthcare costs for seriously mentally ill people with moderate to severe illness. These positive results did not apply to the most severely ill. [Parks et al.] Another approach to integrated case management augments traditional care coordination by allowing trained medical or mental health managers to help complex patients. This has the potential to maximize clinical and functional value while reducing total health-related costs. [Kathol] The *New England Journal of Medicine* reported that disease management models achieved modest improvements in quality of care measures but that the interventions were costing more than the diseases.

Reverse co-location; bringing primary care into CMHCs. There are also a number of pilots integrating primary care into specialty public sector settings. Druss et al. tested a population-based medical care management intervention designed to improve primary medical care in CMHCs. At a 12-month follow-up, the intervention group received an average of 59 percent of recommended preventive services compared with a rate of 22 percent in the usual

care group. Overall, medical care management was associated with significant improvements in the quality and outcomes of primary care. [Druss et al.: *Am J Psychiatry*, Feb. 2010] The state of Missouri has initiated several programs to improve the health of people with serious mental illness. One involved providing primary care nurse liaisons on site at all CMHCs. Preliminary results found that the program almost broke even after 18 months. A follow-up analysis showed a cost savings of 17 percent off expended trends. [Miller JE and Prewitt E: *Reclaiming Lost Decades*, National Association of State Mental Health Program Directors, May 2012]

Data for medical homes and ACOs is pending. The Patient Centered Primary Care Collaborative (PCPCC) is tracking 54 pilot projects from around the country that cover nearly 5 million patients. In these pilots, primary care physicians are creating a patient-centered medical home (PCMH) for their patients that provides some level of care coordination. Data collected thus far, as reported on the PCPCC website, show that medical homes in primary care have decreased emergency room visits, decreased hospitalizations, and decreased the number of outpatient visits per person. However, Mathematica Policy Research reviewed 498 studies published from January 2000 through September 2010 on PCMHs and found only 12 study settings met its criteria as a PCMH and that more evaluation is needed of PCMHs. Less than half of the evaluations assessed all triple aim outcomes.

Healthcare legislation is funding many integrated care demonstration projects, results pending. The Center for Medicare & Medicaid Innovation (CMMI) housed in the Centers for Medicare and Medicaid Services is playing a significant role in the testing of new care models. The ACA specifically charged CMMI with exploring 20 new models of care. Of the 106 projects CMMI has funded, 15 are directed at testing integrated care arrangements for behavioral health care. Several are collaborative care models. The ACA gave the Secretary of Health and Human Services Secretary, who administers CMS, the flexibility to change Medicare and Medicaid programs nationwide based

on the outcomes of these care models, making the CMMI pilot projects highly significant for psychiatry.

Sustainability for developed and emerging integrated models is a major issue. Developing integrated care models that can be sustained into the future will require financial changes, as well as operational changes, to the current system of delivery healthcare. Traditional reimbursement models will not work. Operationally, sophisticated health-records-keeping methods must be in place; performance metrics must be incorporated into everyday practice; healthcare providers must be trained in team-based care; and roles must be clearly defined. The financial obstacles will, however, present the greatest challenges. See the Druss et al. study noted above.

Advancing understanding of the financial and quality consequences of integrated care. Given the prevalence of psychiatric and substance use disorders in primary care and specialty settings and their high total healthcare cost , improving the quality of care to patients with multiple co-morbidities is essential. However, the prevalence and cost of these conditions in financial and quality terms is not widely understood by key purchaser and payer audiences.

Substance use disorders will have to be addressed. There will be increasing attention to substance use disorders by payers, whether as a primary or secondary condition and regardless of whether individuals present in primary care or specialty settings. The role of psychiatry vis-à-vis substance use disorders needs to be better defined and articulated, and more research on effective care models in integrated settings is required.

Mental health disparities and younger populations. The role of collaborative care in addressing issues respecting mental health disparities and children and adolescents has not been well studied and needs investigation.

APA leadership is needed to ensure success of integrated care. Despite the healthcare imperative for integrated care, there is no central or organized leadership within the APA to highlight this agenda. The APA does not have a

designated effort at this time to systematically address integrated care and its essential building blocks of advocacy, accountability, health information technology, and education of members.

APA needs increased presence with the stakeholders. Many stakeholders have vested interests in shaping, promoting, and implementing various integrated care models. The Work Group is concerned that these groups will affect government, regulatory, and payer policies and that the APA must expand and enhance its presence and focus on some or all of these groups:

- The Federal Government, e.g., the Center for Medicare & Medicaid Innovation (CMMI), the Centers for Medicare & Medicaid Services, the Veterans Administration, the Agency for Healthcare Research and Quality (AHRQ).
- Accreditation entities, e.g., URAC, an independent, nonprofit organization that accredits, educates, and measures healthcare programs; National Committee for Quality Assurance (NCQA); the National Quality Forum (NQF)
- Collaborative organizations, which include employers, e.g., the Patient Centered Primary Care Collaborative (PCPCC).
- Medical associations, e.g., the American Academy of Family Physicians, the American College of Physicians, the American Medical Association
- Patient groups, e.g., National Alliance on Mental Illness (NAMI), Mental Health Association (MHA)
- Non-physician healthcare professionals, such as the Case Management Society of America, the American Nurses Association, physician assistants, etc.
- Proprietary groups that will vend collaborative care services to payers, e.g., Tanber

Standards, quality measures, performance metrics, and payment methods for these core models are still in development and/or evolving: For example, URAC's

Standards for Clinically Integrated Networks I & II, the Joint Commission standards for specialty care health homes, and CMMI pilots are all important. These will establish accountability standards that will shape patient care and psychiatric practice. Coordinated psychiatric input has been sparse.

Psychiatrists require core competencies to participate in integrated care models: Integrated care models, especially those incorporating all the core principles noted above, require psychiatrists to perform different clinical and management functions than are otherwise required in clinical practice. Psychiatrists must have a number of areas of expertise in medical care and ongoing population management to effectively perform these functions. Appropriate training and education respecting these issues for the current and future psychiatric work force are essential.

Data on current psychiatric practice is lacking: The number of psychiatrists currently involved with alternate care arrangements is not known. Nor do we have information regarding the training and education and/or technical assistance needs of psychiatry for participating in these new arrangements (e.g., how to contract). Given the cottage industry nature of psychiatric practice and the low adoption of health information technology and electronic medical record keeping (some estimate as few as five percent of psychiatrists use HIT), the Work Group is concerned that psychiatrists will not be ready to operate effectively under new payment or integration models. Psychiatrists may need considerable technical assistance with these issues or in forming larger groups or joining multispecialty groups.

The role of the psychiatrist in team-based healthcare settings must be defined: The responsibilities and risks of all healthcare providers must be clearly defined in a team-based, integrated setting. When partnering with others, psychiatrists will have to determine 1) the amounts and types of services to be exchanged; 2) the ability of both the medical and behavioral staff involved to work

effectively together; 3) how clinical information will be documented and shared; 4) how to protect one's self from clinical risks and legal liabilities; and 5) perhaps most important, what the lines of authority are.

Recommendations

The Work Group thinks there are a number of essential considerations for the APA as it promotes and/or advocates for integrated care solutions. Clearly, the patient's best interests are primary. Although there are various approaches or models to achieve integrated care, it is axiomatic that successful care models incorporate 1) quality/performance metrics; 2) alternative reimbursement schemes; 3) electronic medical records (EMRs) and registries; and 4) team-based approaches to care under physician oversight. The best outcomes in integrated care have thus far been shown to occur in models that include either a psychiatrist providing caseload supervision and decision support to case managers or ongoing evaluation and follow-up visits with a psychiatrist. Currently, no one approach to integrated care seems to resolve the needs of all populations in all settings. However, some of the models have considerable data to support their efficacy in meeting the Triple Aim while others, such as the ACOs, are just beginning to collect data.

As noted, the research evidence base suggests that certain integrated care models have more efficacy than others. For example, various studies show screening and referrals to behavioral health specialists alone are not sufficient to improve outcomes for adults with commonly occurring disorders. Other studies show that the establishment of collaborative care as a standard of mental health care in primary care settings is associated with a wide range of improved clinical, economic, patient, and provider satisfaction outcomes. For some of the new integrated care approaches, e.g., ACOs, medical homes (primary care or specialty based), the evidence base is less well-established and really only beginning to emerge. It seems reasonable, therefore, to concentrate APA's attention and support at this time on those models with the most evidence for improving patient care quality and satisfaction, improving the health of populations, and

reducing costs. While it is critical that proven models of integrated care be given priority attention, it is also vital that emerging models be appropriately evaluated as to their efficacy since there will likely be a range of models deployed.

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

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

Particular attention should be paid to the distinct needs of patients of varying ages, in different care settings and, in particular, in the public sector:

- There is clear evidence from a large body of well-designed studies that psychiatrists have vital roles to play in integrated care models in a variety of settings.
- These roles include oversight of population-based psychiatric care in integrated medical psychiatric settings, including the public sector, and an important consultative role with other primary-care based specialists and other mental health caregivers.

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

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

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

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

APA should maintain particularly close working relationships with the AMA, major primary care medical associations, and specialty collaboratives.

APA should take a lead role with CMS and other federal agencies in developing any quality metrics for integrated care and the patient registries needed to implement these. This should include a priority focus on monitoring projects funded by CMMI.

APA should establish an ongoing inventory of current models of integrated care for all populations and promulgate that information to psychiatrists, other physicians, healthcare leaders, and policy makers. This

should include data on best evidence for integrated care and its implementation. The APA should work closely with psychiatric and medical specialty organizations in this effort. The APA should pay particular attention to models that achieve the Triple Aim, are well-designed, incorporate evidence-based care for psychiatric and medical-psychiatric care, and feature psychiatrists in leadership roles. The APA should establish an interdepartmental capacity to inform members and state associations/district branches about:

- New models of care;
- Results of current research;
- Implications for their practices, including barriers to adoption; and
- Ways to participate or at least influence the future practice of psychiatry given these reform initiatives.

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

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

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

THE FINANCING OF PSYCHIATRIC CARE: STRUCTURE, PAYMENT, AND ADMINISTRATION

Background

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

The behavioral health system in the United States is financed through multiple revenue sources. These include state and county governmental units, the Medicare program, Medicaid, private commercial health insurers, patient out-of-pocket expenditures, and various smaller public and private programs.

Combined, these funding sources comprise a complex patchwork of payer programs, each with its own benefit packages, eligibility, and coverage rules.

The structure and management of payment for psychiatric care, regardless of funding source, is also a confounding issue that requires due consideration, especially as it relates to integrated care models. Behavioral healthcare is generally separated from other healthcare in a way that fails to account for their interdependence. The prevalence of carved-out arrangements for management and payment of psychiatric care, so-called MBHOs, presents a special set of issues for consideration. At the level of essential clinical transactions, there is a large deficit in the understanding of what is needed respecting payment for essential psychiatric services and functions even within integrated care delivery models that recognize the inextricable interdependence of general medical and psychiatric care. Essential clinical and psychiatric management functions must be defined and recognized and payment mechanisms developed to compensate for them.

Moreover, the prevailing fee-for-service reimbursement methodology for healthcare is undergoing revision in many significant ways. Pay for performance is an overarching policy direction and how this is best operationalized for psychiatry within integrated systems or separately is a matter that has not been fully studied. The implications for psychiatric patients and practices where payers are moving toward alternative payment models are significant. In the healthcare payment environment that is emerging, it is doubtful that payment improvements (let alone maintaining current levels) can occur without performance metrics.

Finally, there are ongoing inequities in psychiatric reimbursement by third-party payers relative to other physicians' reimbursement that require redress. These payment disparities will not automatically disappear in a global payment environment. The principles and regulations embedded in MHPAEA provide potential for appropriate remedies regarding many of the issues noted above.

Key Findings

Milliman report: The Work Group commissioned a report by Milliman to estimate the economic impact of integrated medical-behavioral healthcare for commercially insured, Medicare, and Medicaid populations.

Key findings of the study include:

- Persons with a treated psychiatric and or substance use disorder typically cost 2-3 times more on average when accounting for their total medical costs than those without a behavioral condition in all market segments.
- Persons with a treated psychiatric and/or substance use disorder constituted only 14 percent of the total insured studied, but accounted for over 30 percent of total health spending.
- Persons with a treated psychiatric and or substance use disorder had a higher proportion of their total medical non-prescription dollars spent on facility-based services than on professional services.

Total health costs for persons with chronic medical conditions and a psychiatric and/or substance use disorder were compared to those with a chronic medical condition but no behavioral comorbidity. Costs for those with a psychiatric and/or substance use disorder always exceeded the costs for those without. Milliman defined the difference between the two as the "value opportunity," i.e., what could theoretically be saved through an integrated care approach.

A total value opportunity was calculated for each group and yielded the following:

- Total value opportunity of $162 billion in the commercial market
- Total value opportunity of $30.8 billion for Medicare
- Total value opportunity of $100.4 billion for Medicaid
- Total Value Opportunity $293.2 billion

Based on its review of various integrated care studies, Milliman rendered conservative estimates of the cost impact (projected savings) of integration for persons with a treated psychiatric and or substance use disorder:

Commercial	$16-32 billion
Medicare	3- 7 billion
Medicaid	7-10 billion
Total Projected Savings	$26-49 billion

Milliman estimated total annual psychiatric wages to be $7.3 billion. Given the projected savings estimate of $26-48 billion:

- The potential impact of integrated care programs can be 3.5 to 6.6 times annual psychiatrist earnings.
- It is approximately equal to total all physician expenditures as estimated by SAMHSA to be $35 billion by 2014.

Milliman also states this alternatively:

- A theoretically modest ten percent gain-sharing arrangement for psychiatry would increase aggregate annual psychiatrist earnings by 50 percent; and the other
- 90 percent of savings through collaborative care could be used to lower premiums, reinvest in services and/or share with other practitioners who are part of the collaborative care arrangement.
- It estimated total payer expenditures for MH/SUD services are approximately $95 billion per year, and the value opportunity as approximately $293 billion per year. If all state and local payments for MH/SUD services are added to the private and public payer total, SAMHSA estimated this would be $239 billion per year, still less than the Milliman value opportunity of $293 billion.

Medicaid is the largest payer. For mental health services in the United States, Medicaid is the largest payer. It comprises 27 percent of all expenditures for mental health services (60 percent in the public sector). As a result, Medicaid coverage policy can have a significant impact on the health of this population as well as on the quality and costs of both health and behavioral health services. Individuals with mental health disorders comprise almost 11 percent of those enrolled in Medicaid and represent almost 30 percent of all Medicaid medical and behavioral health expenditures.

Medicaid reimbursement policy. Medicaid payment policy is complex and is becoming increasingly decentralized with respect to decision-making regarding coverage and payment policy through the "waiver" process and multiple state demonstration projects.

ACA gives new authority for dual initiatives. The ACA launched new authority for Medicare/Medicaid initiatives for dual eligibles that will reshape Medicare payments for the SPMI population.

Current fee for service (FFS) payment methodologies are projected to shift toward global payment and value purchasing. It is unclear how these alternative payment methodologies compensate for disparities in payment, lack of infrastructure supports, or payment for consultation and care management functions in integrated care settings. In addition, there is likely to be substantial conflict between and among primary care physicians and specialists and cognitive and procedurally based physicians given the need for interim payment and accounting methods within risk-based or other contracts that will likely rely on modified current FFS-based models, at least for the present. The Medicare Fee Schedule, especially relative work value units, will likely retain significance. Medicare SGR reform is a critical matter and will become a benchmark for public and commercial payers.

Fee for Service (FFS) still has a future. Most proposed payment approaches, such as medical homes and shared savings for accountable care organizations, do maintain fee-for-service components. Fee schedule codes and prices are the building blocks for other proposed approaches. Bundled payments for episodes of care and global payments also depend on FFS pricing (e.g., per member per month payments are calculated on the basis of service volume and intensity multiplied by their respective FFS rates), as do other actuarial functions such as premium calculations. Any distortions in the Medicare Fee Schedule are carried over to these payment methods. Moreover, hospitals, healthcare systems, and medical groups utilize FFS-based relative value units to assess physician productivity.

Pay for performance will be more and more prevalent. It is highly likely that payment levels/fee schedules for all physicians will be, in part, dependent on performance metrics. The development and adoption across all payers of appropriate metrics for psychiatry are a critical matter. There is very limited experience with pay-for-performance incentives in behavioral healthcare and little is known about these incentives in the context of population-focused primary care based collaborative care programs.

Financial sustainability for integrated care initiatives is essential. The ability to provide appropriate MH/SUD services in primary care settings (and vice-versa) is impeded by a number of reimbursement barriers. The sustainability of desired integrated care initiatives is dependent on permanent solutions including payment for infrastructure, care management, and currently non-reimbursed consultative services.

We have not endeavored to catalog the entire landscape of alternative payment schemes that have emerged. Regardless, it can be unequivocally stated at this juncture that the appropriateness of these methods for psychiatric practice and the implications for patient care require focused study and analysis.

Payment inequities for psychiatry. Payment to psychiatrists for work valued similarly for other physicians is generally not at par when measured on an RVU basis. This pattern has persisted despite enactment of the parity law.

Structure and management of payment: carved out v. integrated. The advent and evolution of managed behavioral healthcare in the early 1980s fundamentally altered the structure and administration of MH/SUD care delivery and payment. Estimates are that specialty behavioral health organizations (MBHOs) with carved-out arrangements manage treatment for some 171 million individuals under commercial and public sector payers, including coverage of dual eligible individuals. The specialty managed care industry for MH/SUD has always been surrounded by controversy. The increasing focus on the integration of mental health, substance use disorder, and somatic care services is demanding a re-examination of the nature and utility of these carved-out arrangements – and the extent to which they are barriers to optimal integration.

Given the scope of their market penetration as a management option for MH/SUD, it is not clear what the evolution of these models may be in an increasingly integrated environment. There are some advantages (protection of limited MH/SUD dollars) and many

disadvantages to the carve-out models and the legacy issues they bring that are barriers to the quest for integrated care. These must be resolved if they are to remain a management option, especially for public sector populations.

On the other hand, there are also many issues raised when considering the option of integrating the MH/SUD benefits back into the management and budget for general medical care. This is especially acute in the public sector where integrating MH/SUD budgets is viewed as providing improved care and potential financial incentives to care and, negatively, as putting at risk currently-budgeted MH/SUD services.

Regarding integrated care models and accountability (e.g., payment and operations); there are issues that must be resolved because they are vital to successful integration. It is unlikely that without integrated payment the full value of integrated medical and psychiatric/substance use care will be achieved.

Given the primary tenet of patient-centered care, it seems self-evident that regardless of the financing and/or administrative structures, all health plan entities share accountability. Accreditation and related standards for health plans generally, and integrated care specifically, are needed.

FQHC payment advantages. Federally Qualified Health Centers, which are primary-care-based settings, have distinct and consequential reimbursement advantages over CMHCs.

CPT Coding Changes may be needed. Codes that describe essential services and functions provided by psychiatrists in integrated care systems may be needed.

<u>Recommendations</u>

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

- In any system that integrates care, the value of psychiatric care in improving total healthcare quality and reducing costs needs to be accounted for in such a way that the psychiatric care system, our patients, and psychiatrists can benefit from the improvement in cost of total care.
- Appropriate payment arrangements that recognize necessary psychiatric clinical and case management functions as well as other infrastructure costs for care in integrated care models are essential. This is an absolute prerequisite for the sustainability and participation of psychiatry.
- The APA should support payment streams for psychiatric care that are not carved out of existing medical budgets or, if carve-out payers continue to operate, the credentialing, CPT codes, and payment for psychiatric physician services must be integrated with the overall medical budget. Accreditation and related standards should be developed.
- The APA should work with other medical societies to support ongoing improvements to evaluation and management (E/M) coding to bring reimbursements for these codes in line with procedural valuations.
- Contracts for ongoing carve-out services should be structured in such a fashion as to place performance expectations on the quality and cost of medical as well as psychiatric care.
- Integrated care budgets — particularly for public sector patients — must have formal budget and quality mechanisms to protect existing mental health budget resources.
- The APA will need the capacity to track changes to payment systems, the results of demonstration projects, delivery and payment reform, and formal research and the impact on sustainability and various payment sectors. This will include alternative payment methodology developments and their implications for psychiatric care and reimbursement.

- The APA should develop a core program function that specifically monitors and reports on Medicare and Medicaid policy and related program developments regarding state Medicaid plans and program efforts directed at the dual-eligible population in support of federal advocacy and APA's state associations.
- The APA needs a more active and strategic presence in the many nongovernmental groups that will define policy and accreditation standards. This will also require more intensive work with the employer community and a focused public relations strategy.
- The APA should continue strategic efforts to utilize MHPAEA to secure equity for psychiatrists and their patients.

Quality and Performance Measurement

Background

Performance indicators are seen as essential to improving patient care and have been increasingly used for quality improvement initiatives, public accountability, and healthcare reimbursement. Healthcare reform has greatly accelerated the development and use of performance indicators and these will be increasingly applied to psychiatric care and mental health/substance use disorder care.

It is unclear, however, whether psychiatry (and the MH/SUD field generally) is prepared to adequately function in this new environment. Concerns include the status of current measures and practitioner and system readiness to implement them.

The ACA gave even greater importance to quality measurements in 2010, including some that apply specifically to mental health and substance use disorders. As part of the comparative effectiveness research push, ACA established and funded the Patient-Centered Outcomes Research Institute,

In addition, the ACA allocated $10 billion through 2018 to the Center for Medicare & Medicaid Innovation (CMMI), which includes performance metrics in pilot models to be studied.

Under the ACA, health insurers and group health plans are to report annually to the HHS Secretary on quality improvement measures.

We need to know what works and what doesn't work—what models of care, which treatments, and which structures are most effective in meeting the Triple Aim.

A loosely coordinated "national quality enterprise" has already emerged through which clinical performance measures are developed, and more than 40 different behavioral health quality measurement initiatives are currently underway in the United States.

There are now multiple entities that promulgate performance measures, including the National Quality Forum (NQF), the Agency for Healthcare Research and Quality (AHRQ), the AMA, the Physician Consortium for Performance Improvement (PCPI), the Joint Commission, the National Committee for Quality Assurance (NCQA), and the National Quality Enterprise (NQE). A description of these organizations is included in the reference document. The field currently lacks leadership, and that presents an opportunity for psychiatrists. To be a player in the healthcare reform initiatives, psychiatrists will have to be represented at many levels of these organizations.

Findings

Goals: Before performance measures are written, there must be consensus among psychiatrists about what quality domains are most important to measure. Not all measures are equal. Psychiatrists will increasingly be expected to use performance measures as healthcare reform moves forward.

Quality of current performance measures: Few performance measures in behavioral health are fully

validated and reliable, nor are they robustly included in existing measure sets. Psychiatry and other mental health groups do not appear adequately engaged in working with the agencies and organizations that are developing performance measures.

Range of quality measures: It is important to develop and measure indicators not only for individual medical and behavioral health conditions but also for the key processes associated with clinical integration

Awareness of APA members: Although psychiatric quality measures are in their infancy, it is not clear that psychiatrists are sufficiently informed or use measures frequently.

Health information technology (HIT): A central feature that is needed to facilitate quality improvement is health information technology, which includes the use of electronic health records (EHRs). The ACA explicitly requires that HIT be part of the PCMH demonstration projects.

Risk adjustment: Many measures do not adequately account for variations in patient panels nor do they necessarily account for more severely psychiatrically ill patients or patients with multiple comorbidities.

Adoption: Given the greater prevalence of solo or private practice for psychiatry, the adoption of performance measures may be more difficult. It is estimated that less than five percent of psychiatrists are currently using EHRs.

Accreditation and certification: Current programs do not robustly include psychiatric input or adequate mental health substance use measures or measures of coordination with general healthcare and medical comorbidity.

Recommendations

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

- Clarify and articulate the APA's vision for mental health quality measures. Psychiatric measures must not be separated from the rest of medical care.
- Undertake a systematic review and analysis of quality and performance measures that are used to accredit and/or certify alternative care delivery models and/or for healthcare reimbursement purposes.
- Broaden the range of quality measures to include outcome measures and measures of integrated care for individuals with multiple comorbidities.
- Engage where appropriate in research activity on quality in psychiatric practice.
- The APA should consider a leadership role in the development of EHR and registry quality capacity.
- Disseminate psychiatric outcome measures that are meaningful and actionable.
- Continue/expand educational outreach on performance measurement targeting APA membership.
- Continue/expand participation in national initiatives at all levels (federal, private insurance, local, etc.).
- Continue/expand APA efforts in monitoring and participation in health plan certification/accreditation.
- The APA will need to lead on quality metrics for psychiatric care and their consistent adoption across payers and other regulatory entities. This could be approached by identifying a few priority areas for improvement and/or by identifying a series of goals covering various areas of practice.

ELECTRONIC HEALTH RECORDS (EHR) AND RELATED TECHNOLOGY

Background

Electronic Health Records are the electronic framework that provides for the comprehensive management and secure exchange of health information among providers, insurers, government, patients, and other entities. EHRs, in particular, have emerged at the center of the national strategy to improve healthcare quality, communication, prevention and wellness, and to reduce unnecessary cost.

EHRs are embedded in a framework of health information technology (HIT) that also includes telemedicine, e-mail, websites, databases, electronic prescribing, and patient-controlled personal health records. HIT is fundamental to the array of emerging alternate care delivery models. Any entity that coordinates care and promotes accountability among a group of providers for a given patient population will require capabilities that will be difficult to achieve without the use of HIT.

Recent legislation has created a series of initiatives designed to increase the acquisition and use of EHRs and other forms of HIT, including financial incentives to clinicians and hospitals through Medicare and Medicaid; the establishment of networks (Health Information Exchanges) to exchange health information within and between communities; and the development of new technical standards to support health information technology infrastructure. Increased attention and resources have been allocated to other types of HIT as well, such as telemedicine.

Findings

While EHRs are fundamental to healthcare transformation, there are specific issues for psychiatry and the mental health/substance use disorders field, including:

- Technology acquisition – Psychiatrists, who are disproportionately solo and small-group practitioners, have lagged behind other specialties in adopting EHR, in part due to cost or adaption of EHR

to psychiatric care needs. Support for psychiatric acquisition of EHR technology has been limited to large systems and public payer meaningful use, which may only represent a minority of practicing psychiatrists not in private practice or public sector settings. Failure to alter this pattern of EHR use will make it difficult to survive and/or be relevant in the emerging environment.

- Federal policy issues – The decision to exclude non-physician behavioral healthcare providers and community mental health centers or free standing psychiatric hospitals from the HITECH Act means that, at present, there is no federal support for this necessary transformation, limiting vendor interest and adoption.
- Notably, non-physician mental health and substance abuse treatment providers (including CMHCs) are not eligible for the Medicare and Medicaid EHR Incentive Program funds. Eligible hospitals under Medicare are subsection (d) hospitals in the 50 states or DC, critical access hospitals, and Medicare advantage hospitals. Under Medicaid, eligible hospitals are acute care hospitals and children's hospitals. Psychiatric hospitals were not included in the legislation.
- Medicaid Record Confidentiality – Psychiatric and substance use disorder medical records present numerous problems in the emerging era of health information exchange that must be overcome especially with regard to integrated care initiatives. While some aspects of this are distinctive for psychiatrists, the Work Group notes that many patients with MH/SUD are seen solely in the general medical sector where this information is embedded in existing electronic records and that other aspects of medical care can be highly sensitive as well.
- Integrated care models – Success under most emerging integrated care models is dependent on deployment of EHR and patient registries. Psychiatry and the MH/SUD fields' success with these ventures

will be dependent on access to and adoption of EHR. The current low rate of use is an issue, as is the fact that there are limited vendor products available that incorporate the flexibility needed by psychiatrists.

Demonstration Projects: The ACA explicitly requires that information technology be a part of Title XIX Medicaid medical home demonstration projects. It has been pointed out that the new demonstration projects will require maintaining an inventory of evidence-based approaches for integrating care and measuring and improving quality improvement, as well as developing and disseminating standardized templates for EHRs, personal health records, and the registry.

Patient Registries: Registries are mentioned repeatedly in all discussion of HIT. A patient registry is a tool that allows for tracking all of the patients seen in a practice with a particular condition(s) or set of characteristics. In essence, it is a database in which key data about a target population is organized in one place. AHRQ defines a registry as an: "… organized system that uses observational study methods to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes."

Many professional associations, particularly procedural based disciplines, are supporting or plan to support registries. For example, the thoracic surgeons have an outcomes registry, as does cardiology. Registries serve a variety of functions, including reporting clinical performance measures, tracking practices for high risk patients and population management, quality improvement and maintenance of certification, and research. Challenges in establishing a clinically relevant registry in psychiatry include the facts that the model isn't as intuitive with chronic conditions and that outcomes for mental health are difficult to define and capture in a standardized way. Establishing and hosting a registry is a staff and financial-resource intensive endeavor, and some registries will

eventually be spinning off from professional associations into standalone companies.

Health information exchanges: The term *health information exchange* (HIE) actually encompasses two related concepts: as a verb, it is the electronic sharing of health-related information among organizations; as a noun, it is the organization that provides services to enable the electronic sharing of health-related information. HIE can provide the connecting point for an organized, standardized process of data exchange across statewide, regional, and local initiatives.

Research: Researchers at the Office of the National Coordinator (ONC) for HIT published a review of studies on the effectiveness of HIT in a 2011 issue of *Health Affairs*. They found predominantly positive effects on key aspects of care, including quality and efficiency. [Buntin MB et al., The Benefits of Health Information Technology: A Review of the Recent Literature Shows Predominantly Positive Results, *Health Affairs*, March 2011.] On the other hand, *BMC Psychiatry* (November 2011) reported that not a single study has been published supporting any significant benefit to the creation of electronic personal mental health records.

Key organizations: Several organizations are key to funding and setting policy for developing HIT: CMS; the Health Resources and Services Administration (HRSA); the Office of the National Coordinator for HIT (ONC); and the Nationwide Health Information Network Exchange, all of which are described more fully in the reference document.

EHR adoption: It is widely agreed that performance measurement will be most effective when it is minimally intrusive into the clinical workflow. Although EHRs are expected to allow for measurement to be integrated into workflow and therefore lower the administrative burden on practicing clinicians, widespread adoption of EHRs in psychiatry and the technical standards required to uniformly implement measures are still years away. Mental health and substance abuse treatment systems have historically lagged behind other areas of medicine in the development and standardization of information

technology tools. Furthermore, legal/regulatory barriers (42CFR Part 2; psychiatric medical record laws) have limited the exchange of information between primary care and mental health and substance abuse treatment settings. Confusion about applicable laws and obligations under multiple federal and state statues is high. Regardless of specialty, solo practitioners are the lowest adopters of EHRs because of challenges they face, such as limited administrative and technical support and the potentially high cost of purchasing and maintaining systems. The percentage of psychiatrists using EHRs is particularly low – estimates range from five percent to eight percent.

Privacy, security, and confidentiality: High profile breaches of health information security have undermined patient confidence that their sensitive information will be protected. Although technology is under development, today's HIT systems have limited capability for selectively protecting sensitive information from inappropriate sharing. There are many issues regarding psychiatric medical record/substance use disorder confidentiality that need to be vetted and appropriately balanced within integrated EHRs. Currently, there is little if any consensus as to how to do this.

HIE sharing: Due to the complexity and variation in policies and laws, as well as to concerns about the sensitivity of information pertaining to mental health treatment, communities are facing challenges in deciding how information pertaining to mental health information will be shared over health information exchanges. Both of the two most common approaches (sharing mental health information without any additional protection and withholding mental health information from any form of exchange) are problematic for patients with mental illness, especially given high medical comorbidity and the frequency of psychiatric care occurring solely in the general medical sector.

EHR products for behavioral health: The variety of EHR products available is most robust for primary care and smaller for behavioral health settings and clinicians.

- The APA's Committee on Electronic Health Records is developing a list of features that EHRs should include in order to meet the needs of psychiatrists. This list will support many activities, including educating APA members and communicating with software vendors about psychiatrists' needs.
- The APA has partnered with the American College of Physicians and other professional associations to support the American EHR website, which consolidates information about software products submitted by practicing physicians. A survey of APA membership to collect information on EHR systems used by psychiatrists is forthcoming.
- Legislation, which was introduced in the last Congress aimed at correcting current limitations on non-physician mental health providers receiving EHR incentives from Medicare and Medicaid has not been introduced in the current session.

RECOMMENDATIONS

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

- The APA should develop resources that help members select, implement, maintain, and use EHRs

and other forms of HIT. Possibilities could include written resources and online instruction videos, software reviews, accounts of members' experiences with HIT, telephonic consulting and technical support services, and in-person support services.

- Standardized templates for electronic medical records and personal health records should include the data elements needed to manage and coordinate general medical care and mental health and substance abuse care. These systems must be carefully designed to ensure that critical information on health status and services can be extracted for measuring service patterns and performance.
- The APA should continue/expand activities pertaining to HIT privacy. Activities include feedback to the federal government through submission of public comments and responses to requests for information, development of educational content on how to maintain HIT privacy and discuss privacy issues with patients, and talking to HIT vendors about privacy functionality.
- The appropriateness and feasibility of APA developing patient registries for psychiatric patients should be explored. This should include due consideration of various structures and uses and recommendations as to options for the APA. The Council on Research and Quality Care will address this at its May 2013 meeting.
- The APA should explore developing an RFR to vendors with specific technical capacities that would be needed for endorsement and should consider evaluation of its role in the development of EHR products. This activity could be a valuable resource to members, but APA must be aware of the risks involved in dealing with an immature industry.
- The APA should continue/expand quality and performance measurement activities as under the quality performance measurement topic: Performance measurement is a key function of HIT

and includes a variety of components related to payment, quality, and research through patient registries.

- The APA should assess the adoption of and impact of HIT on quality in psychiatric practice and identify strategies to maximize findings that indicate the positive impact.
- The APA should develop policy and training on EHRs and privacy/confidentiality. The importance of electronic health records going forward is self-evident. There are, however, numerous privacy/confidentiality issues for psychiatric records.

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

- The APA should make policy development for confidentiality of MH/SUD records and HIT a priority matter**.** Development of training and technical assistance materials for members will be essential.
- The APA should engage with Health Information Exchange (HIE) efforts*.* Currently, HIEs are forming at the local level, and each locale is handling psychiatric health information differently. In order to realize the potential of HIE to facilitate integrated care, APA could participate in oversight bodies at the national level and develop educational material for APA members.
- The APA should continue/expand efforts to develop resources that help members select, implement, maintain, and use Electric Health Records and other

forms of HIT. Possibilities include an RFR process as noted above, written resources and online instructional video, software reviews, accounts of member experiences with HIT, telephonic consulting and technical support services, and in-person support services.

- The APA should continue/expand its efforts to advocate for expansion of HIT to all aspects of the mental healthcare system. Non-physician mental health clinicians and many specialty mental health settings are currently excluded from current national initiatives. Specific advocacy efforts are needed to correct federal policy.
- The APA should assess the feasibility of maintaining patient registries. Given CMS's interest, APA should do pilot work to assess these more fully. This assessment has begun through APA's Council on Research and Quality.

WORKFORCE, WORK ENVIRONMENT, MEDICAL EDUCATION AND TRAINING

Background

It is clear that key health reform trends underway have important implications for the demand, types, and provision of psychiatric services. The exact shape of these changes, the skills that will be required, and who in the general medical, psychiatric, and broader mental health communities will provide this care is unknown. The plans to be offered through the new exchanges and Medicaid expansion under the ACA will greatly increase the number of insured people with MH/SUD conditions.

Findings

Provider payment rates under ACA coverage expansion health plans: Expansion schemes may not offer payment rates that make participation attractive.

Supply and distribution of psychiatric workforce: What is relevant is that there are known shortage area

designations (distribution issues) for both psychiatric and non-MD behavioral health practitioners. These shortage designations have a high degree of correlation with sites of service delivery that will likely be points of access for many of the newly insured.

Federal health manpower policy: Federal medical workforce policy places premium emphasis on primary care over specialty physicians. There are no foreseeable changes that will radically alter numbers in the near future.

Healthcare reform is predicated on an expanded non-medical workforce. ACA workforce provisions and initiatives for the behavioral health workforce are focused on training and developing non-MD practitioners.

There is a disconnect between the likely need and demand for specialty psychiatric physician services as part of behavioral healthcare delivery and current federal behavioral health manpower development policy.

Coverage expansion, increased demand, the non-medical workforce and scope of practice: The composition (education and training) of the current workforce in most shortage areas/settings and the general non-availability of physicians will likely contribute to increased scope-of-practice debates across all of medicine and on the part of non-medical mental health and substance use disorder practitioners and non-medical primary care practitioners.

Psychiatry's role and responsibility in integrated care models and core competencies required: While integrated care models utilize a wide range of medical and non-medical practitioners in both primary care and behavioral health care, psychiatry has medical skill sets that are essential to successful IC delivery models. This includes general medical expertise, expertise in the psychiatric presentation of medical illness, deep psychopharmacologic knowledge, and training with the most critically ill psychiatric and substance use patients in settings of considerable independent clinical authority. This skill set is not replicable by other physicians or non-physician personnel.

Current physician training initiatives re integrated healthcare: There are a number of training curriculum/course opportunities for practicing psychiatrists currently available through the APA, the AIMS Academy, and the National Council.

Core competencies: There is a gap between the typical current competencies of psychiatric physicians and those needed to function appropriately in integrated care models, particularly in ongoing medical expertise and maintenance of those skills along with development of ambulatory consultative expertise and expertise in population management. These core competencies are not fully developed in most medical education and training programs.

- A curriculum on integrated care for psychiatric residency training programs is under development by the AIMS Center (Advancing Integrated Mental Health Solutions), University of Washington).
- While the need and demand for psychiatry to be appropriately embedded in IC delivery models is relatively self-evident, it is not clear that there are sufficient numbers of trained individuals within the current manpower supply who can meet the demand, or even that a significant number of currently practicing psychiatrists are interested in these roles.

<u>Recommendations</u>

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

milestones for psychiatric residents to achieve proficiency in core competencies for integrated care practice and settings, or highlight existing milestones that are relevant for these efforts.

- Current workforce: Within the healthcare reform movement, many opportunities exist for psychiatrists who have the necessary skills and experience to participate in the new models of integrated care. However, many lack the core competencies respecting a number of necessary skills.
- The APA should develop practice management modules (CME) for its members to enhance their skills in the following areas: reviews of common medical problems in general medical care and public sector populations, leading teams of mental health professionals, setting up and/or participating in integrated care settings, teaching PCPs about identifying and screening for mental health illnesses and substance use disorders, and health information technology.
- Non-psychiatrist physicians and allied practitioners: the APA should explore potential collaboration with primary care personnel (both MD and non-MD) regarding needed education and alliances regarding care delivery development (especially for shortage areas).

Research and the Mental Health Evidence Base

Background

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

A variety of entities will be involved in these research and evaluation endeavors from the Patient-Centered Outcomes Research Institute (PECORI) to SAMHSA and NIH. There are many questions embedded in all of these initiatives for which the present research base does not have answers. While the array of pilots and demonstrations underway have valuation protocols built into them, there will be issues about the utility of the data they generate. All of these efforts will require appropriate monitoring.

The foregoing will play a role in advancing our understanding of how the organization and financing of care affect cost, quality, and access. The APA has a role to play with this health reform research agenda, internally and externally.

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

<u>Research Issues Covering Topical Areas Involved in Health Reform</u>

Integrated Care

- Develop standards for classifying models of integrated care and measuring outcomes of such models.
- What is the effectiveness of integrated care in general medical and related psychiatric practice settings?
- What is the effectiveness of integrated care for those with severe mental illness? What models will work best in this population and help with medical disorders found in them?

- What models of integrated care can be used in rural areas with underserved populations?
- What models work best with various age groups (e.g., children and the elderly population)?
- What accounts for the effectiveness of integrated care – clinician integration, introduction of evidence-based practice, care management, system integration, etc.?
- What organizational models of care are best for certain populations and settings? (Note this goes beyond "integrated" care – perhaps there are other ways that work best for certain groups and settings.)
- What models could ensure sustainability?
- What other factors (e.g., clinician/staff beliefs) may impact effectiveness of integrated care models?
- Support increased research into the mechanisms of increased morbidity and mortality with co-occurring medical and psychiatric disorders.
- Support/conduct epidemiologic studies of co-morbidity (medical, mental illness/substance use) including prevalence and impact of care

Financing of Psychiatric Care

- What is the cost-effectiveness of integrated care models in various populations and settings?
- What are the best models for financing integrated care models?
- What reimbursement models lead to the best outcomes for people with mental illness?
- What models of financing will ensure appropriate care under healthcare reform for those within the current public mental health system?
- What is the contribution of mental illness/substance abuse to overall healthcare costs and the effect of appropriate behavioral healthcare interventions on

those costs? How do these differ by population (e.g., those with dual eligibility, co-morbid conditions)? How do different mental health clinicians affect these costs?

- What models of payment by Medicaid/Medicare are best for those with mental illness?
- What interventions should be covered? Identify those interventions with the highest cost-effectiveness and include not only clinical treatments but others like case management, peer navigators, etc.
- How do various coding schemas affect delivery of care, costs of care, and outcomes?
- What mental health and substance abuse interventions should be part of a basic package of insurance coverage (this becomes especially relevant with health exchanges and expansion of Medicaid)?
- What are the barriers to the adoption of best practices?

Quality and Performance Measurement

- Increase research to build an evidence base for treatment of various illnesses. There is a need to identify gaps in knowledge that should be a priority for clinical research. Which outcome measures most predict improvement, reduced morbidity and mortality from all causes?
- What personalized treatment options are available now or could be developed in the near future?
- Increase the number of quality and performance indicators with a clear link to improved outcomes in those with mental illnesses and substance use disorders.
- Develop pay for performance models in MH/SUD, including integrated models.

- Increase development of patient-centered outcome measures.
- What are the best risk adjustment models? (also relevant to financing)
- What implementation/dissemination models are effective in improving practice?
- What models of person-centered care lead to better outcomes for patients?

Health Information Technology (HIT)

- Develop EHR applications to improve quality of care in various treatment settings. What applications actually improve care and outcomes?
- Develop EHR applications that can monitor individual practice and patient outcomes.
- What EHR data related to those with mental health/substance use disorders are critical for improved treatment outcomes?
- Develop large data network(s) to be used for research on various conditions and to monitor changes in population health.
- Expand practice-based research network for practice research. Incorporation of EHR and other data systems will expand opportunities within this network.
- Expand support for novel and entrepreneurial capacity to assess wellbeing, symptoms, and response to treatment.
- Ethical considerations in HIT.
- Workforce, Training, and Education
- What is the projected demand for services given the increase in coverage under the ACA?

- What is the projected available number of psychiatrists and other mental health care professionals?
- What is the projected available number of primary care physicians, non-physician primary medical caregivers, and specialists who will be providing mental health and substance use disorder services?
- What range of disorders will primary care physicians, non-physician primary care medical caregivers, and specialists treat? What are existing and expected skill sets and training they will need?
- What skill sets are needed now for psychiatrists to practice in future models of health care?
- What are unique skill sets for psychiatrists vs. other mental health clinicians vs. other physicians?
- What recruitment and retention models work best to ensure an adequate number of psychiatrists?
- What education models are most effective in training psychiatrists, primary care physicians currently practicing and those in training?

DSM-V

- How does adherence to DSM-V criteria improve practice and outcomes for patients?
- What changes need to be made in DSM criteria? (This would come from longitudinal studies once DSM-V is implemented.)
- What new coding/payment/performance methods are most effective using DSM-V?

HEALTHCARE REFORM: ORGANIZATIONAL IMPLICATIONS FOR THE APA

Background

The APA, as a specialty medical organization, serves many essential scientific, educational, and advocacy functions for

and/or on behalf of psychiatry and its patients. This occurs both nationally and at state levels.

We have entered into a period of dramatic, rapid, and consequential change in the American healthcare system. Health reform presents a number of significant considerations for the functional activities of the APA. The healthcare environment for patients and physicians will not be business as usual whether we are talking about patient care guidelines, measurement of outcomes and quality, or provider performance. The locus of decision making regarding policy, the complexity of the issues, and the compressed timeframes within which we will need to respond will stretch our resources and governance. While there is and should be legitimate skepticism about the efficacy of any particular changes, it is clear there will be ongoing pressure for change.

The trends and changes in motion will affect the APA membership in various ways. Regardless of whether a psychiatrist's current practice configuration involves her in a small or large way, the question of member readiness and how the APA can best act in all these domains requires due consideration. Whether at the policy or individual psychiatrist level, how does the APA become essential to the deliberations that will occur across many policy settings and serve its members' various needs?

Findings

The APA internal operations responsible for research, quality, education, and advocacy (advocacy for the purposes of this report encompasses the three offices within the Division of Advocacy—Government Relations, Communications, and Healthcare Systems and Financing) have been very active players in the health reform milieu. Core activities range from continued development of quality measures; responses to a myriad of federal regulations, to state society needs for technical assistance, and to member needs for education on integrated care models; and legislative advocacy for psychiatric manpower development. Through these activities, many, but not all, of the moving pieces of the health reform puzzle are being covered. These activities, however, do not yet have a

centrally developed and coordinated strategy based on the APA's priorities and targets concerning health reform.

The APA's governance structure, its various councils and components, mirror internal operations. Most of the pressing health reform issues cut across the areas of expertise based in the various parts of this structure.

The pace of change creates additional pressure and challenges. The APA has an increased need to be able to determine which events are critical and which are not. This includes the need to identify and take action with those entities whose decisions may have a major downstream effect or where we need influence and allies. The ability to have a rapid decision making and action capacity that will enable us to act within the decision-making cycle of other groups is critical.

Monitoring and reporting versus advocacy creates very different problems. Because many of these issues will occur at the state level, but also may be centralized in some in overall federal policy or nationwide non-governmental organizations (NGOs), monitoring, reporting, and executing effective advocacy will tax both resources and governance decision making.

Health reform issues are detailed, complex, and labor intensive to resolve. The nature of the issues APA must respond to are increasingly difficult and often require specialized knowledge/expertise that is not currently possessed by staff and/or cannot be marshaled in a timely manner within the current council/component structure.

Effective communications, advocacy, and technical assistance require new capacity and understanding of what state affiliates need.

Current APA communications efforts, while performing a number of essential functions in priority areas for the APA, do not have a centralized directive regarding health reform issues, or well-honed messaging.

RECOMMENDATIONS

- The APA should establish a set of health reform priority activities (developmental and implementing) consistent with the major findings and recommendations of this report and a strategy/plan of action to implement them.
- The APA should establish an ongoing working group within the current governance structure to oversee this plan of action and regularly report on developments and actions. This should include a plan to ensure a rapid response capability.
- The Medical Director/CEO, under the oversight of the board, should assess how current staff can best be configured to ensure that the functions of this work group are appropriately executed. This should include recommendations concerning additional staff and/or consultant expertise that may need to be retained (with the budget implications). There are various recommendations in other sections of this report that concern internal staffing. These should receive due consideration as part of this effort.
- The APA should develop a communications campaign that addresses how to best advance the APA agenda, internally with its members and externally with key stakeholder audiences. This campaign will likely require external communications expertise. Psychiatry's value proposition for health reform is not self-evident to key policy/payer audiences and members. Moreover, a fully informed and educated membership will be essential to fulfill the demands for psychiatric services that the APA's agenda embodies.
- A centralized strategy for assistance to the APA's state affiliates will have to be developed.
- Governance implications of these efforts, including the rapid response capability, will need to be carefully and directly assessed.