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Administrators in Academic Psychiatry

From the president's desk

by Warren Teeter

I trust everyone has had a nice summer and enjoyed at least some vacation time away from work. I'm sure we will all agree technology has changed the way we do vacations. Are we really getting the mental break we need if we check our voice mails and e-mails while we're on vacation? Or, if we don't check them, we wonder if we'll have a mental breakdown trying to handle them when we get back!

The most important news I have to report is **Alex Jordan's** career transition effective July 1 from the Dept. of Psychiatry to Administrator, Division of Vascular Surgery at U. Washington. The AAP board has approved, and Alex has agreed to continue to serve on our board as Immediate Past President through the end of December, 2002. At that time, he will continue to make himself available to the board in an advisory capacity. **Janet Moore** (Michigan State U) has been asked by the board to return effective January 1, 2003 and assume the role as Immediate Past President. Janet has graciously agreed to serve in this capacity. We are happy for Alex, but will miss his guidance and leadership and the friendships we have enjoyed over the past seven years, but we are happy for his promotion. Alex will be unable to attend our November meeting, but he promises to look us up in April in Atlanta at the APA annual conference.

President-Elect **Dan Hogge** (U Utah) and his committee have been working hard on planning our Fall conference in San Francisco on Saturday, November 9th, 2002 in conjunction with the American Association of Chairs of Departments of Psychiatry (AACDP). We have been talking with **Dr. Dan Winstead**, president of AACDP, about topics for our lunch meeting with the chairs and administrators. There is no shortage of ideas for mutual topics of interest. We will also have an AAP dinner on Friday, November 8 so plan to arrive in time for that. Dan Hogge's article in this newsletter will give you more information on the meeting and watch e-mail and postal mail for your registration form.

As a reminder, of some of this year's goals for AAP include:

- **Organizational Development** – Build on and update our Strategic Plan for 2002-2003.
- **Membership Services and Development** – Expand and replenish our membership base
- **Educational Programs –** Keep the conference content delivery fresh and attractive to attendees
- **Strategic Collaboration –** Develop inter-group participation in groups and subcommittees as deemed appropriate with the American Association of Chairs in Departments of Psychiatry (AACDP), especially as it relates to our collaboration at the Fall, 2002 conference and monitor functionality and effectiveness of our efforts.

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Comings and goings

If there are new AAP members in your state, please feel free to call them and personally welcome them to our organization. One of the things that makes AAP special is its friendly members! The hospitality offered by a personal contact will surely be appreciated.

AAP wishes to extend a warm welcome to the following new members:

Doris Chimera
University of Texas, Galveston

Jennifer Tunget Henry
University of Louisville

Joel Sherr
Loyola University

AAP wishes good luck to the following members:

Very sadly for AAP, Immediate Past President **Alex Jordan** has taken a position as the Administrator of the Department of Vascular Surgery at the University of Washington (see below).

Once again, **Florie Munroe** is on the move. Effective July 29, she will be joining the Yale Health System, with responsibility for privacy, regulatory and billing compliance. Her duties pertain to all divisions in the Yale network, Psych included, so hopefully we'll continue to see Florie around!

Cindy Williams is no longer at Trover Foundation due to a restructuring.

President's message (continued)

- **Governance -** Continue to conduct effective quarterly board meetings via teleconference or in conjunction with annual conferences.

I appreciate the continuing leadership and support of the AAP board members: **Dan Hogge** (University of Utah), President-Elect; **Pat Sanders-Romano** (Albert Einstein SOM), Secretary; **Brenda Paulsen** (University of Arizona), Treasurer; **Kevin Johnston** (Indiana University), Membership Director; **John Digangi** (University of Massachusetts), Member-at-Large; **Jim Landry** (Tulane University), Member-at-Large; **Nish Patel** (Mayo Clinic), Member-at-Large; **Alex Jordan** (University of Washington), Immediate Past President (through 12/31/02); and **Janet Moore** (Michigan State University), Immediate Past President (effective 1/1/03).

Thanks also to **Jan Price** (University of Michigan), **Radmila Bogdanich** (Southern Illinois University) and **David Peterson** (Medical College of Wisconsin) for their editorial efforts to continue to make our newsletter exceptional.

I look forward to seeing many of you at our Fall conference in San Francisco. Please contact Dan Hogge (Dan.Hogge@hsc.utah.edu) if you have any questions about the meeting. Please e-mail me at wteeter@wfubmc.edu or phone (336) 716-3544 if you have any questions or suggestions regarding AAP.

Dear Fellow AAP Members:

As AAP's Immediate Past President, it is with mixed emotions that I inform you I have accepted a job promotion into the Department of Surgery within my home institution, the University of Washington. As of July 1, 2002, I became the Administrator for the Division of Vascular Surgery. Although this is an exciting new opportunity for me, I am also saddened to be leaving the field of Academic Psychiatry and especially AAP. In the past seven years I've been very lucky to have worked not only with some of the brightest clinicians, researchers and educators in the field, but also with a tremendously gifted set of AAP colleagues such as yourself.

When I first joined AAP in 1995, I was immediately impressed by what a warm and wonderful group of talented and dedicated people made up our organization. My respect and appreciation for AAP membership continued to grow, and as I accepted various leadership roles I was rewarded many times beyond my own investment of time and energy. Some of my most treasured professional relationships are to be found within the ranks of AAP membership — relationships which I expect will continue for many years to come.

I have expressed my desire to remain on the board of directors through December 31, 2002, and the board has approved my request. In this time, I hope to continue working with Warren and other AAP leaders as we build upon our previous successes. Meantime, to all AAP members, please accept my deepest thanks for your kind support over the years. I have been greatly enriched though our affiliation, and will always consider myself in many ways "on call" to each and every one of you. Please stay in contact, and I look forward to touching base with you at the Spring 2003 APA conference in Atlanta!

Sincerely, Alex R. Jordan

Fall conference planning

by Dan Hogge

Please mark your calendars for a delightful Fall conference of the Administrators in Academic Psychiatry to be held in conjunction with the American Association of Chairs of Departments of Psychiatry (AACDP) conference. The program will be held Saturday, November 9, 2002 in San Francisco, California at the historic Omni San Francisco Hotel, located at 500 California Street at Montgomery. When you call the hotel at (415) 677-9494, please tell them you are with the AACDP Fall Meeting to assure your guaranteed rate of $179 single/double occupancy. You will need to make your reservation no later than October 8 to secure this rate.

We are very fortunate to have as our keynote speaker **Robert Okin, MD** from the San Francisco General Hospital, Vice-Chair of the Department of Psychiatry. Dr. Okin is a strong advocate for the underserved, expanding programs manyfold during his tenure at San Francisco. His discussion will be about commitment to quality care wherever the need and will illustrate this theme using his experience in providing leadership for a fundamental reform in the Mexican mental health system.

Additionally, the Program Committee has invited **Jack Dembow** who served as the Executive Director of the Jefferson Behavioral Health Network, an integrated provider network offering a comprehensive range of mental healthcare and chemical dependency service throughout southeastern Pennsylvania. His theme will focus on "First Steps in the Development of an Integrated Delivery Network and Mistakes I Would Hope Not to Make Again." We will have other presentations and a group discussion that will be very helpful to our members in these times of change.

We will plan on meeting for dinner as a group Friday night November 8th. The Saturday educational program will run from 8:00 a.m. to 5:00 p.m. Also, we will enjoy a joint luncheon with the Chair's group and a cocktail reception on Saturday evening.

You should receive a meeting brochure by e-mail and by postal mail around the end of August. Please contact **Dan Hogge** at (801) 581-8803 or dan.hogge@hsc.utah.edu if you have any questions regarding this event.

Golden Gate trivia

Does the Golden Gate Bridge have the world's longest suspension span?

Not any more. The 4,200 foot long suspension span of the Golden Gate Bridge was the longest span in the world from the time of its construction in 1937 until New York City's Verrazano Narrows Bridge was opened on November 21, 1964. It is 60 feet longer than the Golden Gate Bridge. The Verrazano was the longest single span bridge until July 17, 1981, when the Humber Bridge in England, spanning the Humber River, was opened for traffic with a main span of 4,626 feet. Today, both the Great Belt East Bridge in Denmark (main span of 5,328 feet) and the Akashi-Kaikyo Bridge in Japan (main span of 6,532 feet) have main span lengths which exceed that of the Humber Bridge.

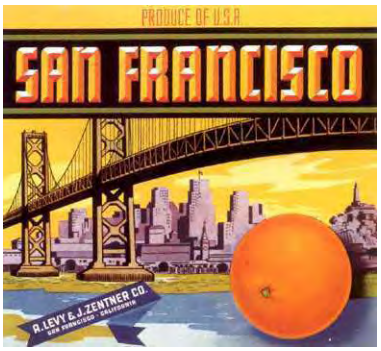
How long did it take to build the bridge?

Just over four years. Construction commenced on January 5, 1933 and the Bridge was open to vehicular traffic on May 28, 1937.

How many workers died during the construction of the bridge?

Eleven men. Until February 17, 1937, there had been only one fatality, setting a new all-time record in a field where one man killed for every million dollars spent had been the norm. On February 17, ten more men lost their lives when a section of scaffold carrying twelve men fell through the safety net.

How many rivets are there in each tower of the Golden Gate Bridge?



There are approximately 600,000 rivets in each tower.

How many vehicles have crossed the Golden Gate bridge?

As of March 31, 2000, 1,634,141,491 vehicles had crossed the Bridge. On February 22, 1985, the billionth car crossed the Golden Gate Bridge.

To have and to hold - but for how long?

Guidelines for records retention

by Lisa H. Schneck, MSI
MGMA Senior Editor

Saving is usually a virtue, but must a practice administrator keep every business, personnel and medical record for posterity? No - but for legal purposes, you should know how long your organization should keep critical documents, whether paper or electronic.

Unfortunately, guidelines for records retention come from various sources and are set at state and federal levels. Locating rules can be as challenging as where to store key documents. A wise manager will establish a records-retention schedule to dispose of unnecessary and outdated material in a timely manner.

Your state's labor department should have general document retention schedules; some states have employers' councils that are trustworthy resources. Human resources associations, such as the Society for Human Resource Management (SHRM), also provide this information but may require membership. You can find information on medical records-retention through state medical boards or departments of health, federal agencies or medical associations. If those sources don't yield the answers you seek, check with legal counsel.

Business records - Records of accounts receivable and payable, budgets, audit statements, bank statements, lease agreements, and other contracts, investment plans, equipment inventory and the like require safekeeping.

To learn what business documents to keep and for how long, start by asking your practice's accounting firm or the Internal Revenue Service.

In general, follow these guidelines for what business records to keep and for how long:

- Agendas/schedules, bank statements, billings, payables, reconciliations: Two years
- Insurance documents, purchase orders, sales contracts and invoices, requisitions: Three years
- Chronological files, shipping and receiving reports: Four years
- Audits, budgets, financial reports, contracts (expired), cancelled checks, committee/meeting minutes: Five years
- Invoices, expense reports, insurance policies (expired): Six years
- Mortgages, notes, leases, tax withholding statements: Eight years
- Financial statements, organization policies, general ledgers and journals, copyrights and trademark registrations, labor contracts, deeds and easements, patents, tax returns and work papers, legal and tax correspondence, licenses: Life of the organization.

Personnel records - Individual states, as well as the federal government, have record-retention requirements for employee files and other personnel information. As the SHRM notes, "Some of the requirements apply to most employers, while others apply primarily to government contractors and subcontractors. Many of these requirements are dependent on the number of employees or the purposes for which the record keeping is designed."

The length of time a business should keep records varies by the legislation governing them. For example, pension and welfare plan records fall under the Employee Retirement Income Security Act (ERISA), which mandates that employers keep them for at least six years. The Equal Pay Act dictates that employers keep payroll records for at least three years.

Medical records - Each state sets its own statute of limitations for malpractice actions; use those limitations as your guide for how long to keep medical records. Your state medical board, state health department or your practice's attorney will have this information.

A good rule of thumb is to keep inactive records on adult patients at least seven years. Keep pediatric records at lest seven years past the patients' age of majority. The American Health Information Management Association (AHIMA) recommends that health organizations keep adult patient records 10 years beyond the most recent encounter, pediatric records up to the age of majority plus the statute of limitations.

Check your physicians' malpractice coverage. How long is it in force? That may guide you in the length of time to keep medical records - well beyond the term of the coverage.

The Centers for Medicare and Medicaid Services (CMS) has on-line information about records retention for specific documents at www.hcfa.gov.

Keep x-rays and other imaging records, raw psychological testing data, electroencephalograms, electrocardiograms and the like for at least five years.

Proper disposal - Destroy paper documents by shredding to ensure they're unreadable and unrecoverable. Delete electronic documents and database records by wiping them from local, network and backup drives and/or disks. To be thorough, include backup disks stored off-site.

(This article appeared in the MGMA Connexion, April 2002. Because so many of our AAP members are not members of MGMA, it's being repeating in The GrAAPvine).

The College corner

Johnston and Munroe Advance to Certified Status; Erwin and Landry Proceed On

by David Peterson, FACMPE

The salsa in San Antonio was apparently good for board examinees as four members of the AAP passed all or a portion of the American College of Medical Practice Executive (ACMPE) board certification exams.

Kevin Johnston, CMPE (Indiana University) and **Florie Munroe, CMPE** (late of St. Mary's Medical Center and now of Yale Health Systems Vertical Network) passed the objective, oral and essay portions of the exam and as a result, advanced to Certified Medical Practice Executive (CMPE) status. Both Kevin and Florie are now prepared to take the next step to Fellow (FACMPE) status by successfully completing a professional paper or 3 case studies.

Says Kevin about the achievement; "I was very surprised at passing the three components in my first attempt. Each was certainly challenging and in some cases related to non-academic situations I had not encountered. I look forward to preparing and working toward a publication. More advice from peers will be helpful during this next step." At the moment, Florie is focusing on her job change and "Fellowship will come later."

Continuing with the good news, **Jim Landry** (Tulane) passed the objective and essay portions of the certification exam. Jim is now working on the oral portion of the exam. The oral component involves delivering two public, profession-appropriate presentations and documenting the experience. Jim hopes to be "certified in a couple of months."

Rich Erwin (University of Missouri) passed the objective portion of the exam and only has the essay portion of the exam to complete (having passed the oral portion in a different venue). Rich hopes to "arrange to take the essay in the fall and has been looking for a theme for the paper requirement."

Passing the exams is not a "gimme." Kevin and Florie join the ranks of 125 other board certified Academic Practice Assembly members throughout the country and 1234 board certified members crossing the academic and private sectors of medical practice management throughout the country. Board certification is no small achievement and Kevin, Florie, Jim and Rich deserve kudos and our congratulations for taking on the challenge.

For more information on joining the ACMPE or the certification process, contact the ACMPE directly at (303) 397-7869 or contact David Peterson, FACMPE at (414) 257-7227, email at peterson@mcw.edu or at the Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 9455 Watertown Plank Road, Milwaukee, Wisconsin 53226.

Defining the profession:

A guide to the body of knowledge for medical practice management

Steer your personal growth and development and advance your organization with the definitive guide for the medical practice management profession.

This guide is a professional resource and tool like no other:

- An interactive document that's available FREE on-line
- Provides practical ways to use the Body of Knowledge in your job and professional development
- Save it and use as your source for job skills, tasks and professional knowledge

Who will find this guide useful?

- Group practice administrators
- Physicians
- Human resource managers
- Educators
- Students

Why use this guide?

- Understand the general competencies that form the foundation of success for medical practice executives
- Learn the eight domains of performance that make up the technical/professional knowledge and skill set of a medical practice executive
- Review the origins of the Body of Knowledge, its importance and continuing evolution
- Learn practical ways to use the Body of Knowledge
- Take a personal inventory with the FREE Technical/Professional Knowledge Inventory and link to resources to help fill gaps in your knowledge base

What's in the guide?

- Five General Competencies for Medical Practice Management
- Professionalism - achieving and preserving professional standards
- Leadership - supporting the organization's strategic direction
- Communication skills - interacting and presenting information clearly and concisely
- Organizational & analytical skills – solving problems, making decisions and developing systems
- Technical/Professional knowledge and skills – developing the knowledge base and skill set necessary to perform activities unique to the job, role or task within the eight performance domains or areas of responsibility:
  - Financial Management
  - Human Resource Management
  - Planning and Marketing
  - Information Management
  - Risk Management
  - Governance and Organizational Dynamics
  - Business and Clinical Operations
  - Professional Responsibility

If you're interested in taking the College certification examinations, or just to polish your medical management skills, this is the document to have. (And you don't have to be an MGMA member to access it!)

Compliance—What's good about a necessary evil?

By Jeff Sinaiko

Medical practice executives often view compliance with Medicare/Medicaid and other government health programs as a necessary evil. They see it as resource-intensive, laden with onerous requirements for physicians and staff, and ultimately costly for the group.

In short, many managers believe compliance represents a net-negative to a medical group's bottom line.

However, while the above perceptions may hold true, a practice can improve compliance, operations and its financial performance all at the same time. The basic drivers of effective compliance are often the same fundamental business principles that lead to outstanding operations and enhanced financial performance. The lesson for medical group managers: If you improve compliance, you should improve your bottom line.

Help ensure prompt payment

Certainly, medical record documentation is a critical component of compliance when it comes to coding accurately. However, the routine billing process also requires thorough documentation.

Additionally, obtaining patients' current demographic and insurance information is the foundation of effective accounts receivable (A/R) management and collection performance improvement. Thus, focusing on accurate, timely data collection from patients and conscientious medical record documentation by physicians can directly affect a group's ability to more often in hospital-owned medical groups or other employed-physician models. Improving coding accuracy presents a significant opportunity to improve revenue and compliance simultaneously.

The keys to improving coding accuracy are auditing, intensive physician education, monitoring performance and the use of certified coders. Efficiency dictates that physicians must take responsibility for coding their own office visits and most services other than surgeries and procedures, which typically are best handled by certified coders working from abstracts of operation reports.

A practice that achieves physician responsibility, accountability and thorough training will find — in addition to more compliant coding — more revenue from fewer under-coded services. Most groups find it effective (and most compliance plans dictate) to use outside experts for an annual audit and for physician education. These audits often occur under attorney-client privilege to protect the results, even when done on a prospective basis, which is also recommended.

Enhance proper management reporting

Reporting quality data consistently has long been a deficiency in the medical group industry. Smaller practices often struggle due to lack of resources, information technology or expertise, while larger groups — particularly hospital-owned practices — have struggled by making the process too complex. As perhaps the most fundamental building block for improved operating performance and compliance, this is a critical area.

In addition to the obvious — profit and loss statements, revenue and A/R reports — standard monthly reporting packages should include services volume by current procedural terminology (CPT) code, for example. This can either be reported for the entire group or by physician, which may be particularly helpful if previous compliance work has identified certain outlier physicians.

Coding patterns outside the norm can be further analyzed to determine valid clinical reasons for the differences or to spot inaccuracies. Such comparative data — encompassing both other group members and the broader Medicare provider population by specialty — are the figures physicians respect most.

Other valuable management reports can serve the dual compliance/profitability role. Look at average fees billed per CPT code to learn if physicians are billing different fees for the same codes within the group. Examine laboratory/radiology codes billed by physicians to identify discrepancies in the use of those services.

Provide appropriate staff training

In a business built on thousands of transactions, the collection of huge amounts of data and endless rules and regulations, strict adherence to established policies and procedures is the only way profitable groups achieve consistent performance and accuracy. These groups rely on employees who are trained, tested, monitored and retrained.

Eliminate exceptions and per-physician variances in procedures to the greatest extent possible. Variations seem to occur most often in academic faculty practices. Performance that strictly adheres to established procedures improves efficiency, reduces required staffing, improves collections, increases charge capture and forms the fundamental key to compliance.

Identify and capture lost charges

If all providers could bill and collect for all the services they provide, payors would be overwhelmed. The volume of uncaptured, unbilled services across the delivery system is simply that great. Clearly, the provider industry cannot afford to leave so much potential revenue on the table — all of which, when captured, would go directly to the bottom line.

A recent audit of one department out of 17 in a major academic faculty practice plan indicated that $750,000 in annual charges were unbilled because the practice never submitted the services on encounter forms. This is not uncommon. Unless carefully monitored, the volume of paperwork and the variability in physician diligence lend themselves to such slippage. In some organizations this slippage can represent huge dollars. If the organization has not established

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specific stopgap procedures, it is a virtual certainty that some work is going unbilled.

Inpatient professional fees represent the most common problem area: The physicians are left virtually on their own to record and submit their charges.

Some groups may monitor this process using technology, but the most effective means of testing, identifying and remedying this potential risk area is a simple, manual reconciliation process. Initially, billing staff should audit one month's daily patient schedules against the number of charges entered and billed for that time period. Once the practice has identified the size of the problem, it can initiate projects to clean up any backlog of unbilled charges.

More importantly, however, this type of reconciliation should be a part of any group's daily procedure. The results prove that solutions do not always have to be fancy, high-tech or complicated and show that simply tightening operations can yield positive results.

Create and maintain updated fee schedules

One of the less-publicized compliance risks, especially for larger or academic groups that have decentralized charge entry, is the billing of different fees for the same code under the same provider number. Experience indicates it is not uncommon for individual physicians to have their charge-entry staff override the standard fees to bill different rates for their own practices. Unfortunately, this can lead to significant compliance risks and potential lost revenue.

Higher fees are not always to blame. One office in a large, decentralized medical group billed drastically reduced fees relative to the rest of the practice because its physicians believed the fees too high. Not only does this create a compliance risk — Medicare would not always be billed the group's best price — but for some high-volume office visits, these fees were even below the payors' allowable rates, losing revenue for the practice every time the codes were billed.

These reporting recommendations can help identify these problems. Additionally, review your fee schedules annually to ensure that you have all appropriate codes in the system, delete outdated codes and check to see that fees reflect appropriate pricing for your organization relative to competitors. With the recent increase in fee-for-service business, charge levels can directly affect group revenue and collections.

Establish and periodically review policies and procedures

Inherent in any effective compliance program and sound business operation is the clear delineation of policy and procedure. Your organization must establish written protocols describing the current approach to operations.

Include physicians in the process — they must support what they and their staff are asked to do. Documented procedures become the basis for physician and employee training, management decisions, staffing levels and compliance auditing/monitoring activities.

Compliance with government health plan mandates is not an option for physicians and medical group managers. You simply have to do it. Your choice, however, is to view it as a necessary evil or as a tool to improve the overall performance of the organization.

The difference between top-performing medical groups and most others is the level of discipline and accuracy reflected in their day-to-day operations. Accuracy — in coding, charge capture, documentation, fee schedules or adherence to established policies and procedures — does not discriminate.

(Reprinted from MGMA Connexion, Vol. 2, Issue 6, July, 2002. Jeff Sinaico is an MGMA member and senior vice president, HPEN, Inc., Los Angeles, CA).

Coming attractions

October 27-30, 2002 — **Medical Group Management Association 2002 Annual Conference**
Las Vegas, Nevada

November 8-9, 2002 — **Administrators in Academic Psychiatry/American Association of Chairs of Departments of Psychiatry Joint Fall Meeting**
San Francisco, California

Behavioral healthcare occupancy is the highest in more than five years, NAPHS annual survey finds

Access to psychiatric and addiction services may be a growing challenge, data suggests

Access to behavioral health services may be a growing challenge in many communities as psychiatric hospital occupancy rates reach the highest levels in more than five years, according to annual survey data released by the National Association of Psychiatric Health Systems (NAPHS). The trend is true for all types of programs (including child, adolescent, adult, older adult, and drug/alcohol programs), according to The NAPHS 2001 Annual Survey Report — Trends in Behavioral Healthcare Systems.

"Behavioral health caregivers are working harder with limited resources," said NAPHS Executive Director Mark Covall in releasing the report. "Higher occupancy is occurring at a time when closings and consolidations have reduced the number of hospitals available nationwide. With fewer beds available, the need for services growing, and lengths of stay short but relatively constant, it is important to ensure that there are adequate resources to meet the growing demand and the increasing costs of delivering care," he said.

Hospital occupancy increased significantly between 1999 and 2000, growing 11% (from 62.3% in 1999 to 69.2% in 2000). Over the last five years, occupancy rates have increased 24.4% (from an average 55.6% in 1996). Occupancy rates are calculated by taking the average daily census for the year and dividing it by the number of set up and staffed beds.

Key Annual Survey Findings - Within the hospital setting, lengths of stay remain very brief. Average hospital lengths of stay for all age groups was 10 days in 2000, nearly the same as 1999 when length of stay was 10.2 days. Median lengths of stay remained stable at 9.2 days in 2000 (the same as 1999). Over the past decade (from 1991 to 2000), hospital lengths of stay plummeted 57%, going from 23.1 days in 1991 to the current 10 days. The downward pressure on lengths of stay is part of a dramatic shift in the role of hospitals toward a stabilization model.

Ambulatory services are an important part of the continuum of care provided. Partial hospital programs admitted an average of 487 individuals in 2000, down slightly from the average admissions of 507 in 1999. At the same time, average partial hospital visits per year increased from 7,088 to 7,715 visits in 2000 - a reflection of the severity of illness being treated at this level of care. "However, fewer partial hospital programs now exist as facilities have struggled with administrative costs due to Medicare regulations, fewer payors for partial hospital services, and managed care organizations' pressure to look to lower-cost alternatives," said Mr. Covall.

The growing reliance on outpatient services can be seen in the increase in both outpatient admissions (up from 1,390 in 1999 to 2,425 in 2000) and outpatient visits (up from 20,332 visits in 1999 to 22,755 in 2000). NAPHS members are providing significant care for the Medicaid and Medicare populations. Together, these government programs accounted for 45.5% of all inpatient admissions in 2000.

About the Annual Survey - The National Association of Psychiatric Health Systems' annual survey is the most extensive database on both the clinical and administrative operations of behavioral health organizations. NAPHS also collects data for the Center for Mental Health Services' Survey of Mental Health Organizations, General Hospital Mental Health Services, and Managed Healthcare Organizations.

The NAPHS 2001 Annual Survey Report is based on responses to the association's annual survey questionnaire distributed in the spring of 2001, which were provided by 120 psychiatric facilities owned and operated by NAPHS system members (NOTE: No survey was conducted in 1998; therefore, comparisons track trends from 1995, 1996, 1997, 1999, and 2000).

The National Association of Psychiatric Health Systems (NAPHS) advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, and adults with mental and substance use disorders. Its members are behavioral healthcare provider organizations, including 300 specialty hospitals, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, partial hospital services, behavioral group practices, and other providers of care. The association was founded in 1933.

(The NAPHS 2001 Annual Survey Report - Trends in Behavioral Healthcare Systems is designed for use by financial analysts, healthcare planners, consultants, hospital executives, and others needing detailed information about specialty psychiatric organizations. The report is $400 prepaid from the National Association of Psychiatric Health Systems, 325 Seventh Street, NW, Suite 625, Washington DC 20004-2802. Call (202) 393-6700, extension 15, for ordering information).

How HIPAA affects the use and disclosure of health information for research

The provisions on uses and disclosures of health information for research under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy Rule have been the subject of an extraordinary amount of controversy. Privacy advocates have argued strenuously that disclosures for these purposes are fraught with risk to the privacy of identifiable health information. At the same time, many academic medical institutions, pharmaceutical and device manufacturers, and other research sponsors have lobbied for changes to the HIPAA research provisions, arguing that they pose significant obstacles to conducting research to the detriment of society and its interests. As discussed below, these lobbying efforts have resulted in modifications being proposed to the Privacy Rule which may make it easier for providers to use and disclose PHI to sponsors and others that seek to use the information for research purposes.

I. The Current HIPAA Research Provisions under the Clinton Administration's Final Rules

A. Uses and Disclosures for Research Purposes Without Individual Authorization

Under the current rules, a covered entity may use or disclose PHI for research purposes without individual authorization, under certain circumstances. This is permitted where the covered entity receives documentation that a waiver, in whole or part, of the individual authorization requirement has been approved by an Institutional Review Board ("IRB") or an equivalent body, composed of specified individuals, called a Privacy Board. Without such documentation, the HIPAA Privacy Rule requires a covered entity to obtain individual authorization to use and disclose protected health information ("PHI") for research purposes.

In drafting these provisions, the Clinton Administration borrowed from many requirements found in other federal regulations, particularly the Common Rule. The provisions of the Common Rule establish protection for human subjects in research conducted or funded by the federal government. The Common Rule generally requires informed consent before research can be conducted on human subjects, but it permits a waiver of informed consent, if an IRB finds that certain criteria are met, including that the research involves no more than a minimal risk to human subjects. Many of the criteria for waiver of informed consent under the Common Rule are incorporated into the HIPAA provisions for use and disclosure of PHI for research purposes without individual authorization.

In order for an IRB or privacy board to approve a waiver or alteration of individual authorization, under the Clinton Administration's Final Rule, an IRB has to find that the research protocol meets the following criteria that are aimed at protecting the privacy of health information:

- The use or disclosure of PHI involves no more than minimal risk to the subjects,
- The waiver or alteration will not adversely affect the privacy rights and welfare of the subjects;
- The research could not practicably be conducted without the alteration or waiver;
- The research could not practicably be conducted without access to and use of the PHI;
- The privacy risks to individuals are reasonable in relation to anticipated benefits, if any, to individuals and the importance of the knowledge that may be reasonably expected from the research;
- There is an adequate plan to protect the identifiers from improper use and disclosure;
- There is an adequate plan to destroy the identifiers at the earliest opportunity consistent with the conduct of the research, unless there is a health or research justification for retaining the identifiers, or such retention is otherwise required by law; and;
- There are adequate written assurances that the PHI will not be reused or disclosed to any person or entity, except as required by law for authorized oversight of the research or for other research purposes that would be permitted by the Privacy Rule.

The documentation approving the waiver or alteration of authorization must include not only the above criteria, but also a statement identifying the IRB or Privacy Board and the date of its approval. It must also contain a brief description of the PHI to be used and a statement that the waiver or alteration was reviewed and approved under the normal or expedited review procedures permitted under the Privacy Rule.

The Privacy Rule also permits a covered entity to use and disclose PHI without individual authorization prior to research being conducted to prepare a research protocol or assess the feasibility of conducting study, if the covered entity obtains certain assurances from the researcher. The assurances must include documentation that (1) the disclosure of PHI is solely for the purpose of preparing a research protocol or to prepare for research; (2) that no PHI will be removed from the premises of the covered entity and (3) that the PHI is necessary to the research. Similarly, a covered entity may use or disclose PHI of decedents for research if the researcher makes certain representations to the covered entity, including that the disclosure is solely for research purposes and the PHI is necessary for the research.

B. Uses and Disclosures for Clinical Research and the Authorization Requirement

Where a covered entity creates PHI for research that involves treatment of an individual, i.e., clinical research, the Privacy Standards under the Clinton Administration's Final Rule requires a

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covered entity to secure individual authorization to use or disclose that information. The drafters of the Privacy Rule believed that PHI created from research involving treatment should be treated with heightened sensitivity.

Authorizations under HIPAA are detailed forms that must contain certain "core" provisions.[1] Under the Final Clinton Administration Rule, authorizations for use or disclosure of PHI in clinical trials must include the provisions required for authorizations requested by a covered entity[2] and provisions in addition to the "core" authorization elements. First, they must include a description of the extent to which some or all of the PHI created for research will be used or disclosed for the purposes of treatment, payment and health care operations. For instance, if the covered entity will seek reimbursement for the routine costs of medical care provided in the clinical trial, it must describe in the authorization what types of information will be given to a payor for this purpose. In addition, if a covered entity obtains or intends to obtain a consent to use or disclose PHI for treatment, payment or health care operations, or has provided a notice of its information practices, the authorization must refer to the consent or notice.

It is important to remember that a research authorization only permits the use and disclosure of PHI created for research. If the covered entity had an existing relationship with a patient and wanted to use or disclose PHI it obtained prior to the research (perhaps for determining eligibility for a trial), it generally would need to obtain a separate authorization from the patient.

In general, covered entities may not condition treatment on an individual signing an authorization to use and disclose PHI. However, an exception is made in the clinical research context. Here, covered providers are permitted to condition treatment provided *as part of a clinical trial* on the patient's authorization to use or disclose PHI for research associated with the trial.

C. The Importance of De-Identification

When considering uses and disclosures of health information for research purposes, it is important to remember that the Privacy Rule does not restrict the use or disclosure of information that has been de-identified. However, disclosure of a code or other means of re-identifying information is considered the same as disclosing identified information which is subject to the Rule. Also, if information is re-identified, a covered entity may use or disclose the information only as permitted or required by the Rule.

There are two ways to create de-identified information under the Clinton Administration's Final Privacy Rule. First, one may qualify for the Rule's safe harbor by removing a comprehensive list of identifiers about the individual or the individual's relatives, employers or household members. Second, information is considered de-identified even if all of the identifiers required to meet the safe harbor are not removed, if a person with appropriate statistical and scientific knowledge determines that the risk of identification is very small.

II. The Notice of Proposed Rulemaking

On March 27, 2002, the Department of Health and Human Services ("HHS") released proposed modifications to the Privacy Rule in a Notice of Proposed Rulemaking ("NPRM"). The NPRM would alter the requirements of the Privacy Rule related to the IRB/Privacy Board criteria used to waive the authorization requirement, research authorizations, transition provisions and de-identification. HHS is expected to finalize the proposed rule changes soon.

First, the NPRM attempts to respond to concern that the waiver criteria are overly complex and, in some cases, contrary to the criteria for waiver of informed consent set forth under the "Common Rule". Deeming it duplicative of other criteria, the NPRM would delete the requirement that the IRB or Privacy Board base a waiver on a determination that the privacy risks to individuals whose PHI is to be used or disclosed are reasonable in relation to the anticipated benefits and the importance of the knowledge that may reasonably be expected to result from the research. In addition, under the NPRM, an IRB or Privacy Board would not be required to determine that the waiver will not adversely affect the privacy rights and welfare of the research participants.

The NPRM also would fold three former stand-alone criteria into the "minimal risk" criterion. Thus, when assessing minimal risk, an IRB or Privacy Board would have to consider the following factors : (1) plans to protect identifiers from improper use and disclosure; (2) plans to destroy identifiers at the earliest opportunity; and (3) adequacy of written assurances against redisclosure. An IRB or Privacy Board would not be limited to considering only these factors, however.

Second, the NPRM would eliminate the requirement that authorizations for research contain provisions in addition to those set forth for all authorizations. Instead, authorizations for research would be subject to the single set of "core" requirements that are generally applicable to all types of authorization. Additionally, the NPRM would streamline authorization-related paperwork by permitting Covered Entities to combine authorizations for research with the informed consent to participate in research.

Addressing some of the unintended consequences of the Privacy Rule's requirement that all authorizations include an expiration date or expiration event, the NPRM would clarify the types of statements that will suffice in the research context. Where an authorization is for research, the NPRM specifies that the statement "end of the research study" is an adequate description of an expiration event. The comments to the NPRM clarify that such a statement encompasses time after the conclusion

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of the research when PHI may be used to meet record retention requirements. Additionally, the NPRM provides that where a use or disclosure is sought solely for the creation or maintenance of a research database or repository, the statement "none" suffices as an expiration date. This provision is strictly limited to research databases and repositories, which are frequently retained indefinitely.

Third, under the NPRM, HHS clarifies the situation surrounding research transition periods. Under the Privacy Rule, for clinical research, legal permission to use or disclose PHI for research obtained prior to the compliance deadline continues to be valid past the compliance deadline for the duration of a trial, even though the permission does not satisfy the requirements of HIPAA. However, in this context, legal permission obtained before the compliance deadline would only be valid for PHI obtained prior to the compliance deadline.

Under the NPRM, for *all* research studies that have, prior to the Privacy Rule's April 14, 2003 compliance date, obtained informed consent, IRB waiver or other legal permission, such legal permission will allow the covered entity to continue to use and disclose PHI for research purposes, until the completion of the research project, even if the permission does not conform to the requirements of the Privacy Rule. The NPRM also would make clear that the transition period is available without regard to whether the research actually begins before the compliance date. The only requirement would be that the legal permission be obtained prior to the compliance date.

Fourth, the NPRM attempts to respond to many organizations, such as the American Academy of Medical Colleges, that claimed that the safe harbor provisions on de-identification were too difficult to satisfy and required the removal of so many identifiers that information was rendered useless. Although HHS chose not to propose changes to the de-identification requirements of the Privacy Rule (primarily because of concerns about the increasing capabilities and sophistication of electronic data matching used to link data elements from various sources), HHS solicits comments in the NPRM on the propriety of establishing a limited data set that would still qualify as de-identified information. The solicitation of comments indicates an interest in considering proposals that do not include directly identifiable information, but would include certain identifiers (such as admission, discharge and service dates, date of death, age and five-digit zip code). It also is seeking comments on whether to include one or more geographic units smaller than a State, such as city and/or county, in addition to, or in lieu of, five-digit zip codes. Finally, HHS would like input on its recommendation that disclosure of the limited data set be conditioned upon a covered entity obtaining a data use or similar agreement, in which the recipient would agree to limit its use of the data to the original reasons supporting the disclosure and not to attempt to re-identify the information or use it to contact the subjects of the information.

Fifth, the NPRM responds to concerns that, because the Privacy Rule does not permit PHI to be removed from the premises of a covered entity during reviews preparatory to research, researchers would be unable to recruit research subjects. The NPRM clarifies that the Privacy Rule's provisions for IRB or Privacy Board waiver of authorization are intended to encompass a partial waiver of authorization to obtain information necessary to recruit potential research participants.

III. Conclusion

The rules on the use and disclosure of PHI for research purposes outlined above are some of the most complex and controversial provisions under HIPAA. The NPRM holds promise to reduce the burden to providers associated with these provisions and it is predicted that they will be accepted by HHS.

Notes

[1] An authorization must contain the following provisions:

- A specific description of the PHI to be used or disclosed;
- The name of the entity or persons authorized to make the requested use or disclose;
- The name of the persons or entities to whom the covered entity may make the requested use or disclosure;
- An expiration date;
- A signature (which may be an electronic signature) and date;
- If the authorization is signed by a legal representative of the individual, a description of the representatives authority;
- A statement that the individual has a right to revoke the authorization to the extent that the information has not been released; and
- A statement in which the individual acknowledges that information disclosed to an entity other than a covered entity may not be protected by federal law.

[2] An authorization requested by a covered entity for its own purposes must contain the following provisions:

- A description of the purpose of the use or disclosure;
- A statement that an individual may inspect or copy the PHI to be used or disclosed in accordance with the Privacy Rule's provisions on right of access;
- A statement that the individual may refuse to sign the authorization;
- If applicable, a statement that the covered entity will receive remuneration from a third party for the use or disclosure of the PHI; and
- Unless otherwise permitted, a statement that the covered entity may not condition treatment on the individual signing the authorization.

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Mental Health Bloopers

- The patient has been depressed ever since she began seeing me in 1983.
- The patient is tearful and crying constantly. She also appears to be depressed.
- A concerned family member called the chemical dependency unit requesting information about admitting her husband. "I don't know what to do. Every day he drinks himself into Bolivia."
- I keep reassuring her that her memory will improve, but again today she forgot to pay her bill.
- The patient had waffles for breakfast and anorexia for lunch.
- She states she's been wondering whether or not the Prozac is helping her depression. I'm going to try cutting her in half and see if that makes any difference.
- The patient's depression seems to be under good control since his wife died.

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Publication deadlines are on the 5th of February, May, August and November. News items and articles are welcome and should be sent to:

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