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Summer 2005

The GrAAPvine

Inside this issue

20th Administrators in Academic Psychiatry

From the president's desk

by Pat Sanders Romano

As I sit at my desk, on a beautiful day in May, penning my third attempt at writing this column, I grapple with how humble I feel as the new president of the Administrators in Academic Psychiatry. This feeling was reinforced by the fabric and content of the 2005 Spring Conference, and especially by the example of my wonderful colleagues.

I was reminded of the dedication to learning of my fellow AAP members when 52 of you rose very early on a Saturday morning to hear **Dr. Scott Wetzler** of Albert Einstein College of Medicine present the annual Newel Lecture. Scott intrigued the group with his discussion of "Academic Psychiatry and Managed Care." **Kathy Jordan-Sedgeman**, **RN**, from the University of Michigan, followed with a presentation of their experience with an innovative home care program for psychiatric patients. The morning was concluded with a lively "Take Two Minutes" segment, moderated by **Brenda Paulsen** (U Arizona). The depth and breadth of knowledge of the attendees was amazing, but what was even more impressive to me was the kindness in sharing of ideas and information.

I was so thrilled to be part of an organization that has such generous and enlightening people as **Radmila Bogdanich** (Southern Illinois U) and **Joe Thomas** (U Michigan), who presented their experiences with "Implementing and Measuring Quality in Outpatient Psychiatry" and the "Development of the Depression Center," respectively. Our day ended with a presentation by **Dr. Brian Bronson** of the NY Veterans Administration on "Mental Health Needs in Unsuspecting Places." The perseverance of the AAPs was evident -- despite a long day, we all stayed through the end, and asked insightful questions of all of the speakers.

Lunch provided a spotlight for the promising talents of a number of our new members who were recognized as "Rising Stars": **Tony Bibbo** (U Maryland**)**, **Wendy Carlten** (Oregon Health Sciences U), **Jeff Charlson** (U Wisconsin), **Doris Chimera** (U Texas Medical Branch**)**, **Jim Rodenbiker** (Creighton U)**, Karen Roe** (New York VAMC) and **Hank Williams** (U Washington)**.** I was reminded of the ongoing contribution to AAP by **David Peterson, FACMPE** (Medical College of Wisconsin), who received the Board of Director's Award. I was thrilled to

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President's message

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give the President's Award to **Janet Moore** (Michigan State U), who has been my idol and role model, and who epitomizes the commitment and enthusiasm of the leadership of AAP. I have difficulty envisioning AAP without **Lee Fleisher** (Vanderbilt U), who, in recognition of his retirement was acknowledged with a Resolution citing his long list of contributions to the organization.

The Spring conference was the time for transition of the Board of Directors. The former Directors, **Dan Hogge** (U Utah**), Brenda Paulsen, Jackie Rux** (Medical College of Wisconsin), and **John DiGangi** (U Massachusetts) who have been Board members since I joined, have been so gracious in their mentoring, and have worked so hard and so creatively to make AAP successful. They have given us a legacy of a sound budget, a dynamic Strategic Plan, a vital membership base and meaningful Bylaws. The members who are remaining in their positions: **Elaine McIntosh** (U Nebraska) and **Steve Blanchard** (U Iowa); as well as our Newsletter Editor, **Jan Price** (U Michigan), have been partners and "cheerleaders" and have the ability to finish my sentences. **Jim Landry** (Tulane U), who is remaining on the Board, and who has been elected President Elect, has for the past year been my right hand, my sounding board, my therapist and my very good friend. I am in awe of **Kevin Johnston** (Indiana U), Immediate Past President, who leaves very large shoes to fill.

The conference was also a time to elect a new Board. **Janice McAdam** (Kansas U) has been elected Treasurer and jumped in, in advance, and worked with Brenda to ensure a smooth transition of the finances. The new Members-At-Large have already accepted their assignments and are eagerly beginning their orientation. **Paul McArthur** (U Rochester) will be the chair and liaison for Strategic Collaboration and Governance, **JoAnne Menard** (U Washington) will work with the Membership Director to maintain and grow our membership, **Debbie Pearlman** (Yale U) will head the new Board function of Benchmarking and will be organizing a new task group, and **Marti Sale** (U Kentucky) will be assisting Jim with Education. I am thrilled to be working with such a talented group.

Finally, our Birthday celebration and the presence of the Past Presidents -- **Doris Haley** (Washington U – retired), **Sandie Wigley** (U Tennessee)**, Lee Fleisher, John O'Laughlen** (U Washington)**, Joe Thomas, Janet Moore, Alex Jordan** (U Washington)**, Warren Teeter** (Wake Forest U), and **Dan Hogge** inspired me for my own presidency.

To put it briefly, the Spring Conference impressed me with the incredible sense of collegiality, caring and friendship, and a keen sense of fun that this group embodies.

I am blessed and honored to assume the presidency of AAP, and I am hopeful that over the next year I will be able to continue the energy of my predecessors, that I will be able to provide oversight of a talented new Board, and that I will be able to guide AAP into the future.

This is the time of year when I get to thank everyone who has helped get this newsletter to press. Without the assistance and good nature of everyone who volunteers, this job would certainly not be as easy or as much fun as it is. I continue to marvel at how lucky I am to have such wonderful friends and colleagues that all I have to do is send out an email plea and so many people step up to offer their writing skills. So thank you to everyone who over the course of this past year has written an article for *The GrAAPvine*. **You're the greatest!**

Jan

Radmila Bogdanich
Lee Fleisher
Patrice Guild
Dan Hogge
Christine Johnston
Kevin Johnston, CMPE
Janice McAdam
Paul McArthur
Elaine McIntosh
Christina Nesbeda
David Peterson, FACMPE
James Rodenbiker
Pat Sanders Romano
Jackie Rux

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:

Diana Daimwood
Mt. Sinai School of Medicine
(212) 659-8854
diana.daimwood@mssm.edu

Judith Hyer
Texas A&M University
(254) 724-0114
jhyer@swmail.sw.org

Ronald Menaker, FACMPE
Mayo Clinic
(507) 538-7340
menaker.ronald@mayo.edu

Tina Moskow
University of Arkansas
(501) 686-5405
thmoskow@uams.edu

Sunita Prabhakar
University of Illinois at Chicago
(312) 413-3783
sprabhakar@psych.uic.edu

Magda Rodriguez-Vega
University of Puerto Rico
(787) 758-2525 x1926
marodriguez@rcm.upr.edu

AAP wishes the best of luck to the following AAP members:

Bob Davies (U Michigan) as he begins a new position with the Department of Psychology

Nish Patel (Mayo Clinic) in his new position in the Transplant Department.

What has the listserv done for you lately?

One of the most valuable benefits AAP provides it's members is the ability to network whenever we need it. Our listserv is the means by which we can "speak" to our colleagues and ask about *THE IMPORTANT ISSUES*!

You've seen lots of activity on the list recently about such diverse topics as Consultation-Liaison monetary support from hospitals, patient searches for contraband, psychiatry administration residency courses, and psychotherapy notes.

Just ask those of us who use the listserv how valuable it is to get information from colleagues to help us work out problems within our departments. For those of you who don't use this resource, think about it the next time you need some new ideas.

You are automatically enrolled in the listserv when you become a member. (If you are not receiving messages, please contact our electronic systems administrator, **Rich Erwin**, at Erwinrw@Health.missouri.edu).

To send a message to the group, send it to aap@adminpsych.org. And, if you receive a message, please consider how smart you are and how much knowledge you have to share! Respond to the questions and give all of us the benefit of your experience. When you respond, remember to click on *Reply All* so that the message is distributed back to the listserv and not just to the sender.

If you use the list, you'll be helping all of us - and I bet you'll learn something too!

Awards, accolades and appreciation

This inaugural year of the member recognition awards saw several worthy recipients acknowledged for their contributions to AAP.

The ***President's Award***, for significant contribution and demonstrated long term commitment to AAP, was given to **Janet Moore** (Michigan State U). Janet served several years on the Board of Directors, including in the presidential rotation. Additionally, Janet was on the original Strategic Planning Committee, chaired the committee to rewrite the organization's By-Laws, and has written several *GrAAPvine* articles. Janet was also the AAP photographer for several years, archiving our activities.

The ***Board of Directors Award,*** for significant contribution during the previous year to the ongoing activities of the organization, was presented to **David Peterson, FACMPE** (Medical College of Wisconsin) for his continued contributions to *The GrAAPvine* in the form of his column, The College Corner.

Finally, the ***Rising Star Award*** is given to all new members (within the first three years of membership) who have participated in a significant way in AAP activities. This could include speaking at a conference, writing an article for *The GrAAPvine*, serving on a committee or any other activity recognized by the Board as contributing to AAP. Recipients this year included **Tony Bibbo** (U Maryland), **Wendy Carlten** (Oregon Health Sciences U), **Jeff Charlton** (U Wisconsin), **Doris Chimera** (U Texas Medical Branch), **Jim Rodenbiker** (Creighton U), **Karen Roe** (NY VAMC), and **Hank Williams** (U Washington).

A special resolution honoring **Lee Fleisher** (Vanderbilt U) was also presented at the business meeting. Lee, who will be retiring in June, has made major contributions to AAP during his membership, serving in the presidential rotation, as a member of the Strategic Planning Committee, presenting at a number of conferences and writing several *GrAAPvine* articles.

Congratulations to all the awardees.

Pat Sanders Romano and Janet Moore

Tony Bibbo, Karen Roe, Wendy Carlten, Hank Williams, Jeff Charlton (missing: Doris Chimera and Jim Rodenbiker)

Dave Peterson and Jan Price

Lee Fleisher and John DiGangi

Fall 2005 educational conference – New Orleans

The Spring conference is barely a memory, but plans are already underway for the Fall 2005 AAP Educational Conference to be held in New Orleans on November 4-5. As is our custom, we will gather the evening of November 4 for a casual dinner and then on Saturday November 5, we will have our educational conference during the day, followed by a networking dinner that evening.

The conference will be held at the Chateau Sonesta Hotel, located in the French Quarter. Room reservations can be made on line at www.chateausonesta.com . The group number for reservations is 665320. Room rates are $159 per night (plus tax) for a standard room, or $189 per night (plus tax) for a premium room. Both the standard and premium rooms are very nice, however, the premium rooms are slightly larger. A credit card is needed to hold the room, but will not be charged until your stay, There is a 72 hour cancellation policy.

The Chateau Sonesta has extended the conference rate from November 1 – 8, so if you would like to extend your stay in New Orleans, here is a great opportunity. I urge everyone to book early. If you encounter problems with your reservations, please contact Jim Landry at 504-988-1975 or jlandry1@tulane.edu for assistance.

Anyone interested in presenting at the fall conference should contact Jim Landry or Pat Romano.

Remember, our conferences are a great venue to meet your presentation requirements for ACMPE certification!

Looking forward to seeing everyone in New Orleans!

Meet the 2005-2006 AAP board of directors

The 2005-2006 AAP Board of Directors was approved at the Spring Conference business meeting in New York. The members of the Board welcome your comments and questions as well as your participation, so please feel free to contact any of them. Their email addresses and phone numbers are printed on the back page of *The GrAAPvine*.

President	Pat Sanders Romano	Albert Einstein College of Medicine
President Elect	Jim Landry	Tulane University
Immediate Past President	Kevin Johnston	Indiana University
Secretary	Elaine McIntosh	University of Nebraska
Treasurer	Janice McAdam	Kansas University
Membership Director	Steve Blanchard	University of Iowa
Member-at-Large		
Strategic Collaborations	Paul McArthur	University of Rochester
Member-at-Large		
Membership	Joanne Menard	University of Washington
Member-at-Large		
Benchmarking	Debbie Pearlman	Yale University
Member-at-Large		
Education	Marti Sale	University of Kentucky

A hAAPy birthday photo album

Past President Doris Haley and husband, Claude

hAAPy Birthday, AAPs

Past President Sandie Wigley

Christine Johnston (Hear no evil), Elaine McIntosh (See no evil) and Joanne Menard (Speak no evil)

AAP's 20th and Janice McAdam's 50th! Happy Birthday, Janice!

Monday night hosts, Jim and Pat Sanders Romano

Past Presidents: (l to r) Alex Jordan, Warren Teeter, Pat Sanders Romano, Joe Thomas, Janet Moore, Lee Fleisher, Dan Hogge, Kevin Johnston

First time attendees: Karen Roe, Pamela King, Judith Hyer, Sunita Prabhakar, Patricia Birkmeyer, Renee Morrow

Preparing the birthday goodies

Conference Highlights

Springtime in New York. The AAP Spring Educational Conference was held on April 15, 2005 in exciting Manhattan. Pat Sanders Romano and her committee put together a wonderful program in a spectacular city. Attendees were provided a well-rounded educational program themed Leadership for Innovation as well as many opportunities to socialize with old friends and new. Because New York is Pat's hometown, she provided a special perspective on the city she is so proud of. From a city guide Pat prepared herself to a tour of Manhattan by foot, train and ferry, several members got a feel for New York many conference visitors don't have an opportunity to get.

Fifty-two members attended the Saturday program, and because it was also AAP's 20th birthday celebration, they all received a bag of birthday goodies to celebrate! Pat planned a lovely birthday party, complete with cake, champagne and chocolate covered strawberries for the occasion. We were also graced by the presence of two past presidents, Sandie Wigley and Doris Haley, who joined us in New York for the festivities.

The William J. Newel Lecture

Academic psychiatry and managed care: An innovative approach

by Janice McAdam, MPA

Scott Wetzler, Ph.D., Professor and Vice Chairman for Managed Behavioral Care in the Department of Psychiatry and Behavioral Sciences at Montefiore Medical Center and Albert Einstein College of Medicine and Chief Operations Officer of University Behavioral Associates (UBA) referred to this lecture as "everything you need to know that they don't teach you in graduate school" or Managed Care 101.

Behavioral managed care is a specialized business aimed at reducing utilization and costs. There is a huge rise of for-profit carve-out companies for behavioral care that are divorced from medical and primary care. Managed care organizations (MCO) achieved substantial reductions in inpatient costs and lengths of stay through aggressive utilization review practices and denials. Loss of inpatient revenue was not offset by revenue from the continuum of care. Managed care has reduced outpatient fees and, by

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micromanaging, has led to lower quality provider networks. "Phantom" networks, which are made up of out of network providers, led to lack of access for consumers despite claims of improved access. These networks led to a huge increase in self-pay arrangements with an outcome of substantial profiteering and high administrative costs.

As the problems increased, the Montefiore department of psychiatry decided the solution was to create their own managed care company. Therefore, UBA, a nonprofit, provider-run behavioral health management services organization was formed in 1995 by the department of psychiatry at Montefiore Medical Center and Albert Einstein College of Medicine.

In order to fulfill the motto, "Bridging Clients, Providers, and Payers," the original goals for UBA were created around the concept of doing managed care business differently than anyone else. Clinicians and consumers would now determine the appropriate treatment believing that high quality care can be the most cost-effective. Coming from an academic approach to psychiatry focused on validated, effective treatments, UBA wanted coordination with medical and primary care. New clinical revenue could be assigned to support academics, which was losing money in government funding but had no lesser need for the funding.

The willingness to live in a cost-constrained environment led to risk contracting different than other managed care companies. Administrators and institutions are

risk averse. Risk contracting means guaranteed revenue but uncertain costs. You know how much you are going to get, you don't know how much it is going to cost to deliver the service. By contracting with insurance companies for all the mental health and substance abuse services provided a defined population at a set global budget you are ascending the premium stream to determine how you are going to spend the money instead of how the money will be spent for you. The higher up the "food chain" (social worker to psychiatrist) you can go the more premium you can secure. Instead of having an insurance company be the intermediary, the provider can benefit financially from quality and efficiency. The clinician is empowered to make care decisions that are aligned with his/her belief and limit the role of health plans regarding referrals, claims payment, and management.

In building UBA, the first realization was that managed care is not rocket science. Whatever they can do, we can do better. Willingness to risk contract was based on actuarial analysis. This analysis is the pattern of utilization of care by patients. Instead of developing care based on total population like insurance companies do, the provider network was defined within a defined geographical region for the full continuum of care. Uncomplicated operational infrastructure was established through a 24-hour toll-free referral line staffed by clinicians. Two key pieces of software were used to automate services: utilization management tracking software used to authorize care and claims payment software with a member eligibility and authorizations component. Clinicians developed utilization and quality management protocols. Member and provider services were defined and put into a package of customer service to sell to companies.

A modest initial investment of only a few thousand dollars was made. The early days were spent convincing hospital administration that UBA was essential for the psychiatry department's continued success. The first contract was 4,000 Medicaid members. Despite some early mistakes, covered membership grew steadily from 4,000 to 100,000 in the first five years.

Today, UBA risk contracting has revenue of $7.2 million per year with agreements with insurance companies such as Aetna, Oxford, HealthFirst (Medicaid in New York), and HealthNet, Empire (BC/BS). Out of the $7.2 million revenue per year about $1.2 million per year are deducted in administrative costs. The total administrative staff is four clinicians and three clerks. The medical loss ratio (MLR) refers to the percentage that is the cost. The MLR is fifty percent or $3.6 million per year to pay for costs to

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provide the service (except the clinician). Departmental providers are given $1.6 million per year in supplement of faculty salaries providing care. The parent hospital receives $500,000 per year. Out of network claims equal $1.5 million per year. Surplus revenue goes to researchers, building, and many items to help the department.

Currently, UBA is made up of a provider network of sixty-four psychiatrists, fifty-six doctoral psychologists, and twenty-eight social workers. Outpatient care utilization is 3% prevalence (in treatment) and 1.5% incidence (begin treatment) with 1,500 new referrals per year and 11,000 visits per year total. Inpatient care has an average length of stay of nine days, 67% for mental health and 33% substances abuse related. A total of 1,900 inpatient days equals 22 days per 1,000 members.

All UBA covered lives are seen by faculty, voluntary faculty, and nonaffiliated clinicians in private practice. As an incentive to entice the doctors to see sicker patients, innovative reimbursement strategies were developed. Some of the strategies included case rates for all treatment in one year up to a maximum of 20 visits; differential payment by discipline, by urgency of referral, by benefit plan, by shared care; average reimbursements of $175 - $225 per visit, and a share in surpluses with the providers.

A treatment paradigm shift has occurred. No longer is there a triangulation between patient, provider, and MCO. Now the patient and provider determine the appropriate level of care. Instead of seeking a "cure," the goals are symptom remission and relapse prevention. The population-based approach is not focused on the individual patient but looking at the entire population of patients in care. Freedom from a fee-based model is realized because the patient is approved for visits for the entire year creating more continuity in care, which can include telephone contacts and intermittent appointments, and other ways of doing business differently. An integrated delivery system links levels of mental health care and creates linkages with primary care.

One provider concern in the UBA model is high expectation about availability and accountability. While allowing for more efficiency in practices, the new model created a change in practice patterns. The providers worried that service utilization would be high but in fact UBA has the expectation that services would be underutilized. Providers wondered what potential ethical dilemmas would exist but UBA finds the same complaints and ethical issues as normal MCO products.

The marketing approach for UBA is that it offers high quality, user-friendly and medicalized behavioral provider network within a competitive global budget. HMOs are interested in locking in profits, reducing administrative headaches, and gaining knowledge in this specialty area. HMOs recognize poor quality and lack of care by behavioral MCOs through complaints from patients and providers. Through enlistment of primary care physician support and documentation of superior performance on NCQA performance standards, UBA has achieved market dominance in its geographic region and refuses to contract with MCOs. The only access to UBA network is through full risks contracts.

The full risks contracts have been successful due to several factors. First, reasonable rates are established based on actuarial analysis and include negotiated increases. Rates are negotiated on the product line being provided, the demographics of the covered population, and the expected growth in membership. Another reason for success is awareness of costs and Incurred but Not Received Payments (IBNR). IBNR is the big unknown. UBA takes a conservative approach in estimating this to maintain an adequate reserve. UBA realizes the importance of keeping the patients in-network to maintain control of costs. Finally, UBA utilizes sophisticated software for tracking patients and authorizations and checking member eligibility.

Risk contracting has had its disappointments too. The parent hospital was unable to negotiate to include UBA in a deal with an HMO company that had 125,000 members. Growth is limited due to challenges in expansion beyond the existing geographic region. The department of psychiatry had difficulty in becoming organized as a provider group that resulted in a few deals for administrative services only.

Moving in a new direction, UBA is working to bring the concept of managed care to "hard-to-engage" populations such as substance abuse and welfare-to-work programs. This has resulted in a Comprehensive Service Model (CSM). New York City Human

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Resources Administration (HRA) is responsible for public assistance as well as Medicaid. HRA is developing programs in welfare reform with a "work first" approach. HRA is dissatisfied with chronic substance abuse treatment that allows people to stay on methadone maintenance for decades, provides no adjunctive treatments, does not focus on work, and creates a culture of dependency.

CSM was created at UBA to help meet the HRA needs. Evaluation and case management services are provided to 1,000 substance abusers on public assistance. The goals are drug abstinence; self-sufficiency through work activity and competitive employment; and disability approvals for those that are eligible. CSM has revenue of $7 million per year from HRA. A reimbursement rate of 80% of the costs of CSM treatments including 15% overhead is realized, earning CSM a 4.5% profit.

The guiding principles of CSM are as follows: 1) Treatment works. 2) Coercive mandated treatment works. 3) Loss of public assistance as a threat. 4) Increase treatment compliance using sanctions, rewards, and supportive linkages. 5) Work helps to maintain abstinence. Work is focused on early. 6) Motivational interviewing as best predictor of compliance. 7) Harm reduction says that clients do not have to be 100% clean to go to work.

Under the guiding principles, CSM provides a number of services, such as mandatory comprehensive evaluation in multiple domains to assess co-morbidities and a determined level of care and employability. With caseloads of 31 clients each, 32 care managers provide care management. The care managers functions are link and referral source, manage care delivery and collaboration with providers, not providing the treatment or being intrusive into the treatment, client tracking regarding compliance and progress, escort and outreach for non-compliant clients, advocacy to reduce barriers to care, motivational enhancement, collateral support, and ally in recovery process.

There are 1,700 referrals per year for substance abuse with Medicaid coverage, which often require more intensity in treatment than methadone maintenance. Each year 800 are referred for medical care and 500 for psychiatric care. The compliance rates are 90% with first appointment and 89% with ongoing care, showing that CSM is successfully engaging the hard to engage.

CSM has taught UBA a few lessons. The first is to think outside the box not only in product development but also in expectations of clients. The second lesson learned is to develop new expertise based on old skills. Successful ways to treat a difficult population were developed by the integration of substance abuse care with medical and psychiatric providers. And finally, CSM was able to contract on a performance basis.

After ten years, UBA provides major support for the psychiatry department's academic and clinical mission. There have been more successes than failures, and UBA has learned from both. In order to enter into contracts, the organizational structure must allow risk-taking and independent legal entities to exist. UBA does wonder why more psychiatry departments do not use a similar strategy.

(Janice McAdam is the administrator of the Kansas University department of psychiatry).

We have some extra shirts!

The selection is dwindling, but if you're interested in a blue denim shirt with our 20th birthday logo, send Jan Price an email at janprice@umich.edu and we'll set you up.

	Size	#available
Womens	Small	3
	Medium	1
	Large	2
Mens	Large	3
	X-Large	2
	2 XL	1

There's no place like home

by Lee Fleisher

This program, describing a collaboration between the Department of Psychiatry at the University of Michigan and the Michigan Visiting Nurses (MVN) program, was presented by **Kathleen Jordan-Sedgeman, RN MS**, a clinical nurse manager within the department of psychiatry.

Data was provided regarding the extent of the significant disease burden represented by psychiatric illness. It was further stated that less than one-third of adults with mental illness receive needed and effective care. Barriers to effective care include fear of hospitalization, stigma, and fragmentation of services. Moreover, prior authorization and utilization review requirements represent significant deterrents to patients receiving necessary care.

It was particularly noted that the brevity of inpatient lengths of stay have made it necessary to

establish rapid stabilization as a primary treatment goal. However, most psychiatric medications take more than four weeks to achieve full effectiveness. Thus, creating systems to promote medication regimen adherence post inpatient discharge is an essential step. While it might be assumed that these concerns are being effectively dealt with through discharge planning, there are many factors which complicate effective discharge planning. These include lack of understanding of the home environment, the unavailability of immediate outpatient follow-up appointments, and the difficulty of providing patient education at a time of crisis.

In 2001, in response to the above, a partnership was formed with MVN to address the needs of patients receiving electroconvulsive therapy. Home care services included assessment of response to treatment, monitoring for possible side effects, and caregiver support. These services led to a reduction of hospital lengths of stay. The program is now being extended to serve the majority of patients in the adult inpatient unit. The goals of this expanded program include reducing inpatient length of stay from 9.8 to 8.8 days, having 80% of patients fill prescriptions within one week of discharge, decreasing readmission rates from 20 to 15%, and maintaining at least a neutral financial impact on both programs.

The presentation made clear that creative solutions are available to persistent and pervasive problems associated with the transition from inpatient to community care.

Lee Fleisher is the administrator of the Vanderbilt University department of psychiatry.

Take two minutes

By Dan Hogge

How and what does your facility do to deal with consultation CPT codes billed as V-codes and reimbursed by third-parties?

To help minimize the impact of the lost revenue many departments have contracted with transplant teams for case rates or negotiated a payment up front before the services are provided. One participant commented that they use an electronic order system that requires specific data fields to be entered including the source of payment as a way to solidify reimbursement.

What is your average fringe benefits percentage?

Marti Sale- 27.9%, Pat Sander Romano 33%, Lee Fleisher 22%-28% (NIH), John DiGangi 27.6% (includes malpractice), Rich Erwin 27.6%, Kevin Johnston 30%-37%, Joe Thomas 24%-40%, Howard Gwon 32%, Margaret Moran 23%, and Janet Moore 20%-50% based on position.

Our department is planning to remodel an inpatient unit. Does anyone have any issues, suggestions, or concerns on this type of remodeling?

Many suggestions were offered including the importance

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of:adequate capital funds for renovation, bed alarms, fire exits, patient safety, and keeping the fire marsha happy.

A general discussion was held regarding the importance of stratifying patients based on the acuity of illness to determine how many locked and or secluded rooms need to be available. Other suggestions included looking at the difference between those who are medically versus psychiatrically ill. A suggestion was made that perhaps a road trip might be useful to visit and see how other patient units are designed.

Research dollars are at a plateau. How are you supporting your infrastructure and or supporting researchers needing manpower and support?

Some departments are operationally adapting to restructure staff to centralize tasks and reduce overhead. Other departments have implemented a clinical trials tax ranging from 2-7% to provide a pool of funds to support research tasks. A centralized front-end research coordinator with a salary range of $40-$50K has been very helpful. Others have centralized just the pre-award functions and kept a more decentralized operation for post-award activity.

How are you dealing with the changing market of clinical trials?

Apparently, many departments are facing declining revenues or are facing operating losses. Comments were made about the difficulties with IRBs, the indirect costs assessments which are felt to be too high, and compliance protocols which are demanding a higher level of office based practices.

Some universities are trying to grapple with the contracting processes by centralizing the front end negotiations to eliminate variances between department contract details.

A trend in clinical trials is the outsourcing of the study work to foreign countries capable of providing the services and results at a much lower cost.

What is your current level of staffing for clinical services?

Staffing ratios varied based on the operation but it was suggested that MGMA does have some broad staffing and practice ratios that are good for benchmarking. There was a general consensus that most department taxes do not cover the actual salary and benefit costs to operate clinics. A few comments were made about staffing ratios close to 10% or higher based on the actual faculty count.

A new nerve stimulator procedure has been approved and general comments were requested as to their use and likelihood as a chargeable procedure.

The procedure is a medical procedure and likely will be billable under the medical benefits of the patient. The likelihood of the implementation within psychiatry will depend on how widespread the treatment modality is for patients. For that reason, there is very little speculation or agreement on how the procedure will play out in the market. A general discussion was held regarding ECT and how this might be a topic of discussion in the fall conference.

Are there groups that have worked with the Studer Group?

A number of individuals indicated they have worked with the Studer Group and have in most cases been quite pleased. The group contracts with an organization for a couple of years and works towards improving the quality, service, and performance of the employees. There was a general consensus that the group is very people oriented.

Who operates a medical/ psychiatry unit?

There were multiple comments about the fact that many institutions are required to discharge the patient from the medical unit and then readmit to the psychiatry unit in order to receive proper reimbursement. Comments were made about the difficulty of mixing the patients and providing the proper training to nurses and staff in order to provide quality care. An overall consensus is that the transition is not quite there and knowing the best practices is difficult.

How do you manage inappropriate admissions to the Emergency Department?

Brief comments were made about the difficulty of managing inappropriate admission of patients to the psychiatry unit from the ED. For the most part the consensus was that the patients are referred back to the Emergency Room until proper screening has taken place and the patient is admitted to the correct discipline.

Dan Hogge is the administrator of the University of Utah department of psychiatry.

Quality outcome assessment program development

by Janet Moore

Radmila Bogdanich (Southern Illinois U) covered an impressive body of material in her conference presentation titled "Developing a Quality Outcome Assessment Program in an Academic Psychiatry Department."

Late in the 1990's, health plans, government agencies, employers, physicians, and consumers recognized the need for an organized approach to clinical outcomes measurement. The Institute of Medicine's report, "Crossing the Quality Chasm: A New Health System for the 21st Century" cited issues such as inadequate healthcare quality, inherent delivery system problems, and the need for pay for performance programs and incentives.

These needs and initiatives prompted a 1996 memo from the psychiatry chair at SIU stating the background and a charge to proceed with the development of a department quality assessment system. In 1997, a Quality Council Charter was developed; in 1998, Continuous Quality Improvement (CQI) was identified as an important aspect of the strategic plan for the practice plan. The initiative spread quickly to school-wide training in late 1998.

Utilizing a three pronged model of Quality Planning, Quality Control/Assurance, and Quality Improvement, the team at SIU moved forward with efforts to improve quality through a systems approach, including inputs, processes, outputs, outcomes, and customer feedback. They identified five essential elements: strong quality leadership; customer-driven quality; continuous improvement; action based on facts, data, and analysis; and employee participation.

In 1999, the group practice developed a patient satisfaction survey, utilized and analyzed regularly. A Clinical Outcomes Committee, chaired by the Medical Director of the Practice Plan audited 175 medical records and utilized the AMA's Accreditation Program for physician group practices as a tool to review the status of medical record documentation. Their findings included a number of charting oversights and errors. These were addressed with a number of committee recommendations implemented at the clinic level.

Also effective were a series of teams formed to prioritize and investigate thirteen initial areas identified as problematic. Work began immediately on the top three: Customer Service, Access, and Development and Training. Among the accomplishments noted was a highly successful Employee Recognition Program, including various types of "Caught in the Act of Excellence" awards for employees nominated by their coworkers.

In 2005, the practice plan joined The Institute for Healthcare Improvement (IHI), and the Breakthrough Series Collaborative to Improve Access and Efficiency in Primary Care (IMPACT). By utilizing the IHI offering of an Outcomes Assessment tool and an IMPACT health outcomes (SF-6) reporting process, the department of psychiatry has been able to report clinical data and compare it with other organizations.

SIU Psychiatry's goal is to assess the health of their patients and the severity of their illness. It is hoped this data will help measure the success of treatment and steer the department in the direction of higher quality patient-centered care.

Janet Moore is the administrator of the Michigan State University department of psychiatry.

Developing the nation's first depression center

by Karen Roe

Joe Thomas (U Michigan) spoke to us about their newly designed, still under construction, Depression Center.

Joe began by telling us how and why the depression center came to be. He discussed why changes were needed at Michigan, their mission and their vision of the future. He stressed that the stigma of depression needs to be reduced and that people need to be educated. Joe went on to discuss the challenges in leading this project, most notably, that people are resistant to change. He discussed how they overcame the obstacles, and how through setting up a program network made up of staff in various areas who had an

interest in the center, they were able to make it happen.

The department worked with network partners to reach new populations. Three examples of populations the Center is trying to reach include those suffering from depression on college campuses, athletes, and in the workplace.

Center planners created subcommittees to look at various operational models in need of redesign. They looked at the resources they would need to grow and sustain the programs. Finally, they looked at how to raise the funds they needed to get this project off the ground. They designed a facility named the "Rachel Upjohn Building" where research and clinical staff could work side by side under one roof. Their task was to bring in $41 million if they were going to get this project approved. With a combination of grants and generous donations, they were ready to break ground. Joe shared with us the design plans and what a beauty it's going to be. After seven years of planning, the Depression Center will be open for business in the Fall of 2006 and we're all invited. Thanks for the invitation, Joe!!

Karen Roe is the administrator of the New York Veterans Administration department of psychiatry.

Mental health care in unsuspecting places: The need for further integration of medical-psychiatric care

by Tony Bibbo

Brian Bronson, MD, Director of Consultation and Liaison Psychiatry at VA New York Harbor Healthcare System, provided a view of future administrative challenges in Psychiatry with a talk entitled, "Mental Health Care in Unsuspecting Places: The Need for Further Integration of Medical-Psychiatric Care." He began by discussing the mind-body dichotomy in the academic health care setting and how that dichotomy begins from day one of medical school - from clinic arrangements (locations, licensing, reimbursement) to providers' perspectives regarding the labeling of "medical patients" versus "psych patients." He maintains that barriers to appropriate integration of mental health care originate in large part from this dichotomy.

Dr. Bronson stated that there is still a division between the biological and psychosocial due to the still-stigmatized image of the field. That division is further exacerbated in the fourth year of medical school where the career choice is made between psychiatry and the "rest of medicine."

Dr. Bronson spent 18 months in Ecuador, where this dichotomy was even more pronounced. The somatization and the presentation of psychiatric illness in primary care became crystallized in his mind due to the fact that patients there rarely went to see psychiatrists. Dr. Bronson used a case example involving an adolescent suffering from depression to illustrate this point. This patient's physical symptoms reflected an underlying emotional distress that was not recognized by the primary care physicians (and not disclosed by the patient due to stigma associated with the distress).

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Dr. Bronson then described his dual fellowship (public psychiatry and consultation-liaison) at Long Island Jewish Health System where he analyzed the mental health care needs in their primary care system. In this system he observed a "health maintenance" model which included only a non-psychiatric social worker. He identified the barriers to effective mental health care in this setting to include:

- psychosocial evaluation is time consuming;
- clinic culture and time demands encourage rapid evaluation;
- training in mental health care is limited; and
- stigma is "endorsed" by primary care providers (reluctance to suggest to patients).

His feeling is that there needs to be mental health collaboration with all levels of clinical providers. The best chance of that collaboration occurs when the mental health consultant (or even better, a mental health team consisting of a psychiatrist, a psychiatric social worker and a psychologist) is present as much as possible in the clinic. According to Dr. Bronson, financial resources tend to be the biggest reason why a mental health team is not part of most clinic settings; however, the medical versus psychiatric mentality also contributes to this situation.

Dr. Bronson acknowledged that his current position allows him access to forward the idea of interdisciplinary collaboration outlined above. He uses this opportunity to educate how the

lack of collaboration often leads to increased length of stay and increased costs to the health care facility. He cited the common condition of confusional states as an example of the need for mental health involvement for the evaluation and treatment of patients and its positive impact on patients' clinical care. Dr. Bronson explained that he is the co-leader of his organization's Interdisciplinary Behavioral Health In Medicine Working Group where he attempts to implement the lessons he has learned. In support of this collaborative approach, he presented the following specific examples: a patient with poor adherence to his diabetic regimen who had refused dialysis; a depressed terminally ill patient who refused life support; a difficult to treat medical patient; a patient with medically unexplained chronic pain; and a homeless veteran with poor continuity of care. In each of these situations, the presence of the mental health team assisted in the overall clinical care of the patient by addressing the many concurrent or causal psychosocial issues.

In summary, Dr. Bronson's concluding thoughts about the need for further integration of medical-psychiatric care were as follows:

- behavioral issues are pervasive throughout general medical health care systems;
- behavioral issues, if not managed properly, can have a critical negative effect on the outcome of health care;
- increasing collaboration between services can improve both provider satisfaction and patient outcomes; and
- the breaking down of the division between mental health and general medical health care (from stigma to the arbitrary mind-brain dichotomy that extends into the training of physicians and influences the way health care services are organized and delivered) is critical to the improvement in the integration of medical-psychiatric care.

Dr. Bronson concluded the presentation by offering advice for administrators in facilitating integrative care:

- engage in advocacy work that encourages integration of services such that patients' biological and psychosocial needs are met;
- encourage interdepartmental cross-training of both permanent staff and trainees;
- foster interdepartmental communication and collaboration between clinicians and department leaders (form interdisciplinary collaborative working groups where possible);
- ensure presence of mental health discipline in medicine clinics as much as possible; and
- work with hospital finance to find ways to justify and fund collaborative clinical services.

Tony Bibbo is the administrator of the University of Maryland - Baltimore department of psychiatry.

Policy on enhancing public access to archived publications resulting from NIH-funded research

Notice: NOT-OD-05-022
National Institutes of Health (NIH)

The NIH Public Access Policy (the "Policy") on enhancing public access to archived publications resulting from NIH-funded research follows:

Beginning May 2, 2005, NIH-funded investigators are requested to submit an electronic version of the author's final manuscript upon acceptance for publication, resulting from research supported, in whole or in part, with direct costs from NIH. The author's final manuscript is defined as the final version accepted for journal publication, and includes all modifications from the publishing peer review process.

This Policy applies to all research grant and career development award mechanisms, cooperative agreements, contracts, Institutional and Individual Ruth L. Kirschstein National Research Service Awards, as well as NIH intramural research studies. The Policy applies to peer-reviewed research publications, resulting from research supported in whole or in part with direct costs from NIH, but it does not apply to book chapters, editorials, reviews, or conference proceedings.

Under this Policy, electronic submission will be made directly to the NIH National Library of Medicine's (NLM) PubMed Central (PMC): http://www.pubmedcentral.nih.gov. PMC is the NIH digital repository of full-text, peer-reviewed biomedical, behavioral, and clinical research journals. It is a publicly-accessible, stable, permanent, and searchable electronic archive.

At the time of submission, the author will specify the timing of the posting of his or her final manuscript for public accessibility through PMC. Posting for public accessibility through PMC is requested and strongly encouraged as soon as possible (and within twelve months of the publisher's official date of final publication).

The publisher may choose to furnish PMC with the publisher's final version, which will supersede the author's final version. Also, if the publisher agrees, public access to the publisher's final version in PMC can occur sooner than the timing originally specified by the author for the author's final version.

Effective with progress reports submitted for Fiscal Year 2006 funding, this Policy provides an alternative means, via PMC, for NIH-supported investigators to fulfill the existing requirement to provide publications as part of progress reports. Though the NIH anticipates that investigators will use this opportunity to submit their manuscripts, sending electronic copies is voluntary and will not be a factor in the review of scientific progress.

By creating an archive of peer-reviewed, NIH-funded research publications, NIH is helping health care providers, educators, and scientists to more readily exchange research results and the public to have greater access to health-related research publications. As the archive grows, the public will be more readily able to access an increasing number of these publications.

Once the system is operational, modifications and enhancements will be made as needed. An NIH Public Access Advisory Working Group will be established to advise NIH/NLM on implementation and assess progress in meeting the goals of the NIH Public Access Policy.

This Policy is intended to improve the internal management of the Federal government, and is not intended to create any right or benefit, substantive or procedural, enforceable at law by a party against the United States, its agencies, its officers, or any person.

Additional details for the public and for submitting authors pertaining to the implementation of this Policy are available at: http://www.nih.gov/about/publicaccess/index.htm.

NIMH withdraws from the senior scientist (K05) career program

Notice: NOT-MH-05-005
National Institute of Mental Health (NIMH)

Effective May 2, 2005, the National Institute of Mental Health (NIMH) will no longer participate in the Senior Scientist Award (K05) program announcement PA-00-021, which was released in the *NIH Guide for Grants and Contracts* on December 2, 1999 <http://grants.nih.gov/grants/guide/pa-files/PA-00-021.html>.

The NIMH will no longer accept new applications, unless they are revisions of applications received before May 2, 2005. Per NIH policy, each applicant can revise a K05 application two times after submission of the original application.

For more information about the different NIMH programs, see our website at (http://www.nimh.nih.gov). Direct inquiries regarding withdrawal of this program to:
Della Hann, Ph.D. Director
Office of Science Policy and Program Planning
National Institute of Mental Health
National Institutes of Health
6001 Executive Boulevard, Rm. 8208, MSC 9667
Bethesda, MD 20892-9669
Email: hannd@nih.gov

Coming attractions

American Medical Group Association
September 12-15, 2005
Chicago, IL
www.amga.org

Medical Group Management Association Educational Conference
October 22-23, 2005 (Academic Practice Assembly Preconference)
October 23-26, 2005
Nashville, TN

Administrators in Academic Psychiatry Spring Conference
November 5, 2005
New Orleans, LA
www.adminpsych.org

Administrators in Academic Psychiatry Spring Educational Conference
May 6, 2006
Chicago, IL

Academic Practice Assembly Educational Conference
May 7-9, 2006
Chicago, IL

The GrAAPvine provides information about educational opportunities of interest to its members. It does not necessarily endorse these programs (except, of course, our own!)

The college corner

Getting started: Board exam preparation

by David Peterson, FACMPE

In the AAP Business Meeting at the Spring conference, some of our colleagues wondered aloud about the time commitment and most effective way to prepare for the Board Certification exams offered by the **American College of Medical Practice Executives (ACMPE)** and I hope, in this column, to offer some suggestions.

To briefly review, the Boards involve a three-part exam process: a 175 question objective exam (approximately 3.25 hours, on-site), a written essay exam (approximately 1.5 hours, on-site) and satisfactory evidence of 2 professional presentations (at least 30 minutes each in length, off-site). The Board exams test the administrator's technical and professional knowledge and skills in eight domains identified in The ACMPE Guide to the Body of Knowledge for Medical Practice Management:

- Financial Management
- Human Resource Management
- Planning and Marketing
- Information Management
- Risk Management
- Governance and Organizational Dynamics
- Business and Clinical Operations
- Professional Responsibility

The exams are offered in various formats ("computerized" or "pencil and paper") in venues around the country. The schedule of exams can be found at the College's website at http://www.mgma.com/acmpe/certrequire.cfm.

There are several ways to prepare for the exams. First, the College offers online and on-site tutorials at different times throughout the year (the latter were just offered in conjunction with the recent Academic Practice Assembly annual conference in New York City). These tutorials provide the administrator insight into the exam process and help the administrator identify strengths and weaknesses in skill sets.

Second, an online "knowledge assessment" takes the exam preparation a step further, and allows the administrator to actually test his/her knowledge against a sample set of objective questions. The questions are scored and feedback is provided to the candidate. The online assessment takes approximately three hours to complete (this can be "interrupted" and does not need to be done all at once). More information about the tutorials, exams and other resources can be found at http://www.mgma.com/acmpe/exams.cfm.

Third, I recommend reviewing the classic book, "Ambulatory Care Management," by Austin Ross, Stephen J. Williams and Eldon L. Schafer. This book offers a comprehensive overview of ambulatory organization and management, and serves as a nice refresher on most, if not all, of the eight domains. It can be purchased through the Medical Group Management Association (www.mgma.com).

Fourth, reviewing the trade literature and honing awareness of current healthcare and general business events in the news helps reinforce the knowledge base.

Fifth and finally, talk to colleagues who have passed the exams. When the question of "who has passed the exams" was posed at the Business Meeting, many AAP hands were raised.

In short, there are several ways to prepare for the exams, and as we heard, some of our colleagues have even sat for them "cold." In any event, passing the Boards is a notable achievement and offers significant, visible validation of the skill sets necessary to succeed as a medical practice executive. If the continuing medical education requirement is also met, Certified Medical Practice Executive (CMPE) status is awarded to the successful candidate.

For more information on joining the ACMPE or the board certification and fellowship process, contact the ACMPE directly at (303) 397-7869 or contact David Peterson, FACMPE at (414) 456-8990, email at peterson@mcw.edu or at the Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wisconsin 53226.

Medicare "place of service" coding

Medicare Part B pays for services provided by physicians to program beneficiaries. These services include medical and surgical procedures and other services such as office visits and medical consultations. Although physicians routinely perform many of these services in a facility setting, including an outpatient hospital department or a freestanding ambulatory surgical center, certain of the same services may also be performed in non-facility settings, such as a physician's office. To account for the increased practice expense incurred by physicians in their offices, Medicare reimburses a higher amount for services performed in this setting.

Physicians are paid for services based on the Medicare physician fee schedule. The Centers for Medicare & Medicaid Services (CMS) established relative value units (RVUs) for physician work, practice expense, and malpractice insurance. Each RVU has a corresponding geographic practice cost index based on the location where the service was performed. To calculate the physician payment, each of the RVUs is multiplied by the appropriate geographic practice cost index. The sum of these products is then multiplied by the nationally uniform conversion factor to determine the payment.

For certain services, Medicare has established two different RVUs for practice expense to compensate physicians for the cost differences that result from performing a service in a facility as opposed to a non-facility setting. Physicians are required to identify the place of service (POS) on the health insurance claim form submitted to Medicare Part B carriers for payment. The correct place of service code ensures that Medicare is not duplicating payment to the physician and the facility for any part of the practice expense incurred to perform a Medicare service.

In order for the physician to receive the higher non-facility practice expense payment, the service must meet the requirements of 42 CFR 414.22(b)(5)(i)(B) as follows:

> . . . The higher non-facility practice expense RVUs apply to services performed in a physician's office, a patient's home, an ASC [ambulatory surgical center] if the physician is performing a procedure not on the ASC approved procedure list, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC performing an ASC approved procedure . . .

While some of the responsibility for overpayment can be placed with the carrier, there are several safeguards which can be implemented at the physician office level. Many physicians do not have controls in place to prevent, or subsequently identify, billings with incorrect place of service codes. Specifically, incorrect place of service coding often occurs for one or more of the following reasons:

- Billing personnel are inadequately trained regarding the correct place of service code for a particular location, may be new to their jobs, or temporarily substituting for more experienced employees.
- Physician's office personnel or billing agents are unaware that incorrect place of service codes could change the Medicare payment amount for a specific service.
- Physician's billing personnel are unsure about the precise definition of a "physician's office", or have not adequately considered whether the assigned "office" place of service code for a particular location is appropriate.
- Undetected flaws in the design or implementation of some billing systems allows the systems to assign incorrect place of service codes to specific physical locations, or to groups of services.
- Default settings for place of service codes within some billing systems are incorrectly set and not manually overridden, or are correctly set and inappropriately overridden, for specific service locations by personnel who do

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not fully understand the default settings.

- Inadvertent data entry errors occur when apparently well-trained billing personnel make isolated mistakes.

The Office of the Inspector General of Health and Human Services is clamping down on these place of service coding errors. It is wise to educate billing staff about this coding regulation and assure that POS codes reflect the actual location of service.

HHS releases proposed rule on HIPAA enforcement

On April 18, the Department of Health and Human Services (HHS) published a notice of proposed rulemaking in the Federal Register that details the basis and procedures for imposing civil penalties on medical practices and other covered entities that violate any of the Health Insurance Portability and Accountability Act (HIPAA) administrative simplification rules. This rule clarifies, for example, the investigation process, bases for liability, determination of the penalty amount, grounds for waiver and the hearing and the appeals process.

To read the proposed rule, see the Federal Register of Monday, April 18, 2005 at http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-7512.pdf.

HPSA bonus payments to psychiatrists

Since July 1, 2005, psychiatrists are eligible to receive Health Professional Shortage Area (HPSA) bonus payments as mandated by the Medicare Prescription Drug Improvement and Modernization Act. The policy was recently recognized in new carrier guidance issued by the Centers for Medicare & Medicaid Services (CMS) clarifying that the HPSA bonus payments are not limited to services determined to be mental health services. The agency stated that HPSA bonus payments are to be made for all professional services provided by psychiatrists within the mental health HPSA.

Contractors that incorrectly recovered any of these payments in overpayment actions have been directed to return the money to psychiatrists.

If the bonuses were not paid initially, CMS has instructed contractors to make payments for all professional services provided by psychiatrists not falling within the designation of mental health services.

To access the list of applicable zip codes, see http://www.cms.hhs.gov/providers/bonuspayment/.

Children's inpatient medicaid funding in jeopardy

Recent audits of psychiatric hospitals by the Health and Human Services Office of the Inspector General have resulted in several states being asked to return millions of dollars to the federal government. At issue, according to Representative Henry Waxman (D-CA), is a misinterpretation of the "IMD exclusion," the exclusion of federal funding for services provided in "institutions for mental diseases." In a letter dated March 8, 2005 to Centers for Medicare and Medicaid Services Administrator Mark McClellan and HHS Acting Inspector General Dan Levinson, Waxman explained "the federal government has refused to pay for such services in order not to displace traditional state responsibility… But in 1972, Congress carved out an exception to the IMD exclusion that permits federal support for children to receive 'inpatient psychiatric hospital services.' This term is defined in regulations to encompass medical treatment provided in accredited institutions."

Waxman, the ranking minority member on the Committee on Government Reform of the US House of Representatives, recently released a study showing that because of a lack of community mental health services, thousands of youth with mental illness are incarcerated in juvenile detention facilities. Some children are held beyond their sentences because they cannot receive adequate services in the community. In 33 states, children are held in detention centers without having charges against them. Waxman believes that by misinterpreting the law, the OIG is only going to make matters worse for disadvantaged youth.

In the letter to the CMS and HHS OIG, Waxman explains how the law was misinterpreted by the agency. "Unfortunately, the Inspector General has misread the law and regulations as permitting support only for 'inpatient psychiatric services' – dropping the word 'hospital.' What has resulted is a bizarre policy under which Medicaid would pay for psychiatric services for children in Medicaid in inpatient facilities, but not for their medical care" (although medical care is traditionally covered by Medicaid).

In his closing, the letter states "The mental health care system for youth is broken, with thousands of children being warehoused in detention centers across the country. Withdrawing millions of dollars in federal funding for children's mental health will increase the pressure on overburdened providers of critical mental health services. As beds close, the numbers of youth needlessly incarcerated to wait for community services will inexorably rise."

Read more about the issue:

To read the entire Waxman letter, go to www.democrats.reform.house.gov/Documents/20050308110415-98765.pdf.

To read the report on mentally ill youth incarceration, go to http://www.democrats.reform.house.gov/Documents/20050124112914-80845.pdf.

To find out more about potential Medicaid changes being considered by the federal government, go to The Bazelon Center for Mental Health Law at http://www.mhreform.org/policy/whithermedicaid.htm.

Rodney Dangerfield - I don't get no respect!

Last week I saw my psychiatrist. I told him, "Doc, I keep thinking I'm a dog." He told me to get off his couch.

I remember I was so depressed I was going to jump out a window on the tenth floor. They sent a psychiatrist up to talk to me. He said, "On your mark..."

My psychiatrist told me I'm going crazy. I told him, "If you don't mind, I'd like a second opinion." He said, "All right. You're ugly too!"

I told my psychiatrist that everyone hates me. He said I was being ridiculous - everyone hasn't met me yet.

Last week I told my psychiatrist, "I keep thinking about suicide." He told me from now on I have to pay in advance.

I told my wife the truth. I told her I was seeing a psychiatrist. Then she told me the truth: that she was seeing a psychiatrist, two plumbers, and a bartender.

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