Vol. 18 No. 2
Spring 2006

The GrAAPvine

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Administrators in Academic Psychiatry

From the president's desk

by Pat Sanders Romano

It is strange for me to realize that this is my last column as President of AAP. Being your president has been a remarkable experience. It started with a 20th birthday celebration in New York City, at the Spring Conference, which was attended by more members and more Past Presidents than ever before. The year brought Hurricane Katrina and an outpouring of caring and assistance for our Gulf Coast members and the experience of relocating our Fall conference from New Orleans to Indianapolis in six weeks. And now I am focused on the planning for the Spring board meeting and conference in Chicago.

I'd like to share with you what a year in the life of an officer of the Administrators in Academic Psychiatry is like.

Being a board member

Twice a year, on the Fridays before the Fall and Spring conferences, we hold all-day board meetings. In between, we also have at least two teleconferences. The board, through the officers and committees, actively works throughout the year to further the AAP mission of improving mental health care delivery, education and research through professional management in departments of psychiatry that are affiliated with academic medical centers.

- We endeavor, through our support of The GrAAPvine, website and the listserv, as well as through the planning of conferences *to promote cooperation, understanding and fellowship within the membership* and *to provide educational opportunities and membership development*. The President-Elect, the Secretary, the Membership Director, the GrAAPvine Editor, and Members at Large as well as committee members work throughout the year to further these objectives.
- Benchmarking, a newly created Board responsibility, overseen by a Member at Large and the Secretary, *provides mechanisms for gathering, analysis and distribution of information pertaining to*

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Comings and goings

Please feel free to call new members 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:

Susan Cambria
Dartmouth Med School
(603) 650-6404
susan.a.cambria@dartmouth.edu

Marion Greenup
New York U
(212) 263-8669
marion.greenup@nyumc.org

Greg Jensen
U Iowa
(319) 356-7122
gregory-jensen@uiowa.edu

Marilynn Powell
U Chicago
(773) 834-0848
mpowell@yoda.bsd.uchicago.edu

AAP wishes the best of luck to the following members:

Kevin and **Christine Johnston** who have both left the Indiana U department of psychiatry.

John Mills
formerly of Wright State U
Department of Psychiatry

A fond farewell

Dear Colleagues,

It is with sadness that I let you know I will no longer be associated with an academic department of psychiatry, and will be leaving AAP. The friendships are so meaningful and I will cherish the memories of fish stories, adventures (Jan's and others), long board meetings, conference preparation . . . and the last minute conference adjustments we worked through at times, networking, social time (where we sometimes got a little wild) and all the knowledge and experiences you shared. You have supported me in so many ways that will certainly help me be successful in the future. My wish is for all of you to experience this same relationship through AAP, knowing you will grow as a person and as a professional. If in Indy, give me a call so we can get together. I wish you the best, and don't be surprised if you get a call from me if I happen to be in your city.

From your friend,
Kevin Johnston

Personally, and on behalf of the entire AAP Board, it is with a great deal of sadness I note the news of Kevin Johnston's departure from our organization. Kevin, as President and then Immediate Past President during my presidential rotation, has provided immeasurable support as I planned two conferences, assumed my place on the MGMA ASIG council, and took over the reins of overseeing the work the AAP Board of Directors. I am particularly grateful to him for stepping up and planning our meeting in Indianapolis this past fall. His work as my predecessor laid a great foundation from which I have been able to lead.

As Kevin moves on to the next phase of his career, I speak for the entire Board when I wish him well. While his intelligence and humor will be missed, by our organization, I am confident that they will lead him on to many more successes.

Pat Sanders Romano

Congratulations . . .

. . . to **Ron Menaker** (Mayo Clinic) on his election to the position of Board Chair, American College of Medical Practice Executives.

President's message (continued)

Continued from page 1

the field and promotes best practices. On a less formal level, the board facilitates collegiality and mutual respect through the sharing of experiences, triumphs and travails, which has become an institutionalized agenda item of our meetings.

- The board, through the efforts of the President, Past-President, Treasurer and Members at Large implements *strategic planning, strategic collaboration with other national organizations* and works *to strengthen the governance and leadership of AAP*.

As the President, this year's board activities have been both personally and professionally rewarding, and presented me with a real opportunity to "give back."

Developing professionally

I, like most of the members, am an island in my school. While there are nitty-gritty procedural issues I share with my colleagues, they just don't understand the 'psyche' of psychiatry.

For me, the connection through AAP to our field, its issues, hot topics, and unique knowledge base, through the educational opportunities provided by the conferences and the listserv discussions, has been invaluable.

While our conferences are always chock-full of information, the last two have been incredible, both for the content as well as for the "feel." In the Spring of 2005, we were a large group, at a larger conference, in a very large hotel in a BIG city. Yet, the whole group stayed throughout the entire day, and learned about Psychiatry and Managed Care, Psychiatric Home Care, Quality in Outpatient Settings, the Development and Implementation of the Depression Center at the University of Michigan, and Administrative Challenges in Psychiatry. The Fall conference was more intimate; it was just "us," in a unique hotel, in a midsize city. Yet, the whole group stayed throughout the entire day and learned about Diverse Mental Health Programs, Prescribing by Psychologists, Telemedicine, Team Building, Disease Management Initiatives for the Seriously and Persistently Mentally Ill.

The standard feature of "Take Two Minutes" at each conference allows for one-on-one sharing of information and experiences that is both rewarding for the person who inquires and for the people who interact. The seeds of program change are sown at these sessions.

With each conference I have absorbed so much and have become even more proud of our field. They are the educational highlights of my year.

Connecting

My closest friends call themselves AAPs and are from all four corners and the heartland of the country.

Perhaps there is something in the nature of the folks who become Administrators in Academic Psychiatry or perhaps there is something in the nature of academic psychiatry administration, but we all just seem to "click." And we "click" like old, old, good friends - although we haven't known each other for all that long. And we love to welcome newcomers into our group. Even though we see each other at most twice a year, we have an easy bond, and great warmth and affection for each other.

We have a collective sense of humor. What other group would use a monkey as their logo?

And, we are joyful. There seems to be a pervasive spirit of glee within the group. We delight in laughter and in fun. We temper our serious mission with enjoyment.

So, as I look at the year winding down, I am grateful for the sense of purpose, the enrichment and the joy that being President has given me. I know that **Jim Landry** and the new board will have a fulfilling year. I encourage our newer members to become involved, and I am so pleased that there is the position of Past President, so I can "hang out" with the board for another year.

Pat

Spring educational conference in the Windy City

You'll be blown away

The Educational Committee is busy planning our Spring Conference to be held in Chicago on Saturday, May 6, 2006 in conjunction with the APA Conference. As usual, we'll have a pre-conference dinner on Friday, May 5. Please plan your arrival in Chicago so that you can join your colleagues for a night of networking and friendship in the Windy City. The registration fee for the conference is $175 and includes our conference networking dinner on Saturday dinner.

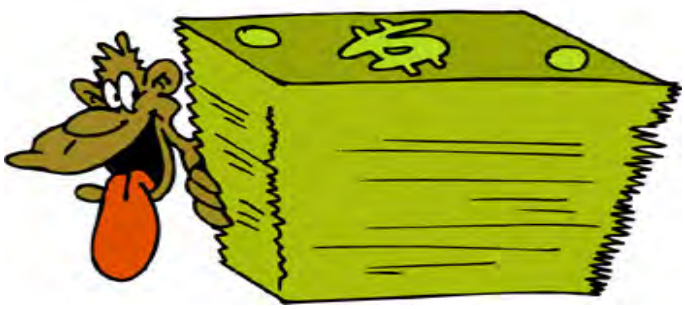
The conference will be held at the Hyatt Regency Chicago located at 151 East Wacker Drive, just off Michigan Avenue in the heart of the Magnificent Mile. (We probably need to keep an eye on Pat and Radmila to make sure they don't go shopping during the conference breaks!) The room rates are $195 per night plus 14.9% occupancy and state tax. I *strongly urge* each of you to make your reservations early to ensure you can be accommodated in this hotel. The phone numbers for reservations are (312) 565-1234 or (800) 633-7313. Mention that you are with the Medical Group Management Association conference to ensure the quoted rate and access to the room block.

AAP's annual business meeting will be held during lunch on Saturday. Business items include election of officers for next year, vote on bylaw changes (if any), and committee reports. If you have any items that need to be addressed at the business meeting please contact President **Pat Romano** (promano@aecom.yu.edu).

While the program is not finalized yet, you are promised a jam-packed educational experience. With potential speakers from JCAHO and the VA, an interesting keynote speaker, and of course the "Take Two Minutes" live listserv, this conference is sure to be a success.

If you are interested in presenting at this conference or at the Tucson conference in the fall, please contact **Jim Landry** (jlandry1@tulane.edu) or **Marti Sale** (mssale00@pop.uky.edu). It is always a plus to have our members present at our conferences – remember, we ARE the experts!

Did you remember to pay your dues?



In order to be able to vote in the upcoming Board election, as well as to continue to receive your AAP member benefits (e.g., The GrAAPvine, access to the listserv), 2006 dues for renewing members must be paid by April.

If you need a new invoice, contact Janice McAdam at :
jmcadam@kumc.edu
or
(316) 293-2669

Windy City trivia

While undoubtedly this is a windy city, with breezes wafting off Lake Michigan, other US cities actually record average wind speeds higher than Chicago, where the average wind speed is only 10.2 MPH. The most common legend as to why Chicago is called the Windy City is that there have been more political conventions held here than any other city, and all those politicians in one place at one time created all the "wind."

Here's some weird and interesting historical trivia about the Windy City:

The Great Chicago Fire raged October 8 and 9, 1871. It destroyed 3.5 square miles of the city, killing around 250. The fire lasted 27 hours and destroyed 17,450 buildings. Sparks from the fire started forest fires that destroyed more than a million acres of Michigan and Wisconsin timberland. Now, here's the funny part: On October 7, 1997, the Chicago City Council approved a resolution which absolved Mrs. O'Leary's cow of all blame for the Great Chicago Fire.

The World's Columbian Exposition was held in Chicago May, 1893 through October, 1893. There were many "firsts" introduced at this fair:

- Aunt Jemima Syrup
- Cracker Jacks
- Cream of Wheat
- Diet carbonated soda
- Juicy Fruit gum
- Pabst Beer
- Shredded Wheat
- The Ferris Wheel (It stood 250 feet above the ground, contained 36 cars, each of which was capable of carrying 60 people, or a total of two-thousand, one-hundred and sixty people at a time!)
- The hamburger was introduced to the United States
- The United States produced its first commemorative stamp set
- The US Postal Service produced its first picture postcards
- The US Mint offered its first commemorative coins: a quarter, half dollar, and dollar.

The first automobile race ever seen in the United States was held in Chicago in 1895. The track ran from Chicago to Evanston, Illinois. The winner was J. Frank Duryea, whose average speed was 7 1/2 miles per hour.

February 14, 1929 was the infamous Valentine's Day Massacre, when members of (supposedly) Al Capone's mobster gang killed seven members of "Bugs" Moran's gang over control of the bootleg liquor business in Chicago.

In 1931, never having been convicted on murder or other violent criminal charges, Al Capone was found guilty of tax evasion and sentenced to 11 years in prison and fined $50,000 plus court costs and restitution.

July 18, 1936, the first Oscar Mayer "Wienermobile" rolled out of General Body Company's factory. It was the invention of Carl Mayer, nephew of Oscar Meyer. The Wienermobile is still touring around the US today.

The world's largest cookie and cracker factory, where Nabisco made 16 billion Oreo cookies in 1995, is located in Chicago.

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The executive suite

Names, numbers and looking forward

by David Peterson, FACMPE

By my count this is the 32nd column devoted to the activities of the American College of Medical Practice Executives (ACMPE) and as we enter calendar year 2006, it is time to once again thank The GrAAPvine's editor, **Jan Price** (U Michigan), and the AAP leadership for allocating valuable newsletter space and support to the ACMPE's mission. The GrAAPvine is a great vehicle for informing our members and readership about the value of continuing education, board certification and the role the ACMPE plays as the defining credentialing body for the medical practice executive.

It is also with our editor's permission that the name of this column has been changed. Previously known as "The College Corner," this column has been renamed, "**The Executive Suite**." As this column has evolved – along with the ACMPE – there has been an increasing acknowledgment in the marketplace of the "executive skill set" that medical practice executives, administrators and directors are required to master to be effective leaders. This column often focuses on this "suite" of skills and my hope is that this new name identifies, captures and acknowledges the expertise the successful medical practice executive can bring to his/her position.

The ACMPE has distilled this suite of skills into 8 "domains:"

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

The ACMPE's Board Certification exams test a candidate's mastery of these domains and confer upon the successfully boarded executive, *Certified Medical Practice Executive* status.

To help medical practice executives through this certification process, the ACMPE and the Medical Group Management Association (MGMA) have developed a new learning tool that will be available in Spring 2006

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Name	Organization	ACMPE status
Birkmeyer, Patricia	University of Texas Medical Branch	Nominee
Chimera, Doris	University of Texas Medical Branch	Nominee
Erwin, Richard	University of Missouri Columbia	CMPE
Hyer, Judith	Texas A & M University	CMPE
Johnston, Kevin	Indiana University	CMPE
Jordan, Alex	University of Washington	CMPE
Landry, James	Tulane University	CMPE
McCray, Georgia	Vanderbilt University	CMPE
Menaker, Ron	Mayo Clinic	FACMPE
Morganthaler, Roxanne	University of Washington	Nominee
Munroe, Florie	Health Quest	CMPE
Peterson, David	Medical College of Wisconsin	FACMPE
Romano, Pat	Albert Einstein College of Medicine	Nominee
Tapper, Jeffrey	Northwestern University	Nominee
Taylor, Marietta	Basset Healthcare	FACMPE
Thomas, Carol	University of Louisville	Nominee
Thomas, Joe	University of Michigan	CMPE
Tunget Henry, Jennifer	University of Louisville	Nominee

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titled the "MGMA Body of Knowledge Review Series." The series will be comprised of a eight booklets and one overview booklet on practice management. The booklets will provide a "review of each management domain by highlighting key concepts, tasks, terminology, regulations and key resources." Subsequent "Executive Suite" columns will focus more on this review series.

Finally, many AAP members (see inset page 6) are members of the ACMPE and each should be congratulated for committing to an organized program of continuing education, certification and professional enrichment. (If anyone has been inadvertently omitted, please let me know).

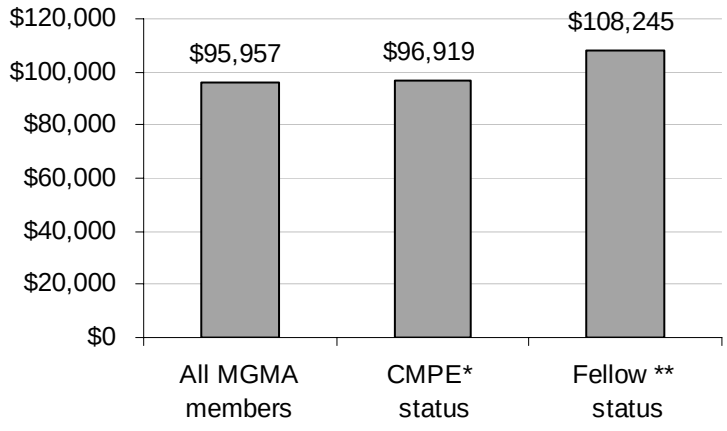
Over the last 5 years, this represents a roughly 4-fold growth in joint AAP and ACMPE membership. The list of board certified (CMPE) members and members in Fellow (FACMPE) status has quietly grown. We wish the Nominees good luck as they work toward CMPE status and good luck to the CMPE's as they work toward Fellow status.

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.

Why should you consider certification?

Median salaries for administrators of practices of 7 to 25 FTE physicians[1]

Source: MGMA Management Compensation Survey 2004 Report Based on 2003 Data



1. Includes academic and non-academic practices in all medical specialties

* Certified Medical Practice Executives are board certified in the medical practice management profession by the American College of Medical Practice Executives (ACMPE), the certification and standard-setting body of MGMA. CMPEs have demonstrated their knowledge and skills by completing comprehensive examinations, presentations and continuing education.

** Fellows in the American College of Medical Practice Executives (FACMPE) have attained the highest designation in ACMPE, the certification and standard-setting body of MGMA. After achieving board certification in medical practice management, they have demonstrated additional competence by completing either a professional paper or three case studies.

Suggested reading

"Guidelines for Interactions between Clinical Faculty and the Pharmaceutical Industry: One Medical School's Approach" Coleman, David L. MD; Kazdin, Alan E. PhD; Miller, Lee Ann MS, RPh; Morrow, Jon S. MD, PhD; Udelsman, Robert MD, MBA *Academic Medicine,* Vol 81(2), February 2006, pp 154-160

A Special Communication article entitled "Health Industry Practices That Create Conflicts of Interest—A Policy Proposal for Academic Medical Centers" (*JAMA* January 25, 2006), addressed the issue of medical professionalism and the conflict of interest between physicians' need to provide quality patient care and the drug industry's desire to sell their products. The article states that current self-regulation efforts do not do a good enough job of protecting patient's interests and that stricter guidelines need to be in place addressing "elimination or modification of common practices related to small gifts, pharmaceutical samples, continuing medical education, funds for physician speakers bureaus, ghostwriting, and consulting and research contracts."

Yale School of Medicine faculty developed new stringent guidelines to ensure the probity of medical decision making and that physicians would not be influenced by financial or personal relationships with the pharmaceutical industry. The faculty developed the guidelines over a one-year period, with input from some pharmaceutical companies. The Yale Medical Group (YMG) approved the guidelines in May 2005 with overwhelming faculty and institutional support.

The authors indicate that their "guidelines will help to preserve the independence of their faculty, reduce the potential for real or perceived bias in clinical decision making and education programs, and promote an effective and ethical partnership between medical schools and the pharmaceutical industry that will facilitate drug discovery and more widespread use of effective therapies."

The Yale guidelines ban any form of gifts to their physicians, in spite of monetary value; they ban industry-sponsored meals and they ban free samples of medications for their physicians and family. The authors indicate that assessing a monetary value is "arbitrary and imprecise." They cite four articles which demonstrate that gifts influence behavior irrespective of the monetary value of the gift. Also, patients don't hold as high a regard for medical professionals who accept gifts. The authors cite a study which revealed that 79% of patients would like physicians to stop seeing pharmaceutical company representatives and 84% indicated they would also like for them to stop receiving gifts.

They also state that gifts contribute to the costs of marketing and pharmaceuticals, thereby compromising access to health care because the costs are increased. (The article states that according to the Pharmaceutical Research and Manufacturers Association of America, in 2003 the pharmaceutical industry spend $33 billion on research and development and $25.3 billion on promotional activities).

The Yale guidelines also address CME events and stipulate that all CME activities, regardless of whether or not CME credit is awarded, must follow the guidelines of the Accreditation Council for Continuing Medical Education. Further, the guidelines also address industry sponsored educational events that take place off campus.

I am impressed by the strong stance that the YMG took in addressing the ever-increasing concerns related to ethical issues impacting physicians in their relationships with the pharmaceutical industry. The YMG guidelines are comprehensive and go a long way towards addressing and improving the public health. This article contains detailed information related to the amount of dollars drug companies spend on marketing and research and development, the number of physicians that regularly meet with drug reps and the frequency of those meetings, and information on types of gifts, financial incentives, etc. If your medical school is considering developing their own guidelines, I would recommend that you read this article, review Yale's guidelines and learn what they have done to ultimately improve ethical decision making by physicians.

(This article was reviewed by Radmila Bogdanich, administrator of the Southern Illinois University department of psychiatry).

Academic administrators can help their practices by helping their residents

By Linda Cutler, FACMPE, MGMA member

Because many residency programs fail to address career options and nonclinical professional development, graduating residents often are ill-equipped to assess employment opportunities. Thoughtful career decisions by physicians result in easier integration into a practice, less physician turnover and savings for the already stretched budgets of academic practices.

Given the high costs of physician recruitment and hiring, it's important that administrators help new physicians acquire the skills needed to assess post-residency practice opportunities. Administrators can help residents:

- Match the results of career-assessment tools with potential practice venues;
- Formulate interview questions to evaluate the operational, financial and cultural environments of a practice; and
- Address the nonlegal aspects of contract negotiation and the transition from residency to employment.

Performing a career assessment

An exploration of residents' career options starts with a self-assessment that provides feedback on how a resident learns, works, solves problems and relates to others. The purpose of the self-assessment is to clarify a resident's:

- Values;
- Skills;
- Behavioral style;
- Preferences relating to practice culture; and
- Preferences relating to personal life.

There are a number of commercial career-assessment tools, including some that categorize personality preferences and psychological types. These assessment tools need to be administered and interpreted by trained professionals.

Given the high costs of physician recruitment and hiring, it's important that administrators help new physicians acquire the skills needed to assess post-residency practice opportunities.

Identifying venues

Administrators can help residents identify practice venues that fit their personal preferences. Discuss with residents the differences among venues regarding patient care, autonomy, compensation, benefits and more. You should address solo, group, academic and industry-affiliated settings; health maintenance organizations and public-service settings; and hospitalist and locum tenens programs.

Performing a cultural assessment

With the help of administrators, residents can better assess the culture of a prospective practice by examining the common interests, personalities, values and visions of the stakeholders. Also examine research, teaching and clinical practice opportunities.

Performing a financial assessment

Administrators can provide specialty-specific benchmarking data from the Medical Group Management Association (MGMA) on overhead and gross revenues to help residents formulate interview questions that reveal the financial viability of a practice. Residents should ask about patient visits, charges and revenue over a three- to five-year period to determine if the practice is growing. Other considerations are whether the patient mix accurately represents the community and the source and volume of new patients, especially if a resident is filling a new position.

Full-time-equivalent (FTE) support staff positions per FTE physician can also reveal much about a practice's financial health. Again, administrators can provide residents with MGMA benchmarks about staffing ratios, but the candidate should understand that a lower ratio can indicate either a highly efficient operation or an understaffed operation, depending on various circumstances. Residents should meet with office staff — managers, head nurses and lead clerical staff.

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Other considerations

Residents should scrutinize practice operations related to patient volume and flow. Technology and equipment should be examined to verify availability and condition. To the technology-savvy physician, a practice without email, hand held devices and electronic medical records could be frustrating.

Compensation arrangements and contract negotiation

Residents also should understand compensation methods and their relationship to practice settings. Specific contractual elements are best addressed by legal counsel. However, administrators can provide nonlegal advice on negotiations, particularly when it comes being flexible and realistic about expectations, ensuring that special requests are made up front..

Putting it all together

The final stage of the career assessment involves examining each job opportunity in light of what the resident has learned. While each must decide for himself or herself which opportunity is the best fit, the administrator can act as a sounding board. The benefits of resident-training programs include increased direction and more realistic expectations about the workplace. Administrators also can determine the impact of the program on physician job satisfaction and turnover by surveying past participants one, three and five years after they complete the program.

(This article was adapted from a professional paper submitted to the American College of Medical Practice Executives (ACMPE) in partial fulfillment of requirements to achieve the certification of Fellow.

National Business Group on Health unveils employer guide to behavioral health services

New guide to dramatically improve services for mental health and substance abuse disorders

WASHINGTON, DC – The National Business Group on Health, a national nonprofit organization, recently released *An Employer's Guide to Behavioral Health Services*, the culmination of a year-long study of employer-sponsored behavioral health services. The *Guide* provides employers with findings and recommendations that will enable them to maximize the quality, effectiveness and appropriateness of behavioral health services.

"Employers, like all purchasers, can use their leverage to improve the design, financing and delivery of behavioral health care in the U.S.," Helen Darling, president of the National Business Group on Health, said at a news conference . . . where the *Guide* was released. "All health services, including behavioral healthcare, are fragmented, uncoordinated, duplicative, and highly uneven in terms of effectiveness, access and quality, but behavioral health benefits have particularly complicated problems and challenges that need to be addressed. These recommendations will help employers and employees receive much higher quality and value for their substantial investment in behavioral health benefits."

Funded by the Department of Health and Human Services' Center for Mental Health Services, the study was conducted by the National Committee on Employer-Sponsored Behavioral Health Services, a 24-member committee of benefits and healthcare experts. The National Business Group on Health formed the committee to review the current state of employer-sponsored behavioral

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health services and develop recommendations to improve the design, quality, structure and integration of programs and services.

"Employers have been at the forefront of improving the quality of healthcare services they sponsor for their workers," said Kathryn Power, director of the Center for Mental Health Services. "In the past, most employers have focused their attention on general healthcare services. Now, as our study and the statistics clearly indicate, employers need to focus on the behavioral health services they provide."

An Employer's Guide to Behavioral Health Services is a roadmap of actionable strategies and recommendations employers can use to examine current services and develop contracting requirements to create and implement effective and high-quality behavioral health services. The *Guide's* recommendations provide a process for employers to examine their current behavioral health benefits and services and to develop contracting requirements to guide their selection of future vendors including health plans, Managed Healthcare Organizations, Managed Behavioral Healthcare Organizations, disability managers, Pharmacy Benefit Managers and Employee Assistance Programs

The *Guide* includes 12 key findings from the committee's study and 18 specific recommendations. Specifically, the *Guide* provides information for employers to:

- Standardize the delivery of behavioral health services and programs, whether delivered in the general medical setting or in the behavioral health system, and ensure that all patients receive effective, high quality services.
- Structure collaboration between general medical providers and behavioral health specialists to improve clinical outcomes
- Include evidence-based treatment modalities in behavioral health benefit structures
- Develop enhanced programs and measures of continuous quality improvement
- Promote quality and accuracy in the practice of prescribing psychotropic drugs
- Improve the efficacy of disease management programs for chronic medical conditions by including behavioral health screening and treatment.

"Mental health and substance abuse disorders currently cost U.S. employers billions of dollars annually in lost worker productivity. This is a great opportunity for employers to improve the quality of their behavioral healthcare services and help ensure that their employees and family members have the best access to needed health services. All will benefit if we reduce the terrible burden of depression and other serious mental health problems that sap strength, productivity and a decent quality of life out of employees and their families. There has never been a more important time to address these problems," concluded Darling.

Summaries of the key findings and recommendations for health plans, disability management vendors, and employee assistance programs may be found in the *Guide's* Executive Summary. The complete *Guide* is available at *www.businessgrouphealth.org*.

(The National Business Group on Health, representing 240 mostly large employers, is the nation's only non-profit organization devoted exclusively to finding innovative and forward-thinking solutions to large employers' most important health care and related benefits issues. The Business Group identifies and shares best practices in health benefits, disability, health and productivity, related paid time off and work/life balance issues. National Business Group on Health members provide health coverage for more than 50 million U.S. workers, retirees and their families.

The Center for Mental Health Service (CMHS) is the Federal agency within the U.S. Substance Abuse and Mental Health Services Administration that leads national efforts to improve prevention and mental health treatment services for all Americans. CMHS pursues its mission by helping States improve and increase the quality and range of treatment, rehabilitation, and support services for people with mental health problems, their families, and communities).

New Institute of Medicine report on improving quality of mental health care

Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders

Millions of Americans today receive health care for mental or substance-use problems and illnesses. These conditions are the leading cause of combined disability and death of women and the second highest of men.

Effective treatments exist and continually improve. However, as with general health care, deficiencies in care delivery prevent many from receiving appropriate treatments. That situation has serious consequences—for people who have the conditions; for their loved ones; for the workplace; for the education, welfare, and justice systems; and for our nation as a whole.

A previous Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001), put forth a strategy for improving health care overall. However, health care for mental and substance-use conditions has a number of distinctive characteristics, such as the greater use of coercion into treatment, separate care delivery systems, a less developed quality measurement infrastructure, and a differently structured marketplace. These and other differences raised questions about whether the Quality Chasm approach is applicable to health care for mental and substance-use conditions and, if so, how it should be applied. This report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, examines those differences, finds that the Quality Chasm framework is applicable to health care for mental and substance-use conditions, and describes a multifaceted and comprehensive strategy to do so.

The strategy addresses issues pertaining to health care for both mental and substance-use conditions and the essential role that health care for both plays in improving overall health and health care. In doing so it details the actions required to achieve those ends-actions required of clinicians; health care organizations; health plans; purchasers; state, local, and federal governments; and all parties involved in health care for mental and substance-use conditions.

The report can be ordered in either book or PDF format from the Institute of Medicine at http://www.nap.edu/catalog/11470.html. It is also available to read and search online at http://www.nap.edu/books/0309100445/html/.

(Reprinted from Institute of Medicine website).

Coming Attractions

National Association of Psychiatric Health Systems Annual Meeting
"Behavioral Healthcare Leadership in Action"
March 19-21, 2006
Washington, DC
www.naphs.org

NIH Regional Seminars in Program Funding and Grants Administration

March 30-31, 2006
Boston, MA

May 30-June 1, 2006
Riverside, CA

grants.nih.gov/grants/seminars.htm

Administrators in Academic Psychiatry Spring Conference
May 5-6, 2006
Chicago, IL
www.adminpsych.org

Academic Practice Assembly Annual Conference
May 7-9, 2006
Chicago, IL
www.mgma.com

Medicare prescription formulary Web site launched

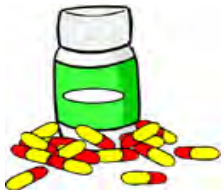
On Jan. 1, 2006 the Medicare prescription drug program opened a new avenue for prescription drug assistance to American seniors. The program is administered by local pharmacy plans that have their own formularies. To aid providers, a new website, Epocrates.com, lists these formularies in a web-based format for easy printing or use on hand-held personal assistants using its free Epocrates Rx® software.

Alternatively, providers may use the Formulary Finder that CMS developed for Medicare patients. The Formulary Finder provides a list of all plans in a given state and links directly to an insurer's website for a complete formulary.

Epocrates software download for hand-held:
http://www2.epocrates.com/products/rx/

Epocrates online formulary:
https://rxonline.epocrates.com/eula.jsp

Medicare Formulary Finder:
http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp



New consultation codes

The AMA's CPT Editorial Panel deleted the follow-up inpatient consultation codes and the confirmatory consultation codes that were billed for consultations requested by patients. Both were found to be redundant. New instructions in the introduction to the consultations codes section in CPT state that only one initial consultation should be provided by a physician per episode of care. The instructions also tell physicians to use subsequent hospital care codes to report services provided after the initial consultation. Consultations requested by the patient or their family should be billed with the appropriate office/outpatient visit codes or inpatient consultation codes.

New CMS websites available

The Centers for Medicare & Medicaid Services (CMS) recently announced the new and improved CMS website located at www.cms.hhs.gov.

The new website employs a user-friendly design to get visitors the information they need with the least amount of clicks. It introduces one-stop shopping "centers" targeted to specific professionals such as providers and partners, who frequent the site.

CMS will continue to evaluate the new website in order to provide the best organization and navigation so you can continue to retrieve the information you are looking for in the most efficient way possible. In order to assist you when you log onto the new site there is an online demonstration that can assist you with your site navigation.

CMS has redesigned its web page dedicated to providing all the latest NPI news for health care providers. Visit http://www.cms.hhs.gov/NationalProvIdentStand/ on the web. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A new fact sheet with answers to questions that health care providers may have regarding the NPI is now available on the web page; bookmark this page as new information and resources will continue to be posted.

CMS issues new non-physician consultation rules

Besides addressing the deletion of several consultation codes (see article page 13), The Center for Medicare and Medicaid Services has recently clarified who can provide a payable consultation service and what documentation is needed.

Transmittal 788, dated December 20, 2005 and effective January 17, 2006, states [revision in italics]:

• Specifically, a consultation *service* is distinguished from *other evaluation and management (E/M) visits* because it is provided by a physician *or qualified nonphysician practitioner (NPP)* whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. *The qualified NPP may perform consultation services within the scope of practice and licensure requirements for NPPs in the State in which he/she practices.* Applicable collaboration and general supervision rules apply as well as billing rules;

• A request for a consultation from an appropriate source and the need for consultation *(i.e., the reason for a consultation service) shall* be documented *by the consultant* in the patient's medical record *and included in the requesting physician or qualified NPP's plan of care in the patient's medical record;* and

• After the consultation is provided, the consultant *shall prepare* a written report of his/her findings *and recommendations,* which *shall be* provided to the referring physician.

• *The intent of a consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional's knowledge.* Consultations may be billed *based on* time if the counseling/coordination of care constitutes more than 50 percent of the face-to-face encounter between the physician *or qualified NPP* and the patient. The preceding requirements *(request, evaluation (or counseling/coordination) and written report) shall also be met when the consultation is based on time for counseling/coordination.*

Psychiatric services: EDs address influx of psych patients

With the availability of mental health services declining nationwide, psychiatric patients have become a growing presence in hospital EDs. To accommodate the influx - which may exacerbate capacity problems and distract providers from other cases - facilities are assembling psychiatric rapid response teams, designating ED space specifically for mental health care, and forging community partnerships.

Reimbursement, treatment trends cut inpatient psychiatric capacity

During the last decade, hospital EDs have emerged as *de facto* mental health providers as state cutbacks and declining reimbursements have forced inpatient psychiatric units to close; subsequent outpatient gridlock has rendered EDs one of few remaining options. A study published in the February 2004 *Academic Emergency Medicine* (Hazlett et al.) provided statistical evidence of this dynamic, showing that psychiatric-related ED visits - those reflecting any of three common psychiatric ICD-9 codes - increased 15% nationwide from 3.7 million in 1992 to 4.3 million in 2000, representing 5.4% of all ED volumes. Moreover, in a national survey of 340 ED physicians conducted by the American College of Emergency Physicians (ACEP), 67% of respondents said mental health services had declined in their community during the previous year, and 60% reported increased pressure on the frontline, particularly because psychiatric patients consume provider attention, increase patient boarding, and force ambulance diversions (ACEP release, 4/27/04). Similarly, a recent analysis of 12 nationally representative communities published by the Center for Studying Health System Change cites psychiatric patient volumes as part of a "convergence … of pressures" currently taxing hospital EDs, restricting access to care, and increasing health care costs ("Rising Pressure: Hospital EDs as Barometers of the Health Care System," November 2005).

Memorial Hermann regional rapid responders alleviate ED pressures

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Faced with these stresses, a number of U.S. facilities have taken steps to absorb and address the growing psychiatric ED patient population. For instance, when psychiatric bed capacity in the greater Houston area surrounding Memorial Hermann Healthcare System declined from 3,000 to 1,500 during the 1990s - a situation further exacerbated by Memorial Hermann's decision to close its 200-bed freestanding psychiatric hospital in December 1999 because of low reimbursements and a migration of mental health services to the outpatient arena - the hospital launched an around-the-clock psychiatric rapid response team to handle the psychiatric ED patient influx (*Watch* interview, 12/19/05). The rapid response team, which sends master's level social workers or psychiatric advanced practice nurses to area EDs to speed treatment of mental health patients, now serves nine Memorial Hermann hospitals, as well as nine other facilities in the region. The team is composed of 23 mental health workers, who are summoned by ED triage nurses and dispatched by a nurse coordinator located at Memorial Hermann's corporate headquarters in Houston.

In addition, because six of the 18 participating EDs are linked to Memorial Hermann's telemedicine system, the nurse coordinator may recommend that the rapid responder consult with providers at the requesting ED via videoconferencing, preventing unnecessary travel and expediting care. The system plans to expand the telemedicine network to all participating EDs by July 2006. According to Fred Ramirez, director of psychiatry at Memorial Hermann, the rapid response team - which fields approximately 450 calls each month - has saved the system $18 million through reduced ED LOS and prevented readmissions; he estimates that nonaffiliated hospitals have saved an additional $18 million. Whereas psychiatric patients previously spent up to 96 hours in area EDs awaiting evaluation and transfer, the rapid response team now helps to discharge or transfer them in an average of 2.2 hours. In addition, the volume of repeat psychiatric ED cases at participating EDs has fallen from 14% in 1999 to less than 0.5% currently, a decrease that Ramirez attributes to appropriate initial treatments and three-day follow-up calls placed by the nurse coordinator. With only $1.2 million to $1.3 million in annual operating expenses - offset by about $300,000 in revenue from participating hospitals' $400-per-call payments - the model is a cost-effective way to provide appropriate mental health care and relieve ED pressures, says Ramirez. He notes, however, that some ED physicians were initially reluctant to take advice from non-physician mental health workers, especially in light of liability concerns. Most of those objections vanished within one to two months, once physicians observed the speed with which the rapid responders discharged or transferred patients.

Hospitals cordon off psychiatric ED space, forge community partnerships

Meanwhile, other facilities are enhancing their physical infrastructures to accommodate the growing number of psychiatric ED patients (Tosczak, *Business Journal of the Greater Triad Area*, 12/19/05). In light of a 25% increase in psychiatric ED visits since 2001, North Carolina-based Wake Forest University Baptist Medical Center is planning to construct a new, larger ED with a separate area for psychiatric patient care that includes six private, secure rooms. Similarly, Forsyth Medical Center in North Carolina relied on a newly opened $18 million ED - featuring a designated area for mental health cases, staffed by specialized providers and equipped with locking rooms - to absorb 4,088 psychiatric ED patients during the first 10 months of 2005, a 9% increase over the same period during 2004. Taking those efforts a step farther, Greenville Hospital System (GHS) in South Carolina has partnered with the state-owned Greenville Mental Health Center to create a GHS-based ED "annex" for psychiatric patients and to earmark several beds at a nearby psychiatric inpatient facility for GHS referrals ("Rising Pressure: Hospital EDs as Barometers of the Health Care System," November 2005). In return for the bed space, GHS and Greenville Mental Health Center fund a full-time psychiatrist at the inpatient facility. While GHS officials say the initiative has eased pressure on the hospital's ED, others in the community have lingering concerns that it is "only a temporary fix for a more systemic problem" that involves state funding shortfalls and limited availability of outpatient appointments.

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How do crazy people go through the forest?

They take the psycho path.

Editorial staff
Editor:
Janis Price
Associate Editors:
Radmila Bogdanich
David Peterson

The GrAAPvine is published quarterly and distributed to the members of Administrators in Academic Psychiatry as part of the membership in AAP.

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

Janis Price
Section Administrator
Department of Psychiatry
University of Michigan Health System
UH9C 9151
Ann Arbor, MI 48109-0120
(734) 936-4860
(734) 936-9983 Fax
janprice@umich.edu