Vol. 21 No. 3
Summer 2009

The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Hank Williams

Another exciting year for AAP on the horizon

Thank you all for having the confidence in me to allow me to serve as your president for the coming year. I appreciate the opportunity, and I am humbled by your support.

A particular thanks to **Steve Blanchard** (U Iowa), Immediate Past President, and the AAP board members serving in the past year. I have learned a lot from each of you.

We have now concluded our 2009 Spring Educational Conference in Los Angeles. It was a great success and a lot of fun. Thank to all of you who attended! If you stayed for APA, you also had a treat, with a host of relevant and dynamic speakers and sessions. Thank you, MGMA, for another great conference!

Like each year, this one will bring new challenges. Today's economy is having a severe impact on most of our institutions, and that filters down to us and our budgets—particularly travel budgets. We began to see this impact with the Spring Conference, as several members who usually attend were unable to do so, due to travel restrictions.

Our conference evaluations and other feedback continue to tell us that sponsoring educational conferences is an important way to serve our membership. Yet the current economic times are calling for some extraordinary, if only temporary, measures. At the AAP business meeting held at the Spring Conference, the Board of Directors proposed the following to the membership, for this coming year only:

- The Fall 2009 conference should be canceled;
- The Spring 2010 conference should not be held in conjunction with the APA conference, and
- The Spring 2010 should be held at another location, and be a 1.5 day conference.

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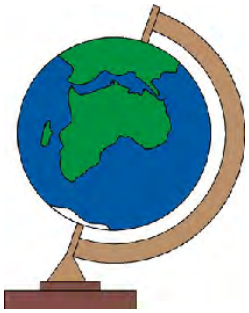
Comings and goings

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:

Todd Gershon
Albert Einstein College of Medicine
(347) 493-8615
tgershon@aecom.yu.edu

President's message

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At the time, I asked the general membership for personal and email feedback to these ideas, and I got plenty, ranging from support to cries of "foul." Some other interesting ideas have emerged from this feedback, that include options like holding the Fall Conference as an AAP event, but maintaining our alliance with MGMA, so that those attending APA will still be able to hold a networking event as an AAP function.

As if this wasn't challenging enough, 2010 is the 25th anniversary of the Administrators in Academic Psychiatry! How do we best celebrate our AAP birthday?

The AAP board will be holding a teleconference in the next several weeks, so let me know your thoughts and ideas on all these things. Please email me any time at hankwill@u.washington.edu, or join in the daily conversation and follow me on Twitter at aap_prez.

With deepest sympathies

The Board of Directors and the membership of Administrators in Academic Psychiatry express their sincere condolences to Paul McArthur and children, Lauren and Zachary, on the recent loss of their wife and mother, Mary Lundberg.

Announcing the 2009-2010 board of directors

The 2009-2010 AAP Board of Directors was approved at the Spring Conference business meeting in Los Angeles. The members of the Board welcome your comments and questions as well as your participation, so please feel free to contact any one of them. All email addresses and phone numbers are printed on the back page of *The GrAAPvine*.

President	Hank Williams	University of Washington
President-Elect	Narriman Shahrokh	University of California - Davis
Immediate Past President	Steve Blanchard	University of Iowa
Secretary	Betty Slavicek	New York University
Treasurer	Tom Tantillo	Children's Hosp of Philadelphia
Membership Director	Tina Nesbeda	University of Massachusetts
Member-at-Large *Strategic Planning/ Governance*	Margaret Moran Dobson	University of Toledo
Member-at-Large *Membership*	Glory Novak	University of Arizona
Member-at-Large *Education*	Radmila Bogdanich	Southern Illinois University
Member-at-Large *Benchmarking*	Toni Ansley	Ohio State University

Awards presented at 2009 conference in Los Angeles

Each year, AAP recognizes outstanding service to the organization by presenting several awards. This year, the Rising Star Award, given to new members who have made a contribution by serving on a committee, writing an article for the newsletter, or in some other way participating in the operation of AAP, were presented to **Betty Slavicek** (New York U), **Shiyoko Cothren** (Penn State U), **Janet Namini** (Northwestern U), **Glory Novak** (U Arizona) and to **Ruth Irwin** (UCLA) for being the "feet on the ground" for the Los Angeles Spring conference.

James Landry (Tulane U), received the President's Award, given for long-term commitment and contributions to the organization.

The Board of Directors Award was conferred upon **Janet Moore** (Michigan State U), given in recognition of a significant contribution to AAP.

William Newel lecture

Transforming a culture: The UCLA Health System experience

by Radmila Bogdanich, MA

David Feinberg, MD, Chief Executive Officer and Vice Chancellor, UCLA Health System, gave a wonderful overview of how during his fellowship he had no intention of working in academic medicine but before he knew it, not only was he working in academic medicine, but he was also involved in administration. Now, more than fifteen years later, Dr. Feinberg is the CEO of UCLA Hospital System and Associate Vice Chancellor. He has found, throughout the years, that if you're going to be successful, you must be humble and passionate about your work.

In his first management role as head of outpatient psychiatry, Dr. Feinberg was given the mandate to improve clinical productivity and revenues. He realized that their practice needed some very basic things. He instituted simple changes like purchasing a credit card terminal to collect payments, recognized the need to focus on collecting copayments and, hiring non-MD's to provide therapy services so that physicians could spend more time doing medication management. To improve managed care referrals, managed care contracts were renegotiated so that clinical faculty could bill under one tax ID number, and all preauthorization referrals were made to the group.

As Dr. Feinberg's responsibilities grew, he realized how important it was to know your staff and to really improve services; you needed to receive feedback from staff and patients. He instituted an open-door policy so that anyone could come and talk with him about problems, if they desired. Before that, staff always protected his time thinking they were doing him a favor.

He realized how important "word of mouth" referrals were. He recognized that to change attitudes about the practice, he had to "walk the talk" and change the culture of the organization to be patient focused. Doctors needed to talk to one another so that patients could have seamless continuity of care. Team work was important. Improving patient satisfaction was his #1 goal. Clinical staff received intensive customer service training and were evaluated weekly by their supervisors. As an example, staff were told to smile when talking to patients. A score of 90% wasn't good enough; it had to be 100%. Staff were fired if their scores did not improved.

Dr. Feinberg gave out his cell phone number to patients and told them to call him if they had any problems. Other key staff made their cell phone numbers available as well. All hospital staff were required to wear uniforms (nurses, housekeeping staff, etc) so that patients could recognize them by their role. If a patient's appointment was delayed, they received a $20 Starbucks gift card. The hospital was redesigned to have gardens and private rooms and 2 public elevators. The hustle and bustle of the hospital was hidden from public view and was designed to look more like a hotel than a hospital. Twenty-four hour visiting hours were instituted, menu selections and food was available twenty-four hours for both visitors and patients, and visitors could order food and eat with the patient in the patient rooms. The hospital was built to withstand an 8.0 earthquake and can be totally self-sufficient for one week. Each room can be turned into an ICU.

Dr. Feinberg firmly believes that patient satisfaction is the key to improving your clinical bottom line and he has the ranking to prove it. UCLA Medical Center has been ranked number one in the West by U.S. News and World Report's annual survey of "America's Best Hospitals." year after year. *(Radmila Bogdanich is the administrator of the Southern Illinois University department of psychiatry).*

Turning psychiatric clinicians into customer care ambassadors: Making the synthesis happen

by Doris Chimera

James Rosser, LCSW, Program Director of Continuing Care – Semel Institute, UCLA Resnick Hospital and Administrative Director, Borderline Personality Disorder Program, began by providing a brief summary of the various clinical programs that comprise the Resnick Neuopsychiatric Hospital. For the purpose of his talk, he focused on the Partial Hospital and Intensive Outpatient programs for children, adolescents and adults. He described the staff as "eighty clinicians working in different programs with very different patient populations - each clinician and program seeing the world differently."

Mr. Rosser indicated that UCLA receives patient satisfaction data from Press Ganey and the results demonstrated that there was room for improvement in a number of areas, including billing for service. At the same time, Psychiatry was focusing on getting clinicians to bill correctly. Therefore, the mission for Mr. Rosser became assuring patient satisfaction and making sure that patient billing was getting done correctly with staff who were all very different. Knowing how incorrect billing is not only a "dissatisfier" for patients but a revenue generation issue, Mr. Rosser knew that he had to blend the two and help clinicians see how "getting the billing right" would also improve patient satisfaction.

Mr. Rosser then talked about the process of improving patient satisfaction from a customer care perspective. He asked, "Shouldn't clinicians just be good at customer care by nature?" What he found was "no." And, the reason had to do with the definitions held by clinicians vs. patients. So, he examined what the patient experience entailed from the patient perspective. A good patient experience means:

- they are made to feel welcome
- they are made to feel like an "honored guest"
- they are made to feel that they are "understood"
- they feel "I am important here"
- they feel "My needs will be met"
- they say "I would recommend other people to come here." This is the GOLD standard of the patient experience and will lead to revenue generation for the organization.

So, why can't we assure that the patient has a good experience? Mr. Rosser stated that the quintessential customer service slogan of "The customer is always right" is where clinicians start to have trouble. Mr. Rosser found that there was a cultural conflict between how clinicians view issues with patients and how customers are treated. This mind set had to change and patients needed to be seen as customers. Much of the "conflict" arose around the training of the clinician. This meant that clinicians were more cautious about interactions with patients outside the treatment room and how their communication and behavior would impact the patient. He said that they are trained to look at the motivation behind any communication with the patient. There was nothing casual or free about the interaction – it was very goal oriented. So, the question became, "what do we do?" The decision was to approach the problem from the clinician's perspective. If we provide the patient with a good "institutional experience," the patient will have better treatment outcomes. If clinicians hear about all the aspects of contact with the institution, they can help with the resolution for both the patient and the institution. They can validate the reality of

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the experience for the patient and place things in the appropriate perspective. They can also teach the patient coping skills.

Mr. Rosser then shared the process he used to teach clinicians how to be customer care ambassadors. His Customer Service 101 – Clinician Version plan (available in the handout) provided specific behavioral steps along with the system of rewards to use to reinforcement positive behavioral change. Changes can be made every day to support an environment of good customer service.

His final comments included the need to budget for a rewards program, either on a department or organizational level. No matter how small the reward, it will be reinforcing and should be used to validate the behavioral change. And probably most important, patient satisfaction and being caring and concerned and taking action is everyone's job. It starts at the top and the whole environment must be respectful.
(Doris Chimera is the director of the Harris County Hospital District).

Weaving compliance into everyday practice

by Paul McArthur

Carol Klove, RN, JD, CHRC, Chief Compliance and Privacy Officer, UCLA Medical Sciences, provided a comprehensive review of the current state of compliance affairs and the challenges it poses for providers. She emphasized that new rules are coming at "lightening speed," providing administrators and clinicians with new constraints and requirements.

Dr. Klove provided an overview of billing and clinical documentation requirements. The fundamentals about medical necessity were reviewed, as were the principles of medical record documentation to support the treatment. Every encounter should be documented and tallied through a centralized billing/encounter process. At UCLA, online training has been developed for coding, billing and privacy training. As a priority, house staff are trained through the modules.

The Office of Inspector General (OIG) uses a Physicians at Teaching Hospitals (PATH) module to review compliance with documentation and billing regulations. Privacy and security of records are more important than HIPAA these days. New state and federal laws, such as California laws that formed the basis for the federal High Tech Act, are more stringent and impose increased fines and penalties. ARRA (American Recovery and Reinvestment Act of 2009) addresses funding for IT infrastructure, meaningful use of electronic health records (EHRs), audits, reports, enforcement and penalties. ARRA will put new notification requirements into effect in September and lists civil fines and penalties made effective in February. A restriction of interest for psychiatry services is that there be no disclosure to health plans for services paid in full out of pocket by patients. This helps handle the situation where patients don't want their health insurance company to know about treatment.

Dr. Klove discussed President Obama's goal for computerization of medical records and significant privacy concerns with this movement. Concerns about identity theft were also reviewed, of concern to providers because of creditor status in accepting co-pays. A "Red Flag Rule" (see page 13) is on the immediate horizon to address patterns, practices or activities that indicate the possible existence of identify theft. Programs need to be updated periodically to address changing risks. Both Protected Health Information (PHI) and Personally Identifiable Information (PII) need careful management.

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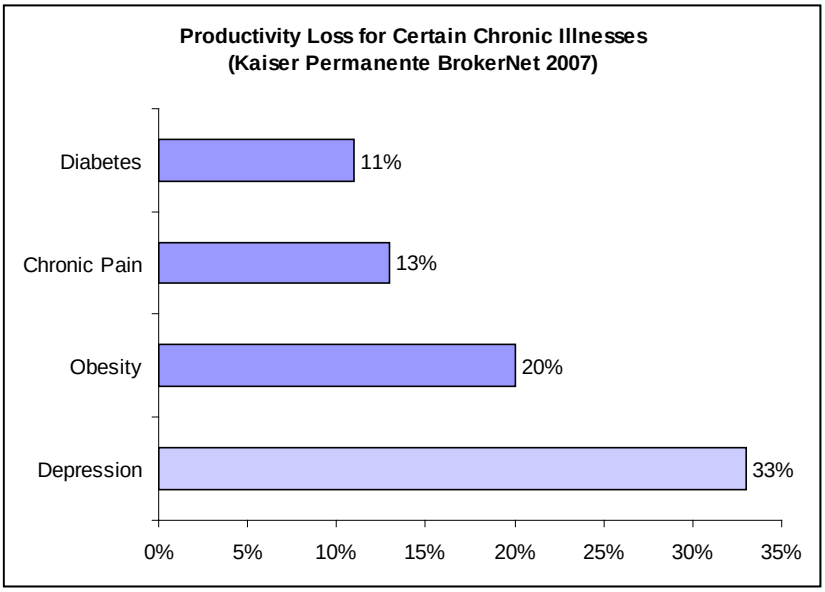
Building confidentiality protection into existing compliance programs is a must. A key to this is knowing who has access to clinical systems and other databases and the extent of the access. Maintaining auditable records of electronic health systems is a requirement. Reasonable precautions must be taken to prevent unauthorized access to PHI. One item of crucial importance is reviewing record access needs of different staff categories annually. Dr. Klove's summary was helpful in understanding the many challenges in structuring a complete compliance program and recommending that it be adjusted on an ongoing basis. *(Paul McArthur is the administrator of the University of Rochester department of psychiatry).*

Psychiatry by the numbers



Source: "The Impact of Chronic Disease on U.S. Health and Prosperity
A Collection of Statistics and Commentary
Almanac of Chronic Disease 2009"
Partnership to Fight Chronic Disease

Simple truths

by David Peterson, FACMPE

The fall and rise of accountability

Few readers would disagree with the statement that many of the problems facing the economy and almost any business today have partially arisen from a lack of some form of accountability, regardless where this lack of accountability originated, be it personal, organizational or societal. Most everyone can cite the anecdotal evidence of lapses in judgment, questionable decision-making and greed. This evidence includes AIG (everyone's favorite example), credit default swaps, collateralized debt obligations, "no doc" mortgages, housing bubbles, easy consumer credit, executive bonuses and finally, a generalized term called "Wall Street excesses," to name a few.

Most would also agree that this lack of accountability contributed to a resource-rich environment with cash as the common denominator. Unfortunately, much of the cash that fed the economic frenzy turned out to be from debt that could not be serviced; hence consequences such as suspended capital spending, home foreclosures, and cutbacks on consumer spending.

Economists will build careers analyzing "what went wrong" and plenty of blame will be affixed to someone or something, but there will also be a "chicken or egg" aspect to the debate regarding which came first. Was it a lack of accountability that led to too much cash or was it too much cash which fed a lack of accountability? Regardless of which begat what, it appears that a cash-rich environment can allow for a degree of administrative/organizational/personal laxness. But, an economic environment absent cash appears to be less forgiving, witnessed by the public outcry over executive bonuses, corporate jets and the general indignation over "Wall Street" excesses.

So the unspoken rule seems to be that tolerance wanes when resources are tight. The extent of this tolerance occurs around the areas of accountability, waste and excess.

When resources are plentiful, systems have an impressive capacity to tolerate a lack of accountability or excess. When resources are scarce, however, systems have an equally impressive ability to shed excess and change expectations for what is acceptable, accountable behavior. There is abundant evidence to support this from President Obama's lectures to the nation from the bully pulpit to the local employer laying off its workforce.

Academic medicine, usually tolerant and often immune from the economic business cycle, has been struck especially hard. Declining payer mixes, rising unemployment, downward pressures on professional fees, dwindling endowment income from investment portfolios, cutbacks in affiliated hospital support and a chill on philanthropy are all a consequence of the economic downturn. Moreover, each and all of these eat into the financial degrees of freedom an academic department has to fund academic programs and support faculty and staff salaries and infrastructure.

Given a relationship between accountability and

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resources and if this relationship were charted, the picture might appear as that in Figure 1, where the degree of accountability runs along the X axis from low to high and the resources available run up the Y axis from few to many. As one moves up and down the lines, accountability and resources rise and fall. A relative location on the top half of the graph – many resources and a high degree of accountability – is an optimal place to be. Find a spot on the lower half of the graph, where there is little accountability and few resources and trouble is inevitable.

Medical practice leaders can identify faculty, staff or programs and place them somewhere on the "accountability line" and then find the level of resources on the "resource line" that supports them. In a resource-rich environment, it is likely more tolerable and financially feasible to maintain an individual or program exhibiting marginal accountability i.e., a location on the left half of the graph. But, as resources decline and accountability remains unchanged i.e., a location on the bottom half of the graph, trouble can be predicted because there are fewer resources (money, equipment or people) to offset marginal accountability.

Although many conclusions could be drawn from such a chart, one conclusion seems clear; that is, a contributing factor to the success or failure of an individual or program is linked to a leader's ability to accurately peg an individual's or program's position on the chart and take the actions necessary to relocate them as needed.

Medical practice leaders use an abundance of management and financial tools and tap into a variety of skill sets to effectively re-align people and resources. The **American College of Medical Practice Executives** has identified a **Body of Knowledge** necessary for the successful medical practice leader. Testing of this knowledge, certification and ongoing continuing education are other services the **ACMPE** provides.

For more information on joining the ACMPE or the board certification and fellowship process, contact the ACMPE directly at 877.275.6462 ext. 889 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.

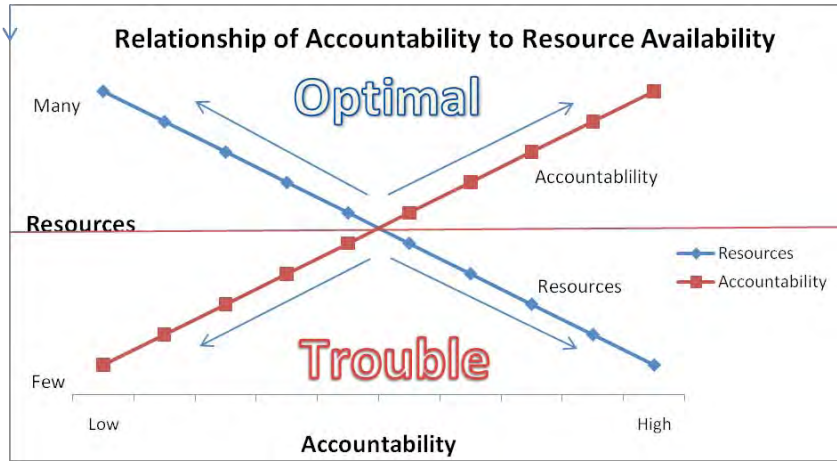

Figure 1

Research, stimulus and AAP

by Hank Williams

AAP members, if your position has you heavily involved in the pre-award world of research, I know you are catching your breath, if only for a minute.

The, American Recovery and Reinvestment Act, or ARRA, has us pretty busy these days. We've now made it through most of the Challenge Grant, GO, Administrative Supplement, and other deadlines. Nationally, over 10,000 NIH Challenge Grant applications alone have been submitted.

It's all very exciting. A snippet of the excitement over the ARRA funding is the ability to include some administrative salary support. Due to the extraordinary administrative oversight and reporting activities associated with awards made under the American Recovery and Reinvestment Act, this salary support will be for the additional administrative services required by the Act, should an award be issued.

Regulatory support for this request is located at OMB Circular A-21 F.6. a. (2.), which states: "Direct charging of salaries of administrative and clerical staff costs may be appropriate where administrative or clerical services required by the project are significantly greater than the routine level of such services provided by academic departments." In my department, the proposal assistance and review workload has doubled in the last 60 days, and yours has too, most likely.

What role does research play in the revenue picture for your "world" this year? The AAP membership is a very diverse group of professionals, serving in many capacities of academic Psychiatry. For many of us, research is not a part of our immediate mission, and has little to do with your daily work life. For others of us, research is core to our working life, and the accompanying revenue and indirect cost generated are major components of, and critical components in, our department's survival.

If your focus is more clinical, or purely administrative, let us know how we can use this space devoted to research better. If you are an AAP with a research focus, also let us know what you need out of this space as a resource.

Over the next year, we'll try not to simply regurgitate NIH releases and deadline dates, but try and make this column a better spot for tools and tips to help us in our research roles. So, please join the conversation on helping us do better. Email me anytime at hankwill@u.washington.edu, or follow me on Twitter, at aap_prez.

(Hank Williams is the President of AAP and the associate director of the University of Washington department of psychiatry).

New adult inpatient mental health program in Northwest Arkansas to be staffed by UAMS physicians

Gov. Mike Beebe of Arkansas recently ceremonially opened a new acute care Behavioral Health Unit at Northwest Medical Center – Springdale that is the culmination of work by six regional partners.

The new program was the dream of the grassroots Northwest Arkansas Acute Care Mental Health Task Force and the result of a cooperative arrangement between Northwest Health System; Ozark Guidance; the University of Arkansas for Medical Sciences (UAMS); Care Foundation, Inc.; Washington Regional Medical Center; and Mercy Health System of Northwest Arkansas.

The staff of the newly renovated 10,000-square-foot unit will begin admitting patients on Tuesday, May 5. The remodeling cost about $2 million, and the addition of this new service has resulted in 36 new jobs at Northwest Medical Center – Springdale.

As part of the agreement, UAMS will be employing physicians who will provide care to patients.

The new program provides much-needed additional adult inpatient psychiatric care capacity for Northwest Arkansas and is financed by a combination of more than $1 million in special funds from the governor's office and appropriations made by the Arkansas General Assembly in 2005 and 2007 (also amounting to more than $1 million), for a total of slightly more than $2 million in start-up funds. The program was publicly announced in mid-August 2008, and construction began in November 2008.

"Reforming our mental healthcare system requires more options for quality care, and these beds create new options in a rapidly growing part of our state," Gov. Beebe said. "Northwest Arkansas has long needed more local facilities for mental health treatment, and with the help of legislators and healthcare providers, we've now been able to make additional beds in Springdale a reality."

The late 1990s and early 2000s saw a wave of inpatient psychiatry program closures at hospitals. Northwest Health System closed its adult inpatient mental health unit, Highland Hall, in April 2002. When Highland Hall opened in 1977, it was Northwest Arkansas' first inpatient psychiatry unit.

"Care Foundation is happy to have played a role in developing a solution to address this very real community need," said Chris Weiser, Chairman of the Care Foundation Board of Directors. "Creating better access to essential healthcare services is one of our areas of primary concern."

How the coalition works

The coalition basically identified a unique role for each of the players. Here's how this shared structure works:

• Northwest Health System renovated the vacant 4th Floor of Northwest Medical Center – Springdale's north patient tower for use as a 28-bed adult inpatient mental health unit. The $1.9 million estimated cost is reimbursed by the state funds, which are administered by fiscal intermediary Ozark Guidance. Northwest Health System, through Ozark Guidance, also receives assistance to help provide acute-care mental health services to the indigent. Northwest Health System operates the unit, providing nursing and support staff and infrastructure for the facility.

• UAMS Psychiatric Research Institute – Northwest provides psychiatrists and psychiatry resident physicians to conduct direct patient care, along with Medical directorship of the program. The Psychiatric Research Institute – Northwest has also established a small

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outpatient clinic to serve the pre- and post-admission needs of some patients, and the program will be used as a teaching site for UAMS psychiatry residency and fellowship programs.

• Ozark Guidance serves as the fiscal intermediary for the state funds and also continues to provide screening, consultative and pre- and post-admission outpatient services.

• Care Foundation, a local nonprofit that promotes healthy communities, will provide up to $415,000 for startup costs over the first two years. Care Foundation was established in 1998, when Northwest Health System was sold and its assets transferred into an endowment for the community. In 2008, the foundation donated $500,000 to help establish the UAMS Northwest Arkansas satellite campus, which accepts its first students in fall 2009 and will host the psychiatry residency program.

• Washington Regional Medical Center and Mercy Health System of Northwest Arkansas each will provide up to $65,000 a year to pay medical consultations provided to the program's economically disadvantaged patients. e an impact not just on Northwest Arkansas, but on the state as a whole," said G. Richard Smith, M.D., director of the UAMS Psychiatric Research Institute and chairman of UAMS' Department of Psychiatry. "With this new inpatient unit, and the new UAMS satellite campus in this part of the state, we are changing the path medical care in Arkansas has taken in the past. That path now goes through Northwest Arkansas."

Tom Petrizzo, chief executive officer of Ozark Guidance, said the program has been a long time in coming. "We at Ozark Guidance are quite ready for this added capacity to serve clients who need more than we can offer in an outpatient setting. We welcome it wholeheartedly," Petrizzo said.

Tom O'Neal, a former Northwest Health administrator who brought the parties together on behalf of the Care Foundation, said the process has affirmed his faith in a collegial approach to meeting community needs. "It is extremely gratifying to see this kind of consensus and shared commitment in responding to a community need," O'Neal said. "As a former health care 'insider,' I know a little about the complexity involved in such undertakings, and that's what makes it all the more impressive that these organizations have stepped up to the plate for the region's welfare."

UAMS is the state's only comprehensive academic health center, with five colleges, a graduate school, a new 540,000-square-foot hospital, six centers of excellence and a statewide network of regional centers. UAMS has 2,652 students and 733 medical residents. Its centers of excellence include the Winthrop P. Rockefeller Cancer Institute, the Jackson T. Stephens Spine & Neurosciences Institute, the Myeloma Institute for Research and Therapy, the Harvey & Bernice Jones Eye Institute, the Psychiatric Research Institute and the Donald W. Reynolds Institute on Aging. It is the state's largest public employer with more than 10,000 employees, including nearly 1,150 physicians who provide medical care to patients at UAMS, Arkansas Children's Hospital, the VA Medical Center and UAMS' Area Health Education Centers throughout the state. Visit www.uams.edu or www.uamshealth.com.

Red flag rule

by Jim Landry

In 2003, Congress enacted the Fair and Accurate Credit Transaction Act (FACTA). The Federal Trade Commission (FTC) is charged with implementing and enforcing these new regulations. Originally enforcement was to be effective October 22, 2008, but was delayed for six months (May 1, 2009) to ensure health care providers time to develop and have in place Identity Theft Prevention Programs. Recently, the deadline was moved back to August 1, 2009.

The primary focus of FACTA, aka Red Flag Rule, is to assure that creditors and financial institutions have programs in place to detect, prevent and mitigate occurrences of identity theft. Each year 9 million Americans have their identities stolen. Identifying information includes drivers' licenses, social security numbers, financial information, medical information, and even criminal records.

Why do health care providers fall under the Red Flag Rule? Simply, most health care providers fall under the FTC's definition of a creditor – providers do not routinely collect payment at the time a service is rendered. Since providers bill patients after services are completed, accept insurance payments and hold the patient liable for the balance of the medical fees, providers are considered "creditors" under these rules.

Each financial institution or creditor must have an Identity Theft Prevention Program that includes policies and procedures to:

- IDENTIFY Red Flags for covered accounts
- DETECT Red Flags that are covered by the Program
- RESPOND to Red Flags to prevent and mitigate identify theft
- ENSURE the Program is updated periodically – to address changes in risk to customers

The FTC provides oversight of this act, and as such is empowered to impose civil penalties not to exceed $2,500 per infraction. There are no criminal penalties for failing to comply with the Red Flag Rule.

The World Privacy Forum outlines specific red flag areas for health care providers:

- A complaint or question from a patient based on the patient's receipt of a bill for another individual; a bill for a product or service that the patient denies receiving; a bill from a health care provider that the patient never patronized; or a notice of insurance benefits for health services never received.
- Records showing medical treatment that is inconsistent with an exam or with a medical history as reported by the patient
- A complaint or question from a patient about the receipt of a collection notice from a bill collector
- A dispute of a bill by a patient who claims to be the victim of any type of identify theft
- A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance

"In the context of health care, medical identify theft is not just a financial matter. It can have real consequences for physical harm to patients," said Naomi Lefkovitz, an attorney with the FTC's Division of Privacy and Identity Protection. *(Jim Landry is the administrator of the Tulane University department of psychiatry).*

Seniors Mental Health Access Improvement Act of 2009

Legislation has been introduced in both the House and Senate to establish Medicare coverage of licensed professional counselors and marriage and family therapists. These bills would significantly improve Medicare beneficiaries' access to outpatient mental health care, in a very cost-effective manner. Medicare is the nation's largest health insurance program, covering more than 40 million Americans. In the next 20 years, the program will nearly double in size as the baby-boom generation becomes eligible for coverage. With the exception of the recent federal parity law that finally equalized outpatient co-payments for mental health and medical/surgical services, the baseline Medicare mental health benefit has not been updated in almost 20 years.

Medicare has covered psychologists and clinical social workers since 1989, but does not cover licensed professional counselors. Many Medicare beneficiaries live in mental health professional shortage areas, and there are more than 110,000 licensed professional counselors across the country ready to provide needed treatment. Lack of access to outpatient mental health treatment harms beneficiaries, and contributes to overutilization of more expensive inpatient care.

The first session of the 111th Congress presents the best opportunity in almost a decade to achieve the long-sought goal of Medicare reimbursement for licensed mental health counselors (LMHCs) and marriage and family therapists. Despite being widely recognized by private sector health plans, licensed professional counselors have yet to be recognized under Medicare. These licensed professional counselors are available to meet the large and growing need for qualified mental health professionals to serve Medicare beneficiaries. Counselors meet education and training standards on par with those of clinical social workers, who have been covered under Medicare for nearly twenty years.

Congress should pass Medicare legislation this year, in order to prevent a scheduled 20% pay cut for physicians under the program from taking effect on January 1, 2010.

The Seniors Mental Health Access Improvement Act of 2009 has already been introduced in the House and Senate: H.R. 1693 and S. 671. The purpose of this act is to:

1. Amend title XVIII (Medicare) of the Social Security Act to provide for coverage of marriage and family therapist services and mental health counselor services under Medicare part B (Supplementary Medical Insurance), particularly those provided in rural health clinics, federally qualified health centers (FQHCs), and in hospice programs.
2. Amend Medicare part C (Miscellaneous) to exclude such services from the skilled nursing facility (SNF) prospective payment system, and
3. Authorize marriage and family therapists and mental health counselors to develop discharge plans for post-hospital services.

Web Watch

Bazelon Study of State Medicaid Services
Following the Rules is a new report by the Bazelon Center summarizing federal Medicaid policy as of November 2008 with respect to community mental health services covered under the Clinic, Rehabilitation and Home- and Community-Based Services (Section 1915(i)) categories of the law. It also presents the results of a review of official state Medicaid policies for these service categories. The report focuses on community-based services and does not discuss services in hospitals, residential treatment centers for children, group homes or other congregate-care or institutional settings. The report is available for purchase from the Bazelon Center's online store; a PDF version is free via www.bazelon.org/pdf/FollowingRules.pdf.

Coming attractions

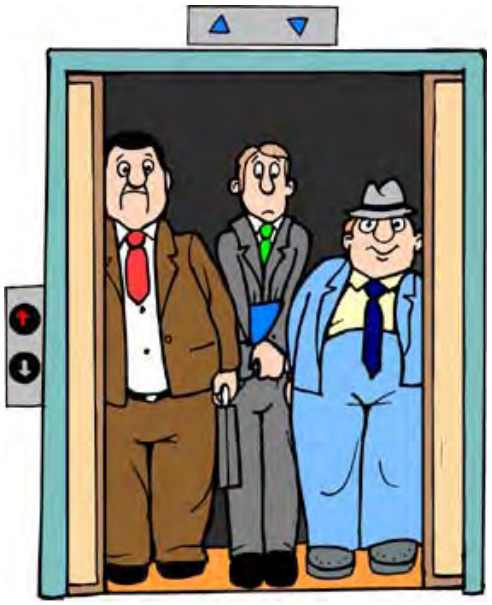
Administrators in Academic Psychiatry Fall Conference
CANCELLED
www.adminpsych.org

Medical Group Management Association Annual Conference
October 11-14, 2009
Denver, CO
www.mgma.com

National Association of Psychiatric Health Systems Association
March 8-10, 2010
Washington, DC
www.naphs.org

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 elevator in our building malfunctioned one day, leaving several of us stranded. Seeing a sign that listed two emergency phone numbers, I dialed the first and explained our situation.



After what seemed to be a very long silence, the voice on the other end said, "I don't know what you expect me to do for you; I'm a psychologist."

"A psychologist?" I replied. "Your phone is listed here as an emergency number. Can't you help us?"

"Well," he finally responded in a measured tone. "How do you feel about being stuck in an elevator?"

Editorial staff

Editor:
Janis Price
Associate Editors:
Radmila Bogdanich
David Peterson
Pat Sanders Romano
Hank Williams

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
UH9D 9822B
Ann Arbor, MI 48109-5118
(734) 936-4860
(734) 936-6880 Fax
janprice@umich.edu