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Fall 2009

The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Hank Williams

Well, we made it through a busy summer! It was the hottest one on record here in Seattle. The list of continuing "hot" issues for each of us to deal with should keep us moving throughout the winter, too.

Speaking of hot issues, be sure and get your registration in today for the *AAP Fall Education Conference*, to be held in New Orleans, November 4-6, 2009.

At our spring conference in Los Angeles, I know we said there would be no fall conference. Afterwards, I received numerous calls and email from you. In essence, you told me (and the Board) you believed our education conferences are an important product of AAP and should be maintained.

About six weeks ago we surveyed the entire membership and got an overwhelming response to continue the fall conference, to continue to have the spring conference, and to maintain the affiliation with MGMA.

Jim Landry (Tulane U) has done a tremendous job of planning and being our AAP member "on the ground" in New Orleans, along with incredible help from **Radmila Bogdanich** (Southern Illinois U) and **Narri Shahrokh (**U California – Davis). The program looks exceptional. It's going to be a lot of fun, too! You get a lot for the low registration fee of $195.

The conference hotel is the Iberville Suites, a Ritz-Carlton property, a block off Bourbon Street in the French Quarter and they are offering a great rate of $119 per night! Don't miss it and bring your family, spouse, or significant other. You can also get the discounted hotel rate two days before and two days after the conference, so make it a vacation! New Orleans is a great town, and I am glad our organization has the opportunity to go there and support the city in our small way.

Call or email me or go to the AAP website if you need a registration form.

There will be an AAP Board of Directors meeting during the day on November 4, followed by the first conference event for all attendees, our traditional Networking Dinner. The program kicks off

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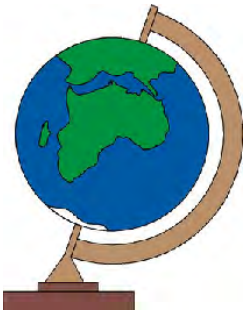
Comings and goings

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:

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President's message

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Thursday morning, November 5 and continues until midday on Friday, with the AAP dinner on Thursday evening.

Times are tough for many of us, and our schools may or may not allow you to travel. I hope if you can only participate in one organization this year, it will be AAP!

Financial pressures on each of our departments will continue to give us new and more difficult challenges for some time to come. That's why I'd like to ask each of you to call on AAP whenever we may be of service. Administrators in Academic Psychiatry is dedicated to serving its membership. The primary ways we serve you are conferences, newsletters, website, listserv, representing our profession to others, and professional networking.

If we are doing a good job with these things, please let us know. If we are not, please let us know. When I say "us" I mean the extraordinary members of our AAP Board of Directors. Always feel free to call or email me directly, and also don't hesitate to call on any of the board members. Our names and contact information are listed on the back page.

See you in The Big Easy!

Hank

Coming attractions

Administrators in Academic Psychiatry Fall Conference
November 5-6, 2009
New Orleans, LA
www.adminpsych.org

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

Administrators in Academic Psychiatry Fall Conference
April 24, 2010

MGMA - Academic Practice Assembly
April 25-27, 2010
Austin, TX
www.adminpsych.org

AAP goes to New Orleans

"Navigating the Economic Storm – Budget, Compliance and Benchmarking" is the theme of the Fall 2009 AAP Education Conference that will be held New Orleans from November 4 -6. Join your colleagues in New Orleans as AAP discusses issues to help its members through the economic challenges that are facing our institutions/ departments.

The Membership Committee has put together an amazing program with high quality speakers who will address current issues that affect our day to day operations. Our key note speakers will be Jennifer Kopke, M.A., L.A.C, Assistant Secretary of the Louisiana Department of Health and Hospitals for the Office of Mental Health, and Richard Dalton, MD, Medical Director of the Office of Mental Health. Kopke and Dalton will discuss challenges faced by the Office of Mental Health during times of economic hardship and budget reductions.

Cecile Tebo, LCSW, Crisis Intervention Unit Administrator, New Orleans Police Department will discuss challenges faced by New Orleans when minimal resources are available to address crisis situations. Tebo was recently named one of the top ten female achievers in New Orleans.She is passionate about her role with mental health in post Katrina New Orleans – this is a DON'T MISS presentation.

Clay Countryman, JD is an expert in healthcare and has published on various compliance

issues. Countryman will discuss Regional Audit Contractors (RAC) audits, Red Flag Rules and the HITECH component of the ARRA legislation and will bring all of us up to date on current federal hot topic regulations.

AAP members **Toni Ansley** (Ohio State U) and **Hank Williams** (U Washington) will be leading two sessions on benchmarking. We all are interested in participating in surveys and receiving benchmarking data specific to psychiatry. Participation in these sessions will move us toward achieving our goal.

AAP's Ask the Experts session, "Take Two Minutes," is always a staple in our program so your questions!

The Fall 2009 Educational Conference is a "Must Attend" conference. Ensure your attendance by sending in your registration today! Hotel rates are $119 per night plus tax. Reservations must be booked by October 13, 2009 to receive the conference rate.

The conference will be held at The Iberville Suites Hotel (this is a hotel within the New Orleans Ritz Carlton). The hotel is located in the historic French Quarter. To book your hotel, go online at www.ibervillesuites.com or call central registrations at 1-866-229-4351. Reservations are under the group name Administrators in Academic Psychiatry. Group code is ARA. Again, to ensure the room rate of $119, reservations must be made by October 13, 2009

The Iberville Suites has also guaranteed the conference room rate for two days prior and two days post conference for those of you who want to extend your stay in New Orleans.

AAP will again provide two networking dinner opportunities – the evenings of November 4 and November 5. Please plan your arrival so you can join your friends and colleagues in these informal settings.

Eating your way through New Orleans

Of all the things New Orleans is famous for, perhaps the best loved are the great variety of cuisines available in the Big Easy. Ingredients from many diverse cultures have influenced the foods found across the city and surrounding areas.

Early Europeans who settled in the area and favored rich foods like gravies and roux, sausages, spices, rice and pastries. These early settlers had slaves who further influenced the cooking with their use of West Indian spices and okra (called gumbo). Native Americans contributed the use of sassafras and bay leaf. The medley of ingredients became the basis of Creole cooking.

Cajun cooking arose from the early Canadian settlers, called Acadians, who settled in the bayous around New Orleans and needed to make do with the local ingredients available to them. Cajun food relies heavily on the shellfish, alligator and spices found in the swamps and waterways.

So, now that you know the history, here's a glossary to make your dining selections easier to decide. Of course, there are many more items to choose from - this is just a taste!

Andouille (pronounced ahn-*dooey*). A mildly spiced Acadian smoked sausage of lean pork, it often flavors gumbos, red beans and rice, and jambalayas.

Beignet (pronounced ben-*yay*). Literally means "fried dough." Originally a rectangular puff of fried dough sprinkled with powdered sugar, the term can also refer to fritters or crullers containing fish or seafood.

Bisque A thick, heartily seasoned soup, bisque is most often made with crawfish, crab, or shrimp.

Bread pudding In the traditional version, stale French bread is soaked in a custard mix, combined with raisins, and baked, then served with a hot sugary sauce flavored with whiskey or rum.

Chicory coffee The ground and roasted root of a European variety of chicory is added to ground coffee in varying proportions. Originally used for reasons of economy, coffee with chicory is now favored by many New Orleanians. It lends an added bitterness to the taste.

Dirty rice In this cousin of jambalaya, bits of meat, such as giblets or sausage, and seasonings are added to white rice before cooking.

Dressed A po'boy "dressed" contains lettuce, tomato, pickles, and mayonnaise or mustard.

Étouffée (pronounced ay-too-*fay*). Literally, "smothered," the term is used most often for a thick stew of crawfish tails or chicken and served over rice. It is similar to a gumbo.

Gumbo From an African word for okra, it can refer to any number of stewlike soups made with seafood or meat and flavored with okra or ground sassafras and myriad other seasonings. Frequent main ingredients are combinations of shrimp, oysters, crab, chicken, andouille, duck, and turkey. A definitive gumbo is served over white rice.

Jambalaya (pronounced jam-buh-*lie*-uh). a relative of Spain's paella. The rice is cooked with a mix of diced meat and seafood in tomato and other seasonings. Shrimp and ham make frequent appearances, as do sausage, green pepper, and celery.

Muffuletta The city's southern Italian grocers created this round-loaf sandwich traditionally filled with ham, salami, mozzarella, and a layer of chopped, marinated green olives.

Po'boy A hefty sandwich, the po'boy is made with the local French bread and any number of fillings: roast beef, fried shrimp, oysters, ham, meatballs in tomato sauce, and cheese are common.

Praline (pronounced *prah*-leen). A sweet patty-shape confection made of pecans, brown sugar, butter, and vanilla.

The executive suite

Green shoots and inflection points

by David Peterson, FACMP

"Green shoots" are everywhere in the business and popular press. Blame it on Ben Bernanke, the Chairman of the Federal Reserve, who used the term earlier this year to describe some glimpses of green (growth and recovery) in an otherwise barren economic landscape. If you haven't already, you'll likely see the term in business and editorial columns where any glimmer of positive news, growth or new development finds a green shoot reference. Whether it is a jump in new car sales or home financing, increased consumer confidence, declines in unemployment claims or declining business inventories, all positive signs in a recovering economy, a green shoot can be found.

References to "inflection points" are equally abundant and according to the former CEO of Intel, these can be defined as "a time in the life of a business when its fundamentals are about to change. That change can mean an opportunity to rise to new heights. But it may just as likely signal the beginning of the end…"[1] Many economists have argued that the US and global economies have been or are at inflection points. Businesses certainly have found themselves on the cusp, i.e. inflection point, of success or failure. To be sure and depending upon the outcome of healthcare reform, the payment for and delivery of medicine could be at an inflection point.

Green shoots and inflection points trickle down to academic departments in a myriad of ways. As administrators in academic psychiatry, we occupy unique positions to help identify and nurture "green shoots" as well as provide a push in the right direction when programs within departments reach an "inflection point."

Look around. There are likely green shoots in abundance in your department. A green shoot could be a faculty member with a budding research idea, a staff member who is creatively thinking or a fledgling program that is finding its legs. Relationship-building could be a green shoot as could progress in the cost containment world. Green shoots can be anywhere and in the unlikeliest of places.

There are also individuals or programs that find themselves at an inflection point, poised at the edge of success or failure. Such inflection points could be a struggling research program that is experiencing steadily diminishing returns, either scientific or financial. Another inflection point could be a clinical program, possibly a former "green shoot," that has reached near critical mass, lacking only that extra human, financial or other resource to get there.

Like green shoots, inflection points often represent opportunities and green shoots can often lead to inflection points. There is much to be gained by recognizing both in a timely way.

Successfully identifying that green shoot and inflection point, determining when to nurture the former and determining the right direction in which to tip the latter requires a broad skill set, one that membership in the **American College of Medical Practice Executives (ACMPE)** can help build, fill in, or expand.

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.

Endnotes

1 "Economic Commentary," http://www.nmfn.com/tn/learnctr--articles--eccom_0809 (retrieved August 25, 2009).

Research news

by Hank Williams

American Reinvestment and Recovery Act 0f 2009

For all of us involved in Research Administration — and I think that's most of us — we made it through the ARRA (American Reinvestment and Recovery Act of 2009) proposal submission onslaught of March, April, and May.

It was a stressful time for staff and administrators who work closely with researchers on proposals. ARRA is a wonderful new program and source of funding, but it is also coming with many new requirements and deadlines.

We're now starting to get the results of those ARRA proposals, finding out who got their Challenge Grants funded, who got Administrative Supplements, and others.

Among the new research issues for this fall will include the additional reporting requirements for those ARRA dollars.

It is very important for each of us to be very involved with our university research offices, and the institution wide efforts to assist with these new requirements.

Watch for those university communications regularly. Put questions you have out on the AAP listserv, and get yourself on the agency email lists (like NIMH) to keep up with the latest.

Complying with ARRA reporting requirements will mean tracking information that many of us have never tracked before, such as job creation, and submitting it with greater frequency and a short turnaround. There are new data elements for reporting and they have to be turned around quickly. Detailed quarterly reports are due to funding agencies within ten days of the quarter end, and the reported information will be posted on a public website within thirty days of the quarter end.

Budgets

Once ARRA was put to bed we had to make it through June and July, with all of the research budget issues of the new year (if your fiscal year began in July).

We each have our own sets of unique budget issues this year. Among the most challenging is the way that our AAP member institutions has of distributing (or not) the indirect dollars earned by those proposals we did that "grew up" to be grants. Those methods of distribution can dramatically affect our department budgets.

I hope your department receives some or all of its indirect research dollars (at the University of Washington we call them "Research Cost Recovery" dollars). We only receive a few of the dollars directly back into our department budget, but they are an important few.

Upcoming NIH deadlines

Now do we get to kick back and relax? No…no…no!

As departments of psychiatry, we are scrambling to keep those direct and indirect research dollars flowing. So let's stay on top of some of the major upcoming NIH submission deadlines. Here are a few of the big ones and the deadlines:

New RO1 or UO1	October 5
RO1 or UO1 Renewals, resubmissions, revisions	November 5
New K Award	October 12
K Award Renewals, resubmissions, revisions	November 12
Training Grants (T Series) New and renewals	September 25

Be sure to give yourself plenty of time to work with the faculty members who will call on you for assistance. You can even be proactive and contact them in advance.

American Recovery and Reinvestment Act impacts privacy provisions of HIPAA

The American Recovery and Reinvestment Act of 2009 (ARRA), the economic stimulus package, was enacted into law through signature of President Obama on February 17, 2009. With regard to HIPAA, the law addresses changes to the business associate (BA) requirements, use of technology, and enhances privacy regulations for covered entities (CE). This article outlines changes in the latter.

ARRA imposes a new requirement on CEs and BAs that prohibits them from directly or indirectly receiving remuneration in exchange for any protected health information (PHI) of an individual, except in certain circumstances (outlined in the bill). It *does not* include, among other reasons, sale of PHI for treatment or research purposes, or supplying a patient with his or her PHI (fee limited to the labor cost to provide the information).

Covered entities will now be required to honor requests to limit disclosure of PHI. An individual has a right to ask a covered entity to limit disclosures of his or her PHI to a health plan to pay for or carry out health care operations, and the covered entity must conform to the request. The individual must, however, pay in full out-of-pocket for the health care item or service.

An individual can also request an accounting of his or her PHI disclosures by a CE in the past three years, if the CE made the disclosures using Electronic Health Record (EHR) technology. A CE that had EHR as of January 1, 2009 must account for disclosures made on or after January 1, 2014. Those covered entities that do not have EHR must account for disclosures made on or after January 1, 2011 or the date that they implement EHR, whichever is later. The Secretary of Health and Human Services will issue regulations in the future regarding what must "be collected about each disclosure."

Under ARRA, CEs and BAs may continue to market products or services that encourage patients to purchase or use the product or service without obtaining an authorization, as long as the communications 1) describe a health-related product or service (or payment for such product or service) that is provided by, or included in a plan of benefits of, the CE making the communication, 2) relate to treatment of the individual, or 3) relate either to case management or care coordination for the individual, or to the recommendation of alternative therapies, treatments, health care providers or settings of care for the individual. ARRA continues to allow CEs to receive direct or indirect payment in exchange for these communications but only if the communication relates to a drug or biologic that the patient is currently prescribed, the payment amount is reasonable, and certain other conditions are met. These changes are effective February 17, 2010.

A guidance is expected by August 2010 from the Secretary of Health and Human Services defining the minimum necessary rule; that is, what is the minimum PHI which should be released to achieve the purpose for which the information has been requested. Until that time, CEs are required to limit the use, disclosure or request of PHI, to the extent possible, to the limited data set or if needed by such entity, to the minimum necessary to accomplish the intended purpose of the use. A limited data set is defined as protected health information that excludes many or all direct identifiers of the individual or of relatives, employers, or household members of the individual.

Other privacy regulations pertain to the accounting of disclosures, notifications if disclosure requirements have been breached and the penalties for these breaches.

The entire American Recovery and Reinvestment Act can be found on the web at http://www.hipaa.com/documents/arra_2009.pdf sections 13401 - 13424 (pages HR 1-146 to HR 1-165).

Elimination of inpatient consult codes being considered

The following is excerpted and adapted from the Federal Register, July 13, 2009**.** *The comment period for this change ended August 31, 2009. The final rule will be forthcoming with a proposed effective date of January 1, 2010..*

Despite efforts, the physician community disagrees with Medicare interpretation and guidance for documentation of transfer of care and consultation. The existing consultation coding definition in the AMA CPT definition remains ambiguous and confusing for certain clinical scenarios and without a clear definition of transfer of care.

The CPT consultation codes are used by physicians and qualified NPPs (non physician providers) to identify their services for Medicare payment. There is an absence of any guidance in the AMA CPT consultation coding definition that distinguishes a transfer of care service (when a new patient visit is billed) from a consultation service (when a consultation service is billed). Medicare does provide guidance although there is disagreement with the policy from AMA CPT staff and some members of the physician community. Because of the disparity between AMA coding guidance and Medicare policy some physicians state they have difficulty in choosing the appropriate code to bill. The payment for both inpatient consultation and office/outpatient consultation services is higher than for initial hospital care and new patient office/outpatient visits. However, the associated physician work is clinically similar. Many physicians contend that there is more work involved with a new patient visit than a consultation service because of the post work involvement with a new patient. The payment for a consultation service has been set higher than for initial visits because a written report must be made to the requesting professional. However, all medically necessary Medicare services require documentation in some form in a patient's medical record. Over the past several years, some physicians have asked CMS to recognize the provision of the consultation report via a different form of communication in lieu of a written letter report to the requesting physician have been eased by lessening the required level of formality and permitting the report to be made in any written form of communication, (including submission of a copy of the evaluation examination taken directly from the medical record and submitted without a letter format) as long as the identity of the physician who furnished the consultation is evident. Although preparation and submission of the consultant's report is no longer the major defining aspect of consultation services, the higher payment has remained.

Both AMA CPT coding rules and Medicare Part B payment policy have always required that there is only one admitting physician of record for a particular patient in the hospital or nursing facility setting. This physician has been the only one permitted to bill the initial hospital care codes or initial nursing facility codes. All other physicians must bill either the subsequent hospital care codes, subsequent nursing facility care codes or consultation codes.

Beginning January 1, 2008, we ceased to recognize office/outpatient consultation CPT codes for payment of hospital outpatient visits (72 FR 66790 through 66795). Instead, hospitals were instructed to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all hospital outpatient visits. Regardless of all of efforts to educate physicians on Medicare guidance for documentation, transfer of care, and consultation policy, disagreement in the physician community prevails

.

Proposal

Beginning January 1, 2010, it is proposed to budget neutrally eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes) by increasing the work RVUs for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits,

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and incorporating the increased use of these visits into PE and malpractice RVU calculations.

Physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. The initial visit in a skilled nursing facility and nursing facility must be furnished by a physician except as otherwise permitted as specified in Sec. 483.40(c)(4). In the nursing facility setting, an NPP who is enrolled in the Medicare program, and who is not employed by the facility, may perform the initial visit when the State law permits this. An NPP, who is enrolled in the Medicare program is permitted to report the initial hospital care visit or new patient office visit, as appropriate, under current Medicare policy. Because of an existing CPT coding rule and current Medicare payment policy regarding the admitting physician, a modifier will be created to identify the admitting physician of record for hospital inpatient and nursing facility admissions. For operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. The admitting physician of record will be required to append the specific modifier to the initial hospital care or initial nursing facility care code which will identify him or her as the admitting physician of record who is overseeing the patient's care. Subsequent care visits by all physicians and qualified NPPs will be reported as subsequent hospital care codes and subsequent nursing facility care codes. The rationale for a differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services. To be consistent with OPPS policy, only new and established office or other clinic visits will be paid under the PFS.

Section 1834(m) of the Act includes "professional consultations'' (including the initial inpatient consultation codes "as subsequently modified by the Secretary'') in the definition of telehealth services. It is recognized that consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site. Therefore, for CY 2010, if the proposed policy to eliminate consultations from the PFS is finalized, it is proposed to create HCPCS codes specific to the telehealth delivery of initial inpatient consultations. The purpose of these codes would be solely to preserve the ability for practitioners to provide and bill for initial inpatient consultations delivered via telehealth. These codes are intended for use by practitioners when furnishing services that meet Medicare requirements relating to coverage and payment for telehealth services. Practitioners would use these codes to submit claims to their Medicare contractors for payment of initial inpatient consultations provided via telehealth. The new HCPCS codes would be limited to the range of services included in the scope of the CPT codes for initial inpatient consultations, and the descriptions would be modified to limit the use of such services for telehealth. The HCPCS codes would clearly designate these as initial inpatient consultations provided via telehealth, and not initial hospital care or initial nursing facility care used for inpatient visits. Utilization of these codes would allow CMS to provide payment for these services, as well as enable it to monitor whether the codes are used appropriately.

If HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations are created, it is also proposed to crosswalk the RVUs for these services from the RVUs for initial hospital care (as described by CPT codes 99221 through 99223). It is believed that this is appropriate because a physician or practitioner furnishing a telehealth service is paid an amount equal to the amount that would have been paid if the service had been furnished without the use of a telecommunication system. Since physicians and practitioners furnishing initial inpatient consultations in a face-to-face encounter to hospital inpatients must continue to

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UNC Health Care offers help for pregnancy-related anxiety and depression

By Margot Carmichael Lester for UNC Health Care

Pregnancy and new motherhood are tough enough, with certain expectations, many of them unrealistic, coming from the mom as well as well-meaning family and friends, says Christina Lomax, a Greensboro mother.

For 10 percent to 15 percent of women, the expectations, anxieties and stress of motherhood lead to debilitating mental health problems during or immediately after pregnancy, and for most, there is no place to turn.

"Women who need help with mood disorders should have it from providers who are experienced, knowledgeable and able to provide the most appropriate care," Lomax says.

In November 2008, UNC Health Care opened what might be the only inpatient perinatal psychiatry program in the country. A break from traditional postpartum mental health programs – if they even exist – the UNC program, at the North Carolina Women's Hospital, is separate from the psychiatry unit, so women, their babies and their families feel more comfortable having their acute needs met.

"Many studies show that maternal depression has a negative effect on infant development, and has been associated with higher rates of colic and increased injuries resulting from the mother's failure to follow routine safety practices like using a car seat," explains Samantha Meltzer-Brody, M.D., assistant professor in the Department of Psychiatry in UNC's School of Medicine and director of the Perinatal Psychiatry Program of the UNC Center for Women's Mood Disorders. "It's also related to impaired mother-child bonding, which can have many long-term consequences."

More alarming: The most serious cases – women suffering from post-partum psychosis – have a 5 percent risk of suicide and 4 percent risk of infanticide. But many women simply slip through cracks, either because they don't seek care or their physicians don't recognize the problem – or know how to treat it if they were to find it. There is no national standard for screening women for depression, Meltzer-Brody says.

"It's critical to provide a supervised setting where we can ensure the safety of mother and baby," says Meltzer-Brody, to created the new inpatient unit. The unit is baby-friendly, offering extended, supervised time for mother and baby to be together.

Clarke May, a new mom who lives in Durham, started to feel anxiety and depression when her son, Max, was 3 months old. "It got to the point where I just couldn't handle it," she says. She stayed in the UNC unit for two weeks, enough time to overcome depression and feel more comfortable caring for Max.

Letting moms visit with their families is part of what makes the inpatient service unique and successful. During her recovery as an inpatient, Max visited his mom often, which helped nurture the bonding experience while helping May overcome depression.

Cognitive behavior therapy helps women like May cope with anxiety, stress, insomnia, lack of confidence and sadness. They also participate in family therapy and learn biofeedback and proper medication management. Comfort measures include gliders in patient rooms, a dedicated pumping room and pumping equipment and milk storage for nursing mothers. Additionally, staff provide lactation consulting and post-partum and obstetric care.

After discharge, care continues through one of two clinics, at UNC or at Rex Hospital in Raleigh. Services are usually covered by most insurance policies.

But the clinics can only help women who request assistance. "The stigma attached to mental illness can double

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itself in the mind of an expectant or new mother and she may shy away from seeking help," says Lomax, who received outpatient services from UNC. "I've met so many other mothers who have experienced mood disorders during and after pregnancy that didn't receive help because they thought they needed to just 'get through it.'"

Meltzer-Brody agrees. "Many women would rather die than go to a psychiatry clinic," she says. "That's why we align ourselves with comprehensive perinatal services and have integrated some of our perinatal outpatient mental health providers into the ob-gyn clinics."

Referrals are not required to receive treatment. Women can request an appointment in the perinatal outpatient program by calling themselves. Direct admission to the inpatient perinatal unit can be secured through a mental health provider.

"I encourage women to look at it this way: You'd seek treatment if you were bleeding or had pregnancy-related diabetes, right? Depression and anxiety are just other complications," Meltzer-Brody says. "We can help you. The sooner you call, the sooner you'll get well."

Inpatient consult codes

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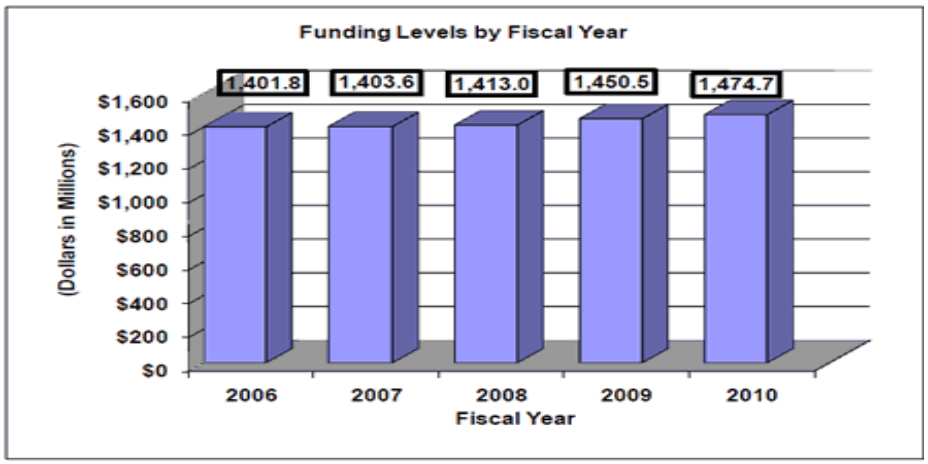
utilize initial hospital care codes (as described by CPT codes 99221 through 99223), it is believed to be appropriate to set the RVUs for the proposed inpatient telehealth consultation G-codes at the same level as for the initial hospital care codes.

This proposed change would be implemented in a budget neutral manner, meaning it would not increase or decrease PFS expenditures. This change would be budget neutral for the work RVUs by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes and the work RVUs for initial hospital and facility visits by approximately 2 percent to reflect the elimination of the facility consultation codes. The utilization for the office consultation codes into the office visits and the utilization of the hospital and facility consultation codes into the initial hospital and facility visits have been crosswalked. This change would be made budget neutral in the PE and malpractice RVU methodologies through the use of the new work RVUs and the crosswalked utilization.

Psychiatry by the numbers

National Institutes of Health
National Institute of Mental Health
Budget Authority Across Fiscal Years



I'd rather have a bottle in front of me than a frontal lobotomy.

Dorothy Parker

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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:

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