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The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Hank Williams

Howdy, Pardners!

Begin making your plans now to attend the AAP Spring Education Conference April 23 and 24, 2010 in Austin, Texas.

This won't be just any conference either. It will be the 25th birthday celebration of AAP! We'll have some special things planned, so you don't want to miss it.

We will host the 2010 conference in conjunction with MGMA's Academic Practice Assembly (APA). APA is scheduled April 25-27, at the same location. Plan to attend that one too!

The Fall Education Conference in New Orleans was incredible! Our attendance was one of the largest ever for a Fall Conference. The program and speakers were of the highest quality and relevance.

Thank you again **Jim Landry** (Tulane U), **Narriman Shahrokh** (UC Davis), and **Radmila Bogdanich** (Southern Illinois U) for all your work and planning.

Have you been to the new AAP website yet? Check it out at www.adminpsych.org. The site looks terrific! Thank you **Elaine McIntosh** (U Nebraska) and **Rich Erwin** (U Missouri) for your amazing work on this. Also thanks to Jim Landry and **Margaret Moran Dobson** U Toledo) for your participation in the vendor selection process.

We are in the process of getting documents, photos, links, and other relevant items loaded onto the site. This also includes past issues of The GrAAPvine! Words cannot begin to express the appreciation we all feel for our editor **Jan Price** (U Michigan). Thank you for all the incredible work you do on this publication year in and year out.

The new listserv is up and going also (elist@adminpsych.org). Use it to quickly ask questions of the membership; it's a wonderful tool.

The AAP Board of Directors consists of 10 elected members, and 2 appointed members. Six of the ten spots will be up for grabs this spring. **Steve Blanchard** (U Iowa), AAP Immediate Past President, is chair of the Nominating Committee. Please call or email

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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:

Justin Adams
Tulane University
504-988-7529
jhadams@tulane.edu

AAP bids farewell to **Tina Nesbed**a (U Massachusetts) who has left psychiatry for the department of Quantitative Health Sciences.

President's message (continued)

Continued from Page 1

Steve or any board member if you are interested in serving. We need you!

Right now we are at about 125 members, and I believe we have had 9 new members so far this year. A special thanks goes to **Tina Nesbeda** (U Massachusetts) who has done a terrific job as the Membership Chair. Sadly for us (but wonderful for her), Tina has resigned her position in the U Mass department of psychiatry and so must also leave her position on the AAP Board. I know we all wish her the best of luck in all her future endeavors. **Glory Novak** (U Arizona), Membership Member-at-Large, will assume Tina's responsibilities for the remainder of this term.

At this time of year, all of us tend to reflect on the past year and all the wonderful things we have to be thankful for. I'm so thankful for each of our members and for the opportunity to get to know you personally. Working with AAP is a joy, and I am so thankful to have professional colleagues who have answered the call to serve academic institutions, and work with the field of psychiatry.

Have a wonderful holiday, everyone!

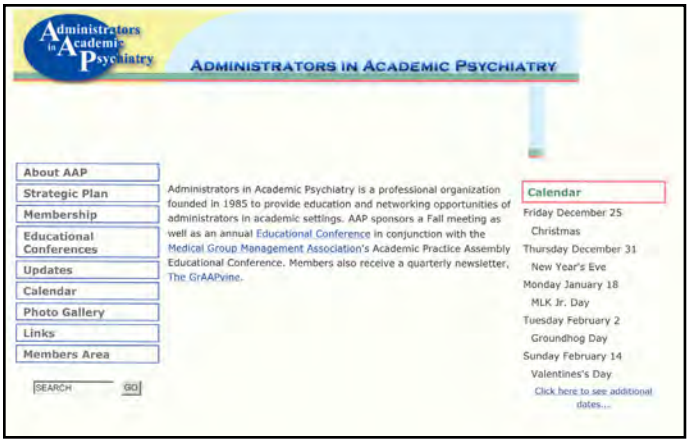
First time conference attendees L to R: Justin Adams, Greg Benham, Pam Wesley and Phil Thompson

New AAP website available

by Elaine McIntosh

For the past two years the AAP Website Committee has been working toward developing a new website that would update the previous website with additional functions. The Committee was made up of **Rich Erwin** (U Missouri), **Jim Landry** (Tulane U), **Margaret Moran Dobson (U Toledo) and Elaine McIntosh** (U Nebraska).

On November 1, the new website went live. The website address is www.adminpsych.org. Even though the website is live, it is still under development; we are still adding and updating information. The process of developing an RFP, evaluating bids and selecting a developer, and paring down our wish list of features to accommodate our budget was taxing at times. The new website does have a list of our Board of Directors with e-mail contact information, historical information about the organization, along with the current bylaws and strategic plan. The guideline for membership in AAP is available on the site with the ability to submit a membership application online. Information about our educational conferences will be available with the ability to register for conferences online. At this time, we are not offering the ability to pay for conference registrations online because of bank costs related to online payment. Upcoming additions will be information about AAP news items, a calendar of events, and a photo gallery of recent events. The website also has a list of provider/professional links and coming soon will be links to members' department websites. The Members Area of the website will eventually become a secure area for members only. We plan to put extended member information in this area in the future. You will also be able to find job postings in this area, the current and archived *GrAAPvine* issues, and a section where you can change your membership information. We were unable to include the capability to have a searchable database because of cost considerations.



The plan will be to update the website on a regular basis and it can be changed as the needs of AAP change. At the fall AAP Board meeting in New Orleans several suggestions were made to improve the website and these are being implemented. Comments from the membership regarding ways to make the website more user friendly or more pertinent to the membership's needs are welcome. Please forward comments/suggestions to Rich Erwin (Erwinrw@Health.missouri.edu) or Elaine McIntosh (emcintos@unmc.edu).

In addition to the development of the website, the listserv maintenance has been shifted to the website developer. The new listserv address is elist@adminpsych.org. The listserv has been very active with questions and responses posted by our membership since its implementation. This activity is very rewarding for the Website Committee because we feel the listserv is a primary benefit to our membership.

This project took much longer than anyone anticipated at the outset. Each Committee member made unique contributions to the completion of the project. Our hope for the future is that the website will be dynamic in providing up-to-date information that serves the needs of our AAP members.

AAP benchmarking efforts

by Radmila Bogdanich, MA

A considerable part of the AAP board meeting was spent on discussing benchmarking survey plans and what direction the organization would like to move in. The AAP Board decided it wants to become the go-to organization for comprehensive and timely benchmarking data for academic psychiatry departments. The goal of the benchmarking survey will be to:

- improve further on current benchmarking data
- develop best practices
- create an alliance and collaboration with the American Association of Chairs of Departments of Psychiatry (AACDP).

The Chairs' group has expressed a strong interest in collaborating with us on a comprehensive benchmarking effort. They have surveyed their members to solicit questions that their group would like to have answered as part of the benchmarking effort. Those questions were submitted to our Benchmarking Committee.

The Board decided to use the AAP 2001 Benchmarking Survey tool as a template and make needed changes to questions to meet our needs. Questions will also be added from recent surveys done by **Hank Williams** (U Washington) and **Toni Ansley** (Ohio State U). The AADCP's questions will be integrated into this instrument as well. AAP will own the data collected. Benchmarking Committee Chair, **Radmila Bogdanich** (Southern Illinois U), will lead the effort. The statistical review will be coordinated by Hank and Radmila. The Benchmarking Committee will develop and present to the Board a business plan outlining the total cost of the survey. Once the plan has been approved by the Board, the Chairs will be approached about supporting this effort financially as well.

Hank has access to a survey database instrument at University of Washington that can be used to send the survey out electronically at no cost to AAP. The system allows for unlimited questions and assists with aggregating data. All questions will be reviewed for reliability before the instrument is finalized. The survey will be sent to all academic psychiatry departments. The logistics of gathering the data are still to be decided.

There was discussion about payment to receive the survey results and if those participating would get the results for free.

A hands-on session was conducted at the fall meeting, with all conference attendees breaking up into three groups. The charge of each group was to review the current tools and the AACDP questions and decide which in each were relevant. The groups also discussed survey methodology and who should have access to the survey data received. Some new areas of interest included: having information broken down by division; clinical programming, residency training, top 10 diagnoses and CPT codes (inpatient and outpatient), faculty productivity, faculty compensation, indirect cost models, practice plan structures, integration/affiliation models of medical school/teaching hospital structures, FTE resident lines of research funding, VA relationships (size and scope), total public sector funding, and margins in practice plans. The groups decided to use MGMA definitions for purposes of consistency. In instances where there are no MGMA definitions, the committee will develop them.

The Benchmarking Committee will meet to review the draft of the new survey instrument which will include all new questions. The draft will be further refined by the Benchmarking Committee. Once the instrument is finalized, the business plan will be developed and submitted to the Board for approval. We plan to have the final instrument ready for review by the membership at the AAP spring meeting. At that time definitions will be reviewed and all questions will be clarified so that everyone answering questions is doing so within the same framework.

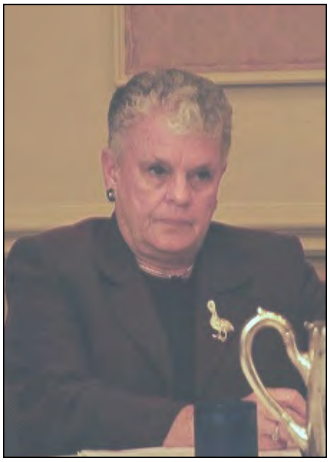
The Benchmarking Survey Committee currently consists of Radmila Bogdanich, Chair; Toni Ansley, Hank Williams, **Narri Shahrokh** (U California-Davis), **Joe Thomas** (U Michigan) , **Lindsey Dozanti** (Case Western Reserve U) and Paul Summergrad, MD (representing the AACDP). If you have any questions please feel free to contact Radmila via email at Rbogdanich@siumed.edu or phone at (217) 545-7650.

Norman MacLeod Lecture

Surviving during economic hardships

by Glory Novak

The Fall AAP conference opened with an engaging presentation relating to circumstances in our host state of Louisiana. Copresenters Jennifer R. Kopke, M.A, LAC, Assistant Secretary, and Richard Dalton, M.D., Medical Director for the Louisiana Office of Mental Health

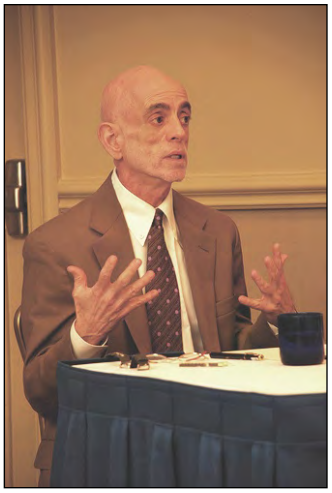


(OMH) discussed how to find opportunities during a time of diminishing resources. Major budget cuts not only affect the parishes of Louisiana, but similar scenarios are playing out in local and state behavioral health organizations nationwide.

Dr. Dalton shared the experience of hurricanes Katrina and Gustav and their impact on the OMH. These natural disasters resulted in far more people needing mental health services, and the OMH almost overnight became part of the largest field hospital in U.S. history. They set up a credentialing system and started serving patients. Instant makeshift pharmacies were set up "on the table" in devastated areas, with professionals sorting and distributing whatever medications were available. OMH had to track where clients fled, and intervene as people with addictive disorders became increasingly agitated. The operation was successful by partnering with Tulane University to provide services during the crises.

The stage was further set by understanding that 1.2 million of Louisiana's 4.4 million residents have Medicaid; the state is in the process of converting its centrally managed mental health system to a network of local governing entities; and let's not forget – the OMH is facing significant budget cuts, as are so many others.

So…at what point does something move from crisis into opportunity? Ms. Kopke suggested that you must determine what you can reconfigure and convince people that you are transforming delivery of services, not taking something away (adding that it is a particular challenge in Louisiana because they *love* old things!) In this case, the OMH began a shift from hospital-based mental health services to community-based services. This included using the Tennessee Outcome Measurement Systems (TOMS) which helps assess mental health needs and allows for meaningful 3- and 6-month follow-up assessments. They were successful in closing an area hospital, and using a team-based approach to provide a variety of therapies throughout the state including evidence-based programs for youth. The cost of care was reduced in the shift to community-based care, and the new model provides better continuity of care as it keeps families together. Other positive changes included transferring long-term adult inpatients to less restrictive settings, consolidating departments,



expanding early childhood services, and establishing service contracts with Tulane.

The presenters summarized the importance of having an overall vision that supports your mission – even more critical when downsizing or facing other crises. Regardless of the circumstances that each entity may be facing, Dr. Dalton reminded us that we must stay focused on where we're going. Effective change takes time.

Glory Novak is the administrator of the U Arizona department of psychiatry.

Crisis intervention

by Jan Price

She doesn't carry a gun, mace or a taser but she gets summoned to some of the most difficult situations in New Orleans. Cecile Tebo, LCSW, Administrator of the New Orleans Police Department Crisis Unit, and her staff of volunteers are called daily by police on the scene to respond to situations involving homicidal, suicidal or gravely mentally ill people in need of care.

As a Licensed Clinical Social Worker, Tebo worked in adoption for many years, first with Volunteers of America and then through her own successful adoption agency. Then, on her 40th birthday, she walked into the NOPD and signed up for the reserves. She was initially a volunteer Reserve Mental Health Technician but by 2004 she had been promoted to Coordinator.

She is the salaried chief of a crew of about four dozen volunteers -- nurses, housewives, students, retirees, and EMTs -- who make up the equivalent of a mental health SWAT team. Most volunteers have a family member with mental illness. There are two teams consisting of two people each working eight-hour shifts between 8 am and midnight daily. (Tebo laughs, "There is no mental illness after midnight!"

The Crisis Unit's main function is to maintain calm at a scene while assessing people's needs and getting them safely where they need to go. "We're dealing with very, very sick people." Tebo, who has been injured on duty, says she is always "on guard," but, "I often have four, five, maybe six officers with me, and they're very protective of me."

The unit gets about 250 calls a month, of which they respond to 68%. Each call takes approximately 1½ hours, so the Crisis Unit is extremely busy. During the last year, the unit responded to 1700 calls. Of these, 855 people were repeaters and 72% were new people, not seen before by the unit. Seventeen percent of the cases

are resolved at the scene, 29% are committed through an order of protective custody, and 71% go voluntarily for care.

Tebo is very proud of the fact that the Crisis Unit has saved NOPD $406,000 while providing a much needed service. She and her volunteers are available for crisis resolution, giving the police the opportunity to "catch the bad guys."

Hurricane Katrina has made a difficult situation much worse. People who prior to the storm would not have been candidates for the Crisis Unit suddenly sought their assistance and those with already identified illnesses became more in need. Charity Hospital, the primary mental health hospital in New Orleans, received massive damage and was closed following the storm. There were no mental health beds in the city. Seriously mentally ill patients were brought to emergency rooms which were not anxious to take them and had no place to admit them, if needed. Tebo, a very charismatic speaker, used the media to turn this around. Emergency rooms now do not turn her patients away. Louisiana State University in New Orleans opened a Mental Health Emergency Room Extension in trailers outside the hospital where 19 patients a day were seen.

To make matters worse, in 2009, due to State budget issues, the New Orleans Adolescent Hospital closed, moving patients three hours away and making it difficult for many parents to participate in their child's care.

In addition to helping the mentally ill on the streets, Tebo is also an advocate of mental health awareness and care. She believes the mental health system is broken and fragmented. She is working to change the lack of respect that mentally ill people encounter. She insists that the public, providers and politicians realize that mental illness is a medical diagnosis and that people with mental illness are not weak or demonic. Then, she says, "The shackles will come off."

Jan Price is the administrator for the hospsital services section of the University of Michigan department of psychiatry.

Benchmarking administrator salaries

by Lindsey Dozanti

Toni Ansley (Ohio State U) discussed the results of the June 30, 2008 Association of American Medical Colleges (AAMC) administrator salary survey for administrators in psychiatry. The survey was sent to 103 schools of which 79 were completed and returned, a response rate of 61%. Base salaries and bonuses were reported by public, private and all schools and five responses for each category were required in order to be included in the survey results.

The survey results demonstrated that clinical science administrators' are paid better than basic science and interdisciplinary administrators. The average salary for clinical administrators in public schools was reported at $109,000, for private schools $120,000 and all schools $112,091.

The survey reported a total of 506 bonuses were paid of which 32% were given in the clinical service area. Public schools reported an average bonus of $11,039, private $14,000 and all schools an average of $12,480.

Total compensation reported clinical science performed better than basic and interdisciplinary administrators' with private schools paying higher than pubic and all schools. Total compensation by schools was reported as $166,000 for private, $137,000 for public and $147,311 for all schools

There were 76 responses for psychiatry clinical administrators. The mean was reported as $118,157 and the 75th percentile was $146,060 of which psychiatry 75th% was ranked ninth among all specialties. The level of education ranged from no BA/BS to MBA/PhD's. The years of experience ranged from fewer than six years to fifteen years or more. Number of full time faculty of twenty-six or fewer to forty-six or more.

Administrators reported 99% were involved with fiscal operations, 97% with contracts and grants, 92% with human resources, 72% facilities/space, 54% information technology, 78% regulatory/compliance, 80% clinical services billing and collections and 20% were involved with some portion of hospital operations.

There was some discussion surrounding how to value administrators who function as both a CFO and CEO. Toni advised she was currently analyzing the average external benchmark which is based on proportional percent effort. She advised that human resource firms are trying to get people to think in the direction of considering if the duties are similar in function vs someone who picks up additional roles as the current average proportion methodology isn't considered a fair way to assign compensation. She reported the new concept is being called "Actual internal equity benchmarking" and that knowledge, skill set, experience, problem solving and results were to be weighted. She encouraged attendees to keep this in mind so compensation isn't unfairly benchmarked even in these economic times.

Toni noted the June 2009 survey was currently being distributed. She emphasized the importance of completing and returning the survey in a timely manner.

Lindsey Dozanti is the administrator of the Case Western Reserve University department of psychiatry.

HIPAA, red flags, and RAC audits, oh my!

by Annemarie Lucas

Attorney Clay J. Countryman from the law firm Kean Miller in Baton Rouge, LA, provided a great overview of three hot compliance topics: HIPAA Breach Notification Requirements, Red Flag Rules, and Medicare RAC audits.

HIPAA Breach Notifications:

The Health Information Technology for Economic and Clinical Health Act (the HITECH Act) of the American Recovery & Reinvestment Act of 2009 required DHHS to issue interim final regulations to require notification of breaches of "unsecured protected health information" by HIPAA covered entities on or afterSeptember 23, 2009. The compliance date is February 22, 2010, so there will be no sanctions until after this date. The breach notification rules require HIPAA covered entities to provide notification to affected individuals and to the Secretary of HHS following the discovery of a breach of unsecured PHI, which includes PHI that hasn't been electronically encrypted or paper that has not been shredded.

A breach is defined as "the acquisition, access, use, or disclosure of unsecured protected health information in a manner not permitted under the HIPAA Privacy Rules which compromises the security or privacy of the protected health information."

To determine if there was a breach, ask yourself, "Was there a risk of harm and was it significant to the individuals?" For example, was a social

security number disclosed? If it didn't cause risk or harm, an organization can choose not to notify, but one still needs to document that it determined not to notify.

Also ask yourself, "To whom was the information disclosed?" Was it disclosed to someone subject to privacy rules? Did you recover the information?

Notification requirements for a covered entity are to be made to the individual and Secretary of HHS, and may include the media. Additionally, a log must be kept of all breaches during the year.

The covered entity must send required notification to individuals without *unreasonable* delay and in no case later than 60 calendar days after the date the breach was discovered by the covered entity. The media must be notified if the breach impacts 500 or more residents in one state. The Secretary of HHS must be notified if the media is notified. For less than 500 individuals, breaches may be submitted annually to HHS via the log.

In any notification always include a brief description of what the covered entity is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches.

Keep in mind that not all violations of the HIPAA Privacy Rule are breaches, and a violation of the HIPAA Security Rule does not by itself constitute a breach.

Additionally, there are some exceptions to the breach notification requirements such as (1) unintentional acquisition, access, or use of PHI by an employee, covered entity, or business associate, if made in good faith within the course of employment and which does not result in further use or disclosure, (2) inadvertent disclosures of PHI from one

person authorized to access PHI to another, and (3) unauthorized disclosures where a covered entity or business associate has a good faith belief that the unauthorized person to whom the PHI was disclosed would not reasonably have been able to retain the information.

FTC Red Flag Rules

The Red Flag Rules apply to any entity that meets the definition of a financial institution or creditor that offers or maintains a covered account as defined by the Red Flag Rules. Basically, if you allow anybody to pay over time you are considered a creditor. A health care provider is a creditor if it regularly bills patients after the completion of services, including for the remainder of medical fees not reimbursed by insurance.

A Red Flag is defined in the regulations as "a pattern, practice, or specific activity that indicates the possible risk of identity theft."

Examples of Red Flags for patients:

- A patient receives a bill for another patient
- A patient receives a bill or EOB for services the patient denies having or for treatment from a provider the patient did not patronize.
- Receipt of a complaint or question from a patient about receiving a collection notice from a bill collector, or about information being added to their credit report by a healthcare provider or insurer.
- A patient who has a previous history of identity theft disputes a bill.

The Red Flag Rules list four basic elements that must be included in an identify theft program:

1. Identify relevant red flags and incorporate them into the program
2. Detect red flags
3. Respond to red flags detected to prevent and mitigate identify theft
4. Ensure the program is updated periodically.

The newest compliance date is June 1, 2010 to have a program, policy and procedures, and training in place.

Medicare Recovery Audit Contractor Audits

The Medicare Modernization Act of 2003 established the Medicare Recovery Audit Contractor (RAC) program as a 3 year demonstration program to identify improper Medicare payments – both overpayments and underpayments. RACs were paid on a contingency fee basis and receive 9% to 12.5% of the improper overpayments and underpayments they collect from providers.

In July 2008, CMS reported that the RACs had succeeded in correcting more than $1.03 billion in Medicare improper payments. Approximately 96% were overpayments collected from providers, while the remaining 4% were underpayments repaid to providers.

The Tax Relief and Health Care Act of 2006 made the RAC program permanent and authorized the Centers for Medicare & Medicaid Services (CMS) to expand the program to all fifty states by 2010.

RAC audits can now only go back three years and there has been a 33.33% success rate in challenging RAC determinations.

The RACs use proprietary software programs to identify potential payment errors in such areas as duplicate payments, fiscal intermediaries' mistakes, medical necessity and coding. The software is geared toward institutions and large dollar claims.

Mr. Countryman noted that it is interesting to watch the way privacy issues are dovetailing with fraud and identify theft issues. It is becoming increasingly important for health care administrators to get up to snuff on compliance issues and he encouraged the group to consider certification in this area.

Annemarie Lucas is the Section Administrator for the ambulatory services section of the University of Michigan department of psychiatry.

The executive suite

Group wisdom on electronic medical records

by David Peterson, FACMPE

As Dan Wickeham, Medical College of Wisconsin's Vice President of Corporate Compliance and Risk Management, and I prepared our talk, titled "New Challenge for Academic Psychiatry: The Electronic Medical Record," for the American Association of Chairs of Departments of Psychiatry Annual Meeting in October, many of you contributed by sharing your wisdom and experience with electronic medical records. More specifically, you responded to the question: *"If you had one single piece of wisdom or point to pass along to our collective "bosses," what would it be?… This single piece of wisdom from each of you could be related to implementation, confidentiality, lessons-learned, ongoing challenges, the future or other things related to an EMR."*

Your responses from across the country, many that touched upon the same points, allowed us to identify and group these "nuggets of wisdom" into eight common themes, all of which found their way into the last third of our presentation, the first third having established a "foundation" for discussion followed by a second third of "hot topics." Below, I'd like to share these nuggets supported by one (of many) representative statements from you:

Nugget #1: Integrate with the Medical Record

"…We did not perceive a need to segregate records… information related to psychiatry is important medical information that should be available to other practitioners."

Nugget #2: Plan and Train

"Get the end-users involved in the planning…process as soon as possible, even if you have to drag them kicking and screaming."

Nugget #3: Develop Templates

"…One of the key benefits for us has been the development of electronic templates for documentation…drop down menus simplify the process… this has also had a positive impact on billing levels…and reimbursement…"

Nugget #4: Eliminate Barriers to Data Entry

"…Look at how tech savvy your psychiatrists are…and their comfort using a computer…be prepared with alternate methods of getting documentation into the EMR rather than typing – such as [voice recognition software]…"

Nugget #5: Understand Systems & Support

"Be really clear…especially as to level of support…and timelines."

Nugget #6: Provide Chairman Leadership

"When we went up on our EMR there were several faculty who resisted. It took strong leadership from our Chair to get the job done."

Nugget #7: Develop Interdisciplinary Teams

"…Make sure the team creating the EMR is interdisciplinary – not only clinically (MD's, nurses, social workers therapists) but administratively (billing, managed care, compliance, regulatory)."

Nugget #8: Get with the Program

"It is clear that this will happen and dragging one's feet will result in getting run over."

The group was lively, with questions and discussion filling the 90 minute presentation. It is abundantly evident that there are clear challenges (and some differing opinions) for psychiatry related to the implementation of an electronic medical record. It was Mr. Wickeham's and my goal to synthesize some of the key issues for psychiatry. Fortunately, there appeared to be much agreement with the eight nuggets above in the final third of the presentation, all of which came from you, the members of the AAP. Thank you for your help.

For 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.

Research news

by Hank Williams

Our individual departments of psychiatry differ greatly with respect to the role that research plays, both in terms of mission and money.

For many of us, the dollars earned through research are vital to our department's success. If you fall in this category, do you feel like your research faculty members are working harder than ever on proposals, yet coming up with fewer funded projects?

Are you worried that your department might have lost its "competitive edge" with respect to research?

Probably not.

Several of our member institutions carefully track psychiatry research proposals, and over the past five years have found the number of research proposals being submitted has risen significantly (in most cases greater than 50%), and the gross amount of research dollars has risen proportionately, yet the ratio of proposals to awards in dollars applied for and dollars awarded, has decreased.

In other words, our principal investigators seem to be working twice as hard for half the research dollars.

Are you finding this to be the case in your department? Let me know.

New NIH application structure

The National Institute of Health (NIH) begins a major restructuring and shortening of applications submitted for Fiscal Year 2011 funding (due dates on or after January 25, 2010).

There are new forms and new instructions—which include shorter page limits All competing applications, including resubmissions, *must* use the new forms and adhere to new page limits and instructions.

NIH suggests that in December, researchers should go back to the updated Funding Opportunity Announcement (FOA) or reissued Parent Announcement, download the new application package and instructions, and read the new application instructions carefully. For due dates on or after January 25, 2010, submit your electronic and paper applications using the new application forms.

NIH's stated goal for these changes is to "continue in its goal to fund the best science, by the best scientists, with the least amount of administrative burden."

NIH is restructuring the applications by aligning the structure and content with review criteria. NIH indicates this alignment will help ensure that both reviewer and applicant expectations coincide for a more efficient and transparent application process. The new application forms incorporate the enhanced peer review criteria for research grants and cooperative agreements that was announced previously.

NIH says it is shortening page limits for competing applications to help reduce the administrative burden placed upon applicants, reviewers, and staff. This change seeks to focus applicants and reviewers on the essentials of the science that are needed for a fair and comprehensive review of the application. Shorter applications may have additional benefits for reviewers such as mitigating information overload, and/or enabling a larger number of reviewers to read each application and participate in review in a more informed manner.

Bill to create national network of depression centers

Senator Debbie Stabenow (D-MI) introduced S. 1857, the ENHANCED Act of 2009, in October. This is a major piece of legislation to "Establish a National Health-Aiding Network of Centers of Excellence for Depression," part of Health Care Reform. It has been referred to the Senate Health, Education, Labor, and Pensions (HELP) Committee.

This bill would establish a national network of centers of excellence for the treatment of depressive disorders. The goal of the bill is to increase the number of people with depressive disorders who receive appropriate and evidence-based treatment, and to establish a national resource to develop and disseminate evidence-based interventions, provide public and professional education, and eradicate the stigma associated with depressive disorders. The concept is based on efforts catalyzed by the University of Michigan Depression Center with 15 other leading U.S. academic medical centers, now known as the National Network of Depression Centers (www.NNDC.org).

Proposed funding for the network is $100 million per year for an initial five year period; $150 million a year for the next five years (until 2016); each center can receive no more than $5 million per year in operating funds. A Coordinating Center would be eligible for an additional $5 million annually.

Senators Sherrod Brown (D-OH) and George Voinovich (R-OH), John Kerry (D-MA), and Kay Bailey Hutchinson (R-TX) are current cosponsors, and Senator Stabenow's office is seeking additional cosponsors. Now that both the Finance Committee and HELP Committee healthcare bills have passed out of committee, the next step will be the merger of these two bills. Before or after the merged bill is brought to the floor for debate, the ENHANCED Act will be introduced as an amendment. As an alternative approach, the ENHANCED Act will be introduced as a stand-alone bill and go through a more traditional legislative process. Another option will be to introduce the act as a part of the Substance Abuse and Mental Health Services Administration (SAMHSA) reauthorization. In any event, SAMHSA is the designated overseeing agency.

A floor statement was submitted with the bill for the Congressional Record along with 4 letters of support from Mental Health America, the American Association for Geriatric Psychiatry, the American Academy of Child and Adolescent Psychiatry, and the American Foundation for Suicide Prevention. The Senator's office will continue to seek additional cosponsors and letters of support.

Administrators in Academic Psychiatry Spring Conference

April 24, 2010
Austin, TX
www.adminpsych.org

Academic Practice Assembly Educational Conference

April 25 - 27, 2010
Austin, TX
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Consultation codes eliminated

On October 30, 2009 the Centers for Medicare & Medicaid Services (CMS) released the 2010 final rule on Medicare physician payment. In its CY 2010 Proposed Physician Fee Schedule (PFS), effective January 1, 2010, CMS has eliminated billing codes for consultation services in most situations. The rule would allow consultation codes in the context of initial visits for telehealth services (G codes), but any other services that are currently billed as consultation codes would have to be billed as new or established office visits, initial hospital visits, or initial nursing facility visits. Instead of consultation codes, providers are instructed to bill initial hospital care (99221-99223), initial nursing facility care (99304-99306) or initial office visits (99201-99205), as applicable. Subsequent consultation visits will continue to be billed with inpatient subsequent care codes (99231-99233). The elimination of consultation codes would effectively eliminate the reimbursement advantage for physician specialists providing consultation services, which have historically been paid at a higher rate than new and established office visits, initial hospital visits, or initial facility visits.

Consultation services are evaluation and management services that are provided by physicians, based on a request by another physician or appropriate source. CMS's policy prior to January 1, 2010 was to only reimburse consultation services if the request was documented, and a written report prepared by the consulting physician. The AMA CPT coding manual does not articulate this documentation requirement, and there are significant disparities among physicians with respect to documentation of the request and written report. There are further disparities regarding the differences between a consultation and a "transfer of care." Due in part to the tension between CMS policy and AMA guidance, CMS acknowledges in the proposed rule that physicians have had difficulty adhering to its standards for reimbursement of consultation services.

CMS also argues that the historical rationale for payment of consultation services at a higher rate, the fact that CMS initially required significantly more documentation with respect to such services, no longer exists. CMS has incrementally changed its documentation requirements due to the conflict between its policy and AMA guidance, so that CMS argues that documentation requirements are now substantially similar among consultation services, office visits, and hospital and facility visits.

In order to distinguish the admitting physician from others who will also now be using the initial care codes, CMS will create a modifier that the admitting provider will append to the initial care code to identify him/her as the admitting provider of record. Others will simply bill the applicable initial care code without a modifier whenever a new patient is seen for the first time.

CMS proposes to implement this rule in a budget-neutral way by increasing the work RVUs for initial hospital and nursing facility visits by about 0.3%, and increasing the wRVUs for both new and existing office visits by about 6%. In addition, CMS will adjust the practice expense and malpractice expense RVUs for the initial visit codes to recognize the increased use of these visits.

These are actual quotes from psychiatrist's charts.

The patient has been depressed ever since she began seeing me in 1993.

The patient is tearful and crying constantly. She also appears to be depressed.

Healthy appearing decrepit 69 year old male, mentally alert but forgetful.

The patient has no history of past suicides.

Patient had waffles for breakfast and anorexia for lunch.

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