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# The GrAAPvine

## Inside this issue



Administrators in Academic Psychiatry

## From the president's desk

*by Narri Shahrokh*

While much of the country has seen extreme weather this summer, we here in Northern California have been experiencing extremely beautiful weather for this time of year—days warm enough to ripen the tomatoes and cool nights with light breezes which we capture by opening our windows in the evenings.

Fall will be here before we know it, so mark your calendars for the AAP Fall Conference in Nashville on October 28-29. Our President Elect, **Toni Ansley** (Ohio State U) and Member-at-Large for Education, **Mario Harding** (Denver Health MC), have been working hard planning this day and a half conference for us with the help of Vanderbilt University's **Pam Wesley**. You will soon receive the registration form and should have already received information about the hotel we will be staying at, the Renaissance Nashville Hotel, located in the downtown area where you will find a diverse assortment of entertainment, dining, cultural and architectural attractions.

Seeing how this will be my first visit to Nashville, I thought I'd learn something about it. The city was founded in 1779, and was originally called Fort Nashborough, after the American Revolutionary War hero Francis Nash. Nowadays, Nashville is synonymous with country music and the Grand Ole Opry. So if you love country, bluegrass, folk, or gospel music, Nashville is for you! We will have our very own **Hank Williams** (U Washington) at the conference, so how can you say no? The most valuable perks of being a member of AAP are the camaraderie, network opportunities and learning experiences that the two yearly conferences offer. So, see you in Nashville!

## 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:

**Virginia Lewis**
Northwestern U
vlewis1@nmff.org

**Brenda Paulsen**
Duke U
(919) 684-5489
brenda.paulsen@duke.edu

AAP bids farewell to these members and good friends:

**Pat Romano** (Albert Einstein Medical School - Yeshiva University) who has recently retired.

**Tom Tantillo** (Children's Hospital of Philadelphia) who has left psychiatry and will be stepping down from his position as AAP treasurer following the Fall meeting.

## Make your plans now for Nashville

Come to Nashville for the AAP Fall Conference October 28-29, 2010. We will be at the beautiful Renaissance Downtown, located in the heart of the business district. The Renaissance provides easy access to many area attractions including Bridgestone Arena, LP Field, B.B. King's Blues Club, Country Music Hall of Fame & Museum, Schermerhorn Symphony Center and Historic Second Avenue District. Room rates at $139.00/ night but you must reserve now to get discounted rate.

Call the hotel at 1-800-327-6618 to make your reservation. Make sure to ask for the group "ACADEMIC PSYCHIATRY" in order to get the contracted group rate.

The agenda and conference registration form will be emailed to you soon (if you haven't already received it).

# How well do you know country music?

**1. Who was the first country artist to sell over 10 million copies of an album?**
A. Garth Brooks
B. Trisha Yearwood
C. Hank Williams Sr.
D. Johnny Cash

**2. Who is Mr. Guitar?**
A. Hank Williams Jr
B. Lester Flatt
C. Johnny Cash
D. Chet Atkins

**3. What country music star was known as the Father of Bluegrass Music?**
A. Roy Acuff
B. Bill Monroe
C. Earl Skruggs
D. Jimmy Dean

**4. Which country singer was inducted into the Country Music Hall of Fame twice?**
A. Waylon Jennings
B. Bill Monroe
C. Roy Rogers
D. Gene Autry

**5. Which country singer is a Rhodes Scholar?**
A. Willie Nelson
B. Hank Williams Jr.
C. Kris Kristopherson
D. Conway Twitty

**6. "Gotta Have a Fiddle in the Band" was recorded by which country music group?**
A. Sons of the Pioneers
B. Alabama
C. Statler Brothers
D. Charlie Daniels Band

**7. Who played professional baseball before becoming a country singer?**
A. Charlie Pride
B. Waylon Jennings
C. Garth Brooks
D. Alan Jackson

1. A. Garth Brooks; 2. D. Chet Atkins; 3. A. Roy Acuff; 4. C. Roy Rogers; 5. C. Kris Kristopherson; 6. B. Alabama; 7. A. Charlie Pride

# National and local models of primary care and behavioral health integration

*by Paul McArthur*

Britta Ostermeyer, MD, and Kathy Reynolds, MSW, provided a comprehensive review of a series of initiatives in integrating community psychiatry into primary care services in Harris County, Texas. The initiatives have gained wide praise and an American Psychiatric Association award for expanding the capacity to address severe shortages in psychiatric services and for improving the lives of persons living with mental illness.

The initiative involved a collaboration of four agencies within the Harris County Hospital District (HDCA) with the goal of increasing timely access to services patients needed. With fifty percent of psychiatric services actually provided by primary care physicians, establishing on-site specialty services and training supports at community health centers helped meet this goal.

Psychiatrists and psychotherapists (LCSW/LMSWs, LPCs and LMFTs) were recruited, hired and placed in the district's community health centers to work side by side with primary care physicians, nurses and social workers. The wait time for new patients at the community's specialty psychiatric outpatient clinic was lengthy before the placements were made. It was reduced significantly to one month or less when the psychiatric care support was in place at the primary care centers. As well, new and non-urgent patients were seen at the community health centers rather than always being referred to the specialty clinic.

The initiative produced significant cost savings to health systems and consumers. As well, it reduced the stigma in obtaining psychiatric services, which was welcomed by patients.

The role emphasized for the psychiatrist and providers in the health centers was that of a consultant. The goal was to stabilize patients and return them to primary care physicians for ongoing treatment. Four hours of psychiatrist time per week was allotted at the centers, with availability by phone outside that time frame. Dr. Ostermeyer pointed out that the new structure helped return psychiatrists to the primary care level of service, a place of service where they belong and which can increase the effectiveness of care.

The program also emphasized education of community health center staff, with a focus on furthering the scope of psychiatric and behavioral interventions by the primary treatment team. Curbside consultations, small-group learning and case conferences are offered for primary care physicians at the centers. Teleconferences and DVDs are offered to the PCPs, as well.

Training and research were integrated into the initiative and the start-up was supported by a number of grants. Ongoing support has been provided by the HCDA. The program is well appreciated and has succeeded in its mission to build a healthier community.

*(Paul McArthur is the administrator of the University of Rochester department of psychiatry).*

# Developmental disabilities center established at Washington University

Improving the lives of infants and children with developmental disabilities will be the focus of Washington University's new Intellectual and Developmental Disabilities Research Center (WUIDDRC) The center, established with a five-year, nearly $6 million grant from the National Institutes of Health (NIH), will focus on research to prevent and treat developmental disabilities in children. Special emphasis will be placed on clinical and translational research as well as on reaching out to families and the community with resources and services.

"Developmental disabilities are very challenging for families," says Terrie E. Inder, MD, PhD, director of the WUIDDRC and professor of pediatrics, of radiology and of neurology and a neonatal specialist at St. Louis Children's Hospital. "Our long-term goal is to provide better care to children in our area through research, advocacy and better clinical services."

Many families with children who have developmental disabilities receive services from the state in which they live, however, those services have been limited due to budget constraints, Inder says. The WUIDDRC will work closely with the State of Missouri, and a member of the center will assist state committees with recent research findings to guide future directions of services.

In addition, the WUIDDRC has reached out to community partners such as the Missouri Foundation for Health; Ranken-Jordan - A Specialty Pediatric Hospital; the Thompson Center for Autism and Neurodevelopmental Disorders at the University of Missouri; the Institute for Human Development in Kansas City, Mo.; and several other programs in Missouri to engage them in the center's services and develop more active collaborations. This will enhance communication of research needs to the WUIDDRC from these state providers and of research findings from the center to patients and families.

The center's research focus will be on cerebral connectivity, genetics and environmental influences. Its sections are administrative, animal models, human clinical, imaging and biostatistics and informatics.

The WUIDDRC received additional startup funding from the McDonnell Centers for System Neuroscience and Cellular and Molecular Neurobiology and from the School of Medicine.

Inder also plans to collaborate with other IDDRCs in the Midwest to share knowledge and resources.

"Collaboration will give us greater knowledge of opportunities for helping families and will move the science forward faster," she says.

More than 60 investigators from 12 university departments will be involved in the center's research. Serving as associate directors are John Constantino, MD, the Blanche F. Ittleson Professor of Psychiatry and professor of pediatrics; David Holtzman, MD, the Andrew B. and Gretchen P. Jones Professor and head of Neurology and professor of developmental biology; Jeffrey D. Milbrandt, MD, PhD, professor and head of the Department of Genetics and professor of medicine, of neurology and of pathology; Jeffrey J. Neil, MD, PhD, the Allen P. and Josephine B. Green Professor of Neurology and professor of radiology, of pediatrics and of neurobiology; and Schwartz.

The Intellectual and Developmental Disabilities Research Centers were established in 1963 as centers of excellence for research in mental retardation and developmental disabilities. Fourteen national centers are funded by the Eunice Kennedy Shriver National Institute for Child Health and Human Development.

*(Press Release, July 19, 2010, by Beth Miller)*

# Free-standing psychiatric hospitals accredited by Joint Commission must report on HBIPS core measures Starting in January 2011

Effective with January 1, 2011 discharges/ episodes of care, all Joint Commission accredited free-standing psychiatric hospitals that are surveyed under the Comprehensive Accreditation Manual for Hospitals: The Official Handbook will be required to use the Hospital Based Inpatient Psychiatric Services (HBIPS) core measure set. Those free-standing psychiatric hospitals with an average daily census greater than ten inpatients will be required to participate using a Joint Commission-listed vendor and submit data to The Joint Commission on all applicable measures that comprise the HBIPS core measure set. General medical/ surgical hospitals with inpatient psychiatric units or that maintain a psychiatric hospital that is accredited as a site under the accreditation of the general medical/ surgical hospital (as opposed to a free-standing psychiatric hospital) will not be required to use the HBIPS measure set. However, they may elect to do so to meet or exceed current overall ORYX core measure set reporting requirements.

The Joint Commission originally implemented the HBIPS measure set in October 2008 as an optional set of ORYX core measures prior to obtaining National Quality Forum (NQF) endorsement of the measures. The Joint Commission now has secured NQF endorsement for six of the seven HBIPS measures. One remaining measure, HBIPS-1 (Admission Screening), did not receive endorsement by the NQF but may be resubmitted in the future should there be an opportunity.

The Joint Commission has elected to move to require the use of the HBIPS measures by Joint Commission accredited free-standing psychiatric hospitals effective with January 1, 2011 data in response to a growing desire for full implementation of the HBIPS measures from the field and other stakeholders, including the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI). Joint Commission accredited free standing psychiatric hospitals impacted by this requirement will be deemed to have met their ORYX core measure reporting requirements through submission of data on the HBIPS core measure set alone. For those free-standing psychiatric hospitals currently collecting and submitting data on nine non-core measures, the use of non-core measures will no longer be required; these nine non-core measure data will no longer be accepted by The Joint Commission on any discharges as of the January 1, 2011 implementation date.

Data collection and submission on all HBIPS core measures, including HBIPS-1, will be required of all hospitals using the HBIPS measure set to meet Joint Commission core measure reporting requirements. For the approximately 320 hospitals that voluntarily elected to collect and submit data on the HBIPS measures to The Joint Commission, and for those hospitals that may elect to do so prior to January 1, 2011, those data will not be publicly reported on Quality Check or used in the Priority Focus Process (PFP) or the Strategic Surveillance System (S3).

However, aggregate HBIPS core measure data received in 2009 and in 2010 from those hospitals that voluntarily elected to collect and submit

data on the HBIPS measures will be included in The Joint Commission's Improving America's Hospitals 2010 Annual Report and the 2011 Annual Report respectively.

Also, data received for HBIPS-1 will not be publicly reported on Quality Check or used in the PFP or S3 until such time as the measure is either endorsed by the National Quality Forum or a determination is made by The Joint Commission Board of Commissioners to publicly report data on HBIPS-1. However, data received for HBIPS-1 will be displayed on each hospital's ORYX Performance Measure Report as a "Test" measure.

For reference, detailed information on the Hospital Based Inpatient Psychiatric Services core measures can be found in the Specifications Manual for Joint Commission National Quality Core Measures at http://manual.jointcommission.org/releases/TJC2010A/.

Psychiatric hospitals required to collect and submit HBIPS data to The Joint Commission effective with January 1, 2011 discharges/episodes of care, and those general medical/surgical hospitals with inpatient psychiatric units that wish to submit data on the HBIPS measure set to meet ORYX performance measurement requirements may select the measure set by accessing the ORYX Measure Selection (OMS) application under Performance Measurement (ORYX) on their secure Joint Commission Extranet site, or by completing the Hospital-Based Inpatient Psychiatric Services Core Measure set Selection Form available on The Joint Commission's website at: http://www.jointcommission.org/AccreditationPrograms/Hospitals/ORYX/selection_change_forms.htm

Additional questions regarding the use of the HBIPS core measure set may be addressed to the ORYX Help Line at 630/792-5085 or via e-mail at HCOOryx@jointcommission.org. Or you may contact Frank Zibrat, Associate Director, ORYX Implementation, Division of Accreditation Operations, The Joint Commission at 630/792-5992 or fzibrat@jointcommission.org.

## PSYCHIATRY BY THE NUMBERS

**1 out of 4 U.S. adults (26%), 18 years of age and older, suffer from a mental disorder.**

**1 in 5 families are affected by mental illness.**

**Only 7% of all health-care expenditures are designated for mental health disorders.**

**10% of children and adolescents suffer from mental illness that is severe enough to cause some level of impairment.**

**Depression ranks as the #1 cause of disability worldwide.**

**The 3rd leading cause of death for those between the ages of 15 and 24 is suicide.**

# Administrators in academic psychiatry

*by David Peterson, FACMPE*

Have you thought about what it takes nowadays to successfully and effectively do your job as an administrator of an academic department of psychiatry?

The American College of Medical Practice Executives (ACMPE) and the Medical Group Management Association (MGMA) have thought about it. Together they have combined to develop a Body of Knowledge encompassing eight subject areas that read like a job description for any of us. The eight areas or "domains" include:

- Business Operations
- Financial Management
- Human Resource Management
- Information Management
- Organization Governance
- Patient Care Systems
- Quality Management
- Risk Management

A visit to MGMA's website at http://www.mgma.com/bok/ reveals even more knowledge content that is required of us. A sample (there are many more) of some of this job content includes:

**Business Operations:** Develop, implement and monitor business operation plans; manage facilities planning and maintenance activities to meet the organization's current and future needs

**Financial Management:** Develop and implement the organization's budget to achieve organizational objectives; analyze and monitor financial performance and report financial results to stakeholders

> So if you … ever find yourself wondering how you spend your day – or more importantly – what value you add to an academic department of psychiatry, stop and reflect on the wide body of knowledge that you draw upon every day to successfully navigate and manage in the world of academic medicine.

**Human Resource Management:** Manage the retention of clinical and nonclinical staff; develop and monitor an effective staffing strategy; establish systems and processes for awareness, education and compliance with employment laws and regulatory standards

**Information Management:** Develop and maintain appropriate internal communication pathways for clinical and nonclinical staff; manage medical information systems including medical records, medication administration and health care related document storage

**Organizational Governance:** Lead the integration of the corporate mission statement into all aspects of the organization's culture; establish, communicate, implement and monitor production and compensation standards for physician and mid-level professional staff

**Patient Care: Systems** Establish and monitor business processes to ensure effective and efficient clinical operations; Design efficient patient flow patterns to maximize physician schedules

**Quality Management:** Identify, develop and maintain benchmarks for establishing practice performance standards; create internal processes and systems to participate in pay-for-performance programs to enhance health care quality

**Risk Management:** Develop and implement a compliance program for federal and state laws and regulations

The same website offers you an opportunity to "assess yourself with a free Personal Inventory and the free domain quizzes on each domain's page." (In a world where there seems to be a price for everything, emphasis has been added here to the word "free").

As administrators of academic departments, another domain or two could be added and certainly could stand alone. Facilitating the education mission and managing the grants process along with the supporting skill sets for each would be two.

So if you (or your Chair, faculty or other stakeholders) ever find yourself wondering how you spend your day – or more importantly – what value you add to an academic department of psychiatry, stop and reflect on the wide body of knowledge that you draw upon every day to successfully navigate and manage in the world of academic medicine.

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.


## Medical Group Management Association
Annual Conference
October 24-27, 2010
New Orleans, LA
www.mgma.com

## Administrators in Academic Psychiatry
Fall Educational Conference
Nashville, TN
October 28-29. 2010
www.adminpsych.org

## The Joint Commission
Behavioral Health Care Standards Update
November 10, 2010

Behavioral Health Care Conference
November 11-12, 2010

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

# Measuring success in academic research

*by Hank Williams*

There aren't very many statistics or benchmarks for measuring or defining success in academic research administration.

AAP hopes to soon change that with some comprehensive survey data results, but in the meantime…

Do you have direct responsibility for the administration of your department's research dollars? If so, please join in the discussion. If not, you are still very likely impacted by the positive or negative results of this large bundle of tasks.

At my university we share administrative (including research) services between the departments of Psychiatry and Neurology.

About a year ago we made the decision to restructure research administration, which previously combined pre- and post- award administration. We now have a clear separation of duties between Pre-Award and Post-Award research administration, and there is a manager for each.

The major duties of Pre-Award administration include assistance to principal investigators in budget preparation, application preparation and review, and submission.

Post-award administration focuses on monitoring and reporting on research budgets, budget closing, and clinical trials management.

Both of these groups work with the university research administration departments—for the Pre-Award Group it's called the Office of Sponsored Programs, and for the Post-Award group it's called Grant and Contract Administration. There are all sorts of little exceptions to these general rules as well.

Sounding a little like your department?

How do you decide if your department is doing a good job or not? We report to the Chair and senior department leadership all the basic information on proposal submissions and awards each month…

- Number of Proposals
- Dollar Amount of Proposals
- Type of Proposal—New, Noncompeting renewal, etc.
- Sponsor,
- Number of awards
- Dollar amount of Award, and others

How is this basic data judged by your departments?

Does it tell a story of success or failure of your department's research efforts? Is this collection of data really telling an adequate story of success, and its degrees, for both new and ongoing research?

We struggle with these questions every day.

What are other measures of success, as an administrator, for your department's research?

- The number and dollar amount of annual research renewals?
- No budget deficit at the end of the project?
- The amount of indirect costs returned to the department?

Every academic department is different, so we find a lot of common ground, but it's hard to find anyone exactly like us. This is part of the excitement for our programs, and keeps us challenged.

Let me know about your research successes, struggles, ideas, tricks and tips, and we'll share them with our members.

# Federal authorization of depression centers of excellence

According to the National Institutes of Health, most people with mood disorders can be effectively treated via medication, psychotherapy or combined treatment. However, according to the Depression and Bipolar Support Alliance (2009), one-third of those suffering from mood disorder (4.8 million) do not receive treatment for one or more of the following reasons: (1) they cannot afford it; (2) do not believe it is needed; (3) are afraid of societal judgment, or (4) do not know where to go for services. Additionally, according to a 2007 article in the *Journal of the American Board of Family Medicine*, identification of depression and bipolar disorder are missed approximately 50 percent of the time and this diagnostic gap yields adverse outcomes.

To address these problems, Senator Debbie Stabenow (D-MI) introduced the Establishing a Network of Health-Advancing National Centers of Excellence for Depression (ENHANCED) Act of 2009, S. 1857 in the Senate and Representatives Patrick Kennedy (D-RI) and Tim Murphy (R-PA) introduced H.R. 4204 in the House. These pieces of legislation will expand depression centers of excellence with the goal of increasing access to the most appropriate and evidence-based depression care and developing and disseminating evidence-based treatment standards to improve accurate and timely diagnosis of depression and bipolar disorders, treat depression and bipolar disorder more effectively, erase the stigma and lessen the huge financial costs associated with these diseases. In addition to already existing Centers in California, Colorado and Michigan, over a dozen more clinical depression centers around the country are being planned to address the need for greater geographic dissemination of high quality depression care. Priority areas for expansion include Iowa, Wisconsin, and Illinois, as well as Southern California, Rhode Island and Florida.

Additionally, they will create a national database for large-sample effectiveness studies and a repository of evidence-based interventions and programs for depression and bipolar disorders. They will also utilize the network of centers as an ongoing national resource for public and professional education and training, with the goal of advancing knowledge and eradicating stigma of these mental disorders.

The legislation also will provide grants through the Substance Abuse and Mental Health Services Administration (SAMHSA) for up to twenty centers of excellence for depressive disorders within the first year and up to 30 such centers within the first five years after enactment. The grants will be made both to institutions of higher education and to public or private non-profit research institutions. Each center is required to contribute $1 of their own funds for every $5 of federal funding received in an effort to leverage federal dollars and maximize operational efficiency and effectiveness. This federal funding will provide much needed resources and coordination to the mental health community allowing them to develop universally accepted evidence-based, multi-disciplinary approaches and real-time clinical and care management guidelines. According to a University of Michigan study, for every $100 million invested, there is an estimated savings of $250 million in healthcare costs and increased productivity.

The University of Michigan Comprehensive Depression Center served as the inaugural national prototype, and the National Network of Depression Centers as the network prototype. Then with leadership provided by Senator Stabenow as a champion, Senator Tom Harkin (D-IA) as supportive Subcommittee Chair, and many others, it continued to play pivotal roles in the process of consulting about academic, clinical, and research strategies.

*(Reprinted and adapted from American Federation of Suicide Prevention Public Policy Issue Brief - 2010).*

# New credentialing process for telemedicine services

The current Medicare Hospital conditions of participation (CoPs) for credentialing and privileging of medical staff require the governing body of the hospital to make all privileging decisions based upon the recommendations of its medical staff after the medical staff has thoroughly examined and verified the credentials of practitioners applying for privileges, and also used specific criteria to determine whether an individual practitioner should be privileged at the hospital. The current critical access hospital (CAH) CoPs require every CAH that is a member of a rural health network to have an agreement for review of physicians and practitioners seeking privileges at the CAH. The agreement must be with a hospital that is a member of the network, a Medicare Quality Improvement Organization (QIO), or another qualified entity identified in the State's rural health plan. In addition, the services provided by each doctor of medicine or osteopathy at the CAH must be evaluated by one of these same three types of outside parties. These requirements apply to all physicians and practitioners seeking privileges at the hospital or CAH, regardless of whether services will be provided in-person and on-site at the hospital or CAH, or remotely through a telecommunications system. CMS regulations currently require hospitals and CAHs receiving telemedicine services to privilege each physician or practitioner providing services to its patients as if such practitioner were on-site.

While hospitals may use third party credentialing verification organizations to relieve the time-consuming burden of compiling and verifying the credentials of practitioners applying for privileges, the hospital's governing body is still responsible for all privileging decisions. Similarly, each CAH is required to have its privileging decisions made by either its governing body or the person responsible for the CAH.

In the past, hospitals that were accredited by the Joint Commission (TJC) were deemed to have met the Medicare CoPs, including the credentialing and privileging requirements, under TJC's statutory deeming authority. Section 125 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), terminated the statutory recognition of TJC's hospital accreditation program, effective July 15, 2010. The law requires TJC to secure CMS approval of its standards in order to confer Medicare deemed status on hospitals after July 15, 2010. This means that CMS no longer has the discretion under the law to accept TJC policies or standards that do not meet or exceed the Medicare CoPs. One TJC policy that has been in direct conflict with the CoPs has been TJC's practice of permitting "privileging by proxy,'' which has allowed TJC-accredited hospitals to utilize a different methodology to privilege ``distant-site'' physicians and practitioners. In short, TJC privileging by proxy standards allowed for one TJC-accredited facility to accept the privileging decisions of another TJC-accredited facility. Hospitals that have used this method to privilege distant-site medical staff technically did not meet CMS requirements that applied to other hospitals even though they were TJC-accredited. When CMS learned of specific instances of such noncompliance through on-site surveys by State Survey Agencies, the hospital was required to change its policies to come into compliance.

TJC-accredited hospitals, therefore, are concerned that they may be unable to meet the long-standing CMS privileging requirements while sustaining their current telemedicine agreements. Small hospital and CAH medical staffs, in particular, are concerned about the burden of privileging hundreds of specialty physicians and practitioners that large academic medical centers make available to them.

CMS came to the conclusion that the present requirement is a duplicative

*Continued on 13*

*Continued from 12*

and burdensome process for physicians, practitioners, and the hospitals involved in this process, particularly small hospitals, which often lack adequate resources to fully carry out the traditional credentialing and privileging process for all of the physicians and practitioners that may be available to provide telemedicine services. In addition to the costs involved, small hospitals often do not have in-house medical staff with the clinical expertise to adequately evaluate and privilege the wide range of specialty physicians that larger hospitals can provide through telemedicine services.

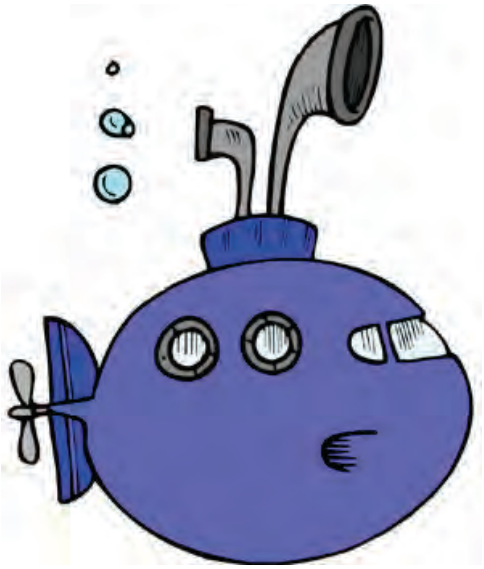
CMS recognizes the advantages and benefits that telemedicine provides for patients and is interested in reducing the burden and the duplicative efforts of the traditional credentialing and privileging process for Medicare-participating hospitals, both those which provide telemedicine services and those which use such services. They have proposed to revise both the hospital and CAH credentialing and privileging requirements to eliminate these regulatory impediments and allow for the advancement of telemedicine nationwide while still protecting the health and safety of patients

This proposal would require the hospital's governing body to ensure that, when telemedicine services are furnished to the hospital's patients through an agreement with a Medicare-participating hospital (the ``distant-site'' hospital) the agreement must specify that it is the responsibility of the governing body of the distant-site hospital providing the telemedicine services to meet the existing requirements with regard to its physicians and practitioners who are providing telemedicine services. These existing provisions cover the distant-site hospital's governing body responsibilities for its medical staff that all Medicare-participating hospitals must meet.

Further, the proposed requirements would allow the governing body of the hospital whose patients are receiving the telemedicine services to grant privileges based on its medical staff recommendations, which would rely on information provided by the distant-site hospital, as a more efficient means of privileging the individual distant-site physicians and practitioners providing the services.

The hospital's governing body can choose to have its medical staff rely upon information furnished by the distant-site hospital when making recommendations on privileges for the individual physicians and practitioners providing such services. This option would allow the hospital's medical staff to rely upon the credentialing and privileging decisions of the distant-site hospital in lieu of the current requirements This option would not prohibit a hospital's medical staff from continuing to perform its own periodic appraisals of telemedicine members of its staff, nor would it bar them from continuing to use the traditional credentialing and privileging process required under the current regulations. The intent of this proposed requirement is to relieve burden for smaller hospitals by providing for a less duplicative and more efficient privileging scheme with regard to physicians and practitioners providing telemedicine services.

However, in an effort to ensure accountability to the process, the hospital, in order to choose this less burdensome option for privileging, must ensure that (1) The distant-site hospital providing the telemedicine services is a Medicare-participating hospital; (2) the individual distant-site physician or practitioner is privileged at the distant-site hospital providing telemedicine services, and that this distant-site hospital provides a current list of the physician's or practitioner's privileges; (3) the individual distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital, whose patients are receiving the telemedicine services, is located; and (4) with respect to a distant-site physician or practitioner granted privileges by the hospital, the hospital has evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site hospital this information for use in its periodic appraisal of the individual distant-site physician or practitioner.



Although fighting the enemy is considered normal, the Army frowns upon fighting among the troops. So much so that after one too many battles royal, a soldier was ordered to undergo a psychiatric evaluation in which he had to endure some odd questions.

"If you saw a submarine in the Sahara, what would you do?"

"Well, I'd throw snowballs at it," he answered.

"Where'd you get the snowballs?" the doctor asked.

"Same place you got the submarine."

**Editorial staff**
***Editor:***
***Janis Price***
***Associate Editors:***
***David Peterson, FACMPE***
***Hank Williams***

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