Ideas

o f r e f e r e n c e

APA President answers terrorism

By Richard Harding, MD

From Psychiatric News *Oct. 5, 2001; reprinted with permission.*

Thursday, September 13: As I write this presidential column for the October 5 issue of *Psychiatric News*, I am feeling overwhelmed by the enormity and savagery of the last 48 hours. For the first time since Pearl Harbor, our nation has been attacked with a loss of life that will be measured in the thousands.

You should know that on Tuesday, September 11, many of our new and senior staff at APA headquarters remained in place all day answering requests from the media and government officials regarding information and psychiatric advice to inform the public--this on a day where the news was full of more hijacked planes inbound to Washington and other rumors. Their service to our patients and our profession is nothing short of heroic. We will be forever grateful.

The psychiatrists from the New York County District Branch, Washington Psychiatric Society, and faculty and residents at training programs in New York City and and the Washington, D.C., area are brave and exhausted, providing psychiatric care to victims and family members who are desperately searching for clues to the fate of their loved ones.

I am impressed that there are few things about this situation that are clear or will be quickly dealt with. President Bush is talking about "war," which implies something different from surgical-strike revenge. Recovery of the dead in the World Trade Center and the Pentagon will take time. As psychiatrists, we know that the emotional scars, panic, and grief that we will deal with will perhaps be the most profound and long lasting of all the sequelae.

It is hard to be forward thinking on a day like today. Allow me to think through the task each of us faces in providing care to our individual patients and improving the public's health in this country and beyond.

- As national leaders talk of quick revenge and "war," we must be thinking of how we will create the healing environment and systems of care to aid the millions of citizens who will be psychiatric casualties of these events.
- We must improve and redesign systems for children who have repeatedly watched horrific events on TV over which they have no control and refocus them on schoolwork and other positive activities over which they can gain control and mastery.
- We must be realistic about our demands for individual privacy during wartime while continuing to protect the population and our patients from overreaction to the fear we each face. We must continue to champion the principles that protect our civil liberties and medical privacy. It will not be popular, but it will be right.
- We must lead in preventing anger that brings out prejudice and hate against Arab Americans and Muslims. We can ill afford to let our collective anger be misdirected inward toward our own members, many of whom have played key roles in rescue and early intervention efforts in New York City and Washington, D.C. By joining together and refusing to become divided, we attain victory over the cowardly terrorists, who, in my opinion, are no more Muslim than members of the Ku Klux Klan are Christian.

Most APA members are not members of the "greatest generation." We are their children and grandchildren. They were common people asked to do uncommon things for the sake of humanity and history. It is clear that this generation will be asked to make extensive sacrifices over an extended period. Surgical strikes will not be adequate, just as brief counseling will in most cases not adequately deal with the trauma we have experienced. We will set up new programs and treatment methods that will spring from the minds

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Fall 2001

Volume XXXVI

Ideas of Reference is the newsletter of the Minnesota Psychiatric Society, a district branch of the American Psychiatric Association.

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From the editor

Ideas of Reference

The newsletter of the Minnesota Psychiatric Society is published quarterly: January, April, July and October for members of MPS and others on request. Signed articles express the opinion of the author and do not necessarily reflect policies of MPS. Articles submitted are subject to review by the editor.

Ideas of Reference accepts advertising. Rates follow:

Display ad	1 Issue	2 Issues	4 Issues
Full Page	$450	$350	$300
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1/4 page	200	150	125
1/8 page	100	85	75

Classified Rates: 25 words or less for $40 with each additional word at $0.25

All advertising copy must be in black and white and is subject to approval by the Editor/Newsletter Committee.

Meetings and events may be listed on the Calendar of Events free of charge.

Ideas of Reference has a quarterly circulation of 500. Deadlines are the 15th of the month prior to publication.

Ideas of Reference

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For the last time…

I am writing my last editorial for *Ideas of Reference* in the aftermath of September 11, 2001, still experiencing some of the emotional numbing and grief following that dreadful day.

I always have been more of a reporter than essayist. But because I am stepping down as MPS newsletter editor after eight years, I had intended to write a message for the membership including some nostalgia for the past, concern for the present, and challenges for the future.

Somehow, the issues that seemed so vital on September 10— Medicare funding, medical record privacy, and psychologist prescribing on the national level; access to care, reimbursement, the foibles of Allina, and the activism of the Attorney General on the Minnesota level—have paled in this time of national crisis.

For this reason I have placed APA President Richard Harding's eloquent letter to the membership on this issue's front page, even though it was published earlier in *Psychiatric News*. Dr. Harding's words challenge us to provide means of care for the expected deluge of children and adults who develop PTSD and other psychiatric disorders as a response to the terrorist attacks. And we need to prepare ourselves for a years-long campaign against terrorism—which in turn may foster a chronic state of heightened arousal in many of our people, leading to further psychopathology.

Unfortunately, we are told there *will* be more terrorist attacks at home as our government proceeds with action against terrorist organizations. Dr. Jowsey reports on the activity of the MPS Disaster Preparedness Committee elsewhere in this issue, asking that more Minnesota psychiatrists participate in disaster training through APA coursework or through the American Red Cross Disaster Training Programs.

Organized medicine and organized psychiatry likely will be developing more structured disaster response approaches. Our public health agencies will need to upgrade their response plans for bio-terrorism, including education for professionals and the public as well. Residency training programs will need to add disaster response training to curricula. I encourage all Minnesota psychiatrists to "stay tuned" and participate in the changes that lie ahead.

* * * * * * * * * *

Thanks for reading ***Ideas of Reference*** for the last eight years!

DCM

Questions, questions...

By Scott Crow, MD
MPS President

On the afternoon of Wednesday, September 12th I gave my regularly scheduled weekly case conference for the medical students rotating through the University Psychiatry Clerkship. As this was one day after the terrorist attacks on the East Coast, the case planned for that day was mostly ignored and we primarily discussed the attacks and everyone's reaction to them.

The students raised many of the same questions we've all been hearing from patients. I heard questions such as: Why did this happen? How can someone have so much anger and why is it directed at us? What kind of person does it take to oversee and coordinate such a series of attacks?

What is coming next? What terrorist acts are yet to come? How will the U.S. and the rest of the world respond? How *should* the U.S. and the rest of the world respond? How safe are we here in Minnesota? How divisive will these events be within our own society? Will things ever be the same again? If not, when will they return back to something that feels like normal? How will these events affect the mental health of those we treat? How much PTSD will this cause?

I was a little unsure what to tell the students; I'm not sure of my own answers to those questions, at least not yet. What I am sure of, however, is that we will have lots of opportunities to try to answer those questions in the months and years ahead. We do have an active Disaster Preparedness Committee at MPS which is ready to help aid us (and the broader mental health community) in responding to whatever lies ahead. ■

Editorial changes for *Ideas of Reference*

By Deane Manolis, MD

The MPS newsletter, *Ideas of Reference*, will have new editorial leadership in 2002, as I am resigning after the completion of this issue.

Succeeding me will be two extremely able MPS members, Drs. Benita Dieperink and Ronald Groat, who will serve as co-editors.

Dr. Dieperink is an early-career psychiatrist, currently on an extended maternity leave from Hennepin County Medical Center. Dr. Groat is a past-president of MPS who continues in private practice, but also is participating actively with several advocacy organizations.

Linda Vukelich, MPS executive director, will continue her superb work as managing editor with responsibility for layout and the "nuts and bolts" of the publication. John Scanlan, MD will also step down as assistant editor

After close to nine years as editor, this is another step in my gradual disengagement from practice and professional activities. I will remain available to the new editors for consultation, and I hope to continue to contribute articles for the newsletter. I have become the unofficial historian for the Minnesota Psychiatric Society and I will continue in this role.

I have enjoyed being newsletter editor—in a way it has been a return to my roots, as I was news editor for my weekly high school newspaper. I thank Linda Vukelich for her fine work and support over the years, as well as the MPS Council and leadership who have always been most supportive. Also, I have appreciated feedback from the MPS membership, and I thank you for the opportunity to serve you. ■

APA launches e-newsletter

The American Psychiatric Association released the first issue of *APA Member Update*, an electronic newsletter, in late September. The monthly publication can be accessed on the APA website Members Only link, or by direct e-mail.

The first issue contains eight short articles of current interest, with a major focus on psychiatry's response to the September 11 terrorist attack. The newsletter replaces *APA Online News*, a weekly publication discontinued earlier this year.

Members may access the newsletter at <www.psych.org/member_update> or by contacting Amy Levey, editor, at <update@psych.org>.

Disaster Preparedness Committee responds to terrorist attack

By Sheila Jowsey, MD, Chair, MPS Disaster Preparedness Committee

The MPS Committee on Disaster Preparedness was formed in 1998. Since then we have been gathering information on the psychiatric sequelae of disaster as well as networking with other agencies involved in disaster preparedness. Our committee held a teleconference on September 12, 2001, and discussed our role in the aftermath of the terrorist attacks.

We focused on the following areas:

1. Helping our patients and the public:

- We concluded that most individuals in Minnesota would be experiencing grief symptoms which should not be pathologized, but would be amenable to discussion and support through support networks in the communities (at work, neighborhood, and religious institutions).
- Patients or individuals at higher risk for symptoms include patients with PTSD, (veterans, refugees), patients with active or untreated psychiatric pathology, the elderly, children, and possibly individuals at fear for reprisals.
- Patients need to have reliable information such as the APA website, <www.psych.org> or <www.redcross.org> and <www.fema.gov>.
- We contacted the director of the Disaster Services for the MN Chapter of the Red Cross and have offered assistance. The Red Cross was interested in a list of mental health providers who could take calls from Red Cross volunteers.
- We have made ourselves available to the media to discuss the psychiatric sequelae of disaster. *(Ed note: Dr. Jowsey did an excellent job on an MPR call-in program.)*
- We will participate in community forums on disaster.

2. Helping our colleagues:

- The MPS website provides a list of appropriate websites which gives accurate information on disaster mental health, <www.mnpsych.org> for more details.
- A slide presentation on disaster preparedness is available for clinicians wishing to educate psychiatry residents, other mental health providers, and interested primary care providers. The information on these slides comes from presentations made at the APA's Committee on Disaster Preparedness (contact Linda Vukelich, MPS executive director, at email address: <vukelich@earthlink.net>).
- We have contacted the psychiatric department heads at the University of Minnesota, Mayo Clinic, and the VAMC in Minneapolis to offer support and information.

A number of psychiatrists have expressed an interest in disaster psychiatry. The Red Cross provides training in disaster mental health which then allows the mental health provider to assist the Red Cross in disasters. The training focuses on supporting Red Cross volunteers but also helps educate volunteers about the role of the Red Cross in disaster. If you are interested in this training, please contact your local branch of the American Red Cross, or Audrey Zellman, Red Cross Disaster Services, (651) 291-6785.

Our committee is interested in developing a list of members who would be willing to help with media interviews, public education, and coordinating mental health services. Please contact Linda Vukelich to become a member of our committee or to be on the volunteer list. Please consider making yourself available for this important work. ■

General Principles of Disaster Preparedness

Immediate Post-Disaster Psychiatric Interventions

- establish safety, respite, physiological recovery
- consult with emergency hospital personnel
- consult with high risk groups
- relieve symptoms of post-disaster stress
  - -- prescribe sleep medication
  - -- provide reality orientation
  - -- encourage ventilation of feelings
- establish outreach programs to provide community support
- educate medical personnel, community groups (media, schools, PTA's, hospitals, corporations) on normal response to trauma and loss
- consult with community

Child and Adolescent Victims

- greatest risk if family injured, school/home damaged
- may develop • clinging behavior • persistent fears • nightmares •easy startle • irritability, loss of concentration • behavior problems • physical complaints • withdrawal, sadness, listlessness

-APA CME Course on Disaster Preparedness

Legislative redistricting

by Dominic Sposeto
MPS lobbyist

If there is one word that can make most state legislators quake in their boots it is the word "redistricting". Redistricting is the term given to the redrawing of legislative boundaries that is required by our state and federal constitutions. Every ten years immediately after the federal census, both state and federal legislative districts must be redrawn to reflect changes in the state's population to assure "equal representation". These changes have major political implications for the state and an even greater effect on elected officials.

It is the responsibility of the state legislature to address the redrawing of both the state legislative and Minnesota congressional district boundaries. Would you think that this effort could get a little political? You bet. It is very unusual that the state legislature can even agree on a redistricting plan since both political parties tend to advance plans that favor their own candidates. After the last census, the DFL controlled legislature submitted a plan to then Republican Governor Arne Carlson who immediately vetoed it. However, because of a snafu in the governor's office the veto message was not delivered in time and the courts overruled the governor's veto letting the DFL plan stand. This mistake cost some of the governor's staff their jobs and upset Republican Party activists for years. I doubt this will happen again.

It is pretty clear given the 2000 census data that the political make-up of the state will dramatically change with redistricting.

If the legislature and the governor are unable to agree on a redistricting plan, the Minnesota Supreme Court is directed to develop a final plan for the state. With an Independent governor, a Republican House and a DFL Senate, its pretty much a sure bet that the court will be brought in to draw legislative boundaries for the next election.

There is another word that goes hand in hand with redistricting and that is gerrymandering. Gerrymandering refers to the practice of drawing legislative boundaries in such a way as to ensure the probable election or defeat of a specific candidate or party. Once the census figures are finalized and the population requirements of each district are known, the data on all registered voters is added to a database. With this accomplished, one can reasonably predict whether that district will vote Democrat or Republican.

Another common practice in redistricting is doubling-up—where district lines are redrawn to place two incumbents in the same district and allow a new district to be created without a sitting legislator. Both parties lean heavily on this tactic to eliminate incumbent legislators of the other party.

Years ago, the ability to redraw these districts was limited to a few party officials who controlled voter information. Now with advanced technology it has become much easier to draft and redraft redistricting plans based upon computer models. Both the Democrats and the Republicans were busy behind the scenes drawing and redrawing legislative districts to ensure that they would have an advantage in the next election. Governor Ventura's Independence Party has also been working on a plan that they hope will allow them to elect independent candidates to the state legislature. All three plans will be presented to the state legislature during the 2002 legislative session.

It is pretty clear given the 2000 census data that the political make-up of the state will dramatically change with redistricting. Rural Minnesota will lose several legislative seats and the inner cities of Minneapolis and St. Paul will also lose seats. Both of these areas of the state have been traditional Democratic strongholds. The benefactors of the state's population shift will be the suburban Twin Cities, especially the growing outer-ring suburbs. Suburban cities like Woodbury, Eagan and Eden Prairie will gain seats. This would tend to benefit Republicans.

Many incumbent legislators from places like the Iron Range and Minneapolis will no longer have safe legislative districts. In some cases if they wish to remain in office, they will be forced to run against one of their incumbent colleagues. Presented with this dilemma, it is not unusual for some legislators to decide that it is time to throw in the towel. The number of legislators who decide to retire is always significant immediately after a new redistricting plan takes effect.

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MPS Council meeting highlights

Highlights and action items from recent MPS Council meetings:

July 21, 2001

The Council met at Fairview University Hospital on Saturday July 21, 2001.

President's Report—Dr. Crow announced that Dr. David Cline agreed to chair the reactivated membership committee, and that the committee would have an organizational meeting within the next month. Dr. Crow also announced that Dr. O'Connor will be resigning as chair of the Ethics Committee due to his becoming MPS president-elect. A new Ethics chair will be sought. Linda Vukelich reported that MPS has its own internet listserv, which will be available to all MPS members.

Treasurer's Report—May and June financials were reviewed followed by discussion of reasonable investment strategies. **Action:** Dr. Realmuto was authorized to move money market and other liquid funds in order to obtain the best return.

Public Affairs Committee—Dr Kashtan reported on the activities for Mental Health Awareness Week, and announced that she would be resigning as Public Affairs chair due to election as APA Assembly Representative. Dr. Unni, Counselor, reported on her extensive activities for Mental Health Awareness Week in Rochester; MPS leadership was unaware of her activities. **Action:** Dr. Unni will be nominated for an APA Public Affairs Network award.

Membership Committee—Dr. Cline led a discussion on temporary dues relief for members who stay home with children. The Council agreed that this would be handled on a case-by-case basis. **Action:** The Council approved one new member in training, two transfers in, one transfer out, and two upgrades from MIT to general member.

Legislative Report—Dominic Sposeto reviewed the legislative session. The utilization review bill will become effective on August 1, 2001. Changes in the commitment law were pushed back to July 1, 2002, and will likely be modified in the 2002 legislative session.

Private Practice Committee—Dr Anderson reported on the progress on the standard preauthorization form which should be approved sometime in the fall of 2001. He also reported the Private Practice Committee would like to form a task force to develop recommendations for mental health insurance coverage in Minnesota. The recommendations would then be presented to insurance plans as well as the Minnesota Department of Commerce. **Action:** Council authorized the formation of a task force with suggested membership names.

Medicare Advisory Committee—Dr. Manolis reported on the APA Medicare Advisory Committee meeting in May. The APA will be attempting to develop a model local medical review policy for use by all Medicare Part B carriers. The importance of LMRPs is that many other insurance plans tend to follow Medicare policy.

September 15, 2001

The Council met at Fairview University Hospital on Saturday September 15, 2001, with Dr. O'Connor presiding in the absence of Dr. Crow.

The Council meeting began with a moment of silence to remember those lost in the attacks in New York and Washington on September 11.

President's Report—The search for new chairs of Ethics and Public Affairs Committee continues. There was discussion on a policy for sale of the MPS membership labels to outside organizations. In the absence of a formal policy, the Council reaffirmed the practice of the MPS president reviewing requests for purchase of membership lists and disapproving purchases by commercial ventures. The Council agreed that a policy was in order, and asked Linda Vukelich to obtain the MMA policy. The Council also reviewed the APA request for a poll on Assembly term limits. **Action:** The Council reaffirmed its policy opposing term limits for the APA Assembly represen-

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Members on the go!

New Members in Training:

Adam Carpenter, MD
Residency— University of Minnesota

Todd Crawford, MD
Residency— Hennepin-Regions

Heidi Sorenson, MD
Residency— University of Minnesota

Reinstated General Member:

Raymond J. Kennedy, III, MD
Practicing—St. Paul

Transfer Out:

Ashwin Gowda, MD to New York

Transfer In:

Anne Felde, MD
Practicing—Minneapolis VAMC

Steven Harker, MD
Residency—University of Minnesota

Permanent Inactive Status:

J. William Elliott, MD

Task Force on Quality Psychiatric Care

On recommendation of the MPS Private Practice Committee, the MPS Council on July 21, 2001 established a Task Force on Quality Psychiatric Care. This group is charged with developing recommendations for Minnesota insurance plans to cover mental health services more in keeping with the community standard of care.

The group, chaired by Private Practice Committee Chairman Floyd Anderson had two meetings and exchanged multiple e-mail messages in developing some recommendations for the Council. Members of the group included Drs. Suzanne Albrecht, Robert Baumer, Lee Beecher, Scott Crow, George Dawson, William Dikel, Michael Koch and Galen Stahle in addition to Dr. Anderson. This group of psychiatrists represents a broad range of psychiatric practice—inpatient/outpatient, adult/child and adolescent, private/public, and private/academic.

The group initially came up with eleven recommendations, which were then brought to the September 15 meeting of the MPS Council. The Council approved eight of the eleven recommendations.

These eight recommendations now will be polished and edited, before being distributed to the membership at large for comment and further recommendation. The goal is for approval in final form before the end of the year, to use in meetings with the Minnesota Department of Commerce and insurance organizations in 2002. ■

Membership Committee reactivated

At the July Council meeting, MPS President Scott Crow appointed David Cline, MD as the new chair of the MPS Membership Committee.

In recent years the Membership Committee has been inactive, with membership responsibilities being performed by the secretary/treasurer. With increasing concern about a drop in membership at both the APA and MPS levels, the MPS Council agreed that an active Membership Committee was vital for this organization.

In addition to Dr. Cline, new members of the committee include Drs. Suzanne Albrecht, Judy Kashtan, Deane Manolis, and Elizabeth Reeve. The Council suggested that the past-president continue as a member of the Membership Committee.

At an organizational meeting, committee members discussed issues of attracting and retaining members. A particular problem noticed both nationally and in Minnesota is that members-in-training frequently drop their membership when they begin practice. Also, there are a substantial number of psychiatrists in Minnesota who are not MPS members but there is no good in-state data base to identify these individuals.

With the above in mind, the Membership Committee decided to meet with residents of the three training programs in Minnesota to provide orientation and education about the value of membership in MPS/APA. Also, through APA, the Membership Committee will obtain the AMA psychiatric data base for Minnesota so that non-member psychiatrists may be contacted regarding membership. The committee will also continue to contact those members close to being dropped for non-payment of dues, or who write letters of resignation.

Committee members did meet with University of Minnesota residents on September 21, and medical students currently on the psychiatry rotation also attended the meeting. The residents exhibited considerable interest in MPS, and requested further meetings to provide information about varieties of psychiatric practice and practice opportunities in Minnesota.

The committee plans to meet with residents in the Mayo and Hennepin-Regions programs in upcoming months. ■

Call for volunteers: Be part of a "media army"

The National Alliance for the Mentally Ill of Minnesota (NAMI-MN), acting as chair of the Minnesota Legislative Network, has put out a call for volunteers to be expert contacts for media inquiries. They are also looking for experts to communicate with the legislature and provide committee testimony and other key contact requests on an "as needed" basis. All inquiries will go through the MPS offices, but a ready roster of volunteers and their specific areas of interest and expertise is needed. Please contact the MPS offices if you are interested in helping or if you would like more information.

Psychiatrists active at MMA annual meeting

By Susan Jenkins, MD

The Minnesota Medical Association House of Delegates met in St. Cloud on September 19-21. MPS members attending included: Lee Beecher and Karen Dickson, West Metro Trustees; delegates Robert Nesheim, Jon Van Loon, James Jordan and Susan Jenkins, the MPS delegate to the meeting.

The MPS brought no motions to the floor this year, but our members brought motions sponsored by their local medical societies which had direct bearing on the practice of psychiatry.

Resolution #406, "Task Force to Study the Appropriate Mental Health of Children," introduced by James Jordan (Ramsey County), was enthusiastically received by our physician colleagues in such diverse specialties as pediatrics, family medicine, and emergency medicine. Physicians across the state are experiencing practice pressures and witnessing difficulties among their patients because of the lack of access to psychiatric care for children. The resolution cited the Citizen's League report on the current state of psychiatry in Minnesota and the US Surgeon General's report on psychiatric access nationally. There was little debate, and the resolution was passed with the final wording: "**Resolved**, that the Minnesota Medical Association create a task force with the Minnesota Psychiatric Society, the Minnesota Society of Child and Adolescent Psychiatrists, and other appropriate professional organizations, to develop recommendations for improving access to and timeliness of high-quality mental health evaluation and treatment services for children with mental health problems and for the parents/adults responsible for their care, and be it further **Resolved**, that the Minnesota Medical Association, the Minnesota Psychiatric Society, the Minnesota Society of Child and Adolescent Psychiatrists, and other appropriate organizations work jointly to implement the recommendations of the task force."

Another resolution was brought by Robert Nesheim (Lake Superior). He expressed concern about the lack of respect in the press for physicians who are responsibly seeking care for themselves for chemical dependence or mental health problems. He reported having seen colleagues battered in the press with sensational stories, at a time when they needed the support and compassion that we extend to other persons confronting these problems. There was debate over the fact that the MMA cannot (and should not) determine what the press reports, while recognizing the validity of Dr. Nesheim's concerns. The final resolution passed with the wording: "**Resolved**, that the Minnesota Medical Association encourage identification, evaluation, and treatment of chemical dependency, and be it further **Resolved**, that the Minnesota Medical Association endorse the efforts of the Minnesota Board of Medical Practice to ensure patient safety, as well as proper respect and treatment for chemically dependent physicians, and be it further **Resolved** that the Minnesota Medical Association provide information to the media and public regarding monitoring and treatment programs for chemically dependent physicians, which encourage their

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BCBSM drops prior authorization

Blue Cross Blue Shield of Minnesota discontinued most prior authorization requirements for outpatient mental health and chemical dependency treatment on October 10. This change and previously announced expanded coverage for behavioral health treatment follow the settlement of Attorney General Mike Hatch's suit against BCBSM earlier this year.

The prior authorization change applies to indemnity (Aware) and HMO (Blue Plus) plans, with the exception of federal employee and self-funded plans, including Honeywell and QWEST. Prior authorization will not be required beyond the tenth hour as before. Patients in the HMO plan may see professionals in the Aware network, but may have a higher co-pay. Required notification for inpatient, day treatment, and intensive outpatient programs will continue.

In a September letter to its Aware subscribers, BCBSM for the first time authorized outpatient mental health coverage for individual policyholders, discontinuing a longstanding discriminatory feature of Blue Cross individual plans. Expanded coverage also extended to out-of-network chemical dependency treatment and payment for court-ordered treatment.

Also a part of the settlement, a three-member review panel for disputed Blue Cross claims was appointed in early October. The panel members are all judges, and it is unclear whether they will have medical consultants in the review process.

For further information on these changes, call BCBSM provider services at (651) 662-5200 or (800) 262-0820. ■

Hospital Care— The Best and Worst of Times

by George Dawson, MD

I have been an inpatient psychiatrist in the Twin Cities for the past 12 years. The job has always been a challenge, but it is getting more challenging. This occurs at a time when we have the ability to help more patients than ever before. There are a number of factors than impact on both inpatient care delivery and continuity with outpatient systems. None of them are improving at this time. The same problems that have closed psychiatric beds on the East Coast threaten inpatient treatment in Minnesota.

At some point in time, inpatient psychiatry units came under pressure to admit and treat a wider variety of problems than originally intended. Psychiatry units have become easy targets from a number interests seeking to contain their costs at the cost of inpatient units.

Over a decade ago, I began receiving denials for detoxification from drug and alcohol withdrawal states and crisis admissions for behavioral disturbances at group homes. Denial letters suggested detox facilities or "crisis beds" instead of hospital treatment. The reviewers seemed more aware of community facilities for social and medical detoxification than I was. Over the last ten years, these facilities have become even less available to address such problems. A detox facility that refers the most to our emergency department accepts only a limited number of people with acute alcohol intoxication, who must have an acceptable breathylizer level to get admitted to detox. As a result most people with acute street drug intoxications still end up on inpatient services. Limited detox bed space also results in admissions for alcohol intoxication if "detox is full."

In another example, in the past I admitted patients with dementia who became aggressive in nursing homes to Medicine services. But emergency department Medicine services have become more discerning in their admissions policies and now a demented patient with no previous psychiatric history is commonly admitted to psychiatry. It is also common to get delerious and hallucinating elderly patients with no previous psychiatric or dementia history, who then require a medical workup on the psychiatric unit.

Recent federal laws (EMTALA) that have every hospital emergency department looking for open psychiatric beds throughout the state compound the admissions problem. The resulting referrals across systems of care disrupt continuity and remove patients from their families and local systems of support. It is becoming common to receive an admission from facilities that are sixty miles away.

The effect of inappropriate admissions on the care of patients with schizophrenia, bipolar disorder, and depression is often dramatic. The inpatient environment is disrupted, especially at night. Many patients admitted on holds for detoxification or commitment do not see the need to be admitted to a psychiatric unit or participate in programming for mental health problems. Patients with dementias are also not able to participate in the inpatient program. Many patients are debilitated to the point that they need assistance with ambulation and monitoring their intake. The families of patients with dementia frequently object to psychiatric admissions and request that their family member be transferred to a medical service.

There are as many problems on the discharge side. In my team meetings we are very cognizant of length of stay constraints. We discuss the plan for stabilization and discharge as early as possible after admission. I get regular reports showing my statistics and how they compare with my colleagues. What the people compiling the numbers do not understand is that the discharge process is nearly completely out of my control. About one third of the patients admitted to my ward every year are involved in some type of probate court proceeding. Some of these hearings are completely unnecessary; they are basically artifacts of the current Minnesota commitment statutes involving antipsychotic medication consent. In other states, many of these hearings occur in an outpatient rather than an inpatient setting. A commitment hearing adds about two weeks to the length of stay. This additional time is due to the deliberate pace probate courts use to conduct the hearings. These additional days are reimbursed only for the handful of patients who are committed, have Medical Assistance, and are approved for an extended stay by the admissions staff at the regional treatment center.

The job has always been a challenge, but it is getting more challenging.

If a patient is committed, there can be an incredible wait for transfer to a regional treatment

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Dominic Sposeto: the view after fifteen years

By Linda Vukelich

In January, Dominic Sposeto marked fifteen years as MPS's legislative consultant. Since he began lobbying in Minnesota nearly twenty-five years ago, he has seen a lot of changes at the Capitol.

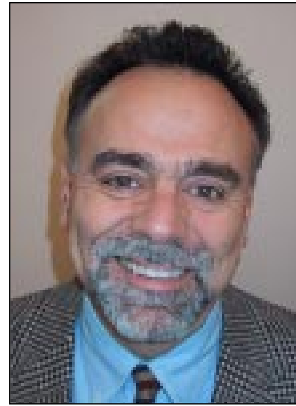
Born and raised in Des Moines, IA, Dominic earned his BA in History and his MBA in Political Science from the University of Iowa. He began his career in Minnesota in 1977 as the director of Government Relations for the Minnesota Dental Association. In 1980 he started consulting with insurance and banking organizations and later with health care organizations. Dominic has worked with MPS since 1986.

During the past fifteen legislative sessions, MPS has counted on Dominic to review some 3000 bills proposed each session, then synthesize and develop strategies to deal with those that affect psychiatry. He then follows these bills through committees, the House and Senate floors, and finally, sometimes Conference Committee. It is a complicated process and it can take months, but Dominic notes that each session has its own feel. He adjusts to each session's pace, reserving energy to be ready for a strong finish. He notes that preparation before the session begins gives him (and his clients) an informational edge, so he gathers information and reads reports when the legislature is not in session.

Even Dominic's leisure activities seem to mirror his work. He plays golf, often with other lobbyists and policymakers, and he enjoys long distance bike races. Raising three teenagers with his wife, Kitty Schneider, is another marathon interest he treasures.

Over the years, Dominic has seen an increased awareness of the role of psychiatrists as medical doctors in mental health care. Legislators are beginning to hear and respond to MPS complaints about barriers created by managed care. They seem to be less trusting of HMOs and more sympathetic to psychiatrists' and patients' efforts to improve care. Battles over scope of practice issues, including social work licensing, nurse practitioners and naturopathic physicians stand out in his memory because they are so personal.

Another area of focus has been the major reduction in health care money designated for mental health. In fact, this issue is relevant year after year. Mental health funding is a perennial favorite for mental health advocates and adversaries alike. Other issues under consideration annually continue the debates over commitment vs. patient rights and inpatient vs. community-based treatment. Obviously these issues



will continue to be important.

Minnesota has a reputation as a leader, and our programs and legislation are generally ahead of the curve. Dominic cites examples like parity, and utilization review statutes requiring state licensed psychiatrists to do final reviews as being models for other states and even federal legislation.

According to Dominic, one of the most helpful changes he has noted, is that legislators are better educated about stigma, thanks in part to the efforts of the MPS Public Affairs Committee. Programs designed to educate the public about mental illness have made it possible for more legislators to come forward and talk about their own encounters and those of their family members with the mental health care system. This has helped the public move forward to dismiss old stereotypes and work together to try to create better systems of care.

Together, MPS members have been a part of some very positive changes over the past fifteen years. As a result, we can all continue to work for better health care for patients and better systems of care for everyone. ■

November 2, 2001

Wyndham Garden Hotel

4460 West 78th Street Circle
Bloomington, Minnesota

Program information is available at www.MnPsychSoc.org or call 651-407-1873.

Last visit with my psychiatrist

By Matthew Finke

Reprinted with permission by the author and by NAMI-MN's Mental Health Advocate

Ed Note: I followed this young man for a period of about eight years when I was a consultant at the Douglas County Mental Health Clinic in Alexandria, MN. There is a certain poignancy and sadness in his response to my retirement and his observations on living with a major mental disorder, and I thought his message would be instructive to the MPS membership.

In his letter giving me permission to reprint, he writes: "Please extend my deepest gratitude and hope for the future to you and your staff that we will one day have a public-at-large and doctors that better understand outpatients with mental illness."

I recently saw my psychiatrist for the last time, as he is retiring after 37 years of being a psychiatrist. So, I thought that it would be an excellent time for him to tell me what he really thought of me, since last gestures are generally truthful.

He told me that he thought that I had a good chance of having a good life as long as I keep working hard trying to meet and make friends and find a job that I can handle mentally.

I asked him if he thought that I was mentally ill, as I thought he might really level with me if he hadn't been telling me the truth all along.

He told me that I have schizo-affective disorder, which is a mood and thought disorder without the positive symptoms of schizophrenia such as delusions of grandeur, delusions of persecution, and/or catatonia.

I figure that he is telling me the truth as of the fact that he is no longer trying to drum up business for himself anymore.

Then we came to the part of the discussion where he asks me how I feel. So, I told him.

I said that I feel embarrassed, pathetic, humiliated and ashamed that I have to depend on nurses and doctors for my physical and mental well-being like a little child.

Call me a male chauvinist but I guess I bought into the foremost virtues of cowboys and mountain men, the very American virtues of self-reliance, intestinal fortitude, and an arrogant indifference to negative criticisms.

The doctor then told me that he thought that our culture's stigma of mental illness is changing from the assertion that mentally ill persons simply lack motivation to the fact that mental illness is a disease which is treatable but incurable.

I recently went on a trip to Minneapolis to a nightclub where a band was playing. I never would have gone if not for my brother taking me with him.

To my own surprise, however I found it stunningly depressing to see all the young, healthy men and women my age and younger in all their vitality and enthusiasm for the goings on. It made me begin to contemplate my situation of being a mentally ill person.

I hope that someday all my endeavors to keep from committing suicide will have made me feel that I have made some account of my life and that I accomplished whatever it is that God sent me here to accomplish.

I furthermore told the doctor that I feel that it is harder to be a schizophrenic that has a higher than average tolerance to stress. Because of the fact that for the most part I function enough to live on my own, look physically fit, and can converse intelligently with people that investigate my situation.

Then we came to the part of the discussion where he asks me how I feel. So, I told him.

The easiest, quickest, most convenient reaction is for them to ask, "What's your problem?" Or, "What's wrong with you?"

After which, usually when I'm in the middle of doing something, I get perplexed and state that I am fine for lack of having an explanation for my condition in less than five words.

Some people even say that my explanation isn't an excuse at all. It is very difficult and frustrating to try to deal with these types of people. Furthermore, I am very resentful of them telling me these hurtful things.

I guess the most thorough explanation as to how a person with schizophrenia feels from my own perspective is as follows:

To languish in a state of lethargy in quiet, agonizing desperation accentuated sporadically by moments of sheer and utter terror for little or no reason. (Italics by editor.)

Finally, I told my doctor thank you for not giving up on me, for his insightful advice and supporting my spirit. I shook his hand and said, "Thank you, sir," and left. ■

From MPS neighborhoods

From the Department of Human Services

In May State-Operated Services (SOS) added a new Regional Medical Director for the SOS Southern Network (St. Peter Regional Treatment Center and Willmar Regional Treatment Center). He is Dr. Robert Brooks, a California trained, board certified psychiatrist who has worked in the California and Colorado state mental health systems, and the New York, Vermont and Massachusetts mental health systems. His expertise is the use of information technology in psychiatry. His assignment with SOS includes clinical operations over-sight of the Southern Network; participation in SOS strategic planning; involvement in the development and review of SOS clinical policies and practices; clinical and administrative consultation to the programs, services and staff of the Southern Network; liaison to the stakeholders of the Southern Network including consumers and families; and oversight of network-wide education and training.

Dr. Brooks joins Dr. Craig Martin, SOS Metro Network Medical Director; Dr. Robert Jones, SOS Northern Network Medical Director; Dr. Michael Farnsworth, SOS Forensic Services Medical Director and Dr. Alan Radke, State Medical Director, all members of the Clinical Policy Commission.

Alan Radke, MD

From Hutchinson Area Health Care Psychiatrists

The mental health and chemical dependency programs at Hutchinson Community Hospital are a part of Hutchinson Area Health Care (HAHC) which is owned by the city of Hutchinson. We are located 50 miles west of the junction of Interstate 494 and Highway 7 in Minnetonka. A full range of services including inpatient, outpatient and day treatment mental health programs and inpatient detoxification and outpatient chemical dependency programs are offered.

The staff currently includes three full-time psychiatrists: Drs. Stacy Nichols, Steven Sonnek (child psychiatry), and Glenn Lewis. There are also three part-time psychiatrists: Drs. Hilary Sandall, John Bohrod and James Swenson. In addition to the psychiatric staff there are four full-time doctoral psychologists including a neuropsychologist, and four masters level therapists.

The programs serve a large population in an area primarily in and around McLeod County, but also we receive patients from Willmar and even Ortonville to the west, from Buffalo and Waconia in the east, and from New Ulm in the south and St. Cloud in the north.

The twelve-bed inpatient unit is well designed and well staffed and it is usually full. Like the plight of our brethren in Mankato who wrote of the consequence of EMTALA in the last newsletter issue, when Twin Cities psychiatric beds are full we must accept transfer from those hospitals if we have any empty beds. This at times fills our beds and forces us to turn away or transfer out of our emergency room our own patients and other residents of Hutchinson (whose taxes pay for the facility and its staff).

Because of the excellence of its program, staff and administration, many of the psychiatrists and psychologists and others choose to commute to Hutchinson and sometimes car pool from and to western suburbs of Minneapolis. There are now openings for two more full-time psychiatrists to do both inpatient and outpatient work so if you're interested in working in a probably less hectic and pressured environment than that in which you now find yourself let us know. We would be glad to take you on a tour and show you with pride our staff and facilities.

Glenn M. Lewis, MD

From the Women Psychiatrists Committee

The Women Psychiatrists remain active with Saturday brunch meetings for networking. It is fun to see old friends, colleagues and their children as they grow. Babysitting is provided and kids have fun as well.

Kasia Litak, MD had a spring meeting at her home and Molly Silas, MD had a fall meeting at her home. Karen Dickson, MD will host a winter brunch meeting sometime in February.

These networking brunches are informal and fun. Residents and early career women especially benefit. All are welcome! ■

Karen Dickson, MD

Request for Scientific Program submissions

The APA is requesting Scientific Program submissions for the 54th Institute on Psychiatric Services to be held in Chicago, IL October 9-13, 2002.

The theme of the Institute is "Community Counts: Creating and Supporting Systems of Care". The deadline for submissions is December 3, 2001, although posters may be submitted as late as June 3, 2002.

Application forms for submissions may be obtained from the APA Institute Office, (202) 682-6314.

Health Care Help line

US Senator Mark Dayton has opened a toll free Health Care Help line for patients who have been refused treatment by their HMOs and believe they should not have been denied. Although Senate rules do not allow members to use their office funds for public service announcements, Dayton paid $3500 from his own pocket for public service announcements which ask: "What can you do when you need medical care but your HMO or insurance company says no? Call toll-free 1 (866) 296-4319. If you have already received treatment and your HMO or insurer refuses to pay, Senator Dayton's Health Care Help line can provide assistance."

Senator Dayton at a Washington press conference said, "I am not asking the insurance companies to do anything for patients than that which is called for in their contracts. It's unfortunate that it takes a call from a US Senator to elicit a response." Three staff members will manage the cases, sitting down with insurers to determine a resolution in each instance.

A message to the members of the APA

from The Psychiatrists' Program, APA-endorsed Professional Liability Insurance Program

In light of the tragic events of September 11, we recognize that there will be an increased need for mental health counseling and services.

If you are insured through The Psychiatrists' Program, the APA-endorsed Professional Liability Insurance Program, your policy provides coverage for the rendering of psychiatric services as a volunteer. Be sure, however, that if you want to volunteer in a state where you are not licensed, you check with the licensing authority before proceeding to provide any treatment.

Additionally, in support of the need for immediate and expanded mental health services, we are pleased to offer insurance with an expedited underwriting application process (24 hours whenever possible) to APA members who do not currently have individual coverage and want to provide volunteer mental health services. Please call Ms. Leslie Cummings at 1 (800) 246-3333, ext. 389 for more information or email <TheProgram@prms.com>.

Welcome new residents!

Hennepin-Regions
Zurya Anjum, MD
Heather Berg-Patel, MD
David Cooperman, MD
Todd Crawford, MD
Amitabh Tipnis, MD
Sheela Singa, MD (PGY-III)
Eduardo Trinidad, MD (PGY-II)

Mayo
John Beld, MD (PGY-IV)
Jeffrey Watabe, MD (PGY-III)
Peter Huang, MD (PGY-II)
Eve Charity Berryhill, MD
Maryellen L. Dodd, MD
Kathleen Mary Heaney, MD
Tamera Jeraj Dolenc, MD
Kari Ann Martin, MD
Louis Jon Nykamp, MD
Paul Thadeo Teman, MD
Megan Quin Litney, MD
Sencan E. Kadaster, MD (CAP Resident)

U of M
Adam Carpenter, MD
Roger Flanigan, MD
(Psychiatry-Family Practice)
Carrie Parente, MD
Suzy Petersen, MD
Julie Peterson, MD
Sean Meade, MD
(Psychiatry-Family Practice)
Marie Wang, MD

MMA Offers HIPAA Workshops

If you've been meaning to get to a workshop about the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and haven't yet gotten around to it, here's another chance. Half-day workshops will be offered for $95 at 10 locations around the state including St. Cloud, Rochester, and Duluth. The workshops cover the nuts and bolts of all major aspects of HIPAA; the impact of HIPAA on providers; how to begin preparing for HIPAA implementations; integrating HIPAA into your practice guidelines for best practices; and gap analysis for your organization.

For exact times and locations, visit the MMA website at www.MMAonline.net or call Juli Childs at the Minnesota Health Data Institute at (651) 917-6703.

Coding, documenting, and confidentiality

From Psychiatric Practice & Managed Care, *July/August 2001; reprinted with permission.*

By now it's a familiar refrain...coding and documentation, coding and documentation. These issues are at the heart of nearly all discussions about protecting the confidentiality of medical records. "Good coding and documentation practices make it less likely that the sensitive parts of medical records will be unduly exposed, especially considering the new HIPAA regulations," said Irvin L. (Sam) Muszynski, JD, Director of APA's Office of Healthcare Systems and Financing. Psychiatrists have to be ever vigilant in protecting confidentiality.

Case in point: In North Carolina several APA members became engaged in a dispute with Blue Cross and Blue Shield of North Carolina about access to their medical records, specifically their psychiatric notes. "Thanks to our members' concern about patient confidentiality," notes Robin B. Huffman, executive director of the North Carolina Psychiatric Association (NCPA), "NCPA and APA have begun a process of clarifying the procedures that the Blues will use from now on in auditing psychiatric medical records."

To bring psychiatrists in North Carolina up to date on their conversations with the Blues, NCPA and APA held a workshop on coding, documentation, and the new HIPAA guidelines on June 8, 2001, in Chapel Hill. More than 70 psychiatrists and other mental health professionals attended. During the workshop, Mr. Muszynski assured psychiatrists that they will have no problem complying with Medicare guidelines, medical record audits by MCOs or other insurers, or the new privacy regulations if they code and document appropriately. With tongue in cheek, though, Mr. Muszynski began his presentation with a list of ten reasons members may have for not coding and documenting properly.

Take-Aways from Workshop

CPT Coding—Chester Schmidt, Jr., MD, author of the APA's *CPT Handbook for Psychiatrists*, emphasized that before psychiatrists can protect their medical records, physicians must first *have* a record. Needless to say, the medical record must be well documented. At a minimum, documents should include:

- Date of Service
- Length of encounter
- Description of the patient's mental state, including mental status examination
- Description of the service provided
- Discussion of medical decision making, e.g., changes in treatment plan, etc.
- Treatments implemented
- Response to treatment
- A legible signature

HIPAA Privacy Regs—Jacqueline Melonas, RN, JD, and Donna Vanderpool, JD, from Professional Risk Management Services, Inc., walked psychiatrists through the intricacies of the new regulations on privacy enacted by the Health Insurance Portability and Accountability Act (HIPAA). "If you have been following good documentation procedures, you will be in compliance and consistent with good risk-management practices," said Ms. Melonas. However, she urged members to begin thinking about the HIPAA regulations now. Although they will not go into effect until spring 2003, many insurance plans, hospitals, and managed care companies are already in the process of instituting them. For example, as of November, 2000, the North Carolina Blues adopted the HIPAA guidelines as policy.

Ms. Vanderpool spoke directly to the critical issue of psychotherapy notes, about which she wrote in the

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Top Ten List

Why I Don't Code and Document

10 Getting paid isn't all *that* important.
9 The time spent is not reimbursable.
8 Can't read my handwriting.
7 Too many codes, so little time.
6 It's too complicated.
5 Someone might ask for the patient's record.
4 "Business" details interfere with good patient care.
3 Can't find a CPT book.
2 They didn't teach me this in medical school.
and...
1 I thought 90801 was a zip code.

APA Component Report

by Linda Vukelich

The Annual Fall APA Components meeting was held in early September. I attended as a member of the District Branch Advisory Committee. The committee meetings focus on everything from information systems to research ethics. All components work closely with APA staff to collect information and make suggestions to improve the organization and better meet member needs. Components submit their findings and suggestions to the Board of Trustees for consideration. Along with the Assembly, Components provide an opportunity for member input into the overall effectiveness of the organization.

My involvement over the past three years has been unique because I am not a member of the APA. The District Branch Advisory Committee is comprised of district branch executives and works with the Committee on District Branch Relations whose members are all APA members. This joint committee has tackled issues related to revenue sharing, membership recruitment and retention, and information technology. The chair is always the Senior Vice President, so the ideas aired in committee meetings are heard and championed with the Board of Trustees.

The APA member involvement in the Committee on District Branch Relations has been somewhat disappointing. I would like to encourage MPS members to contact me or the chair of both committees, Marcia Goin, MD if you are interested in getting involved. The commitment includes meetings in the fall and at the Annual Meeting. The APA covers fall meeting expenses. If you have any questions or need more information, please call me at 651-407-1873 or email me at <vukelich@earthlink.net>. ■

Coding, documenting and confidentiality

Continued from page 14

March/April 2001 issue of *Psychiatric Practice*.

According to the privacy rules, psychotherapy notes are limited to **information that is kept separate** by the provider for his or her own purpose and that contains sensitive information relevant to no one other than the treating practitioner.

> **NOTE:** The physician whose provider number (UPIN) appears on the HCFA 1500 billing form is responsible for the CPT codes and bills submitted. This responsibility rests with the physician regardless of whether the physician is self-employed or an employee of a hospital, clinic, agency or university faculty practice.

She cautioned members to keep in mind that the following information is *not* part of psychotherapy notes:

- Medication prescribing and monitoring
- Counseling session start and stop times
- Modalities and frequencies of treatment furnished
- Results of clinical tests
- Any summary of the following items: diagnosis, functional status, progress to date, symptoms, treatment plan, or prognosis.

Ms. Vanderpool added, “Psychiatrists must also remember that if notes are kept separate, they may still be discoverable in litigation; the rule clearly states that it is not relevant to privilege (which is governed by state law).”

Conclusion

The workshop ended with a commitment from everyone in the room to continue working with all third-party payers to refine their policies and appropriately apply them to psychiatrists’ medical records. “Regarding Blue Cross/Blue Shield, we are negotiating better procedures for all members, which are actually better procedures for insurers as well,” said Mr. Muszynski. He continued, “With the Blues in North Carolina, once understandings that are acceptable are completed, we can use them as a template.” Ms. Huffman seconded this and added, “Our experience in North Carolina working with APA can provide a model that all of the DBs and state societies can use. The workshop in particular was a win-win for our DB and the APA.”

If you or your district branch have an issue that has wide-reaching ramifications for the practice of psychiatry, please call the APA Managed Care Help Line (800) 772-4271.

Ms. Vanderpool’s article on the HIPAA guidelines is available from the Help Line. ■

Minnesota, APA Medicare Advisory Committee update

by Eric Larson, MD

The Minnesota Medicare Carrier Advisory Committee (CAC) held its quarterly meeting on September 13, 2001 in Minneapolis, with Drs. Deane Manolis and Eric Larson attending as psychiatric representatives.

As you know, the Healthcare Financing Administration (HFCA) has changed its name to the Centers for Medicare and Medicaid Services (CMS). The name change corresponds with its stated desire to work more collegially with physicians—to focus more on provider education, and to provide and seek feedback. The proof will be in the doing, of course.

The members of the CAC made it clear that they wanted to see accuracy and fairness in the measurement and definitions of error rates in Medicare coding and billing. To his credit, the local Medicare representative seemed solicitous and did not mention the words "fraud" or "abuse".

Interested physicians can explore further at the CMS website <www.hcfa.gov>. Go to the "Plans and Providers" link, then to "Medicare Learning Network" link for educational materials. A national coding simplification task force has been convened, with recommendations due Spring 2002. Questions about Medicare can be directed to 1 (800) MEDICARE or 1 (800) 633-4227.

Psychiatric topics are discussed about once a year at this committee. However, it seems useful for us to participate, to give feedback on these topics when they come up, and to keep abreast of other important issues for medicine in general.

We also are members of the APA Medicare Carrier Advisory Committee (MAC), made up of APA members across the country who keep in touch by email and meet at the APA Annual meeting, and September Components meeting. This group has coordinated national efforts to identify and correct arbitrary and unfair interpretation of billing regulations by HCFA. At its September meeting, the MAC identified two priorities:

- To develop a model Local Medical Review Policy for psychiatric services for use by all Medicare carriers.
- To convince CMS (HCFA) to drop the "restricted" status for family therapy codes (90846/90847), so the carriers can stop prepayment audits for these codes.

Ellen Jaffe is the APA contact for concerns about Medicare <ejaffe@psych.org>. Questions can also be directed to Eric Larson <larsoew@parknicollet.com>, and I can pass them on to Ellen Jaffe. ■

Federal parity law sunsets

Despite the efforts of MN Sen. Paul Wellstone, the Mental Health Parity Act of 1996 expired on September 30, due to a sunset provision in the law. A bill extending and expanding MH parity was blocked from Senate floor action in late September, an apparent victim of the aftermath of the September 11 terrorist attack.

The Mental Health Equitable Treatment Act, authored by Senators Wellstone and Pete Domenici of New Mexico, has 65 co-sponsors in the Senate. It is modeled after the mental health provisions of the Federal Employees Health Benefits Program.

The bill was blocked by a small group of Republican senators who insisted the bill would cause an unacceptable increase in health care costs, despite the Congressional Budget Office estimate of a mere 1% increase in health insurance premiums. The opponents threatened legislative maneuvering such as attaching unpopular amendments to the legislation.

Senator Wellstone's MN staff urges phone calls to four senators to ask them to drop their opposition to the bill, S.543:

- Wyoming Sen. Mike Enzi at (202) 224-3424
- Texas Sen. Phil Gramm at (202) 224-2934
- New Hampshire Sen. Judd Gregg at (202) 224-3324
- Oklahoma Sen. Don Nickles at (202) 224-5754

APA Candidates for 2002

The APA Nominating Committee announces its unanimous selection of candidates for the 2002 election. This information was posted on the Board of Trustees listserv on September 12, 2001, and was reported to the board at its October 8-9, 2001 meeting:

President-Elect: Marcia Kraft Goin, MD, California
Sidney H. Weissman, MD, Illinois

Vice-President: Barry F. Chaitin, MD, California
Steven S. Sharfstein, MD, Maryland

Treasurer: Carol A. Bernstein, MD, New York
Michael J. Vergare, MD, Pennsylvania

Trustee-at-Large: David Fassler, MD, Vermont
Herbert S. Peyser, MD, New York

Member-in-Training Trustee-Elect:
Angela D. Harper, MD, University of South Carolina
Sonia G. Patel, MD, University of Hawaii
William C. Wood, MD, McLean Hospital

MMA Annual Meeting
Continued from page 8
recovery without compromising patient safety."

Other resolutions addressed issues of interest to our members. One resolution sought recognition that obesity is an epidemic medical disorder, deserves to be treated by health care professionals, and therefore should be reimbursable by third-party payers. Several MMA members commented on the irony that insurance plans often pay for bariatric surgery, but not for lifestyle counseling or outpatient weight control programs. Another resolution, supported by Karen Dickson (West Metro), addressed the need to mandate Hepatitis B, Hepatitis C, and HIV screening for all incarcerated offenders, along with necessary counseling and vaccination for Hepatitis B. Lee Beecher (West Metro) introduced a resolution that the MMA develop model physician health plan contracts to protect privacy and quality of patient care. A more complex resolution involving patient protection and fairness in health care contracts did not pass.

Finally, I took heart from a resolution for the MMA to "study and put forward recommendations to address the issue of inadequate reimbursement for outpatient care for individuals with complex medical illnesses." While the authors were primary care physicians addressing the care of elderly patients with multiple illnesses (e.g., the patient with hypertension, diabetes, and heart failure), we might find a corner under which to place multi-dimensional care for our outpatients, who often need medication monitoring, psychotherapy, and social services, all integrated with oversight by a psychiatrist.

Each time I attend the MMA annual meeting, I am gratified to learn that our physician colleagues hold us in high esteem. If you haven't attended, I recommend volunteering as a delegate. It was a privilege attending as your delegate. ■

Child and Adult Psychiatrists

The Park Nicollet Health Services Department of Mental Health seeks highly qualified applicants for positions in outpatient child psychiatry and combined inpatient/outpatient adult psychiatry. Successful candidates will join 22 adult psychiatrists and 4 child psychiatrists, along with 68 clinical mental health professionals, in a growing practice which provides outstanding clinical services as well as opportunities for teaching and research. Faculty appointments are obtainable at Hennepin County Medical Center and The University of Minnesota. Park Nicollet Health Services is renowned for clinical excellence, innovation in service delivery and collegiality. We are a comprehensive, nonprofit healthcare system that contracts with all major insurers. The Minneapolis area is famous for its cultural attractions, healthcare and educational systems, natural beauty and overall quality of life. Salary and benefits are highly competitive. Send resume and cover letter to Stephanie Hatier, Clinician Recruitment, Park Nicollet Health Services, 3800 Park Nicollet Boulevard 7N, Minneapolis, MN 55416; FAX: (952) 993-2819; for further information call Stephanie Hatier (952) 993-2703).

Council highlights

Continued from page 6

tative. Linda Vukelich reported that the MPS Disaster Preparedness Committee met after the recent terrorist attacks and provided back up support for the Minnesota chapter of the American Red Cross.

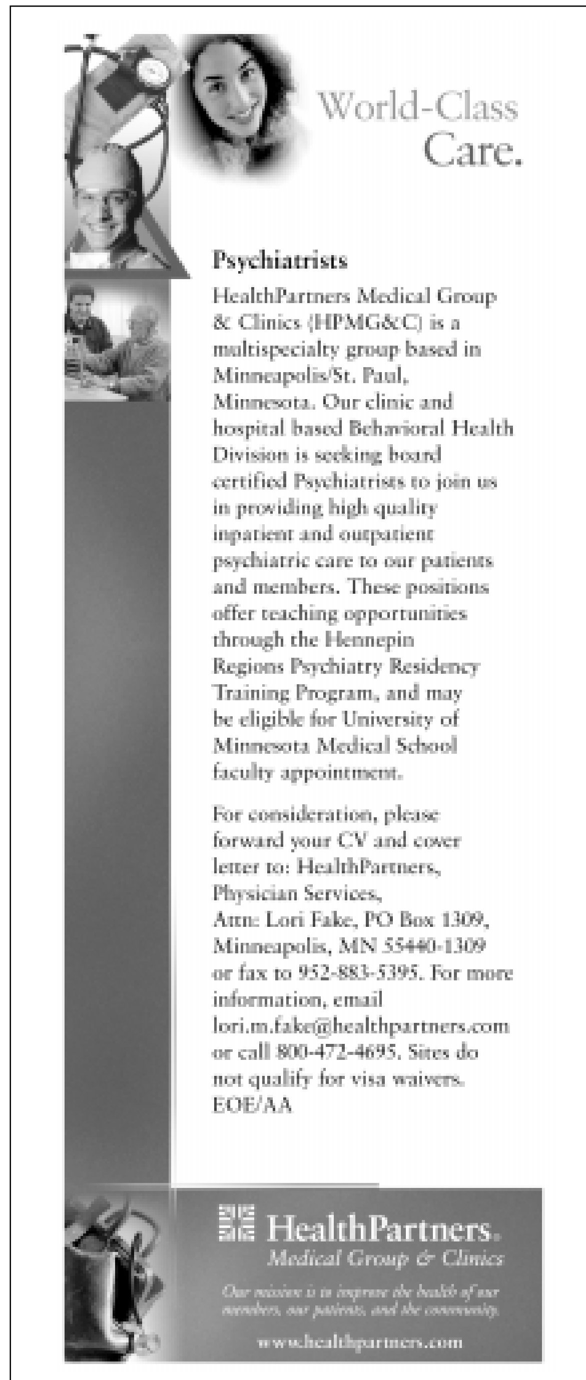
Treasurer's Report—The financials for July and August were reviewed and found to be in good order. Dr. Realmuto led a discussion regarding priorities for MPS expenditures, in preparation for developing next year's budget. Lobbying expense is a major budget item, and the Council agreed to ask Dominic Sposeto for an annual report on his activities representing MPS.

Membership Committee—Dr. Manolis reported for Dr. Cline that the Membership Committee agreed to send representatives to the three training programs, meeting with residents to encourage MPS membership. The new Membership Committee includes Dr. Cline as chair, and Drs. Albrecht, Kashtan, Manolis and Reeve. **Action:** The Council approved three new members in training, two transfers in, one transfer out, and one reinstated general member.

Private Practice Committee— Dr. Anderson reported on the Private Practice Committee's Task Force on Quality Psychiatric Care. This group, which was appointed at the last Council meeting, met several times and developed eleven ideas to recommend to the Commerce Department and Minnesota insurance plans. The Council reviewed the list, suggesting that three of the ideas be dropped. **Action:** The Council approved the list for Drs, Anderson and Stahle to wordsmith and edit, then send the list to MPS members for feedback.

Old Business—Dr. Manolis, who previously nominated Dr. Bob Baumer for the Area IV Council Bartholow Award, provided a draft letter of nomination for the Council's approval. **Action:** The Council approved the letter which will be forwarded along with a nominating packet to the chair of the Bartholow Award Committee.

New Business--Dr. Dieperink, chair of the Early Career Psychiatrist Committee, reported that his committee was relatively inactive, and that as a VAMC psychiatrist he was not fully aware of the problems of ECPs in private practice. He thought that a co-chair from the private practice sector would be helpful. Dr. Anderson agreed to discuss this at the Private Practice Committee and that this committee might be willing to offer a program to benefit ECPs. ■



APA President answers terrorism

Continued from page 1

of psychiatrists trained in our traditions of the doctor-patient relationship and psychodynamic principles and honed on the cutting edge of biological science.

This great profession is being summoned by history to take a leadership role in helping a country recover from an unprecedented trauma. The road map is a little unclear 48 hours out, but APA is blessed with experts in responding to disasters, posttraumatic stress disorder, grief, anxiety, and loss. We will borrow ideas from our uniformed services colleagues and help them improve their service to citizens in the military. We will unify our approaches to helping those in this country and our global brothers and sisters. We will use this tragedy to unite ourselves for the good of our patients and improve our treatments for the good of all.

The cowardly terrorists who thought their fanatic actions would divide us, cower us, and bring us to our knees were mistaken. They don't know us. Now we will show them who we truly are. ■

Hospital Care
Continued from page 9

center. By incredible I mean that the wait can be four to six times the average length of stay for an inpatient service making the total length of stay up to eight times the average. During this time treatment proceeds with a goal of discharge if possible, but for this group of patients the inpatient unit is a defacto regional treatment center—which is *not* funded by the state.

Discharges to group homes and nursing homes are as problematic. The same funding issues that have counties limiting access to detox facilities has resulted in limited access to group homes and nursing homes. Amazingly, psychiatric inpatients are often given no priority for placement. Case managers are gatekeepers for group homes. Some counties may delay case management intake for a month. Rule 25 chemical dependency counselors are gatekeepers for the chemical dependency treatment system in Minnesota. Many do not see patients on a timely basis in hospitals. If a patient is admitted for detoxification from cocaine and has a severe cocaine addiction, the inpatient team knows that a discharge plan based on the patient calling Rule 25 is usually not a discharge plan at all. There are also gatekeepers for nursing homes who do required Level II screenings. The patient in this process often has a pre-existing psychiatric diagnosis and a more recent diagnosis of dementia. The discharge process usually involves a wait for the screening and a longer wait to place the patient in a health care facility with a "behavioral unit". All three divisions of bureaucracy prolong inpatient hospitalizations unnecessarily.

Apart from specific admission and discharge processes that prolong inpatient stays, there are additional constraints that adversely impact the quality of inpatient care. These include:

- Overcrowding and high noise levels, which appear to be a consequence of cost shifting and unfunded care. There are clearly not as many state-of-the-art facilities for psychiatric care as for better reimbursed programs, e.g. cardiology, surgery specialties, or gastroenterology.
- Access to specialty care is another problem. Many patients with chronic psychiatric illness have acute dental problems or active medical and surgical problems at the time of admission. In the case of depression and associated pain syndromes it is critical that both problems are addressed during the admission. Access to appropriate specialists to provide this level of treatment is dwindling.
- Additional regulations affecting inpatient care have added to the costs and not added to the quality. A good example is regulation limiting the use of seclusion and restraint that have led to use of disproportionate resources in that area, decreasing the availability of staff for other therapeutic endeavors, and increasing staff and patient injuries.

As most inpatient psychiatrists know, the same bean counters that send the length of stay statistics can send productivity data with the same zeal. Computerized billing and coding data can be presented in a number of formats that show no matter how many RVUs are generated, it is not enough. The ultimate form of cost shifting occurs when the psychiatrist becomes accountable for a payer mix that reimburses treatment at lower and lower rates. The concept of the Medicare conversion factor is meaningless when calculations show that the actual conversion factor used to pay for psychiatric salaries is much less based on the payer mix. The payer mix is worsened in turn by months of unreimbursed care. Consequently, psychiatrists find they need to work much longer to maintain the same income.

The trend of increasing utilization of psychiatric inpatient units for a broad array of services, underfunding the provision of these services, and isolating them from what is needed to provide a continuum of care is one of the great paradoxes of psychiatric treatment in the new millenium. In order to keep the doors open, multiple levels of government and social service agencies must work cooperatively. Inpatient psychiatrists in Minnesota and across the country are not getting the needed level of cooperation. We are experiencing the worst, in what could be the best, of times. ■

Legislative redistricting
Continued from page 5

The required redrawing of congressional district lines after the 2000 census may result in some interesting decisions for our state's current eight members of Congress. Since we normally expect our Congressmen to actually live in the district they represent, some current members of Congress may be considering a move in the near future. The proposed Republican plan would put Minneapolis and St. Paul into one large metropolitan district. Depending on how the lines are drawn, long time Congressman Martin Sabo could be forced to run against newly elected Congresswoman Betty McCollum. Or, with a modest change in the boundaries, McCollum could be forced to run against Congressman Bill Luther.

Newly elected Congressman Mark Kennedy could be put into a district with Congressman Jim Ramstad or a district with Congressman Colin Peterson. Representative Peterson could be put into a district with longtime Congressman Jim Oberstar. Musical chairs could go on and on.

Politicians will on be on edge for the next several months awaiting the final redistricting plan, which is due in March. Then they will be able to develop their reelection plans, which could include forced retirement or maybe a new mailing address. Not a great time to be an elected official but maybe a good time to be a realtor. ■

Calendar

Nov 2 MPS Psychopharmacology Update, Wyndham Hotel, Bloomington, MN. For more information call Linda Vukelich at (651) 407-1873 or get registration form and brochure from the website at <www.MnPsychSoc.org>.

Nov 3 Suicide Awareness Voices of Education (SAVE) Public Seminar, Hennepin Technical College, Brooklyn Park, MN. For more information call (952) 946-7998.

Nov 9 Annual Conference, National Alliance for the Mentally Ill of Minnesota (NAMI-MN),Holiday Inn St. Paul East, St. Paul, MN. For more information, call (651) 645-2948.

Nov 15-18 48th Annual Meting of the Academy of Psychosomatic Medicine, "Preserving Meaning in the Practice of C-L Psychiatry," San Antonio, TX. For more information, call (773) 784-2025 or see <www.apm.org>.

Dec 6-9 Annual Meeting, International Society for Traumatic Stress Studies, New Orleans, LA. For more information, call (847) 480-9028.

Dec 13-16 12th Annual Meeting and Symposium of the American Adacemy of Addiction Psychiatry, Amelia Island, FL. For more information, call Becky Stein, AAAP, (913) 262-4311 or see <www.aaap.org>.

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