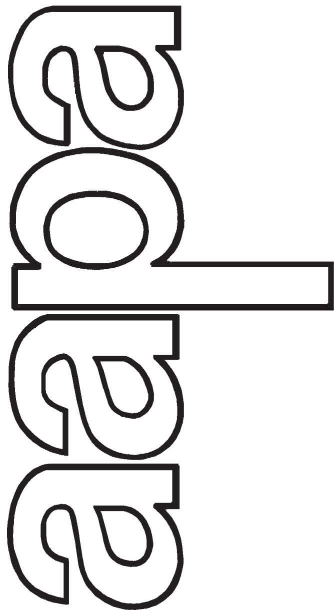

PSYCHIATRIST ADMINISTRATOR

NewsJournal of the

American Association of Psychiatric Administrators

Volume 8: 2008 Issue 2

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Editor — Sy Atezaz Saeed, MD, MS

Published 4 times a year
Winter • Spring • Summer • Fall

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MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT, 2008

On June 24, 2008 the House passed the Medicare Improvements for Patients and Providers Act, H.R. 6331. This legislation prevented the pending ten percent payment reduction for physicians in Medicare, enhanced Medicare preventive and mental health benefits, improved and extended programs for low-income Medicare beneficiaries, and extended expiring provisions for rural and other providers. On July 15, 2008, the President vetoed this legislation. Subsequently, on that same day, the House of Representatives and the Senate voted to override the President's veto of the bill. The House vote was 383–41 and the Senate vote was 70–26. H.R. 6331 became P.L. 110-275. On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 was enacted, making critical reforms and improvements to the Medicare program.

American Psychiatric Association (APA) hailed Medicare veto override and the new law as historic improvements in mental health coverage that ended more than 40 years of discrimination against patients who need mental health services.[1]

Since the Medicare program was first established, patients receiving mental health services in private offices and other outpatient settings have had to pay a co-payment of 50 percent, as opposed to the 20 percent co-payment charged for all other care under Part B. The Medicare Improvements for Patients and Providers Act of 2008 phases out the 50 percent coinsurance from 2010 through 2013. Starting in 2014, the co-payment for outpatient mental health treatment will be the same 20 percent as other Medicare services, ending the disparity between Medicare coverage of mental health services and other medical care.

The new Medicare law also includes coverage by Medicare Part D of benzodiazepine and barbiturate prescriptions which will be effective on January 1, 2013. It provides statutory authority under the Part D drug benefit for the Centers for Medicare and Medicaid Services (CMS) to ensure broad coverage on prescription drug plan formularies for antipsychotics, antidepressants, and anticonvulsants. Effective with the date of enactment, Medicare law will include special protections to ensure that medically vulnerable patients will be assured access to "all or substantially all" of the medications they require, specifically including antidepressants and antipsychotics among other medications. The new law also provides changes to eligibility for the Part D Low-Income Subsidy (LIS) program. These reforms include an increase in the amount of allowable resources, elimination of barriers to enrollment and the current late enrollment penalty and new exemptions for the value of a life insurance policy and in-kind support and maintenance. Eligibility for the LIS significantly lowers premiums and cost sharing for drug coverage and exempts beneficiaries from the "doughnut hole" coverage gap.[2]

Some of the highlights:

1. Provides 18-month Medicare physician payment fix, stopping the 10.6% Medicare physician payment cut on July 1, 2008, and the 5.4% cut on Jan. 1, 2009, extending the June 2008 rates through Dec. 31, 2008, and providing an additional 1.1% update for 2009.[3]
2. Phases in a reduction in co pays for mental health to the same level as other outpatient services (20%).
3. Provides a 5% pay increase for certain mental health services from July 1, 2008, through Dec. 1, 2009.
4. Allows Part D coverage of benzodiazepines and barbiturates.
5. Provides a 2% bonus in 2009 and 2010 for e-prescribing by eligible physicians, reduced to 1% in 2011 and 2012 and 0.5% in 2013. If eligible physicians do not e-prescribe, imposes penalties of -1% in 2012, -1.5% in 2013, and -2% in 2014 and beyond. Provides hardship exceptions.
6. Reinstates the therapy caps exceptions process as of July 1st. Therefore, medically necessary

Continued on next page

therapy services, in excess of the therapy caps, will continue to be paid by Medicare in accordance with the exceptions process.

7. Delays the Durable Medical Equipment Competitive Bidding Program, which affects only Medicare beneficiaries in traditional fee-for-service in 10 competitive bidding areas. Medicare beneficiaries may use any Medicare-approved supplier for Durable Medical Equipment. If a beneficiary changed suppliers when this new program started (July 1, 2008), they can either continue to use the new supplier or choose another supplier. The original DME payment rates in effect prior to July 1 are reinstated retroactively.
8. The bill extends and improves low-income assistance programs for Medicare beneficiaries whose income is below $14,040. This includes the "Qualified Individual" program which pays part B premiums for low-income beneficiaries with incomes of $12,480 to $14,040 a year.
9. The bill protects access to care in rural America by extending and building upon expiring provisions, including:
   - Improving payments for sole community hospitals, critical access hospitals, and ambulances;
   - Extending expiring provisions that preserve payment equity for rural physicians and rural hospitals that run clinical laboratories;
   - Increasing access to tele-health services and speech-language therapy;
   - Retaining access to Medicare Advantage by ensuring private-fee-for-service plans in rural areas can continue to operate as they do today, if there are fewer than two plan options.

References

1. American Psychiatric Association. APA Hails Medicare Veto Override; New Law Makes Historic Improvements in Mental Health Coverage. News Release. Available at http://www.psych.org/MainMenu/Newsroom.aspx. Accessed August 6, 2008.
2. GovTrack.us. H.R. 6331--110th Congress (2008): Medicare Improvement for Patients and Providers Act of 2008, GovTrack.us (database of federal legislation). Available at http://www.govtrack.us/congress/bill.xpd?tab=summary&bill=h110-6331 . Accessed Aug 13, 2008.
3. Center for Medicare and Medicaid Services. New 2008 Medicare Physician Fee Schedule Payment Rates Effective for Dates of Service July 1, 2008 through December 31, 2008. Available at http://www.cms.hhs.gov/PhysicianFeeSched. Accessed Aug 13, 2008.

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Arthur Lazarus, M.D., M.B.A.

Dear Colleagues:

The AAPA course in administrative psychiatry, given each year for the past several years at the annual meeting of the APA, has emphasized the importance of finance and accounting in psychiatric administration (thanks to Dr. Shivkumar Hatti for teaching finance concepts to course participants). As administrators, we have a duty to control spending, but I fear that many psychiatrists view that responsibility as outside the purview of their job. Nowadays, however, physician executives are expected to pay as close attention to the cost of care as they are the quality of care.

Experts predict that healthcare spending in the United States will reach $5 trillion within 10 years, or approximately 20 percent of GDP. Overall, U.S. healthcare expenditures are 2.4 times the average of those of all developed countries, yet health outcomes for U.S. patients, whether measured by life expectancy, disease-specific mortality rates, or other variables, are unimpressive. Over time and through disconnected events, the U.S. healthcare system has evolved into a "perfect storm" that drives over-utilization and increases the cost of health care.

I do not think universal health care will shelter us from the storm, because if you conceptualize the current healthcare system as a two-payer system, private and public (e.g., VA, Medicare and Medicaid), then we are only one step removed from universal healthcare right now. Any savings realized by eliminating the private healthcare sector are likely to be marginal, or costs might actually increase in the hands of the U.S. government. Besides, in a country generally dubious about giving government control of the market–any market–universal healthcare may never work. (Drs. Steven Sharfstein and Ronald Davis will debate this issue at the IPS meeting in Chicago.)

I can't pretend to know how to solve the nation's healthcare crisis. But I do believe that psychiatric administrators can help alleviate many problems in the health system simply by keeping close tabs on spending in their departments and institutions and eliminating waste. In addition, psychiatric administrators can use certain tools to help improve healthcare quality and decrease costs.

We can design and implement quality programs to decrease the economic burden of mental illnesses–disease management programs that include prevention and the integration of medical and psychiatric services. Those of us who work in the managed care industry can advocate for cost-cutting tools such as consumer-directed health plans and the use of predictive modeling to target those who aren't yet sick but who might be soon.

Many of us can participate in marketing activities to help raise the profile of our organizations and destigmatize mental illnesses, for example, by conducting public health seminars. Speaking engagements may also help generate referrals and contribute a profit to your organization. When was the last time you represented your organization in front of the public or helped to put a face on the National Alliance on Mental Illness or the Depression and Bipolar Support Alliance?

Every year that slips by without an effective antidote to the fiscal crisis in health care ratchets up the pressure and the likelihood of an unavoidable call for urgent action. So please begin taking action today. If you do not think you can make a difference, then let me remind you of the starfish story. Many starfish washed up on shore. A young boy started picking them up and throwing them back into the ocean. Someone saw what he was doing and told him that it was pointless, that there were too many to save, that it wouldn't make a difference. Throwing another starfish into the sea, the little boy responded, "It makes a difference to this one."

UPDATE ON LEGISLATION, POLITICAL DEVELOPMENTS AND TRENDS AFFECTING HEALTHCARE DELIVERY AND FINANCING

Lawrence Goldberg, MD

After fifteen or so years of stagnation, following the defeat of the Clinton Administration's healthcare initiative, we are finally seeing the potential for some very significant developments affecting the delivery of healthcare in the next few years. Since the Clinton failure, government had left the initiative largely to the private sector, hoping that managed care companies could reign in costs and keep coverage affordable and accessible for the working population. However, politicians and the public have grown disenchanted with the insurers' ability to effect cost containment through promoting greater efficiency and selectively contracting with providers. After some initial success in the early years of managed care, these efforts have failed to stem rising costs. When these efforts have proved insufficient, the companies have had to fall back on achieving savings through disenrolling membership and imposing limitations on coverage. Most progressive initiatives we have seen in recent years have flowed from state governments, trying to control costs in their Medicaid programs, as well as to increase access to insurance for the low-wage uninsured worker and for the higher risk sicker or older individual.

Two pieces of legislation passed recently by Congress already herald the changing climate toward greater Federal activism on health. On July 15, Congress overrode a presidential veto to pass the Medicare Improvements for Patients and Providers Act, which chiefly rolled back a scheduled cut in physicians' fees imposed for budgetary reasons. It also provided a 5% increase in reimbursement for psychotherapy services for both inpatient and outpatient treatment (codes 90801-90829). More significantly, starting in 2010, the longstanding 50% co-payment requirement for outpatient mental health services will be reduced in decrements of about 5% per year through 2013. In 2014 and thereafter, the coinsurance rate will be the same 20% that has been historically charged for other medical services. Also, beginning in 2013, Medicare Part D will begin paying for benzodiazepines and barbiturates. The law also includes language that would bar the Part D program from instituting formulary restrictions on any antidepressants or antipsychotics.

The second major piece of legislation is the mental health parity bill. Different versions of the bill passed in the House and Senate, so a compromise version will have to be worked out. The final version will most likely adhere to the Senate version in providing parity for only a specified list of the more biologically-based mental disorders, rather than the entire DSM, as the House version had provided. It will also stipulate that parity must be provided for out of network mental health services, if the plan offers out of network medical-surgical services. Visit limits and co-payment amounts will have to be the same as for the medical coverage, as well as the overall dollar limits previously cited in the 1996 federal law. It's expected that the new law will extend parity to the millions of people whose insurance is ERISA-exempt, that is, employer self-funded plans not covered under the various state parity laws currently in effect.

This year's presidential campaign has focused much attention on the candidates' contrasting approaches to overhauling the healthcare financing system. Indeed, the prospects are the best they have been in many years that major changes will take place, though the full extent of the lobbying efforts to defeat these proposals has yet to be seen. Obama's program involves setting up a system of health insurance purchasing exchanges, so as to ensure affordable coverage for individuals currently excluded from the commercial market, or so dissatisfied with their employer-provided coverage as to wish to change. Employers who do not offer health benefits for their workers would have to pay into this system. There would also be subsidies for the cost of premiums for low income people. Insurers would

Continued on next page

be required to insure all applicants, without turning any one away based on risk. Insurers are leery of this proposal, mainly in that they look to government to guarantee that the expenses of severely ill individuals will not adversely affect their profits. However, Obama's proposal addresses this by providing a mechanism to reinsure the private plans for a portion of their catastrophic costs. Advocates of universal access fear that the lack of a mandate that everyone buy insurance will make the cost of the program too great. They fear that adverse selection will operate to attract a sicker than average subset of the entire population to enroll, without the receipt of premiums that would be paid in by the young and the healthy.

The McCain proposal centers around decoupling health insurance from employment, and giving everyone a tax credit to purchase insurance privately on the open market. Individuals would be allowed to buy insurance from out of state plans, or through trade association plans set up to service smaller employers. This is consistent with the conservative philosophy of allowing the unfettered market to bring down costs through competition, as well as the value of individual responsibility and control. Employees wishing to retain their employer-provided coverage would be taxed on the value of the coverage provided. While many employers would welcome relief from the staggering costs of their current benefit plans, they are anxious that healthier employees would flee their plans, leaving only older and retired members behind, again causing adverse selection pressures on the solvency of the plans. Critics of his plan focus on the likelihood that large numbers of people would continue to be turned down for coverage, or continue to find it unaffordable despite the favorable tax treatment. There is nothing to stop the plans from age-rating premiums, pushing up the cost for older individuals, or excluding pre-existing conditions. Under McCain's plan, those people priced out of the commercial market would be accommodated in State managed assigned risk pools, but the few such pools already in existence have provided coverage only at high cost or with very limited benefits.

The anticipated widening of access to health care from these proposals, while welcome and long overdue, will only serve to intensify the funding pressures anticipated in society as baby boomers age and increasingly need more complex and extensive care. While increasing income taxes is politically untenable, increases in the Medicare payroll taxes seem inevitable. Many proposals to effect greater cost containment have been discussed, both by the candidates and by health economists. A number of largely untested cost containment strategies have been widely discussed and debated, such as: 1)greater emphasis on prevention, screening and early detection of illness, 2)wider use of electronic medical records and e-prescribing, 3)paying primary MD's more to provide coordination of care among specialists treating a patient and decrease reliance on specialists, 4)expansion of consumer-directed health care and health savings accounts, and 5) reform of malpractice laws to limit frivolous suits and excessive awards. Many of the savings from these measures would be only modest, and slow in coming. Payers are reluctant to make long-term investments in prevention, since a large percentage of their membership shifts among insurers at the end of every underwriting cycle. Outcome studies on disease management programs have shown questionable returns on investment.

Largely absent from the public discourse on health has been the recognition that access to expensive and untested treatments will eventually have to be restricted. In effect, some manner of rationing is inevitable. Many argue that this already takes place, based on patients' economic level and the generosity of their health plans. Rationing by the payers will always be subject to attack as ethically questionable due to financial conflicts of interest. Many healthcare experts are now calling for the establishment of a quasi-governmental but independent body to make assessments of new and existing treatment technologies, based on effectiveness and possibly also cost, using the best available research evidence. This entity's recommendations would serve as a basis for decisions by both public and private payers in making coverage decisions. Disseminating their findings, it is hoped, will serve to lessen the wide variation in practices between different provider groups, and between different geographic regions.

Continued on next page

The National Health Service in the UK has already established such a body, the National Health Institute for Clinical Excellence (NICE). In a recent report, NICE held that there is no superiority or cost benefit to using second generation antipsychotic medications relative to standard agents. Such determinations are made after conducting a systematic review of all the available study results, both published and unpublished, using meta-analytic techniques. In the US, comparative effectiveness studies are addressed in a limited way through the Agency for Healthcare Research and Quality (AHRQ), which has been active in promoting evidence-based reviews and serves as a clearing house for clinical practice guidelines. There is also a Medicare Coverage Advisory Committee that is charged with evaluating the effectiveness of new medical technology. Its determinations serve as guidelines to its various regional carriers in making coverage determinations. The actual extent of the role that comparative cost factors may play in a Medicare coverage determination continues controversial. The new US agency currently under discussion would play a more proactive role in identifying areas needed for more study, and in funding comparative effectiveness research on a large scale. A bill to establish such an agency, which would function as a private, non-profit corporation, has just been introduced in the Senate by Senators Max Baucus and Kent Conrad. They propose a stable funding stream for the entity that would be free of the highly politicized annual Congressional appropriations process.

At its best, American medical care is unsurpassed anywhere else in the world. However, the reality is that it is often uncoordinated, inefficient and wasteful. Extraordinary resources are routinely expended for care that provides questionable benefit to either survival or quality of life. The most rational and fair alternative to continuing to fund this ever expanding financial burden is for society to begin to make difficult choices in accordance with our values regarding the worth of each life however diminished and impaired. Professional leadership will be required to make sure that it is done in a way that is consistent with sound evidence-based clinical judgment and ethical principles.

Dr. Goldberg is an Associate Medical Director with United Behavioral Health. The opinions he expresses here are entirely his own. He is the Current Chair of the AAPA Insurance and Managed Care Committee.

References:

1. Aaron HJ. Can We Say No?: The Challenge of Rationing Health Care. Washington D.C., The Brookings Institution, 2005.
2. National Health Policy Forum Background Paper, Value-Based Coverage Policy in the US and the UK: Different Paths to a Common Goal. Washington, D.C. George Washington University. November 29, 2006. Available at www.nhpf.org
3. Clancy CM, Getting to “Smart” Health Care, Rowe JW et al, The Emerging Context for Advances in Comparative Effectiveness Assessment, Buto K and Juhn P, Can a Center for Comparative Effectiveness Information Succeed? Perspectives from a Health Care Company, Wilensky GR, Developing a Center for Comparative Effectiveness Information. All in Health Affairs- Web Exclusive. Washington D.C., Project Hope. Available at www.healthaffairs.org/webexclusives. November 7, 2006.
4. Orszag PR. Research on Comparative Effectiveness of Medical Treatments: Options for an Expanded Federal Role. Washington D.C., Congressional Budget Office, Testimony before the House Ways and Means Committee, Sub-committee on Health, June 12, 2007.
5. Laszewski R. Health Policy and Marketplace Review, available on web at http://healthpolicyandmarket.blogspot.com

LESSONS FROM SABIN

H. Steven Moffic, M.D.

Whoever obtained James Sabin, M.D. to comment on "Medical Directors, Insurers, and Murder: Lessons from the Case of Nataline Sarkisyan" in the last issue scored a coup. Dr. Sabin pointed out so many invaluable lessons for psychiatrist administrators. I would suggest rereading the article whether or not you are interested in my response. In addition, though I usually dislike most Blogs due to their extreme subjectivity and lack of editing, I would say that the blog of Dr. Sabin is an exception, a carefully reasoned and readable analysis of many healthcare administrative and organizational ethical dilemmas that should be of interest to us (healthcareorganizationalethics.blogspot.com).

Most impressively, he showed his affinity to our AAPA Ethical Principles for Psychiatric Administrators and how they can be applied to a real clinical case, and not even a psychiatric one at that. Let's hear about more such examples.

Secondly, he pointed out how our special skills as PSYCHIATRIST administrators could be helpful to any healthcare organization, if only they would ask us. Maybe we should be more proactive in conveying our knowledge about splitting, the Oedipal conflict, modeling, and other psychological processes that influence the success of organizations. Wouldn't it be interesting – and isn't it time – to have a psychiatrist at the head of the American Medical Association?

Dr. Sabin left it open, if not suggesting, for others of us to follow-up with comments of our own on the case. After saying he had distilled four lessons, he said "I am sure others will identify more." So I will now attempt to identify more. But first a disclaimer. Jim was my teacher and model for learning about ethical challenges (and solutions) in mental health managed care. He even recommended me to write a book on that topic, which I did, though I'm sure he could have written a better one. I've been both gratified and wishing I had never met him. Why? As he discussed, getting in the middle of managed care splitting can be dangerous to one's mental health. But somebodies have to do it ethically, otherwise we will continue to have big or little tragedies like that of Sarkisyan.

I do have some questions and comments about what Dr. Sabin said before moving on to other lessons. I do think that there were predecessors to Aetna using outside independent reviewers before 1991. I know we did in our own academic mental health carve-out. However, "independent" is most misleading when it is paid for by only one side like CIGNA in the case discussed. As to the importance of an evidence base, that will rarely be sufficient for an individual patient. The conclusion that there was no evidence that the procedure would save Sarkisyan ends up not holding ethical and clinical water, because she could have been an exception to the evidence. We've all seen individual cases that respond in a way that no evidence-based information would have anticipated.

What other ethical lessons does this case have for me, and possibly others? When the profit motive is high and predominant, as it must be in most private managed care companies and the private businesses that pay them, then profits will take priority over patients and clinicians. In other words, business ethics will be more important than healthcare ethics. The other potential benefits of managed care, such as reduction of unnecessary or poor care and improvement of quality, will only become more prominent if the profit motive is reduced. If managed care survives in future health system reform, I would recommend that it be not-for-profit. Therefore, if a universal system emerges in the United States, it should be one that the public as a whole buys into, not imposed by profit-seeking businesses.

Outside, or "independent" reviewers, so crucial to ensuring that proper decisions are being made by managed care companies, should not be paid solely by these same companies. That is like "the fox guarding the henhouse." This arrangement is too suspect for conflict of interest, as is often the case in forensic psychiatry, where vastly different opinions

Continued on next page

are rendered depending on whether the prosecution or defense is paying for the opinion of the "expert" psychiatric witness. I would suggest they should be paid from a pool of money contributed by the payers, the public, managed care companies, hospitals, and clinicians (i.e., multiply "taxed"). This is the same principle as that of our country's fore founders, who attempted to set up a system of checks and balances. Indeed, balancing different constituencies is often the biggest challenge we have in being the most ethical psychiatric administrators that we can be.

Dr. Moffic is a professor in the Department of Psychiatry & Behavioral Medicine at the Medical College of Wisconsin as well as in the Department of Family and Community Medicine.

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LITERATURE SCAN

The Literature Scan is our regular column that reviews recent literature of interest to administrators in behavioral health care systems. The column covers a period of approximately 6 months. Papers are selected on such topics as administration, consumer satisfaction, delivery of health care, education, efficacy, ethics, evidence-based practice, leadership, and management. The daily demands of administration and practice often leave little time for browsing journals. It's our hope that this column may fill the gap.

Cleary M, Walter G, Matheson S. What is the Role of e-Technology in Mental Health Services and Psychiatric Research? Journal of Psychosocial Nursing and Mental Health Services. 2008 Apr;46(4):42-8.

In this article, the authors explore the role of e-technology, with an emphasis on the advantages and disadvantages of its use for health care and mental health research. E-technology is broadly understood to include the Internet and related information technologies, and in recent years, its use has grown rapidly. The Internet is a major source of health information, and there is potential to deliver enhanced services through this medium. In addition, e-technology's role in future mental health service delivery and research will continue to expand as increased numbers of consumers, caregivers, health professionals, and the general population go online, particularly as the technology is refined and made even more user friendly.

Dierks C. Legal and Social Responsibility in Health Service Chains. Studies in Health Technology and Informatics. 2008;134:107-11.

This article addresses how personal health settings establishing health service chains lead to new legal challenges. Also discussed is that the safe harbor principle of doctor-patient relationships should be extended to include multilateral relations and other parties by reconciling a broad variety of legal regulations with detailed contractual agreements. Further discussions are on security and privacy, liability, risk management, and reimbursement and how these issues have to be ruled.

Dimond B. The Mental Capacity Act 2005: Children and Young Persons. The British Journal of Nursing. 2008 Feb 28-Mar 12;17(4):248-50.

In this article the author considers the extent to which the Mental Capacity Act relates to children. While the Act applies to those over 16 years old, certain provisions only apply to those over 18 years old: the author considers these advance decisions/living-will, and the power to set up or be appointed under a lasting power of attorney. However, there are provisions which could apply to a child under 16 years old if he or she is unlikely to have the requisite mental capacity at 16 years. There are powers set up to enable easy transfer of proceedings between the Court of Protection and the Family Division of the High Court and vice versa.

Fisher CB, Oransky M. Informed Consent to Psychotherapy: Protecting the Dignity and Respecting the Autonomy of Patients. Journal of Clinical Psychology. 2008 May;64(5):576-88.

The authors of this article report how well-implemented informed consent procedures demonstrate psychotherapists' respect for clients' right to self-determination. Psychotherapists can initiate meaningful contributions to treatment through enhancing mutual trust, building rapport, and facilitating a sense of ownership. This article details key components of informed consent to psychotherapy by placing them within real-world psychotherapy scenarios. The authors provide information on client-therapist discussions of the nature and course of therapy, fees and payment policies, the involvement of third parties, confidentiality policies, and new and untested treatments. In addition, this article addresses informed consent procedures for individuals with impaired cognitive capacities and under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) regulations.

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Gilburt H, Rose D, Slade M. The Importance of Relationships in Mental Health Care: A Qualitative Study of Service Users' Experiences of Psychiatric Hospital Admission in the UK. BMC Health Services Research. 2008 Apr 25;8:92.

In this article, The authors state that while a number of studies have looked at life on service users' experiences of life on psychiatric wards, there has been no research conducted that has approached these experiences from the user perspective since the introduction of community care. This study used a participatory approach to develop an understanding of the processes which defined the user experience of hospitalization. Nineteen service users who experienced inpatient stays in psychiatric hospitals in London were interviewed in the community. Results found that relationships formed the core of service users' experiences. Three further codes, treatment, freedom and environment defined the role of hospital and its physical aspects. Also, themes of communication, safety, trust, coercion, and cultural competency contributed to the concept of relationships. The authors concluded that relationships with an individual which comprised effective communication, cultural sensitivity, and the absence of coercion resulted in that person being attributed with a sense of trust. This resulted in the patient experiencing the hospital as a place of safety in terms of risk from other patients and staff. Barriers to positive relationships included ineffective and negative communication, a lack of trust, a lack of safety in terms of staff as ineffective in preventing violence, and as perpetrators themselves, and the use of coercion by staff. The authors stress that this unique perspective both acts as a source of triangulation with previous studies and highlights the importance of the therapeutic relationship in providing a safe and therapeutic setting for the treatment of people with acute mental health problems.

Goering P, Boydell KM, Pignatiello A. The Relevance of Qualitative Research for Clinical Programs in Psychiatry. Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie. 2008 Mar;53(3):145-51.

The authors of this paper stress that it is time to move beyond education about qualitative research theory and methods, and on to using them to understand and improve psychiatric practice. There is a good fit between this agenda and current thinking about research use that broadens definitions of evidence beyond the results of experiments. In their paper, the authors describe a qualitative program evaluation to illustrate what kind of useful knowledge is generated and how it can be created through a clinician-researcher partnership. They go on to explain how the linkage and exchange model of effective knowledge translation described involves interaction between clinicians and researchers throughout the research process and results in mutual learning through the planning, disseminating, and application of existing or new qualitative research in decision making.

Holden D, Dew E. Telemedicine in a Rural Gero-Psychiatric Inpatient Unit: Comparison of Perception/Satisfaction to Onsite Psychiatric Care. Telemedicine Journal and e-health: the Official Journal of the American Telemedicine Association. 2008 May;14(4):381-4.

Telemedicine in a rural, gero-psychiatric inpatient unit is a groundbreaking concept. The use of telemedicine in rural communities, both inpatient and outpatient, is a significant way to provide specialty care that might otherwise only be available in urban areas. Establishing its credibility through perception/satisfaction studies and clinical outcome studies is therefore crucial. The authors of this article attempt to provide some of the necessary data. A review of the literature reveals limited data to demonstrate the impact of telemedicine on inpatient healthcare satisfaction and perceived outcomes as compared to traditional, on-site physician practice. They found that none of the literature addresses the use of telemedicine in an inpatient gero-psychiatric unit. However, the authors state that McCurtain Memorial Hospital is a pioneer in the use of telemedicine to provide acute gero-psychiatric care in a community-based inpatient setting. Pre- and post-patient/family satisfaction survey data for a period ranging 12 months prior to inception of telemedicine and 12 months post inception were aggregated and analyzed. The

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results indicate that there is a positive correlation between telemedicine and the patient/family satisfaction with and perception of benefits of treatment. In addition the authors indicate that it must be noted that patient/family perception of outcome and actual measures of clinical outcome are not the same. Clinical outcome data must also be collected to fully assess the success of telemedicine in this arena.

Layman EJ. Ethical Issues and the Electronic Health Record. The Health Care Manager. 2008 Apr-Jun;27(2):165-76.

In this review, the author discusses how ethical issues related to electronic health records (EHRs) confront health personnel. Electronic health records create conflict among several ethical principles, however electronic health records may represent beneficence because they are alleged to increase access to health care, improve the quality of care and health, and decrease costs. The author suggests that research has not consistently demonstrated access for disadvantaged persons, the accuracy of EHRs, their positive effects on productivity, nor decreased costs. Should beneficence be universally acknowledged, conflicts exist with other ethical principles. Autonomy is jeopardized when patients' health data are shared or linked without the patients' knowledge. Fidelity is breached by the exposure of thousands of patients' health data through mistakes or theft. Lack of confidence in the security of health data may induce patients to conceal sensitive information. Consequently, their treatment may be compromised. Justice is breached when persons, because of their socioeconomic class or age, do not have equal access to health information resources and public health services. The author concludes that health personnel, leaders, and policy makers should discuss the ethical implications of EHRs before the occurrence of conflicts among the ethical principles.

Moreno K, Sanchez E, Salvador-Carulla L. Methodological Advances in Unit Cost Calculation of Psychiatric Residential Care in Spain. The Journal of Mental Health Policy and Economics. 2008 Jun;11(2):79-88.

Background information shows that the care of the severe mentally ill who need intensive support for their daily living (dependent persons), accounts for an increasingly large proportion of public expenditure in many European countries. An adaptation of the Activity-Based-Costing methodology was applied in Navarre, a region in the North of Spain, as a pilot project for the public mental health services. A unit cost per care process was obtained for all levels of care considered in each service during 2005. The European Service Mapping Schedule (ESMS) codes were used to classify the services for later comparisons. Finally, in order to avoid problems of asymmetric cost distribution, a simple Bayesian model was used. The authors reported the results obtained for long-term residential care and noted that there are important variations between unit costs when considering different levels of care. The results obtained using the cost methodology described provide more useful information than those using conventional methods, although its implementation requires much time to compile the necessary information during the initial stages and the collaboration of staff and managers working in the services. However, in some services, if no important variations exist in patient care, another method would be advisable. The authors conclude that detailed work is required at the beginning of the implementation in order to avoid the calculation of distorted figures and to improve the levels of decision making within the Health Care Service. Spain has adopted a new care system for the dependent population. To finance this new system, reliable figures must be calculated for each type of user in order to establish tariffs or public prices. This study provides a useful management tool to assist in decision-making.

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Myers J, Frieden TR, Bherwani KM, Henning KJ. Ethics in Public Health Research: Privacy and Public Health at Risk: Public Health Confidentiality in the Digital Age. American Journal of Public Health. 2008 May;98(5):793-801. Epub 2008 Apr 1.

This article discusses how public health agencies are increasingly using electronic means to acquire, use, maintain, and store personal health information. Although electronic data formats can improve performance of core public health functions, they can potentially threaten privacy because they can be easily duplicated and transmitted to unauthorized persons. Although such security breaches do occur, electronic data can be better secured than paper records because authentication, authorization, auditing, and accountability can be facilitated. Public health professionals should collaborate with law and information technology colleagues to assess possible threats, implement updated policies, train staff, and develop preventive engineering measures to protect information. In addition, tightened physical and electronic controls can prevent misuse of data, minimize the risk of security breaches, and help maintain the reputation and integrity of public health agencies.

Resnik DB, Zeldin DC. Environmental Health Research on Hazards in the Home and the Duty to Warn. Bioethics. 2008 May;22(4):209-17.

It has been found that when environmental health researchers study hazards in the home, they often discover information that may be relevant to protecting the health and safety of the research subjects and occupants. The authors of this article describe the ethical and legal basis as a duty to warn research subjects and occupants about hazards in the home and explore the extent of this duty. Investigators should inform research subjects and occupants about the results of tests conducted as part of the research protocol only if the information is likely to be accurate, reliable, and medically useful. Furthermore, investigators should warn subjects and occupants about hazards they happen to discover while they are in the home. Investigators should not report illegal hazards discovered in the home to the authorities, unless those hazards constitute abuse or neglect of children or mentally disabled people living in the home. When investigators decide to warn research subjects and occupants about hazards in the home, they should take some steps to help them make effective use of this information, such as providing additional counseling or making a referral for remediation or medical treatment. Investigators should discuss these issues with research subjects during the informed consent process.

Schofield C. Mental Capacity Act 2005--What do Doctors Know? Medicine, Science, and the Law. 2008 Apr;48(2):113-6.

The Mental Capacity Act 2005 was partially implemented in April 2007. The author of this article emphasizes that doctors should be aware of the Act and what implications it has on their clinical practice. A survey taken looked at the knowledge of physicians and psychiatrists regarding assessing capacity within the Act by means of a questionnaire. The results showed that 100% of physicians and 70% of the psychiatrists answered questions wrongly in the questionnaire. Furthermore, 97% of physicians and 70% of psychiatrists did not have some aspects of knowledge about capacity. Statistically significant differences in responses between physicians and psychiatrists were in relation to their knowledge of the existence and implementation of the Act. Answers were related to active schizophrenia, weighing up pros and cons, and recent assessment of incapability in relation to being by definition incapable. This study shows that psychiatrists do slightly better in answering questions about the Mental Capacity Act 2005 and about capacity when compared with physicians; however both groups could improve their knowledge. With the full implementation of the Act in October 2007, this study shows the urgency and importance of training in the area of capacity for all doctors.

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Shore JH, Brooks E, Savin D, Orton H, Grigsby J, Manson SM. Acceptability of Telepsychiatry in American Indians. Telemedicine Journal and E-Health. 2008 Jun;14(5):461-6.

In this article the authors discuss how telepsychiatry differs from in-person treatment in terms of its delivery mechanism, and how this dissimilarity may increase cultural differences between the provider and the patient. Because cultural competence and identification can impact patient satisfaction ratings, the authors wanted to explore whether cultural differences in a study population influenced telepsychiatric and in-person interviews. They compared the acceptability of conducting psychiatric assessments with rural American Indian veterans by real-time videoconferencing versus in-person administration. The Structured Clinical Interview for DSM-IIIR (SCID) was given to participants both in person and by telehealth. A process measure was created to assess participants' responses to the interview type concerning the usability of the technology, the perceptions of the interviewee/interviewer interaction, the cultural competence of the interview, and satisfaction with the interview and the interview process. The process measure was administered to 53 American Indian Vietnam veterans both in-person and by real-time interactive videoconferencing. Mean responses were compared for each participant. Interviewers were also asked several of the same questions as the participants and answers were compared to the corresponding participant responses. In general, the authors found that telepsychiatry was well received and comparable in level of patient comfort, satisfaction, and cultural acceptance to in-person interviews. They also found evidence to suggest that interviewers sometimes interpreted participant satisfaction as significantly less favorable as the participants actually responded. Despite the potential of videoconferencing to increase cultural differences, the authors found that it is an acceptable means for psychiatric assessment of American Indian veterans and presents an opportunity to provide mental health services to a population that might otherwise not have access.

Smits FT, Wittkampf KA, Schene AH, Bindels PJ, Van Weert HC. Interventions on Frequent Attenders in Primary Care. A Systematic Literature Review. Scandinavian Journal of Primary Health Care. 2008 Jun;26(2):111-6.

The objective of this systematic review was to analyze which interventions are effective in influencing morbidity, quality of life, and healthcare utilization of frequently attending patients (FAs) in primary care. A systematic literature search was performed for articles describing interventions on FAs in primary care (Medline, Embase, and PsycINFO). The outcomes were morbidity, quality of life (QoL), and use of healthcare. Two independent assessors selected all randomized clinical trials (RCT) and assessed the quality of the selected RCTs. The results showed that five primary care based RCTs were identified. Three RCTs used frequent attendance to select patients at risk of distress, major depression, and anxiety disorders. These RCTs applied psychological and psychiatric interventions and focused on undiagnosed psychiatric morbidity of FAs. Two of them found more depression-free days and a better QoL after treating major depressive disorder in FAs. Also, no other RCT found any positive effect on morbidity or QoL. Two RCTs studied an intervention which focused on reducing frequent attendance. No intervention significantly lowered attendance. Due to the difference in study settings and the variation in methods of selecting patients, meta-analysis of the results was not possible. The authors concluded that no study showed convincing evidence that an intervention improves QoL or morbidity of frequently attending primary care patients, although a small effect might be possible in a subgroup of depressed frequent attendees. In addition, no evidence was found that it is possible to influence healthcare utilization of FAs.

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Wisdom JP, Bielavitz S, McFarland B, Collins JC, Hamer A, Haxby D, Pollack DA. Preparing to Implement Medication Algorithms: Staff Perspectives and System Infrastructure. Journal of Psychiatric Practice. 2008 Jul;14(4):209-15.

In this study researchers conducted interviews with 68 clinical and administrative employees of four inpatient and four outpatient mental health facilities in Oregon. The researchers wanted to assess the readiness of mental health facilities in Oregon to implement medication algorithms using the Medication Management Approaches in the Psychiatry toolkit (MedMAP) developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). Respondents had generally positive opinions about the algorithms, but they also expressed many concerns about logistics and implementation, chiefly related to medication selection and expected restrictions on choices for prescribing providers and patients. The researchers concluded that in implementing medication algorithms, it may be beneficial to assess staff perspectives as well as the capabilities of the program's infrastructure. The extent to which staff concerns, values, and needs are anticipated and promptly and responsively addressed is likely to have a major influence on successful implementation.

Younggren JN, Harris EA. Can You Keep a Secret? Confidentiality in Psychotherapy. Journal of Clinical Psychology. 2008 May;64(5):589-600.

In their article, Younggren and Harris explain how confidentiality is the secret-keeping duty that arises from the establishment of the professional relationship psychologists develop with their clients. It is a duty created by the professional relationship, set forth in the American Psychological Association's (2002) Ethical Principles and Code of Conduct, and codified in many state regulations. Nevertheless, the difference between confidentiality and legal privilege (how, why, and when it can be violated) and the reasons for so doing are not well understood by many practitioners. While on the surface confidentiality might seem to be an easy concept to apply to professional practice, in fact it is quite complex and filled with exceptions that frequently differ from circumstance to circumstance and from state to state. A lack of respect for and a lack of familiarity with the significance of these exceptions could have dire professional consequences. In this article, Younggren and Harris review the ethical imperative of confidentiality and then provide examples of legal cases that help to better understand its complexity. Then, they offer strategies designed to help mental health practitioners when they are confronted with questions regarding confidentiality and privilege.

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