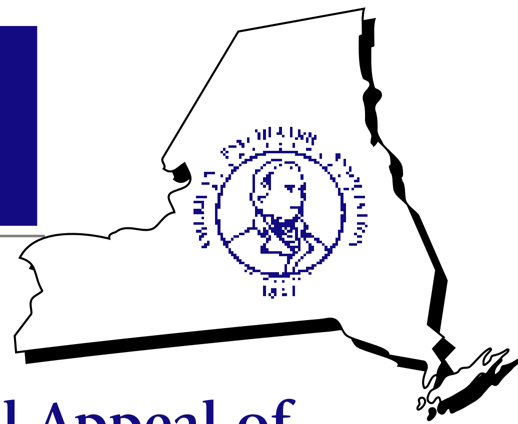
THE BULLETIN

NEW YORK STATE PSYCHIATRIC ASSOCIATION

Fall 2000, Vol. 43, #3 • Bringing New York State Psychiatrists Together



President's Message: APA Revenue Sharing

by Jim Nininger, M.D., President, New York State Psychiatric Association

The APA Board of Trustees has approved a revenue sharing proposal to provide revenue sharing to district branches and state associations from APA net non–dues revenue. Current estimates are that about $700,000 will available for distribution this year. Non–dues revenue includes revenue from various activities including the APA annual meeting and advertising income. APA leadership has recognized that the district branches and state associations rely primarily on membership dues to support their local organizations and do not have access to outside revenue sources. For most district branches and state associations, membership dues make up over 90% of their annual income, while membership dues are only 19% of the APA's annual income.

Jim Nininger, M.D.

A special APA Task Force charged with developing procedures for implementing the revenue sharing proposal met last spring and considered various allocation methodologies that would guarantee a minimum payment to each state regardless of the number of members and how funds would be allocated in states with multiple district branches and a state association.

Both issues raise critical questions for New York State. While we support the principle that the smallest states should receive a minimum payment, the allocation methodology should not unfairly penalize states such as New York with thousands of members. Also, we want to make sure that there is adequate input from New York regarding any APA requirements regarding allocation of revenue sharing among the state district branches and the state association. To that end, the NYSPA Executive Com-

[See **President's Message** on page 2]

Successful External Appeal of Managed Care Denial of Treatment

By Edward Gordon, M.D., NYSPA Past President

The Bulletin would be pleased to receive letters commenting on managed care denials and appeals and your individual experiences –Ed.

Synopsis: On June 6 of this year, I admitted a patient for treatment of severe depression. She had taken a massive overdose of medication 48 hours before but was not discovered until 24 hours after the overdose. Her husband, who had difficulty awakening her, had her brought to the emergency room by the State Police. In the emergency room she stated that she wanted to die, wished that she had succeeded, because "my life is hopeless." She had a history of major depression with multiple psychiatric hospitalizations over the years and at least three admissions within the last two years.

Ed Gordon, M.D.

After being medically cleared, she was admitted to the psychiatric unit. Her treatment course was stormy and her improvement was only very gradual. This was because of her intolerance to medication as well as the degree of her depression. After a week in the hospital with little clinical improvement, her antidepressant had to be changed because of the development of a rash. A second antidepressant was started. For the next two weeks she was considered to be suicidal and appeared to be planning another attempt.

Angela (not her name, of course) gave a long history of having been neglected, passed from family member to family member during all of her childhood, and abused physically and sexually. During adolescence and adulthood she persisted in developing relationships with abusive men.

Her health insurer has a carve out arrangement with a managed behavioral health company, which became

[See **Denial of Service** on page 5]

HCFA Publishes Draft E/M Guidelines For Comment

Because of the wide condemnation of the 1995 and 1997 E/M Documentation guidelines, HCFA has been working on a revised version, which will "simplify the guidelines, reduce the burden on physicians, and foster consistent and fair medical review."

A Town Hall meeting was held on June 22, 2000 to discuss the new draft guidelines and elicit comment. Eugene Cassell, of the APA Division of Government Relations, attended. APA will be issuing a memorandum on this development soon.

HCFA is interested in widely disseminating the new Draft Guidelines and obtaining as much comment as possible before publishing them as a final regulation. There will be field testing across the nation as well as in individual physicians' offices. The new draft guidelines represent a return to the documentation requirements before the 1995 version, and may lead to further simplification. It is not anticipated that they will be published for final comment before 2002. In the meantime, the 1995 and 1997 guidelines remain in effect.

Nancy-Ann DeParle, Administrator of HCFA, published an announcement of the new guidelines in *JAMA* of June 21, 2000. The JAMA article is available at <http://jama.ama-assn.org/issues/v283n23/full/jhf00000-1.html>.

The HCFA announcements, including the Town Hall presentation and status report, as well as a copy of the draft guidelines, and the 1995 and 1997 guidelines for comparison, are available for download at the HCFA website: <http://www.hcfa.gov/medicare/mcarpti.htm>. An article in the *AMA News* discussing the guidelines is available for download at <http://www.ama-assn.org/sci-pubs/amnews/pick_00/gvl10710.htm#s1>.

Seth Stein, NYSPA Executive Director and Ed Gordon, MD, NYSPA Past President will be reviewing the guidelines and reporting on them in the near future. Keep checking the NYSPA web site at www.nyspsych.org regularly for updates on this fast moving situation.

Recent Court Decisions Break New Legal Ground

HMO May Be Sued For Unauthorized Disclosure of Confidential Information

by Seth P. Stein, Esq., NYSPA Executive Director

In a decision that will likely be reviewed by the New York Court of Appeals, the Appellate Division, 3rd Department, on May 11, 2000, ruled that a patient enrolled in an HMO (Community Health Plan - Kaiser Corporation) could proceed with her lawsuit alleging that a medical records clerk employed by the HMO improperly disclosed information about the patient's treatment received from a psychiatric social worker employed by the HMO.

Seth Stein, Esq.

The lawsuit alleges that the clerk disclosed confidential information about the patient to friends. The appellate court held that the statutory duty of confidentiality imposed upon HMOs considered together with the long established legal principle that health care providers can be held liable for breaches of confidentiality gives right to a cause of action against an HMO for the unauthorized disclosure by a clerk.

This case is the first in New York to hold an HMO liable for the improper conduct of its non–professional employees. The decision reasoned that it would be unreasonable to protect a medical corporation such as a HMO from liability for unauthorized disclosure by an employee when a private practitioner would be liable in a similar situation. A vigorous dissent argued that the decision in effect created a new cause of action that was not sanctioned by statute or case law. This issue of HMO liability will have to be resolved by the NY Court of Appeals and the Court of Appeals will shortly consider whether it will accept this case for its review.

New York City Must Provide Discharge Planning for Jail Inmates with Mental Illness

In a decision published this July, New York Supreme Court Justice Richard F. Braun granted a preliminary injunction directing the City of New York to provide discharge planning for all NYC jail inmates with serious mental illness. Details of this decision and its ramifications can be found in Dr. Owens' article on page 7, but the gist is the trial court in its decision described current City discharge procedure as follows:

> "Upon release from Rikers Island, generally inmates are not provided any mental health services, government benefits assistance, housing referrals, or other services, or planning therefore. Rather, all that is done for inmates release from Rikers Island is that they are taken by bus to the Queens Plaza subway station between 2:00 and 6:00 a.m. and given $1.50 plus two subway tokens …"

[See **Court Decisions** on page 2]

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Information for Contributors
The Bulletin welcomes articles and letters that NYSPA members will find timely, relevant, and compelling. Articles should be between 750 and 1500 words (three to five double–spaced manuscript pages) and letters no more than 750 words. All submissions must be made electronically, preferably by email to the editor. All authors are encouraged to also provide a photograph of themselves which will be printed alongside their article.

Information for Advertisers
The Bulletin welcomes advertisements from both NYSPA members and commercial enterprises. Total circulation averages 5,500 copies per issue. The Bulletin is received by all 5,000 members of the American Psychiatric Association who belong to a district branch in New York State. The Bulletin is also sent to the leadership of other district branches across the United States and to New York State legislators, medical libraries, and science writers. The Bulletin is published quarterly. Both classified advertisements and display advertisements are available. Please contact the editor for current rates and media requirements. NYSPA members receive a discount of 50% off the basic classified ad rate.

The opinions expressed in the articles or letters are the sole responsibility of the individual authors, and may not necessarily represent the views of NYSPA, its members, or its officers.

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From the Editor… School's in Session!

Leslie Citrome, M.D., M.P.H.

As I write this, the summer of 2000 is coming to a close. We will be starting the new "school year" with a brand new editorial board. Joining veterans Howard Owens, M.D. and Ann Sullivan, M.D., will be Howard Telson, M.D. of New York City, Thomas Gift, M.D. of Rochester, and Jeffery Smith, M.D. of Scarsdale. I am especially pleased that Upstate New York is finally represented on the board and we can look forward to news and perspectives from there. These editorial board members-volunteers have agreed to write, solicit articles, proof read, and seek out advertising. If you have any ideas, suggestions, or contributions, feel free to contact them or myself. A good starting point would be to either e-mail me at citrome@nki.rfmh.org, or call me at 845-398-5595.

The Bulletin will also be looking for an Associate Editor in the year 2001, and ready to take the reins when my term is up at the end of 2002. Serving on the Editorial Board would be a good start, and there is still some room for expansion beyond the current roster. Please contact me if you have any interest in this line of work.

This issue of **The Bulletin** contains information about Revenue Sharing with the central APA — a topic that has consumed much energy on the part of your Assembly Representatives. They and the Area II Council Executive Committee are working hard to formulate an equitable plan to divide up the non-dues income being offered back to the members. I urge you to ask your own DB reps about this issue and what it could mean, especially if this idea is expanded in future years.

This issue also contains some interesting reports about Managed Care and its vulnerabilities. Ed Gordon, M.D. describes a successful battle in which denial of care was overruled in the interests of the patient. Seth Stein, our Executive Director, reports on how an HMO may be sued for unauthorized disclosure of confidential information.

Martha Crowner, M.D., in her continuing series, has another fascinating interview with a local activist, this time Katherine Falk, M.D., founder of The Project for Psychiatric Outreach to the Homeless, Inc.

Thioridazine gets a sendoff in a mock obituary listing on page 3. Your comments on this topic are also welcome.

The 2000 New York State Legislative session is reported on by Barry Perlman, M.D. and Richard Gallo. One of the items that escaped the scrutiny of the regular press were the proposals put forth by some legislators that would stigmatize the prescribing of psychotropic medication to children and adults alike. Reading the actual bills sent chills down my spine — read about the legislation under the "Guns and Medicine" subhead on page 6.

Finally, I would like to make another appeal for more advertisements. I recently got feedback from an Upstate advertiser who was seeking a psychiatrist to join his practice. Not only was he successful in hiring someone, but that person saw the advertisement in **The Bulletin**! With a reach of over 5000 readers, **The Bulletin** is the only professional publication that is specifically targeted to New York State psychiatrists. Think of **The Bulletin** for your advertising needs.

Enjoy the Autumn! ■

President's Message

Continued from page 1

mittee has prepared a Position Statement on APA revenue sharing setting forth the following key recommendations:

- Revenue sharing should be allocated to each state on a per capita basis using the number of APA members in each state. However, any state whose share on per capita membership share is less than $5,000 should receive an increase so that the minimum payment to a state is $5,000.
- Revenue sharing funds should be used to implement the strategic goals developed by the APA Task Force on Strategic Planning and approved by the APA BOT: Advocating for the Profession; Advocating for Patients; Defining and Supporting Professional Values; Supporting Education, Training and Career Development; Enhancing the Scientific Basis of Psychiatric Care.
- In order to implement the top three APA priorities, revenue sharing funds should be used for the following activities: legislative and regulatory advocacy, litigation, public affairs, managed care, scope of practice, insurance coverage. In addition to these priority activities, revenue sharing can also be used to support membership services, ethics activities and state and district branch infrastructure.
- In states with multiple district branches and state associations (Missouri, California and New York), the district branches in Missouri, the Area VI Council for California, and the Area II Council for New York, should each develop a local methodology for distributing the APA revenue sharing allocated to each state among the district branches and state association. The state allocation methodology should reflect the allocation of functions and responsibilities among the district branches and state association in relation to the APA Strategic Goals and in conformity with applicable legal requirements of APA's new 501(c)(6) status. The state allocation methodology should be submitted to the APA for its review and approval. Once the state allocation methodology is approved by the APA, shared revenue should be disbursed to each district branch and state association directly by the APA.

Since the APA Board of Trustees will be making its final decision regarding procedures for revenue sharing this fall, it is imperative that New York State district branches and NYSPA communicate our concerns and suggestions to the Task Force and APA BOT to insure a fair and equitable procedure. I hope that each district branch will be prepared to discuss this issue at the Fall NYSPA meeting on October 14-15, 2000, so that we can insure input before the APA BOT makes its final decision later this year. ■

Court Decisions

Continued from page 1

This lawsuit brought by the Urban Justice Center argued that the City was subject to the mandatory discharge planning requirement of New York Mental Hygiene Law. The City of New York has filed an appeal and the case will be heard on an expedited basis by the Appellate Division this fall. Undoubtedly, this case will ultimately be resolved by the NY Court of Appeals where the higher court in New York will determine the the City's responsibility for discharge planning for jail inmates with serious mental illness. ■

Mental Health Research Conference Announced!

The Thirteenth Annual New York State Office of Mental Health Research Conference is scheduled for December 4, 5 & 6, 2000 at the Desmond Hotel in Albany, New York. This conference has become nationally recognized as a unique event in public sector psychiatry, attended by psychiatrists and clinicians working in state and local settings, recipients, family members, advocates and other interested parties.

This year, the program will feature an opening presentation by Dr. Steven Hyman, Director of the National Institute of Mental Health. The conference offers over 30 educational sessions, on topics such as endocrinology and telemedicine, mental illness and the court system, as well as a live interactive satellite broadcast on risk factors for violence. The conference also offers numerous opportunities to hear from researchers from New York's research institutes: the Nathan S. Kline Institute for Psychiatric Research and the New York State Psychiatric Institute, as well as an extensive poster session demonstrating latest research findings from across the state.

For more information, or for registration materials, contact the Division of Research, New York State Office of Mental Health, 44 Holland Avenue, Albany, NY, 12229 or call (518) 473-7768.

LETTERS TO THE EDITOR

Letters to the Editor are welcomed but are limited to 750 words. Send your submissions to:

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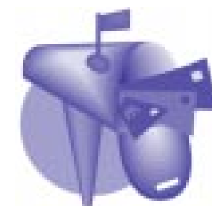

This and That: APA Leadership Overview

by Herb Peyser, M.D.

My reports usually read something like "the Board did this, the Board did that," but that doesn't give the members an overview of what the leadership is actually doing and how it does it. So…

Herb Peyser, M.D.

Initiatives reach the Board from the Assembly, components, Board members and staff, but the major ones come from the President who shapes those initiatives, inserts his/her own, and leads the Board. The Board then does its "advise and consent" thing (or sometimes "not consent and amend"). Presidents have various items in their agenda but there is usually some major theme, which they have only one year to carry out. Although there's no assurance the next President will work as hard on it there is, however, great continuity on the major issues.

Allan Tasman's theme was the corporate restructuring of the APA, the relationship between management and governance, the reallocation of funds, and the creation of the 501[c][6] so that dues could be cut, non–dues revenue shared with the DBs and State Societies (SSs), and more active advocacy. Dan Borenstein built on that and is pursuing a business initiative to convince employers as major purchasers of health care that parity of coverage of psychiatric with physical disorders is useful and desirable. APA's work with legislatures and courts has done much but HMOs still evade parity by agreeing to equal reimbursement and caps but then managing care more harshly. So we must go directly to the source.

No one knows where our health care system is going. We have a hybrid system, with national health insurance (Medicare, Medicaid), governmental health systems (VA, prisons, public sector, the military), and private systems (HMOs, carve-outs, insurance). We see coalescence of the public and private sectors as government privatizes the public systems but keeps some regulation of them, and as legislatures and courts intervene in the private systems with patients' rights initiatives and the like.

Rod Munoz had advocated adding medical savings accounts and catastrophic insurance coverage to the system. That along with employers' vouchers and defined contributions replacing defined benefits could return some decision–making and control of health care to patients. But government might have to be brought in here to subsidize the working poor and the uninsured and monitor the process.

The APA's task is to firm itself up as a bargaining agent for the patients, the profession and the members with all of the above activities and entities. That is what lay behind Rod's, Allan's and Dan's work.

* * * * *

Another concern has been the relationship between governance and management, and between central APA and the DBs/SSs and members. This has become particularly important with the great staff turnover, not too unusual when a new Medical Director comes in and develops his/her own team. But there was loss of institutional memory and failure of new staff to know APA's structure, relationships and ways. Staff must reach out to the DBs/SSs and the members to learn about these matters.

Not doing enough of that and staff remaining relatively isolated from APA governance and membership have been significant factors in the problems we have had over the past year with the information and membership systems, dues billing and the database. This caused expense for APA and trouble for the DBs/SSs. Many DBs/SSs had to dip into their reserves and were unable to budget and make plans. In the past five months it has become much better than it had been but it is still not fully in place.

The improvement was due in great part to the staff, as a result of Board actions, consulting much more with the DBs/SSs and the members, but the contact must be further increased to insure efficiency and prevent duplication and expense. For example, staff devised some good member recruitment-retention initiatives involving vouchers and discounts for purchasing APA publications, but when the question of central staff calling members delinquent in their dues came up it was necessary to point out to them that this is already being done locally, by many DB/SS Execs and officers, people closer to the members than the central staff. Many DBs/SSs would be less than happy if not involved.

Some of us have been pushing for increased Board and governance contact with staff projects. Lack of such led, for one example, to the problem almost two years ago when APA staff launched a central referral service with Lilly support. Some of us got governance involved and got management then to go to the DBs/SSs where they were told that would in many cases conflict with similar DB/SS activities, and where many members expressed concerns about Lilly's involvement (this was shortly after the AMA Sunbeam incident). The project was dropped, but management could have done that before launching it.

* * * * *

APA is a membership organization and differs not only from for–profits but also non–membership non–profits. The Boards are different. Theirs are composed of people chosen for their financial and corporate expertise and to bring in money. Ours is elected by and accountable to the members. It is for that reason that it should be in close contact with staff projects so as to answer members' questions and guard their interests.

A few of us developed a small Work Group of member experts from the components to work closely with the Information Service, review IS items coming to the Board and give information to the Board on such matters as our database, billing services, Website, Local and Wide Area Network programs, Medem.com (the health information website we participate in with AMA and eight other specialty societies), etc. A similar group developed last fall had difficulties, but this one will be more effective and the Board will be able to get more on top of the situation.

Another Work Group has developed a questionnaire for the members as part of a review of the election process. Some want to restrict the campaigning further, seeing it to have become expensive (one presidential campaigner apparently spent $50,000) and time–consuming (favoring those subsidized as opposed to private practitioners), unprofessional (unlike the other specialty societies), intrusive, burdensome, turning off members from voting, and keeping good people from running. Others want fewer restrictions, seeing them as undemocratic and interfering with people out of the "system" being able to attain office. The members will tell us.

Finances have been getting somewhat more difficult, with large expenses for the information service and decreasing membership with decreasing dues income. We must be careful about becoming too dependent on pharmaceutical money.

* * * * *

The Board also approved giving $20,000 to NYSPA for its fight against scope of practice legislation in NYS, and other sums to California, Georgia, and Texas for their legislative battles. It supported the World Psychiatric Association's investigation into allegations of misuse of psychiatry by China involving the Falun Gong, increased collaboration with allied organizations, opposed direct Medicare reimbursement of marriage/family therapists, supported non–discriminatory Medicare prescription drug coverage, and initiated a process to measure residency training in core competencies. It asked the Council on Psychiatric Services to advise it how opposition to carve–outs, requested by the Assembly, would impact on the public sector. And other matters. ■

OBITUARY

Thioridazine

Thioridazine succumbed after a long illness on July 7, 2000, joining sertindole in the QTc graveyard. As announced in a "Dear Doctor or Pharmacist" letter from Novartis Pharmaceuticals Corporation, a boxed warning has been added about the danger of arrhythmias and sudden death.

Thioridazine is now indicated only for schizophrenic patients who fail to show an acceptable response to adequate courses of treatment with other antipsychotic drugs. Thioridazine is now contraindicated with certain other drugs, including fluvoxamine, propranolol, pindolol, any inhibitor of cytochrome P450 2D6, and other agents known to prolong QTc. Baseline ECG and serum potassium is now recommended. Patients currently receiving thioridazine need to be informed of these risks, and switching to another antipsychotic ought to be considered.

Born in Europe in the 1960s, thioridazine, also known as Mellaril, enjoyed a reputation of being a low potency antipsychotic. Although not available by injection, it was popular as both a pill and a liquid, for a diverse group of patients. Both adults and children alike were recipients. Reports of retinitis pigmentosa capped the maximum dose at 800 mg./day in an era of high–dose neuroleptic treatment. Recently there had been more talk about the atypical properties of thioridazine, making it more attractive. Thioridazine is survived by an array of other antipsychotics, new and old.

■

St. Vincent's Ad

Project for Psychiatric Outreach to the Homeless An Interview with Katherine Falk, M.D.

By Martha Crowner, M.D.

Dr. Falk, President and Founder of The Project for Psychiatric Outreach to the Homeless, Inc. (PPOH) was interviewed by Dr. Crowner on August 3, 2000. What follows is a summary of that meeting. –Ed.

Q: How and when did the Project for Psychiatric Outreach to the Homeless start?

A: I got enraged. In the Fall of 1985, I called the police about two homeless men who obviously needed to be taken to a hospital. The first was sitting on the sidewalk on East 56th Street and Lexington Avenue wearing only an undershirt and *The New York Times*. When I called the police, saying that there was a half–naked man who was ill and needed to be taken to a hospital, I was asked if he was naked from the waist up or the waist down. P.S. The police did nothing. Two weeks later I called them again about a different man who clearly needed help. Again, the police did not take him to a hospital. In this conversation I learned that the police routinely did not take anyone to a psych ER. There was too much paperwork involved, too much time spent waiting in the ER, and then, within a few days, they were back on the street in exactly the same condition, on exactly the same corner.

So I made some phone calls. I wanted to know: If the homeless mentally ill were not taken to hospitals, where did they go and who took care of them? I learned that there were many community agencies in many neighborhoods that were mandated to work with them. And there were mental health teams. But none were funded to include psychiatrists. The only route to psychiatric care was through ERs or clinics. Astoundingly, social workers were expected to work with seriously ill patients without the benefit of psychiatric intervention.

The homeless situation was visibly much worse in 1985 than it is today. I had already decided I wanted to do something, when it occurred to me that as a psychiatrist I was trained to treat these individuals. I realized I was uniquely qualified to help these people, not just ladle soup in a shelter kitchen and I felt obligated to act.

I initially organized the program through the New York County District Branch in the Fall of 1985. I asked Len Harris, who was then Director of Public Relations for *The New York Times*, to write the letter asking for psychiatrists to volunteer. This letter was sent to every member of the NYCoDB in the spring of 1986, and the program was up and running by June.

We started with three agencies and seven psychiatrists: Project Reachout did all the outreach to homeless mentally ill adults on the Upper West Side and all of Central Park; The Neighborhood Coalition for Shelter had a permanent residence for formerly homeless, mentally ill adults on East 81st Street; and the Center for Urban Community Services (CUCS) had a drop–in center on West 115th Street. In the early years, it was an all-volunteer effort — psychiatrists gave a few hours each week at an agency where they provided psychiatric services.

Q: Were you working in the public sector?

A: No, at the time I was exclusively in private practice on the Upper East Side of Manhattan.

Q: How has PPOH grown in intervening years?

A: In 1991 we incorporated as a not–for–profit organization, separate from the APA. In 1993 we received a grant from the Robin Hood Foundation to train residents. An important part of program now is the Clinical Elective Program (CEP) through which we offer clinical electives to residents from nine hospital training programs in the city. Each semester we have from 20 to 30 residents with us. We also provide training for a Fellow in Public Psychiatry from the New York State Psychiatric Institute and a Fellow in Psychotherapy from Mount Sinai.

Recently, we have received several large grants which have allowed us to hire psychiatrists who can commit to at least eigth to ten hours a week. We annually see more than 1,500 individuals — men, women and children. We have 45 psychiatrists who provide evaluations, diagnosis, and ongoing treatment at 27 sites.

Q: Does PPOH serve people living on the street and in shelters?

A: We see individuals at all levels of homelessness. For those who are still living on the streets or in the parks, we see them in outreach programs, soup kitchens and drop-in centers. We also treat people in shelters and continue to see them after they find homes in permanent supportive housing. We believe that they need life-long treatment and that treatment needs to be provided onsite in order to stop the revolving door of homelessness. In addition to programs for adults, we also provide psychiatric services in a variety of specialty programs: a shelter for battered women; family shelters for women and their kids; a drop-in center for runaway teenagers; a drop-in center for gay, lesbian, and transgendered teenagers and young adults; and programs specifically for the elderly.

Q: What services does your project provide?

A: We work with agencies that provide all services on site. We call it "one-stop shopping"—this includes case management, medication management, and referral to housing as well as medical and psychiatric services. We collaborate with case workers and agency staff because we need each other and none of us can do the job alone.

We've found it makes a huge difference to have a psychiatrist on site. Psychiatrists can run groups, prescribe medication, and also see patients in individual psychotherapy. Follow-up is possible because the clients have developed relationships with their case workers and the agency. We support the agencies in other ways, too. We help coordinate services and think through difficult problems; we often help arrange involuntary transport to a hospital. Additionally, we provide staff education, in-service training, and staff support. When all the services are available on site, the client is able to make use of them and the end result is—they get better.

Q: Why is there a need for your project? It seems obvious that psychiatrists are needed.

A: Psychiatry had virtually abandoned these patients. Some psychiatrists I talked to thought the homeless just needed more social workers. They do need social workers, but that's not enough. As psychiatrists, we have a unique contribution to make. Here's a concrete example. There was an elderly woman living on the steps of a settlement house for months, probably for years, winter and summer. She had been a nurse. Of course, the settlement house staff tried to get her to come indoors but without luck. They saw her condition deteriorate over the years, and finally they called us desperate for help. We sent them a psychiatrist. He saw her twice, and she came inside.

Q: What do psychiatrists have that is unique?

A: That's hard to say. Our training as psychiatrists is unique. We learn to form a trusting relationship quickly with patients. And it is the relationship that allows everything else to happen.

Q: What has changed in the last 10 years?

A: Patients have more and better services available. Many people can get housed because their mental illness has been stabilized and there has been more permanent housing made available. Unfortunately, much of that permanent housing has been filled. Today we need more units of permanent supportive housing with all services available on site.

Q: What else do you need?

A: We need more psychiatrists willing to work with this population and more funding for all kinds of services.

Q: How can readers volunteer?

A: Call Cathy Treiber at 212-579-2650. We ask psychiatrists for a minimum commitment of two hours per week. This is very gratifying work. We can tailor the placement to psychiatrists' interests in an area of New York that is close to their office or home. ■

Eli Lilly Ad

Denial of Service

Continued from page 1

increasingly impatient with Angela's slow progress. As is the common practice these days, they requested "Doc to Doc" phone conferences with a reviewer employed by the managed care company. After the second such review I received a notice from the unit social worker that the insurance had been denied, as of June 20. The social worker was preparing to make arrangements for the patient to continue in a shelter.

However, after reminding her that the patient was not ready for discharge, I requested an "expedited" appeal. I was informed that the case would be reviewed by a second physician, also employed by the managed benefits company and waited for her to contact me. She never did. Twenty four hours later, I was told that the second physician had also denied care and that, although I was not required to discharge the patient, no further treatment would be authorized.

Reviewer number one had learned from me during two separate conversations that this patient continued to be depressed, continued to be suicidal, continued to be at risk for another serious attempt and was not ready for discharge. He never requested copies of records but denied care simply on the basis of his company's "level of care guidelines."

A belated letter of denial, when finally received, and addressed to the patient, stated, "We are unable to authorize benefit coverage for this continued stay due to the failure to meet UBH criteria of medical necessity for this level of care." The letter continued, "medical necessity requirements for certification of continued inpatient mental health care are not met, as the patient is not an acute risk to self or others, or unable to care for self." Further: "This determination does not mean that you need to be discharged or do not require additional health care," that the company was "not certifying additional benefit coverage for this level of care," adding "We expect that clinically necessary treatment decisions will be made by the treatment provider."

NYS External Appeals

In New York state a regulation was promulgated on June 18, 1999 providing for external appeals of adverse determinations of healthcare plans. This provides for an independent review of adverse decisions of insurance companies upon request of the patient. Angela agreed that she needed additional care and I instructed the hospital social worker to prepare an emergency appeal. The appeal documents were completed and faxed to the New York State Insurance Department on June 23.

As I was aware that the information which would be made available to the independent reviewer by the insurance company was biased and incomplete, I composed a letter summarizing Angela's treatment, attached a copy of the admitting history and physical examination and all medical progress notes for the admission. These were forwarded by New York State to their external appeal agent, "Medical Care Management Corporation," a Maryland company.

New York state law requires that patients be informed of care denial within 24 hours. Between June 19 when we were informed of the denial of care beginning June 20, and the completion of the external appeal application, the patient had not been informed of a denial except by the telephone contact with the social worker. However, in the face of a mandated external appeal, a letter was hurriedly put together by the company, backdated to June 20 and faxed to my office and to the state on June 23. The state employee coordinating this appeal was courteous, helpful, and provided a great deal of assistance in putting together the appeals package. An emergency appeal was appropriate, as the patient was still in hospital, and continued treatment was urgently required.

On June 29 I received a letter by fax informing me of the result of the external appeal. The letter informed me that the case had been reviewed, that the determination was binding on the health plan and enrollee and sent me a copy of their determination which said "Approved health plan denial of coverage overruled, health plan must pay for the proposed treatment." The reviewer gave as reasons supporting his approval of treatment the following: "Given her current depression and suicidality (with recent plan and intent), history of trauma, the chaos of her home environment, the lack of adequate social supports, and the absence of a consistent therapeutic relationship, she continues to be at high risk for suicide without further treatment," adding "she is clearly not improved to the point where a discharge to an unstable environment (or possibly to a shelter) would be safe for her."

A two–page opinion was attached, with two references. The reviewer observed: "the patient has a history of major depression, complicated by her history of childhood physical and sexual abuse. It is likely that the chronicity of her depression, recurrent suicidal behaviors, poor and abusive interpersonal relationships, and medication non–compliance all have roots in these traumatic experiences." He gave weight to my comments, notes, and my accompanying letter, adding "as her psychiatrist suggests, recent medications need at least to be consolidated before discharge." Thus, the external reviewer's statement that the patient "did not demonstrate an imminent risk to self" is not consistent with clinical data, psychiatric opinion, and what mainstream psychiatric literature would assess as high suicide risk."

The report gave a brief summary of the qualifications of the reviewer, who was well qualified for this review. In addition to a small private practice, he is an assistant professor of psychiatry, teaches medical students, residents, and geriatric fellows and conducts research. He described himself as having authored nearly 30 publications and described yet additional qualifications. It was gratifying that such a well–qualified reviewer agreed with my treatment in every regard, and that the New York law provided access to a balanced, informed review.

NYS Experience

On Monday, July 31, 2000 *The New York Times* devoted a small paragraph to a report of the first year of the external appeals program. Three hundred, thirty–one denials were overturned and 329 decisions of the organizations were upheld. The state Insurance Commissioner was quoted as saying, "The external appeals law established a prompt, consistent and fair process with treatment decisions

[See **Denial of Service** on page 8]

MIT CORNER

What Residents & Fellows Should Know About APA Governance

By Shauna P. Reinblatt, M.D., MIT Deputy Representative

Shauna P. Reinblatt, M.D.

Have you ever wondered what the APA has to offer its members–in–training in addition to the Green Journal, Malpractice Insurance and networking opportunities with other psychiatry trainees? As many resident members already know, the organization encourages trainee involvement at both local and national levels. Members–in–training (MIT's), including both residents and fellows, are essential to the future of psychiatry. The APA provides us with an opportunity to keep informed about mental health issues and education.

At the local level, there is the District Branch, where residents can become involved in various committees to exchange ideas and discuss concerns. The District Branch MIT Representative is the Chair to the MIT Committee, which enables networking between trainees from diverse teaching hospitals and backgrounds. Membership recruitment and participation in continuing medical education lectures are only part of what the APA can offer residents at the district branch level. In New York State, there are thirteen District Branches.

The United States and Canada are divided into seven areas. New York State, because of its high concentration of psychiatrists, is its own area, area II. MITs participate in area governance in a number of ways. The MIT Representative and Deputy Representative (details to follow in the next paragraph), participate in the Area Council, representing the concerns of residents and fellows. There is an MIT Committee that meets biannually as well.

At the national level, we are represented by many members–in–training in varying capacities:

- **The Assembly Committee of MITs (ACOM) is comprised of 14 representatives, from each of seven areas. There are Deputy Representatives and Representatives from each area. Residents serve on ACOM for a total of two years, during which time, in addition to serving on the Area Council, their role is to vocalize MIT concerns in the APA Assembly. The APA Assembly addresses issue such as practice guidelines, resident education and patient advocacy; it is a forum for these items to be discussed and policies formed. Each of the seven geographic areas elects an MIT Deputy Representative on a yearly basis. This person progresses to Representative status in the second year of their term and then is allotted voting rights. Our MIT elections in New York State are coming up; Applications for nomination are due in November.**
- **The Committee of Residents and Fellows (CORF)** also consist of MIT representatives from the seven APA regions and from several fellowships (such as APA/Glaxo Wellcome). CORF meets to address resident issues such as education and quality of life. They also work on the Council on Medical Education and Career Development, as well as in conjunction with other organizations such as the AMA. CORF also publishes the Psychiatric Resident Newsletter, PRN, which we receive quarterly.
- **MIT Trustee and Trustee Elect (MITT/MITTE)** are elected positions, in the past by all members and this year by just the MIT's. The MIT Trustee Elect observes the workings of the Board of the APA for a year and then is granted voting privileges for a year as MITT. All non–voting MIT members on the Board offer counsel to the voting MITT, and represent resident members before Board of Trustee members.

Fellowships co-sponsored by businesses and the APA have been created for MITs who seek to broaden their exposure to minority, community psychiatry and research opportunities.

The annual meeting of the APA provides a multitude of mentoring and educational activities. There are also activities structured specifically for MITs at the conference, which are not only interesting but also useful.

I hope this has helped to demystify the often–confusing acronyms used to describe positions and structures in the APA. It is essential for MIT's to join and contribute to the future of the APA, as well as to vote in our elections. For more information on this subject, please access the APA website at <www.psych.org>. ■

Call for Nominations for MIT Deputy Representatives

Nominations are due in the fall. For details, please contact the NYSPA central office at 516-542-0094 or the MIT Representative, Cathryn Galanter, M.D. at 212-305-6440.

CLASSIFIED ADVERTISEMENTS

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Albany Report Fall 2000

By Barry B. Perlman, M.D., Chair Legislation Committee and Richard J. Gallo, Government Relations Advocate

The New York State Legislature finished its "Regular Session" on June 14, returned for a special one–day session the following week, then headed for the campaign trail. The Senate and Assembly managed to produce a timely state budget this year, as well as a modest array of headline worthy bills which the Governor has signed into law. These include:

- Comprehensive legislation to combat gun violence;
- Legislation to promote safer and more effective learning environments within New York's schools;
- Sexual assault reform legislation; and
- Zero tolerance for hate crimes legislation.

The Senate and Assembly also passed — during the closing hours of the session — a physician profiling bill that, while still objectionable from the perspective of organized medicine, is a far less onerous measure than what was originally proposed. As of this writing, the bill has yet to be delivered to the Governor nor has the Governor given any indication as to whether or not he is inclined toward signing or vetoing it.

The 2000 Legislative Session was fraught with infighting at the top.

On the Republican side, the Governor and the Senate Majority Leader battled openly over issues of mandate relief for local governments and gun control reform. The conflicts worsened dramatically when several middle and upper level state employees with ties to Senator Bruno abruptly lost their jobs.

For Democrats, the issue was resentment over the Speaker of the Assembly's inaccessibility to rank and file Assembly Democrats. This unhappiness escalated into a full scale but unsuccessful coup attempt replete with reprisals that shuffled the Assembly leadership deck just when the Lower House was finishing its work for the year.

Fighting for Psychiatry

NYSPA's legislative priorities for this year centered on the continuing issues of insurance parity for mental illness, the Executive Budget, and scope of practice legislation for mental health practitioners. In addition, NYSPA:

- worked closely with the State Medical Society and other medical specialty organizations on the physician profiling issue;
- fought to defeat two Senate bills calling psychotropic medication a major cause of school violence and adult crimes;
- worked to secure legislative approval of the Governor's budget proposal for $125 million in "new" money for the implementation of "Kendra's Law" and other initiatives to serve the SPMI population; and,
- expressed support for letting the Mental Health Special Needs Plan law expire on the basis that the objectives of the statute have been realized through other initiatives.

Parity for Mental Illness

The widely supported campaign to end New York State's longstanding authority to limit or exclude health insurance benefits for mental illness once again failed to pass in the Senate despite being sponsored by twenty-three of thirty-six Senate Republican majority members.

As we reported in the Bulletin and elsewhere earlier this year, the State Assembly unanimously passed a broad based mental health insurance parity bill (MHIP) last January — just three weeks into the 2000 Legislative Session. While the Assembly has passed a MHIP three years in a row; the Senate has managed only once (in 1999) to advance a MHIP of their own beyond the Senate Insurance Committee.

Those who follow the issue in New York know the Senate and Assembly have different MHIP proposals. Both the Senate and Assembly bills would ban the practice of limiting benefits for mental illness where such limitations are not applied to other illnesses in a given plan. Neither bill compels a health plan to continue or initiate coverage for mental illness. Both bills apply only to group policies and plans. Neither the Senate nor the Assembly bill affects ERISA exempt, Worker's Compensation, or individual–direct–pay plans.

The Assembly bill affects indemnity plans, "blanket" plans, (like those purchased by colleges for their students), and HMO plans. The Senate bill, on the other hand, applies only to managed care plans — HMOs and managed mental health carveouts in HMOs or indemnity plans. There are other differences of a technical nature between the two bills that we expect will be reconciled in future bill prints.

Given the feedback from legislators and others about how far the parity campaign had progressed in 1999, it was reckoned 2000 would be the year the Legislature sent a MHIP bill to the Governor. But it wasn't to be. And while we will analyze and speculate about the outcome and what we might do differently next year, the fact remains, that for all the strength in the arguments and tactics promoting a parity legislation in the New York State Senate, the stakeholders on the opposite side of the issue continue to prevail.

Scope of Practice Legislation

If you substitute the phrase "scope of practice" for the word "parity" in the preceding sentence and include the State Assembly in the mix you might well be reading a proponent's perspective on the outcome of the mental health professions bill this year. Psychiatry, for its part, did prevail again on the licensing issue.

As with the parity issue, the year began with optimism about reaching an accord on a mental health professions bill, one responsive to concerns of psychiatry. Some progress was made with the yet–to–be–licensed "mental health practitioners." These groups agreed to the concept (but not the bill language) proposed by NYSPA, that certain presenting conditions would trigger a required consultation between the non–physician therapist and a physician. However, the concept of requiring a consultation with a physician, under any circumstances, was totally unacceptable to the psychologists and the social workers.

Other important but less fundamental concerns raised by NYSPA where met with mixed responses from the proponent groups. The psychologists, for example, objected to all but cosmetic changes to their section of the bill. They argued that psychiatry's issues were either irrelevant or should be handled in separate legislation. The social workers expressed roughly the same sentiments. On the other hand, the marriage and family therapists, as well as the other as yet unlicensed professions named in the bill, continued to pursue a compromise reflective of NYSPA's concerns.

For those who might be new to this issue, we want to acknowledge and stress the importance of the partnership between NYSPA and the Medical Society of the State of New York (MSSNY) on this subject. We have been joined at the hip throughout this long and arduous affair. In addition, we gratefully acknowledge the generous financial support of the APA that enabled us to continue the invaluable services of our special advisors Philip Pinsky, Esq. and Andrew Roffe, Esq. Also, there are other organizations voicing strong opposition to the bill as written. The National Association of Black Social Workers has vigorously opposed those sections of the bill dealing with the licensing of social workers, especially the creation of a subspecialty license in "clinical social work." The Hospital Association of the State of New York has written in opposition to the bill, as well.

At the end of the Legislative Session this year, both the Senate and Assembly determined the bill needed more work and it was held in committee in both Houses. We anticipate a continued struggle on this issue in the upcoming 2001 Session.

Guns and Medicine

The tragedy at Columbine High School and the rash of similar incidents in other parts of the nation spurred New York lawmakers this year to act on legislation combating gun violence and promoting school safety. Legislation on the issues emerged from every quarter of the lawmaking processes. The Governor had a package of bills, as did the legislative

[See **Albany Report** on page 8]

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Continuity of Care for the Mentally Ill in Jail

By Howard Owens, M.D.

On July 12 Manhattan Supreme Court Justice Richard F. Braun issued a temporary injunction that requires the City of New York to provide discharge planning for all jail inmates who receive significant mental health care while incarcerated in City jails. Current practice has been that the City does not provide any discharge plans or continuity of care for most of the mentally ill inmates released from the jails. This court decision has immediate significance for general psychiatrists practicing in the New York City area, because many of the released jail inmates are in fact the same people who at other times show up in emergency rooms, outpatient clinics, drug treatment programs, and inpatient services in general hospitals. Because of the movement in recent years to close down state psychiatric inpatient wards, the jails have increasingly become the asylums of last resort for the seriously and persistently mentally ill. In the past psychiatrists and mental health advocates were concerned about the "revolving door" between the mental hospital and the community; ironically, we now face a new "revolving door," with seriously mentally ill people going from jail back to the community and then to jail again with episodes of treatment in the jail but with no arrangement for follow–up care outside. Patients who may have limited insight or motivation then face an insurmountable task in arranging for the resumption of their outpatient treatment. Patients who have been treated for weeks with anti–psychotic medication are routinely released from jail with no supply of medication and face a forty–five day waiting period to have Medicaid benefits re-instated. Even a patient who is motivated to get back into treatment may decompensate before he or she ever gets medication. While continuity of care is supposed to be the watchword of modern psychiatry, the gap between the jail and community treatment is a glaring exception to this principle. Justice Braun's ruling represents one way that the problem could be corrected.

Howard Owens, M.D.

The court decision arose out of a class action suit (*Brad H. v. City of New York, 117882/99)* filed on behalf of several mentally ill jail inmates. The plaintiffs contended that 25,000 mentally ill inmates are treated in the City jails each year and then released without provision for any follow-up treatment. The City argued that jail inmates have no right to the kind of discharge planning that is required for patients released from mental hospitals. The City also claimed that discharge planning was not possible because many inmates are in jail for less than 45 days. (This contention might seem strange to many psychiatrists in general hospitals, where the average length of stay is a fraction of forty-five days.)

In issuing his injunction, Justice Braun concluded that there was a potential for immediate harm to inmates if the City did not begin to provide discharge planning. He also found that the New York State Legislature intended in its Mental Hygiene Law to protect the mental health of all the people of the state, including mentally ill inmates. He further suggested that discharge planning could begin as soon as any significant treatment begins and would not have to wait until the inmate's criminal case is concluded. (The court defined "significant treatment" as anything more than one or two sessions of treatment.)

This is not the end of the story, because the City of New York is apparently considering an appeal of the injunction, and the court has not yet (as of this writing) issued an order that specifies the exact services that must be provided to released mentally ill inmates. If Justice Braun's decision does survive an appeal, however, it will have significant implications for continuity of care for one of the most under–served populations of the mentally ill in New York. ■

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JANSEN AD REPEAT

Denial of Service

Continued from page 5

being made because they are smart medical choices and not simply sound financial decisions."

My experience in this case would substantiate the commissioner's conclusions.

I would urge all of you to appeal all denials of care on behalf of patients who require care which exceeds the insurance companies "standards" but which are required by good clinical judgment.

Information regarding the appeals process can be obtained on the NYSPA web site, <www.nyspsych.org>. A memorandum on external appeals written by Nancy A. Hampton, Esq., of the NYSPA central office summarizes the law and the process for appeal and gives the phone number (1-800-332-2729) of the New York State Insurance Department. This memorandum is available from the NYSPA central office for those who do not have access to the web site. Ms. Hampton would be happy to assist members in understanding the appeals process and completing the appeal.

One additional caveat: the entire process is dependent on the patient's requesting the appeal. Therefore, where a patient's care is managed by a carve out company, it would be wise to obtain a signed request for an appeal from a patient at the beginning of treatment in order to facilitate the appeal, especially since non–emergent appeals may be instituted well after a patient is discharged (and possibly lost to contact).

Albany Report

Continued from page 6

leaders of both political parties in both Houses.

Among the items to surface as part of the Senate Majority's gun violence and school safety initiatives, were two bills introduced by Senator Owen Johnson (R-Nassau). One bill called for the establishment of an advisory council to study the effects of psychotropic medications on children and adolescents, with an emphasis on revealing the relationship between using such medications and tendencies toward committing violence or suicide. The other bill would have required the police to report to a central criminal justice registry any crime or suicide committed by a person taking psychotropic medication.

Rarely have we seen legislation with such an anti-psychiatric bias. The advisory committee bill was written in such a way as to drive the study results in a single direction unfavorable to using psychotropic medications to treat children.

Working closely with the Greater Long Island Psychiatric Society (GLIPS), and with informational assistance from APA's Division of Government Relations, NYSPA was able to suppress the advisory council bill in the Senate but not the reporting requirement bill. The latter bill reached the Senate floor and was passed there on the last night the Legislative Session. We are pleased to note that our usual champions within the Senate Majority voted against the bill in that House. There was no interest in the bill in the Assembly and it died in committee there.

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For further information and pre-registration, contact the Course Coordinator, Alan Tuckman, MD, at (845) 354-6363.

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