President's Message

By Glenn Martin, M.D.

One of the challenges of a membership organization is trying to assure that the goals and desires of the membership are heard and help guide the organization. NYSAPA uses a committee structure focused on obvious areas of interest (e.g., legislation, child and adolescent psychiatry, public psychiatry, etc.) and a system of representatives (e.g., elected officers and most council members) to bring their concerns to the council. Individuals in both roles can play a strong part in setting the direction of the association.

The proposal, made in March but tabled to the fall meeting to allow for further refinement, specifically addresses district branch presidents to the Council and expands the members of the Executive Committee to include several additional representatives from subcommittees. The full proposal can be obtained from your DB representative or the two-year, cap on Medicaid spending. By mid-April, an on-time budget cannot wait until the next full meeting. This December, at its 15th the NYS Council and all NYS committee chairs will host a meeting at the Lakeland Marriott. I would like to highlight for readers a few upcoming action items before the Council and encourage you to work with your district branch representatives and presidents to make sure your opinions are heard. First, we will once again take up the reorganization of the Council structure.

Medicaid Behavioral Healthcare and the 2011 NYS Budget: Taking Stock

By Barry B. Perlman, M.D.

CMS Finalizes eRx Hardship Exemptions; Extends Deadline to Nov. 1

By Rachel A. Fernbach, Esq.

According to the new governor, Andrew Cuomo, taking stock of the state’s budget is one of their top priorities. By mid-April, an on-time budget cannot wait until the next full meeting. This December, at its 15th the NYS Council and all NYS committee chairs will host a meeting at the Lakeland Marriott. I would like to highlight for readers a few upcoming action items before the Council and encourage you to work with your district branch representatives and presidents to make sure your opinions are heard. First, we will once again take up the reorganization of the Council structure.

The Council also plans to address the adoption of a NYS conflict of interest policy. Last Spring, four NYS Past Presidents jointly submitted a letter to the Council highlighting the lack of a clear conflict of interest policy for council members, committee members and NYS officers and candidates. The letter also expressed concern that the policy needed and would benefit the association. As a result, I appointed a small work group comprised of South M.D., North, and Beth Pepe, M.D. to work on the details and report back to the Executive Committee. Fundamentally, the work is

CMS Finalizes eRx Hardship Exemptions; Extends Deadline to Nov. 1

By Rachel A. Fernbach, Esq.

O n September 6, 2011, CMS published a final rule implementing changes to the Medicare Electronic Prescribing (eRx) Incentive Program. The main purpose of the rulemaking was to create additional hardship exemptions to avoid unfairly penalizing physicians who, for a variety of reasons, are unable to meet the requirements of the incentive program. Under the final rule, physicians who qualify for an exemption will avoid the 1% penalty to be imposed in 2012 on physicians who failed to engage in electronic prescribing between January 1, 2011 and June 30, 2011. Physicians who wish to apply for a hardship exemption must do so prior to November 1, 2011. The proposed rule originally set the application deadline at October 1, but CMS extended the date by one month to give physicians additional time to review the exemptions and submit an exemption request.

The eRx Incentive Program provides for a 1% penalty in 2012 for physicians who did not engage in electronic prescribing at least 10 times during the first six months of 2011. However, certain physicians are exempt from the penalty. First, physicians who have fewer than 100 Medicare patient visits between January 1, 2011 and June 30, 2011 are exempt from e-prescribing for 2011 and will receive an exemption from the 1% penalty. Second, physicians with 90% of their services coded using a CPT code other than the ones included in the incentive program will also automatically avoid the 2012 penalty.

The CMS codes that are eligible for the program are for outpatient services only (office, outpatient clinic, nurse home, adult home and patient’s home). Inpatient services are not eligible. Typically, a 1% penalty will be assessed for physicians who don’t comply with the program requirements. However, those who are penalized will be allowed to apply for an exemption. The exemption process is described in more detail in a separate CMS notice.

In the scientific literature since original evidence-based APA Practice Guidelines: Where We’ve Been, Where We’re Going

By James Nininger, M.D.

Practice guidelines are systematically developed patient care strategies intended to assist physicians in clinical decision making. The American Psychiatric Association (APA) began developing evidence-based practice guidelines for the treatment of psychiatric disorders in 1989 under the leadership of Area III’s Jack McInerny, M.D. The current Coordinating Committee, Chair J. David Yager, M.D. I serve as Vice-Chair and the Medical Editor is Laura Fochtmann, M.D., also from Area II. Marvin Koss, M.D. is Area I’s current liaison to the Practice Guidelines Steering Committee. He was preceded by Deborah Cross, M.D. The development process followed recommendations of the American Medical Association and the Institute of Medicine to result in guidelines with scientific backing, validity, reproducibility, and clarity.

The first evidence-based APA Practice Guideline developed under this process, addressed Eating Disorders and was published in 1993. Guidelines now available on PsychiatryOnline address fourteen different mental disorders or topics and include recommendations in second and third editions, such as the third edition guideline on Major Depressive Disorder published in 2010. Each guideline is accompanied by a quick reference guide. For many guidelines, a continuing medical education (CME) course is also available at APA’s website for CME credit.

APA guidelines now encompass a wide variety of areas, including general psychiatry, primary care, child and adolescent psychiatry, substance abuse, and geriatrics. For busy psychiatrists, continuing medical education programs that improve the care of patients who are mentally ill are an important part of the continuing education process. Writing guidelines is not a one-time activity, but rather, enrolling guidelines on back page

[See President on page 5]
Update On Parity Implementation

By Rachel A. Fernbach, Esq.

The federal regulations issued pursuant to the Mental Health Parity and Addiction Equity Act of 2008 apply to group health plans with more than 50 employees for new plan years starting on or after July 1, 2010. For most calendar year plans, the compliance date was January 1, 2011. Since the beginning of this year, NYS, in collaboration with its members, has been closely monitoring that these parity plans comply with current rates and media requirements. The Bulletin welcomes articles and letters that NYSMPA 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 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.

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Electronic Prescribing continued from page 1

New Hardship Exemptions

- Inability to Electronically Prescribe due to Local, State or Federal Law or regulation. This hardship exemption may apply to a New York psychiatrist who prescribes controlled substances (i.e., benzodiazepines), but who are unable to engage in electronic prescribing because New York State Department of Health regulations currently prohibits physicians from electronically prescribing controlled substances. (DOH has announced that it is working to revise its regulations to allow electronic prescribing of controlled substances). This hardship exemption will assist psychiatrists who prescribe benzodiazepines but are otherwise unable to avoid the eRx penalty because they had more than 100 cases during the first six months of 2011. Because the bulk of their prescribing activity is associated with CPT claims that are not eligible for the incentive program. This particular hardship exemption may not prove all that useful for psychiatrists.

- Registration to participate in the Medicare or Medicaid EHR Incentive Program and adoption of certified EHR technology: This exemption will apply to physicians who (i) register for the Medicare or Medicaid EHR Incentive Program and (ii) adopt certified EHR technology no later than October 1, 2011. According to the final rule, the term “adopt” means have certified EHR technology available for immediate use. Please note that the current incentive program already included two hardship exemptions (for physicians in rural areas without high speed internet access or sufficient available pharmacies for electronic prescribing), which are not likely to apply to physicians in New York State.

- Applying for a Hardship Exemption

CMS has created a web-based tool for physicians to submit their request for an electronic prescription via the Internet. All physicians seeking to request a hardship exemption MUST utilize the web-based tool.

Exemption requests will NOT be accepted via U.S. mail or electronic mail. How to access the web-based tool:

1. Go to http://www.cms.gov/hie/online
2. On the left hand side, click on Payment Adjustments Information.
3. At bottom of page, click on Communication Support Page, which is listed under “Related Links Outside CMS.”

The exemption request must include identifying information about the physician (i.e., NPI), an indication of whether or not the hardship is being applied for, a justification statement, and an attestation of the accuracy of the information provided.

To assist members, NYSPA has posted sample language on its website which can be used in the justification statement section. NYSPA feels it is unlikely that psychiatrists will be able to take advantage of hardship exemption number 3 and hardship exemption number 4 is self-explanatory. To review the sample language, please visit the Members Only Section of the website (www.nyspsy.org) and click on the Electronic Prescribing Tab.

NYSPA Comments on Proposed Rule

On behalf of its members, NYSPA timely submitted comments to CMS generally expressing support for the proposed hardship exemptions. In addition, NYSPA proposed that CMS create an additional hardship exemption for physicians whose patients will not consent to the use of electronic prescribing. When a prescription is entered into an eRx system, the provider physicians will have access to all other past and present electronic prescriptions written for that patient, for understandable medical safety reasons. Members have reported that some patients, due to privacy concerns, have refused to grant consent to the use of electronic prescribing and the psychiatrist is then constrained by that limitation and will have no choice but to write a paper prescription for that patient. If this happens on a regular basis, this may create a significant disadvantage for psychiatrists who have adopted compliant eRx systems, but whose patients direct them to use paper prescriptions only, these psychiatrists will be unable to qualify for the incentive payment because they will have fewer opportunities to write electronic prescriptions for patient visits within the measure’s denominator codes. Second, if these psychiatrists do not qualify for any other type of hardship exemption, they will become subject to the penalty.

NYS Budget continued from page 1

other side, Senator Jay Rockefeller and 36 Senate colleagues have written to President Obama commending him for his opposition to any ‘block grants’ which would undermine the “fundamental guarantee of Medicaid coverage” to the nation’s 68 million Medicaid beneficiaries. The Obama administration is also pushing back by trying to maintain access to mental health services which would make it more difficult for states to reduce reimbursement to doctors and hospitals by fulfilling the program’s mandate for compensable care comparable to others. Unfortunately, it has been reported that the administration also may be seeking to entertain deep reductions in funding for Medicaid as part of the negotiations related to raising the nation’s debt ceiling.

At this time, it is impossible to know how things will work out, especially as they are playing out against the multi-year phase-in of the Patient Protection and Affordable Care Act. However, for New Yorkers concerned about behavioral healthcare, it seems that we are fortunate that our leaders approached this task thoughtfully and with balance. Certainly serious ‘hiss’ have occurred, such as reduction in pay- ments to hospitals for the ‘disproportionate’ share of uninsured patients, reimbursement cuts which have led to the closing of many. Continuing Day Treatment (CDT) programs and perhaps doom ing those remaining, the creation of new drug lists for psychotropic medications and the ending of ‘physician prevals’ in prescribing, continued reductions of numbers of beds in state psychiatric centers, and payment thresholds for clinical level of care.

While we would have foraged for less reductions to CDT programs, which represent a modern form of ‘asylum’ for many fragile persons with serious and persistent mental illness (SPMI), and for a continuation of ‘provider prevals’ in prescribing in order to better protect our patients from a macro perspective, we appreciate that there will be no enrollment limitations and most core services have been reasonably preserved. Even where thresholds have been initiated, regulators have been able to preserve and extend access to services by counting multiple clinic visits which seem as a single encounter for purposes of reaching threshold trigger points. Indeed, it is possible that some of the item of concern in the NYS Budget may be revised next year, such as the loss of the ‘provider prevals’ requirement for prescriptions in the Medicaid formulary. Furthermore, Congress established a two-year transition period for transitioning to electronic prescribing for those currently insured under existing Medicaid fee-for-service into managed care arrangements. A new Behavioral Medicaid Redesign Initiative will oversee the process, in an effort to create a more seamless system of care within regional behavioral networks while protecting the depredations which have occurred too frequently when persons with SPMI have been forced into managed care plans. The Taskforce’s members represent a broad array of stakeholders from advocacy groups for persons with SPMI, their families, and provider organizations. Other interest- ed parties, such as NYSPA, will also be watching the process closely and working to improve its outcome. It is the resort to a public process which will play out over time, rather than one which is rushed, secretive, and radical, which gives interested New Yorkers hope that the end result will be one they can reasonably support, with those receiving and those providing services in our state. Advocates of all stripes will also need to closely monitor and vigorously advocate at the federal level to avoid draconian reductions which would inevitably adversely limit the preservation of adequate services in New York and other states.

Dr. Perlman is the Director of the Department of Psychiatry at Saint Joseph’s Medical Center in Yonkers, New York. He is currently Legislative Chair and a Past President of the New York State Psychiatric Association. Dr. Perlman is also a past Chair of the NYS Mental Health Services Council.

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New York State Psychiatric Association • THE BULLETIN
Governor Appoints Drs. Martin & Sullivan to Public Health and Health Planning Council

The Governor, through the State Senate unanimously confirmed Governor Cuomo’s nomination of Glenn Martin, M.D., NYSPA President, and Ann Sullivan, M.D., former Assistant Commissioner of the Mental Health Services Council and the Public Health and Health Planning Council. Under the Health Insurance Reform process, Senator Shirley Huntley (D-Queens), former chair of the Senate Mental Health Committee, sponsored legislation on making a “very good choice” with his nomination of Dr. Martin, High Risk Medication McDonald (R-Bensalem), current chair of the Senate Mental Health Council, lauded the “tremendous credentials” of Dr. Sullivan.

The Public Health and Health Planning Council, formed through the merger of the State Hospital Review and Planning Council and the Public Health Council, effective December 31, 2010, is a 24-member board on which the Governor approves or disapproves Certificate of Need applications for the establishment of hospitals, nursing centers and nursing homes in New York. Chapter 58 of the Laws of 2010, which provides for the establishment of the Public Health and Health Planning Council requires that two of its members be members of the Mental Health Services Council. 

End of Session Report

Historic and transformational are probably the two best words to describe the 2011 Legislative Session. By the time the Legislature banded the gavel for adjournment in late June, the Governor had seen his initiatives become law, including proposals that expansion of New York City rent regulations, marriage equality for same-sex couples and the most substantial ethics reform in a generation. Caught up in this tidal wave of transformation are changes to the way health care will be delivered in New York. These changes are well underway with the adoption of the budget for the 2011-12 fiscal year, which projects that the State will obtain $2.3 billion in savings in State Medicaid spending through the Medicaid Redesign Team recommendations. In fact, as envisioned, every Medicaid beneficiary – more than 5 million currently – will be in some form of “care management or coordination” within three years.

As far as psychiatry and NYSPA are concerned, it was a particularly active session with NYSPA fully engaged on several fronts including working to protect patients’ access to the Medicaid preferred drug program, the redesign of services for those with serious and persistent mental illness under Medicaid, advancing legislation that would allow independent practicing physicians to collectively negotiate, and staunchly opposing dramatic scope of practice expansions for allied health care professionals to ensure that patients seeking the authority to voluntarily or involuntarily admit patients to mental health facilities.

Prescriber Previews/Pharmacy Benefit Under Medicaid

The 2011-12 budget included a recommendation by the Medicaid Redesign Team to require Medicaid fee-for-service pharmacy benefits for those currently enrolled in managed care plans to be transitioned to such plans effective October 1, 2011, thereby eliminating the “prescriber-pre

Other Legislative News

• Legislation that would provide due process protections to Medicaid providers and the Office of the Medicaid Inspector General (OMIG) passed the Assembly and Senate (Supported by NYSPA)

Additionally, NYSPA will be urging the Governor to sign this bill when it is delivered to him by the Legislature.

• Legislation (6 bills in all) that would have dramatically increased medical liability premium rates for physicians -- including one bill that would prohibit ex parte interview of plaintiffs’ treating physician and it would not have been taken up by the Senate before adjournment.

For further information on any of the matters described in this article, please contact Richard Gallo (518) 467-3545 or richardgallo@gallo-associates.org.

President cont. from page 1

group proposed that NYSPA adopt a policy similar to the one currently used by national APA, with the same disclosure formulation and a one-year re-election term. In addition, the Executive Committee accepted the report with the proviso that all disclosures resulting from this recommendation be made available only to NYSPA members via the members-only section of the NYSPA website. The report of the workshop will be presented to the full Council for review and hopefully, approval this October. The workshop also strongly recommended that additional subcommittees be established in specific areas to continue the work. The Council will also begin a review of previous changes to the bylaws that have recently been submitted to the Board of Trustees by the APA Election Committee. Dr. Robert Kelly, Chair of the APA Election Committee, will address the Council at our October meeting to provide further rationale and background. The report and proposed changes are comprehensive and far reaching and recommend removing many of the restrictions on print and electronic communications currently in place. A plan to foster candidates was also proposed.

Once again, you can find this material online in the members-only section of the NYSPA website.

At the Fall meeting, the Council will also review a selection of action papers that have been submitted to the Assembly for vote now under the oversight of the NYSPA Defender Committee. At the Fall meeting, the Council will also review a selection of action papers that have been submitted to the Assembly for vote now under the oversight of the NYSPA Defender Committee. At the Fall meeting, the Council will also review a selection of action papers that have been submitted to the Assembly for vote now under the oversight of the NYSPA Defender Committee.
there are concerns that performance measures may not always be clinically meaningful and may have unintended consequences such as reduced patient satisfaction or leading physicians to more likely avoid difficult-to-treat patients, perhaps because of concerns that psychiatry is now being developed by managed care organizations, health care systems, government agencies, and others. The APA has advocated that guidelines on psychiatric treatments should be based on APA practice guidelines. To date, the guideline development process has included appointment of an expert work group who are APA members, adherence to disclosure and conflict of interest policies intended to minimize bias from competing interests especially from industry relationships, systematic review of available evidence including creation of evidence tables, broad review of existing guidelines, the APA membership, allied organizations and patient and family advocacy groups, final approval of guidelines by the APA Assembly and Board of Trustees, and regular review and revision. Development of the guidelines is funded solely by APA. No direct industry or commercial funding for APA guideline development has ever been accepted. In 2011, at the request of the United States Congress, the Institute of Medicine published a companion report recommending standards for the development of trustworthy clinical practice guidelines and for the development of systematic reviews to inform guidelines. In response to these reports, APA’s Steering Committee on Practice Guidelines has begun to pilot changes to APA’s guideline development process. These changes ensure multidisciplinary expertise on guideline work groups, organizing guidelines around focused clinical questions rather than broad categories of illness, obtaining input on the questions from patient and family representatives, using independent raters to score literature search results, and using the GRADE system to separately rate recommendations according to strength of recommendation and strength of supporting evidence. In addition to these changes intended to address the Institute of Medicine standards, the Steering Committee is pilot testing other technical and process innovations intended to further improve the quality of APA guidelines, make them more user friendly, and facilitate our efforts to keep up to date. These innovations include use of formal surveys of large panels of clinical and research experts to assess expert consensus around potential recommendations, use of a modified Delphi method to determine consensus of work groups, use of medical informatics principles to streamline screening of literature search results, formulating guidelines as modules to facilitate their integration into electronic media including health records, and use of standing work groups to continuously review new evidence and update recommendations as an as needed basis. Some of these innovations are being funded by a medical informatics grant from the National Library of Medicine that was awarded in 2010. Keeping guidelines current and updated is challenging. Time consuming and potentially very expensive! This goal is even more daunting if the recent standards proposed by the Institute of Medicine are to be met. Roger Peele, M.D., a member of the APA Assembly and others have urged that the guidelines be more frequently updated, ideally to be “living” documents intended to attain this end adequate resources for staff time and even further commitment by APA volunteers, such as those comprising the work groups, must be established. How high a priority is this to our members? Guidelines on psychiatric evaluation and treatment are now being developed using the pilot process described above with first publication anticipated in 2013. In addition to improving patient care, APA guidelines are used to educate psychiatrists, other physicians, mental health professionals, and the general public about evidence-based psychiatric treatments. They also contribute to the credibility of the field by demonstrating the ever-increasing quality of evidence for psychiatric treatments, at times meeting or exceeding the quality of evidence for treatments of other medical specialties. Guidelines also identify gaps in critical information where additional research is needed. Finally, good guidelines provide a scientific and clinically sensitive basis for decision-making by payers, purchasers, and resource regulators. Evidence-based practice has been defined as the conscious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient, integrating individual clinical expertise with the best available external clinical evidence from systematic research. Some have raised concerns that guidelines could be misinterpreted or misused by third parties, such as insurers or regulatory agencies, in ways that might constrain care. The risk is less likely with APA guideline than with guidelines developed outside the profession, especially those developed to control healthcare costs without rigorous review of available evidence or consideration of clinical consensus about best practices. The medicolegal impact of APA practice guidelines has not been studied in detail and there are mixed opinions about the impact of guidelines on the volume of malpractice suits and the magnitude of compensation to plaintiffs. Some medical specialties report that guidelines seem to have reduced malpractice claims, and at least one specialty (anesthesiology) has noted lower malpractice insurance premiums. Since the publication of APA’s first practice guideline in 1993, no clear trends have emerged that would suggest either an increase or decrease in the related number of malpractice claims.

Conclusions
Practice guidelines represent an important step in enhancing the evidence-based practice of psychiatry. Guideline development is evolving into a more evidence-based field, with methodological approaches such as those by the GRADE Working Group and the standards of the Institute of Medicine representing important advancements. APA will continue to explore and test these and our own innovations, with the goal of producing guidelines that are as good, authoritative, and carefully considered as can be practically achieved. Psychiatrists who use APA guidelines and other reference guides are encouraged to submit suggestions for improvement of these tools. A feedback form is available at http://apsych.org/survey/ reviewform.cfm.