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The GrAAPvine

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Administrators in Academic Psychiatry

From the president's desk

by Radmila Bogdanich

First of all, I hope everyone had a wonderful holiday season. I would like to use this opportunity to give you a few updates about what's been going on with the AAP since I last wrote.

As many of you know, since there are so many issues the Board is tackling the year, we decided to have a special strategic planning retreat in July, 2011, in Chicago. During that meeting we worked on revising the strategic plan. Our focus included developing a working relationship with the American Association of Chairs of Departments of Psychiatry; increasing revenues for our organization via benchmarking studies, posting of job ads, etc.; developing a formal ongoing benchmarking plan; and finally, creating opportunities for the professional development and growth of our members. We made further tweaks to the Bylaws which will be sent to the membership electronically early in 2012. We will vote on the Bylaw changes at our Spring meeting.

For those of you who attended our Fall conference in Santa Fe, you know that it was outstanding in every way. I'd like to thank President Elect **Lindsey Dozanti** (Case Western Reserve U.) and the Education Committee [**Beth Ambinder** (Johns Hopkins SOM) and **Sarah Thomas** (U New Mexico)] for planning such a wonderful conference in such a beautiful town. Special thanks also goes to Sarah for going above and beyond the normal scope of duties as the AAP's conference site coordinator, securing the beautiful Hotel Santa Fe, and arranging the delicious networking dinners showcasing the cuisine of the southwest. The workshop topics were very informative, our discussions were lively and I think everyone went away feeling that the time spent was stimulating and worthwhile.

At our meeting, the Board recognized and honored **Rich Erwin** (U Missouri, Columbia) for his service as Webmaster for the AAP. Rich has served as Webmaster of the AAP for as long as I can remember. We are very thankful and appreciative of his many years of dedicated service. Thank you again, Rich!

Our 2010 Benchmarking Survey has been published and

Continued on Page 2

Comings and goings

Please feel free to call new members and personally welcome them to our organization. One of the things that makes AAP special is its friendly members! The hospitality offered by a personal contact will surely be appreciated.

AAP wishes to extend a warm welcome to the following new members:

Chad Abernathy
Columbia U
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Melissa Sinclair
U Colorado
(720) 777-6203
melissa.xinclair@ucdenver.edu

Diana Zambrano
Duke U
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Hank Williams has moved from AAP bids farewell to these members and good friends:

Gregory Brownstein
Tufts University

Susan Cook has left the U Michigan department of psychiatry for the Wayne State finance department.

Patricia Levins has transferred to the Medical College of Georgia Department of Pediatrics.

Joe Thomas has retired from the U Michigan department of psychiatry.

Former member and AAP Treasurer, **Thomas Tantillo**, was named executive director of drug and alcohol Tom was previously the administrative director of behavioral health at The Children's Hospital of Philadelphia. Penn Foundation is a not-for-profit organization that provides mental health and substance use services throughout Bucks and Montgomery counties.

President's message (continued)

distributed. Thank you again to all of you who participated. We gathered a wealth of useful information and I must say that I am very proud of the final product. If you didn't participate in the survey but would like to purchase a copy, please contact me at rbogdanich@siumed.edu.

Janet Namini (Northwestern U) is now officially in charge of Benchmarking and you will be hearing more from her as we move forward with focused benchmarking projects.

I am pleased to report that we now have a new website for our organization, which was previewed at our Fall meeting. We also have a new webmaster, **David Allen** (U Alabama) Member at Large, David worked closely with Rich to assure a seamless transition. The look of our new site is very different; it will be interactive and is designed to

capture the breadth of all that the AAP has to offer. There will be a Members Only toolbar, info for non-members, tools for professional development, historical listserv questions and answers available, the ability to register for conferences online, etc. David and his associate Lacinda Riesland have put a lot of time and effort in designing a state of the art website for our organization and have done a wonderful job.

Narri Shahrokh, (U California, Davis), Immediate Past President has assembled the Nominating Committee for open Board positions. The committee consists of **Jim Landry**, (Tulane U) and **Elaine McIntosh** (U Nebraska). The slate of officers will be available prior to the Spring conference business meeting.

Recently I was reading the travel section of our local newspaper and there was a large article devoted to Charleston, South Carolina. While I read the article, it became apparent why our members chose this location as the site for our Annual Spring Conference scheduled for April 19-20, 2011. Charleston has so much to offer; charm, history, beautiful weather, beaches, shopping, great restaurants, etc. Our education committee (Lindsey Dozanti and Beth Ambinder), along with **Nan Barker** (U S. Carolina), our site coordinator, have been busy working on arrangements and securing speakers. More details will be forthcoming. If you're interested in helping with the conference or have ideas for topics, please contact Lindsey at Lindsey.Dozanti@UHhospitals.org.

I'm looking forward to seeing you all in Charleston this spring.

Correction

The second page of a table listing the schools and individuals who participated in the AAP 2010 Benchmarking survey was inadvertently left off the table published in the 23.3 issue of The GrAAPvine. My apologies!

Contact	Chair	University
Debbie Pearlman	John H. Krystal, MD	Yale
Peterson/Rux	Laura Roberts, MD	Medical College of Wisconsin
Narriman Shahrokh	Robert Hales, MD	Univ of California, Davis
Betty Slavicek	Charles Marmar, MD	New York University SOM
Elizabeth Smith	Michael Vergare, MD	Jefferson Medical College, PA
Joe Thomas	Gregory Dalack, MD	Univ of Michigan
Jennifer Walsh	Jack Barchas, MD	Cornell
Rene Morrow	Gail Mattox, MD	Morehouse SOM GA
David Logan	Susan McLeer, MD	Drexel
Warren Teeter	W. Vaugh McCall, MD	Wake Forest Univ SOM
Bronson Troyer	Christopher McDougle, MD	Indiana Univ SOM
Pam Wesley	Stephan Heckers, MD	Vanderbilt Univ TN
Hank Williams	Richard Veith, MD	Univ of Washington, Seattle WA

Charleston in the spring - conference planning underway

Rooms have been reserved at the Francis Marion Hotel, in located downtown Charleston on historic Marion Square where you have an easy walk to magnificent gardens, house museums, antique shops, restaurants and local boutiques. The hotel rises12 stories above the historic district which offers spectacular views of Charleston's church steeples, antelbellum mansions and the famous harbor.

The room rate is $204 and will be honored from April 15th - April 21st; However, the 18th and the 19th are the only dates reserved for the projected total number of attendees. The rooms reserved preconference are limited to 5 - 10 for the same room rate and 10 - 20 rooms post conference.

Hotel parking is currently $17 for valet services and $12 for self parking daily.

Wired and wireless Internet access is available in guest rooms and throughout the hotel at no charge.

Charleston is such a unique place and the educational program promises to be packed with valuable information so please join us and be sure to book your reservation by calling 1-877-756-2121 or 843-722-0600 and identify yourself as a member of Administrators in Academic Psychiatry.

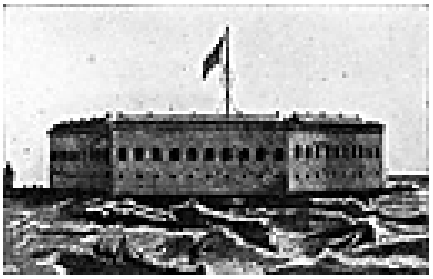
Reminder, pre and post room rates are on a first come, first serve basis and the cut off date is March 16th by 5pm.

A brief history of Fort Sumter

Charleston, South Carolina, is rich in southern charm and hospitality. Antebellum homes, revolutionary era churches, and the colorful architecture of Rainbow Row are just some of what Charleston is famous for.

Charleston also played a pivotal role in the Civil War, most famously as the location where the shots on Fort Sumter, starting the Civil War, were fired.

On December 20, 1860, South Carolina delegates to a special secession convention voted unanimously to secede from the United States of America. In November, Abraham Lincoln had been elected President of the United States with little support from the southern states. The critical significance of this election was expressed in South Carolina's Declaration of the Immediate Causes of Secession: "A geographical line has been drawn across the Union, and all states north of that line have united in the election of a man to the high office of president of the United States, whose opinions and purposes are hostile to slavery." The Declaration claimed that



secession was justified because the Federal government had violated the constitutional compact by encroaching upon the rights of the sovereign states. As the primary violation, the Declaration listed the failure of 14 northern states to enforce the Federal Fugitive Slave Act or to restrict the actions of antislavery organizations.

Decades of growing strife between North and South erupted in civil war on April 12, 1861, when Confederate artillery opened fire on this federal fort in Charleston Harbor. Fort Sumter surrendered 34 hours later. Union forces would try for nearly four years to take it back. For the next two years, as great battles were being fought in Virginia and Tennessee, Charleston Harbor remained relatively quiet. But just outside the harbor, U.S. Navy ships had formed a blockade to keep southern cargo vessels from using Charleston's port.

Over the course of the next 20 months, following numerous failed attempts by the Union to retake the fort, an estimated seven million pounds of artillery projectiles, about 44,000 in all, were fired at Fort Sumter. This tremendous effort to destroy the fort proved unsuccessful. Even though the top two levels were reduced to rubble, Confederate forces defiantly held Fort Sumter. During the siege Confederate soldiers and slaves used sandbags, cotton bales, timbers and brick rubble to strengthen the fort's walls. This was the longest siege of the Civil War, and among the longest anywhere in modern warfare.

Finally, on February 17, 1865, Confederate forces evacuated Fort Sumter. General William T. Sherman's Union army, marching from Savannah, Georgia to Columbia, South Carolina, cut off Charleston's communications and supply routes, forcing the Confederate troops to abandon the area.

Responding to the Affordable Care Act

Models and questions related to the Medical Home and Primary Care/Behavioral Health Integration

by Karen Cobham-Owens

Caroline Bonham, MD, Deputy Director, UNM Department of Psychiatry, Center for Rural & Community Behavioral Health (CRCBH) presented the William J. Newel Lecture on the Affordable Care Act (ACA). The Act's new rules on preventive care require health plans to cover wellness and preventive services without copayment or cost to families. This includes screening for depression in adults and adolescents. Despite the uncertain future of the ACA, primarily related to insurance and payment reform and coverage expansion, there is broad consensus that delivery system redesign will take place with increased emphasis on screening/prevention and primary care/medical homes. There will be a shift in resource allocation from "all things inpatient and institutional" to "prevention, early intervention, primary care and behavioral health.". The importance of screening and prevention in behavioral health will be more important since 50% all lifetime cases of mental illness start by age 14; 75% by age 24 (Kesser, 2007) and mental illness starts young but usually is not treated until the patient is older. There is broad consensus for the need to integrate primary care and behavioral health through

"medical homes." The lifespan for people with serious mental illness is shorter (Colton & Manderscheid, 2006) with increased rates of chronic medical conditions among such individuals (Dickey 2002).

Early detection and intervention is cost effective. Untreated mental illness equals higher medical costs for people with chronic mental illness, addiction issues, or chronic medical conditions such as diabetes, heart failure, high cholesterol, etc. These medical conditions are often exasperated by psychiatric medications. In an Australian model, patients in early detection program were treated at one-third the cost over an eight year period with fewer symptoms and twice as many with jobs (Mihalopoulos et al, 2009).

There are several Medicaid options for Healthcare Homes for enrollees with chronic conditions (effective January 2011):

- State plan option allowing Medicaid beneficiaries with or at risk of two or more chronic conditions (including mental illness or substance abuse) to designate a "health home."
- Community mental health organizations are included as eligible providers
- States that apply and receive a State Plan Amendment to operate this pilot program will receive a 90% Federal Match.

The integration of behavioral health and primary care can be achieved through several different models ranging from a primary/specialty healthcare system with a full time CMH Mental Health Professional and Psychiatrist on site, to a county system of clinics with mental health and primary care services on site with a social worker to triage and refer to services, to behavioral health (BH) services in a specialty BH system with a BH nurse and case manager assuring access to primary care. Implementation should include wellness initiatives and health promotion activities such as eating healthy, smoking cessation, and physical activity, better screenings and recording of medical conditions, and systematic data collection.

The competencies of Behavioral Health Providers in Primary Care Settings will necessitate the following

which should be built into trainee education:

- Finely honed clinical assessment skills
- Cognitive behavioral intervention skills (and other brief interventions e.g. IPT, ISPT)
- Group and educational intervention skills
- Consultation and Communication skills
- Psychopharmacology and Behavioral Medicine knowledge base
- Flexible, independent and action/urgency orientation
- Solution rather than process orientation
- Prevention orientation
- Team and collaboration orientation
- Clinical protocols and pathways orientation
- Focus on impacting functioning, not personality
- Experience with the Severely Mentally Ill population and how the public mental health (MH) system works
- Understanding of the impact of stigma
- Strong organizational and computer competency
- Cultural competency

Many outstanding questions still remain. Given many states currently "carve out" behavioral health spending, if we want to integrate, how do we:

- Develop and ensure a continuum of care for behavioral health, including prevention, early recognition and early intervention?
- Link behavioral health services to medical homes, be they in primary care or behavioral health settings?
- Ensure effective medical care for people with behavioral health conditions?
- Ensure effective behavioral health care for people with medical conditions?
- How do we identify and re-invest any cost saving tied to effective early medical treatment for people with behavioral health conditions or early behavioral treatment back into the behavioral health system?

For states that have managed care for Medicaid behavioral health benefits:

- Will PCPs be added to the networks of BH providers?
- Where there are regional subcapitation arrangements, how would the relationship with PCPs be structured?
- If the PCPs are brought in under the auspices of the BH managed care system, will they have to play by the same medical necessity/target population/ documentation rules as the Controlled Substances Act, defeating the purpose of serving a broader Medicaid population in a primary care setting?
- Would this affect the payments to the managed care system and target populations?
- Where does the funding come from for the Primary care screening/early intervention services? From the Primary Care side? Or from the BH side?

Other questions regarding financing in both the public and private sector include:

- Is BH consultation in a Primary care setting a medical or BH service?
- Is medical consultation in a MH setting a medical or MH service?
- How are same day services from a PCP and a MH provider handled?
- How will pharmacy issues on the PC side be handled? General psycho-pharm? Suboxone? (some medications are reimbursed only under MH or Primary Care)
- How will issues of MH/ SU program licensure, documentation and data submission, clinician licensure, credentialing, and supervision for MH/SU services provided in primary care settings be addressed?
- Which entity bears real responsibility for BH services?
- Is there a way for both sides to have some investment in and share cost saving?

(Karen Cobham-Owens is the administrator of the Emory University department of psychiatry).

Teletechnologies in resident education

by John Herzke

Dr. Jeffery Katzman, Professor and Vice Chair of Education and Academic Affairs in the University of New Mexico School of Medicine's Department of Psychiatry, presented an innovative approach to education undertaken at the University of New Mexico. Due to the unique challenges in New Mexico of patient populations in remote, widespread locations and limited mental healthcare provider resources, teletechnology has particular appeal in this state. This contributed to the increasing adoption of teleconferencing to assist with direct patient medical and mental health care, and also a grant-funded primary care initiative called "Project ECHO." Dr. Katzman described Project ECHO as an internationally renowned program with connections throughout the state to primary care providers, a central interdisciplinary review panel, and weekly presentation of medical cases to the panel with the opportunity for providers to earn CME credits. Project ECHO has achieved significant success in its distributive form of education, and Dr. Katzman recognized an opportunity to apply the same principles in reverse to psychotherapy and to incorporate psychotherapy expertise from any region of the country into the training of his residents at UNM.

Dr. Katzman leveraged some of the resources associated with Project ECHO (e.g. teleconferencing equipment, IT staff, etc.) to reformat the structure of a "Psychodynamic Psychotherapy Case Conference." He recruited four analysts across the country, and each worked with and provided supervision for the ten participating residents for eight weeks, for a total program length of thirty-two weeks. The analysts each received a $2,000 honorarium award from the Department for this work. The results of this new conference structure were evident in the improvement of average conference ratings by residents from 3.5 to 5.0 (1 – 5 scale), and extremely positive review comments from the residents. Further, individual resident supervisors indicated a noteworthy improvement in the ability of PGYIII residents to engage in psychotherapy.

Dr. Katzman described a similar application of teleconferencing technologies to a specific type of short-term psychotherapy known as ISTDP, which is based on principles from psychodynamic psychotherapy and attachment theory. Dr. Allan Abbass from Dalhousie University in Halifax, Canada was invited as an ISTDP expert to lecture and lead an ISTDP training program remotely from Canada, and Dr. Patricia Coughlin, another leading ISTDP expert, also provided remote case supervision. A day-long training session was followed by a ten week didactic program via VPN client software. No local supervisors or trainers were present for the residents, and the supervision was entirely video-based with videotaped patient sessions reviewed by the remote supervisor. Due to the videotaping of patient therapy sessions, patient consent was required. This program was recently cited in the journal Psychotherapy.

As with many technologies, the UNM program did experience some technical difficulties, such as time delays and the occasional frozen screen, but found ways to either resolve or work around them. For example, time delays were observed to be more common in the afternoon hours, so the program minimized the issue by scheduling teleconference sessions in the morning when possible. Also, many typical teleconference equipment and other IT-related costs were minimized by leveraging the grant-funded Project ECHO, so equipment and IT staff expenses represent some of the cost barriers to consider in setting up similar programs in other locations.

Dr. Katzman's presentation illustrated the appeal and potential that teletechnology presents for enhancing the quality of resident education and psychotherapy supervision. It provides a new means for training programs to partner together in educational pursuits and reach broader audiences on a national and international scale. Dr. Katzman confirmed that these efforts have contributed directly to a positive impact on program recruitment and have enabled UNM to be more selective within its residency program applicant pool.

(John Herzke is the administrator of the of Johns Hopkins School of Medicine department of psychiatry).

The changing face of medicine: The next generation of physicians

by Deb Tatchin

The many accomplishments of Dr. Brenda Murphy Bova, Ph.D.,Professor and Chief of Staff to the President, University of New Mexico, include research with various populations in the areas of mentoring and generations in the workplace. Some of her publications include *Workplace Learning and Generation X, Mentoring Revisited: The African-Women's Experience,* and *Closing the Gap: The Mentoring of Generation X.*

Dr. Bova began her presentation by cautioning us not to use the information to pigeonhole people. She challenges us to instead, ask ourselves, "How can I be more effective?" or "How can I better understand behavior?"

We have to recognize that we work in a multigenerational workforce. We must understand and manage work trends. They include increased use of technologies, increased expectation for work/ life flexibility, increased expectations for continual development, and increased emphasis on innovation.

The demographics of our workforce challenge us to respond to these trends. Between 2010 and 2020, 70 million Americans will retire from the workforce and 40 million will enter the workforce. By 2020 the 55-64 year old age group will grow by 73%. Those 65 and older continuing to work will grow by 54%. How will we adapt to this?

What are the educational trends? By 2016 significantly more females will earn advanced degrees. According to Dr. Bova, today's college graduates spend less than 5,000 hours of their lives reading and more than 10,000 hours playing video games. Grade inflation has resulted in large amounts of grads feeling entitled. The male/female wage gap is at its lowest point in history.

We have to recognize that we work in a multigenerational workforce. We must understand and manage work trends. They include increased use of technologies, increased expectation for work-life flexibility, increased expectations for continual development, and increased emphasis on innovation.

What about medical demographics? The current physician workforce is still dominated by male physicians 42 and older, but women comprise half or the new medical school graduates for the first time in history. Increasing numbers of both male and female physicians work part time. In 2010 a full 13% of male physicians and 36% of female physicians worked part time.

Our workforce is multigenerational but Dr. Bova cautions us that not every member of a generation will share everything in common with other members of that generation.

Generational differences cause challenges in our interactions with supervisors, employees, patients, clients and vendors. If we want to maximize organizational effectiveness we need to understand all aspects of this diversity. A few specific differences include communication styles and expectations, work styles, attitudes about work/life balance, comfort with technology, views about loyalty and authority, and acceptance of change.

To make the most of our workforce we have to understand all four generations: the **Silent Generation** (born between 1925 and 1942) 63 million strong, the **Boom Generation** (born 1943-1961) 77 million strong, the **Gen X** (born 1962 – 1981) 44 million strong, and **Gen Y** (born 1982-2000) 70 million strong.

What makes them so different? Each generation was impacted by seminal events. For the Silent Generation the factors were WWII, the Great Depression and the rise of

labor unions. They tend to postpone gratification and are loyal to family, country and job. They adhere to rules and they are risk adverse.

The Boom Generation tends to be optimistic, they redefine roles, manage with buzz words and revolutionize retirement. They were brought up in a very competitive environment and are themselves competitive. Seminal events for them included the McCarthy hearings, Rosa Parks' refusal to move to the back of the bus, the availability of student loans, birth control and the assassination of John Kennedy. This generation demands social change. How do you utilize them? You use them as mentors and address their technological challenges.

Gen X, or the Twenty Somethings, grew up with computers and email, had to live with the AIDS epidemic, watched corporations downsize and watched Challenger explode. As a consequence they have dedication to projects, ideas and tasks, not to employers. They have independence, a free agent approach to careers, are comfortable with diversity and they have a "want it now" approach.

Gen Y is 70 million strong. They are ethnically diverse. They were over parented, over indulged and over protected. Many have been raised by "helicopter" parents (who hover and are over involved in the lives of their children). Their core values include optimism, volunteerism and speed. They are the generation that plays inside with stuff not outside with others. They saw John Lennon assassinated and CNN became the first all-news network. Japan passed the U.S. as the largest automaker. The oldest of them were born in 1980, so their managers must recognize that the Kennedy tragedy was a plane crash not an assassination. A 45 is a gun - not a vinyl record. For them, there have always been ATM machines and screw off bottle caps. Most have never seen a black and white TV and there has always been a national holiday celebrating Martin Luther King Jr. They will be free agents; they will change jobs every 2-4 years. They will want to take off work every 8-10 years much like a sabbatical. Instead of a linear career they will utilize a hop-scotch approach. They approach work in a 24/7 world. They work remotely from anywhere and might want time off during the traditional work day and dedicate their evenings to work.

Dr. Bova challenges us to embrace the differences and adapt to them. She tells us that wishing others were more like us is not a strategy. Respect diversity; recognize differences in work/life balance. Encourage reverse mentoring, a Boomer learning technology from a young adult. Continually audit the demographics of your workplace.

(Deb Tatchin is the Finance Administrator for the University of Michigan department of psychiatry).

Have you paid your dues yet?

Decision memo for screening and behavioral counseling interventions in primary care to reduce alcohol misuse

The Centers for Medicare and Medicaid Services (CMS) has determined that the evidence is adequate to conclude that screening and behavioral counseling to reduce alcohol misuse, which is recommended with a grade of B by the U.S. Preventive Services Task Force (USPSTF) for adults, including pregnant women, in primary care settings, is reasonable and necessary for the prevention or early detection of illness or disability, and is appropriate for individuals entitled to benefits under Part A or enrolled under Part B.

Therefore CMS will cover annual alcohol screening and for those that screen positive, up to four brief, face-to-face, behavioral counseling interventions per year for Medicare beneficiaries, including pregnant women:

- Who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet criteria for alcohol dependence (defined as at least three of the following: tolerance; withdrawal symptoms; impaired control; preoccupation with acquisition and/or use; persistent desire or unsuccessful efforts to quit; sustains social, occupational, or recreational disability; use continues despite adverse consequences); and
- Who are competent and alert at the time that counseling is provided; and
- Whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.

Each of the behavioral counseling interventions should be consistent with the 5A's approach that has been adopted by the USPSTF to describe such services:

- Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior change goals/methods.
- Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits.
- Agree: Collaboratively select appropriate treatment goals and methods based on the patient's interest in and willingness to change the behavior.
- Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate.
- Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

For the purposes of this decision memorandum, a primary care setting is defined as one in which there is provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities and hospices are not considered primary care settings under this definition.

Managing your research portfolio - Part 3

by Hank Williams

This is the third in a series of articles for The GrAAPvine that will discuss different issues and tools involved in managing your research portfolio. In this issue we will cover tracking indirect/RCR costs.

The diversity among AAP members and their represented institutions is part of what makes up the wonderful complexity of our organization. It also means that this discussion, like many, is not relevant to everyone, and more relevant to some than to others.

Does your department receive, or "recover", monies from those indirect charges to the research award dollars of your Principal Investigators (PI's), or does the central university, or the School of Medicine, hang on to it? Let's use the term indirect cost recovery to refer to those monies.

It was a bit surprising to find that not all of AAP's member departments receive indirect cost recovery, based on the results of the recent AAP member survey. However, if you are one of those departments, perhaps you do in fact share in that indirect cost recovery in a more "indirect" way.

For those member institutions sharing in the indirect cost recovery, the percentage is just as diverse. Often the central university, the Dean's office, and on down the line, each take a piece of that pie, and then determine what the individual department receives.

Okay, so you do get indirect cost recovery at "x" percent, what do you do with it next?

Many departments allow the PI's to "claim" it for their research, or claim at least a portion of it. At the other end of the spectrum, many—in fact most— departments retain all of it to support departmental operations.

The recent AAP survey indicates that indirect cost recovery represents a significant, and important, part of the annual operations budget. This makes the budget planning and tracking of those dollars critical to the success of our operations now more than ever.

How do you, our AAP members, track those dollars?

Do you use last year's budget number? This is often done, but not always the safest, and not recommended.

Here are a few suggestions to consider:

- You need to closely monitor your department's awarded research dollars, and the accompanying indirect cost charges.
- Map out the timing of the expenditure of those awarded dollars, since the indirect dollars are usually accrued as expenses of the research grants are posted.
- Know the percentage of those accrued indirect dollars that will come to your department, and when you will receive them. There is often almost a year lag between the posted expense, indirect dollar accrual, and your actual receipt of the funds.
- Finally, develop your own "pipeline" of anticipated research submissions over the next one to five years. Use this list to predict future indirect cost recovery.

While most federal award dollars return indirect costs at the university rate, there are many state and private awards that frequently only offer reduced or no indirect costs. These awards are just as important to track and predict in your pipeline. You will need to budget dollars to support the award infrastructure and activities not paid by these direct award dollars.

UNC opens first inpatient perinatal psychiatry unit in U.S.

CHAPEL HILL, N.C. - (Sept. 14, 2011) The University of North Carolina Department of Psychiatry and the UNC Center for Women's Mood Disorders have opened a 5-bed unit for women with moderate to severe post-partum depression (PPD). The unit is the first of its kind in the United States.

It is modeled after European mom-and-baby units. Ten to fifteen percent of women have PPD, 5 percent of them will need specialized inpatient care. The new unit has specialized programming for women during pregnancy and postpartum.

Services available in the new unit include:

- Individualized assessment and treatment plans with a multidisciplinary team
- Group therapies including behavioral, psycho-educational, art and mindfulness
- Biofeedback therapy
- Mother-infant attachment therapy
- Family and partner assisted interpersonal psychotherapy
- Therapeutic yoga geared for pregnancy and postpartum women
- Protected sleep times
- Extended visiting hours to maximize positive mother-baby interaction
- Gliders for pumping and nursing in patient rooms
- Hospital grade breast pumps, refrigeration and freezer storage
- Lactation, Nutrition and Ob-Gyn consultants

Administrators in Academic Psychiatry

Spring Educational Conference
Charleston, SC
April 19-20, 2012
www.adminpsych.us

American Psychiatric Association

Annual Meeting
Philadelphia, PA
May 5-9, 2012
ww.psych.org

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

Changing milieus

by David Peterson, FACMPE

Anyone working in field of psychiatry long enough will understand the word "milieu." A French word, milieu means "surroundings, especially of a social or cultural nature" according to dictionary.com. In psychiatry, the word is frequently used to describe a therapeutic setting such as that found on a psychiatric inpatient unit or in other group settings.

Stepping back from the psychiatric environment though, milieu is a great word to describe the larger social, business and economic environments in which we reside and operate. And these milieu's, as Bob Dylan would say, "are a-changin."

If the financial crisis beginning in 2008 wasn't enough to spark change in the milieu, the debt ceiling debate has certainly turbo-charged the call for change and added angst to an already iffy environment. The debate over the recent payroll tax extension and other federal budget issues signals more change and adds uncertainty to the financial markets, for example, and to the outlook for the federal budget and the economy in general.

So how is all of this affecting psychiatry and the field of mental health?

Health care reform has had an obvious impact. Parity, for one, has opened the door for more coverage and in some instances, increased reimbursements. Artificial thresholds have been lifted, opening the door – pun intended - for more access (assuming there is provider capacity to meet the demand).

At the federal level, healthcare reform has also assumed some assertive cuts in Medicare spending, especially on the Part B side of the ledger. Most of us have seen scenarios forecasting the impact on departmental Medicare revenues should such cuts occur. To date, these cuts have been staved off in last minute rescue packages, but the ability to sustain payments to physicians at current levels remain vulnerable.

Research funding will also be affected as the federal budget debate continues. Conventional wisdom states that first time R01 applications will require multiple submissions before approval, and that funding for first-time submissions will be more rare. Administrative cuts in existing grants are also likely as the NIH budgets are squeezed.

At the state level, stubborn levels of unemployment strain state budgets and the number of individuals and families eligible for Medicaid continues to grow, putting pressure on budgets and crimping the ability for some states to pay the bills. The impact on hospital affiliates and providers is obvious.

None of these things are new, but combined seem to represent what many refer to as the "new normal;" that is, an environment of tight resources, slower growth and more accountability. The implications for psychiatry administrators and medical practice executives in general are to:

- plan accordingly,
- budget conservatively,
- educate stakeholders,
- think carefully about ongoing financial commitments,
- evaluate risk,
- re-set faculty and staff expectations, and
- prepare for more change.

The MGMA and the ACMPE (now combined organizations reflecting a changed milieu) offer a considerable number of tools and information pathways to stay on top of the issues. Anyone caught by surprise just hasn't been paying attention to the changing milieus.

For information on joining the ACMPE or the board certification and fellowship process, contact the ACMPE directly at 877.275.6462 ext. 889 or contact David Peterson, FACMPE at 414.955.8990, email at peterson@mcw.edu or at the Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wisconsin 53226.

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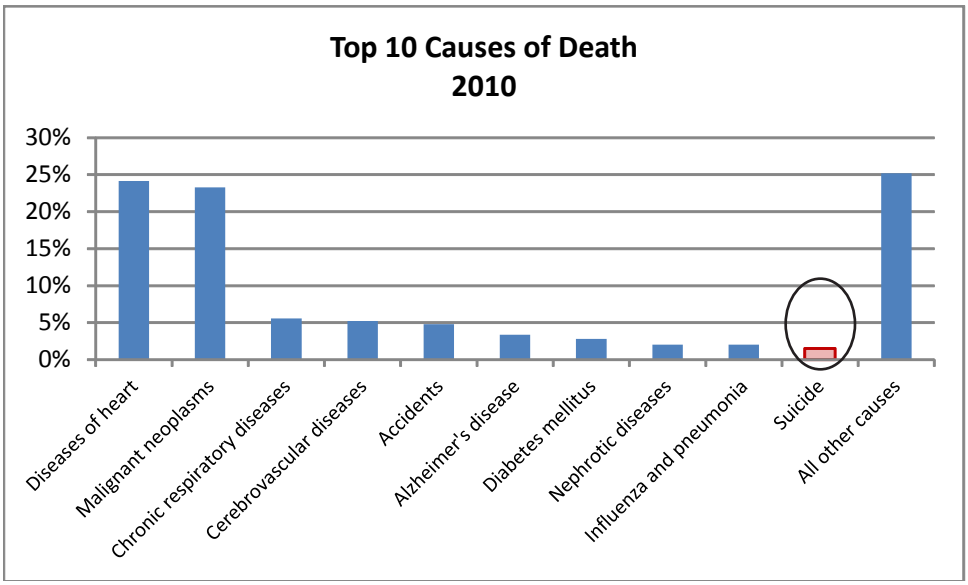

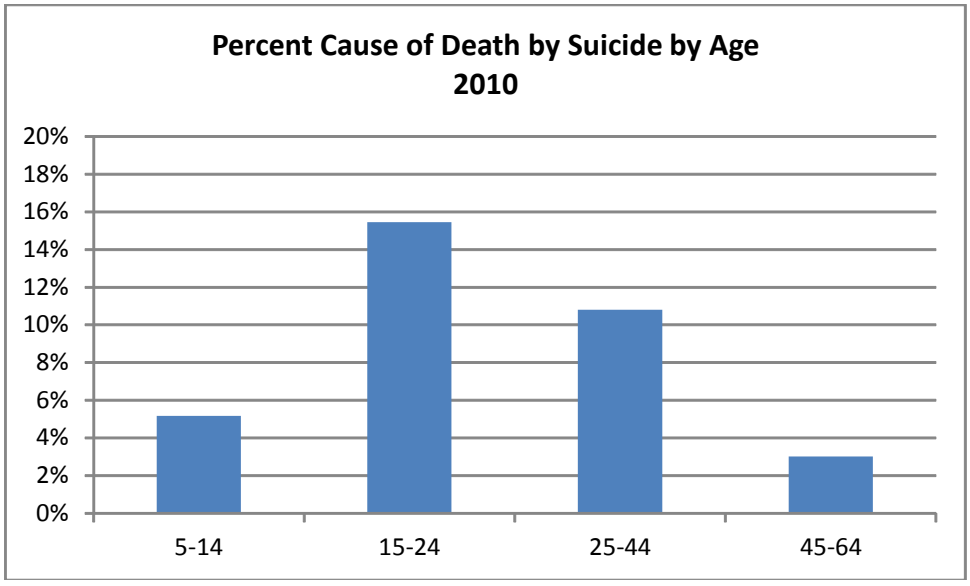

From National Vital Statistics Report, Deaths: Preliminary Data for 2010, Volume 60, Number 4 January 11, 2012, http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf

Did you hear about the new support group for Antisocial Behavior Disorder?

It never met!

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