THE GRAAPVINE

Vol. 14 No. 2

Spring 2002

From the president's desk

by Alex Jordan

They say "time flies when you're having fun," and it's certainly been true for me this past year. Seems like yesterday I was writing my first message for our AAP newsletter, and here it is almost the end of the year and I'm writing my final message. My main purpose in these remarks is to thank everyone who has been so supportive of me and of our goals this past year, as well as to encourage others to become even more actively involved in AAP.

First, however, I want to be sure to invite each of you to our Spring Educational Conference in San Antonio. The conference will be held on Saturday, April 13, 2002, and I know that **Warren Teeter** (Wake Forest U) and his Education Committee have some very informative and valuable speakers and events lined up. It will also be a great opportunity for informal networking with peers in academic psychiatry. I especially want to encourage all of our new members to attend — I'll never forget my first AAP spring conference and know that each of you will also find your first spring conference just as memorable.

This past year I have felt very honored and inspired to have been president. What an important time in the development of our organization! At so many points during this past year it became apparent to me how much the Board of Directors and I have been standing on the shoulders of all the generous and talented leaders who served our organization previously. This year we accomplished nearly all of our important annual goals — thanks to the active involvement of our board, standing committees and the outpouring of effort from our general membership.

In brief summary, here are some of our achievements this past year: We had a very positive and productive experience with our two new standing committees (Membership and Education), completed a benchmarking survey, held a joint meeting with the Chair's group, grew membership through a membership drive, and revised our membership survey. Also, we began asking the important questions regarding how we go about revitalizing our strategic planning and management in future years.

In previous messages I've highlighted the specifics of our achievements in more detail, but my focus in this message is to encourage everyone to get even more involved in making our organization an increasingly valuable resource. There are many ways you as one individual can become more involved, from being part of a panel presentation during a conference to being part of a phone tree during a membership drive. Many of those who become involved in these ways are so professionally rewarded that they want to do even more, including taking on a leadership role by participating on a standing committee or on the Board of Directors as an officer. These are all terrific ways to get to know your peers more closely, and to feel even more a part of this great national group. Regardless of the way you choose to get involved, the rewards of such involvement far exceed the investment you make.

Finally, I want to thank everyone who has been so supportive of my efforts and those of the Board over the past year. Many times the individual strengths and actions of our members have been brought forward in creative, resourceful and impressive ways. There were so many inspiring people around me this year who really care about AAP and about serving our members by achieving our collective goals. Thank you one and all, and let's have a great time in San Antonio!

Administrators in Academic Psychiatry

Inside this issue

Comings and goings

If there are new AAP members in your state, please feel free to call them 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.

For additional membership information, please refer to the AAP database at http://www2.mgma.com/asig/login.cfm.

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

Elaine McIntosh
University of Nebraska

Sandra McSparron
MCP and Hahnemann University

Toni Padrick
University of North Carolina

Cindy Williams
University of Louisville
Trover Clinic

AAP wishes good luck to the following members:
Margot Surridge (Wayne State U) who has moved to Kansas University Medical Center to assume the administrator role in the Department of Internal Medicine.

Address change request

Have you moved recently - or in the past three years? In sending out invoices for membership renewal, we've discovered errors in the addresses listed in the membership directory.

We'd like to ask you to take a few minutes to check the AAP database at http://www2.mgma.com/asig/login.cfm to verify your address. Use your MGMA member number as your member ID. (If you don't know what it is, or if you aren't a member of MGMA, e-mail Rich Erwin at erwinrw@health.missouri.edu to find out how to access the database). You don't need an Admin Password to see your record.

If your address - or any other information - is incorrect, click the "Update Your Record" button and make all the necessary changes.

It's important to keep this database accurate to ensure that you continue to get all the information we have for you!

REMINDER!!!

We're getting ready to compile the final results of the AAP 2001 Faculty Incentive Survey. If you haven't already responded to the questionnaire, please do so immediately so that your department is counted in the results. The greater the response the more meaningful the results will be.

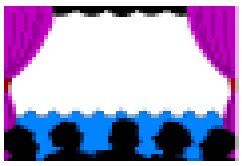
Send to:
Radmila Bogdanich
Assistant to Chair
Department of Psychiatry
Southern Illinois University
751 N. Rutledge Street
Springfield, IL 62794

or

if in e-mail form:
RBogdanich@siumed.edu

(See article on page 6 and attend the AAP conference in San Antonio to hear the results of this valuable survey).

Coming attractions



April 13, 2002	**AAP Spring Educational Conference** San Antonio, TX
April 14-16, 2002	**APA/MGMA Educational Conference** San Antonio, TX
April 28-30, 2002	**National Association of Psychiatric Health Systems annual meeting** Washington, DC)

2002 spring conference plans firming up

We're looking forward to seeing many of you at the AAP Annual Conference at the Marriott Rivercenter in San Antonio in conjunction with the MGMA/APA on April 13-16, 2002. We are planning an exciting conference for Administrators in Academic Psychiatry on Saturday, April 13. You will be receiving a registration form in the mail and by e-mail approximately March 1. If you plan to attend the MGMA/APA conference Sunday, April 14 through Tuesday, April 16 and have not received your conference booklet, you can go to the website www.mgma.com/education/calendar/apa02.cfm or call toll free 1-877-275-6462. The theme of this year's APA program is "Viva la Mission - Taking Care of the Patient, the Practice, the People and the Peso".

Plans for our AAP conference on April 13 are being finalized. We are honored to have **Rob Duca**, administrator of the UCSF Department of Psychiatry and past president of the Academic Practice Assembly, speak to us on "Administrative Leadership within the Academic Unit." **Russell Armistead**, consultant and past Vice President for Health Affairs, Finance and Administration, Wake Forest University School of Medicine will speak with us on interesting and important issues we face in our jobs. **Radmila Bogdanich** (Southern Illinois University) will give us an update on the 2001 AAP benchmarking survey. We will also have our popular panel discussions on topics of special interest. Our business meeting and election of officers will be held during Saturday's luncheon. AAP will once again be hosting a breakout session during the APA conference on Monday afternoon at 3:30 P.M.

For those who arrive early enough on Friday, April 12, we will gather in the lobby at a time to be determined and go out for an informal dinner Friday evening. After a fulfilling day on Saturday, we will go out for our annual AAP dinner.

Again, expect to receive your registration form in the mail and e-mail around March 1. If you do not receive a program packet, please call **Dan Hogge** (University of Utah), AAP Membership Director, at (801) 581-8803. Please call **Warren Teeter** at (336) 716-3544 if you have any questions about the program. For room reservations, call the Marriott Riverside at 1-800-648-4462 and give them group code APAAPAA to get the conference discount rate. We look forward to seeing you in San Antonio April 13.

SAN ANTONIO ADVENTURES

When you think of San Antonio, do you think first of the Alamo? It is certainly the most famous of all the San Antonio landmarks but there's so much more to do in this beautiful city.

Our hotel for the Spring AAP/APA conferences, April 13-16, 2002, is the Marriott Rivercenter, located on San Antonio's colorful Riverwalk. Trendy shops, clubs and restaurants line both sides of the San Antonio River. There's always a festive atmosphere along the Riverwalk footpaths with many-colored lights and music of all sorts playing. Of course, if you don't want to walk, you can always take the river barge tour.

The original old town San Antonio is also on Riverwalk. Called La Villita (Little Town), it was developed in the mid-19th century as a settlement adjacent to Mission San Antonio de Valero (the Alamo). Today, La Villita is a vibrant artist community.

Of course, no trip to San Antonio would be complete without a visit to the

Alamo. Located downtown, just blocks from our hotel, the Alamo is situated anachronistically among all of the glass and steel buildings of modern San Antonio. But, stepping inside the walls of the mission, you lose all sense of current times and step back into the world of Davey Crockett and Jim Bowie. You'll marvel at how tiny such a significant piece of history is.

Since you'll probably be strolling (or riding the boat) around town on your own, we'll look outside of San Antonio proper for our annual AAP "adventure." This year, we'll travel to Natural Bridge Cavern, about 45 minutes outside of the city (we'll need cars) for a spelunking adventure! If you're bringing your family, this is a terrific afternoon activity for the kids! Guided tours last 75 minutes and you don't need any special gear except comfortable shoes that provide good traction on steep, wet surfaces. The year round cavern temperature is 70° with a relative humidity of 99% so it's warm even though it's underground.

With rooms with names like Pluto's Anteroom, Castle of the White Giants, and Hall of the Mountain King, there's sure to be some fantastic formations for us to see. Ticket prices for adults (13 - 64) are $12 and children (4 - 12) $7. We don't have to make reservations in advance but I'll get a head (and car) count during the meeting on Saturday for a Sunday excursion.

We're looking forward to seeing everyone in San Antonio so mark your calendars!

Suggested reading

Suggested reading is intended to apprise AAP members of informative publications in health care administration, mental health and other related fields which have been read by our colleagues and may be of interest to other members as well. Members are encouraged to submit to The GrAAPvine *a complete bibliographic citation and a synopsis of any books or articles which the reader has found to be insightful and believes would be relevant reading for other psychiatry administrators.*

Christianson, Jon B.; Parente, Stephen T. ; Taylor, Ruth. "Defined-Contribution Health Insurance Products: Development and Prospects" *Health Affairs,* Volume 21, Number 1, January/February 2002, pgs. 49-64.

One thing we can be sure of in health care is the ever-evolving health insurance marketplace. For the past two years now, the newest thing to come along in health insurance is the Defined-Contribution Health Insurance Product (DCP). The advent of DCP's in the market indicates that employer health insurance coverage options are experiencing a shift away from the traditional managed care plans. This article gives an excellent overview of the history of DCP's, the kinds of products the various plans offer, how they're different from managed care companies (MCO's), how providers are paid, the various structures of the consumer directed spending accounts, the current status of DCP's in today's market, venture capitalist and infrastructure support, the competition's response, and what the future holds.

Most of us are somewhat familiar with these plans. The basic premise behind these plans is that the employee is more involved in health care purchasing decisions and how their health insurance resources will be utilized. DCP's are usually comprised of a consumer health spending account, some type of insurance policy and internet access to medical decision-making

There are many variations in how these plans are structured. These variations can make the plans seem complex and difficult to understand. Some DCP's use existing provider networks to market their product. Also, there are different methods of how providers are paid. Consumer personal spending accounts vary by design. Some plans have major medical components. Further, internet resources for medical decision making are different among the plans, target markets vary, and they utilize different marketing strategies. Sources of revenue are also different among the plans. Some plans receive premiums from the employers, others receive a portion of the premium, and transaction fees may be included in the provider's prices. Other plans charge a per employee per month charge to the employer or an administrative charge per employee per month.

To date, most of the DCP's, except for Destiny Health (which is funded by its South African parent), start out by soliciting venture capital support. Venture capitalists have seats on the boards of the DCP's so they can assure their interests will be represented. Venture capitalists expect a normal term of investment of 3-5 years. After that time, the fund's investment is expected to be liquidated through a public stock offering, acquisition by another company or another private investor. This puts pressure on DCP's to offer products that are successful and widely acceptable within a relatively short time frame.

Some believe that DCP's will have a significant impact on how health care consumers relate to the health insurance system. A survey conducted by Price Waterhouse indicated that more than 50 percent of employers will use some kind of DCP over the next ten years. Some current health plans, including health insurers and MCO's, will partner with DCP's or develop a similar product of their own, to offer to consumers. DCP's have formed a professional association know as the Consumer Driven Health Care Association (CDHCA), their first conference was held in Chicago in June, 2001. The CDHCA's goal is to educate employers, policy makers and the general public about DCP's.

As far as what the future holds for DCP's, the authors discuss three conditions that Everett Rogers identified in his work that supports relatively rapid diffusion of innovations. According to the authors, these conditions apply to DCP's. The first condition is that the innovation is "compatible" with existing values or needs. This is the case with DCP's—many employers think employees need a greater role in decision-making and everyone thinks that costs need to be held down. The second condition relates to ability to try the innovation out. Employers can offer DCP's to employers on a trial basis. The third condition identified by Rogers is "observability" and that if the results of early adopters of DCP's are easily observable by others they will be adopted more readily. This can easily be done because employees and employers share their observations with others.

However, the authors also note the challenges facing DCP's. Most notably, the models are very complex and can be confusing to employees, this in turn may contribute to poor decision making by those employees. The other challenge is that organizations that grow from small to midsize are at high risk of failure. However, both of these obstacles can be overcome. First, by employers educating their employees on how to make spending decisions wisely. Second, by assuring that as the organization grows, the restructuring of management from "hand-off" to operational is undertaken

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professionally using sound organizational growth principles..

The authors conclude that current conditions are ripe for the expansion of DCP's. The economic slowdown and continued rise in health insurance premiums will make them more attractive to employers. The challenge to the employers will be their ability to motivate consumers to become more actively involved in containing the ever-increasing costs of health care and health insurance premiums.

(Reviewed by Radmila Bogdanich, Administrator, Department of Psychiatry, Southern Illinois University).

Update on 2001 academic psychiatry benchmarking survey

by Radmila Bogdanich, MA

There are 125 medical schools in this country. I am pleased to report that to date, we have received 45 responses to the survey since it was distributed in September. Elizabeth Smith and I gave a presentation in October at a joint session of AAP and the American Association of Chairs of Departments of Psychiatry on preliminary results based on the surveys we had received through mid-October. At that time, we had 34 responses. The data was very informative and well received by both groups. There are still a number of our members who have promised to return their department's data but haven't done so, as of this writing. I can't stress to you enough how important it is to have as many departments participate as possible. I don't know of any psychiatry department in the country that wouldn't find our benchmarking data useful. This will help all of us in the long run.

I will be presenting the survey results at our spring meeting. Participating schools will receive a full copy of the report. Table 1 is a listing of the schools that have already submitted their data.

If your department isn't on the list, please contact me so that I can e-mail a copy of the survey to you. My e-mail address is rbogdanich@siumed.edu Thank you for your participation.

Baylor College of Medicine	Cornell University	Georgetown University
Indiana University	Johns Hopkins University	Louisiana State University
Marshall University	Mayo Medical College	MCP Hahnemann University
Medical College of Georgia	Medical College of Ohio	Medical College of Virginia
Medical College of Wisconsin	Mercer School of Medicine	Michigan State University
Northwestern University	Southern Illinois University	St. Louis University
Temple University	Thomas Jefferson University	Tulane University
University of Arizona	University of Arkansas	University of California- Davis
University of Cincinnati	University of Florida	University of Hawaii
University of Kentucky	University of Maryland	University of Massachusetts
University of Michigan	University of Mississippi	U Missouri-Columbia
University of Missouri-KC	University of Nebraska	University of Nevada
University of North Dakota	University of Texas	University of Utah
University of Vermont	University of Washington	Vanderbilt University
Virginia Commonwealth University	Wake Forest University	West Virginia University

Table 1.
Schools submitting benchmarking survey as of February 15, 2002

The GrAAPvine is pleased to present articles featuring programs from our departments of psychiatry. If you have a program you'd like to highlight, please contact Jan Price (see back page for contact information). Articles can be original or press releases from your department or medical school.

Nation's first comprehensive Depression Center to be established at University of Michigan

The nation's first comprehensive center devoted to treatment, research and education in depression has recently been established at the University of Michigan Health System.

The new U-M Depression Center will bring together and expand the University's wide range of coordinated patient care services; its extensive, world-class clinical and laboratory research efforts; its patient, family and community education programs; and its renowned training programs for health care professionals and students. This broad scope will make it the first such center in the United States, and allow the U-M to advance the field of depression on all fronts.

"The time is right to focus all the resources we can on understanding and defeating this illness, and the social stigma that it carries, so that we can help the 18 million Americans who suffer from depression every year," says John Greden, M.D., the center's executive director. He added that the U-M will now embark on a major fundraising campaign to support the center's activities.

With the center, Greden says, "We hope to lead the way in accelerating the pace of neuroscience research in depression, bringing the products of that research to patients, and reaching out to those who are coping with depression, those who care for them, and those who make decisions about their care." Greden is chair of the Department of Psychiatry, and the Rachel Upjohn Professor of Psychiatry and Clinical Neurosciences, at the U-M Medical School.

The center will address depression in people of all ages, as well as the postpartum, bipolar and treatment-resistant forms. More than 100 physicians, scientists, psychologists, social workers, nurses, and staff form a network that will care for patients, conduct research and provide education.

Says UMHS chief executive officer Gilbert S. Omenn, M.D., Ph.D., "We're proud to lead the nation in enhancing and linking scientific studies of depression and care of depressed patients across many specialties. We invite the community and our peers to join us in our new venture."

Depression, which the World Health Organization has ranked as one of the top four most disabling diagnoses in the world, is a set of illnesses with complex physical and psychological roots - and one that challenges researchers, health care providers, patients, families, employers, insurers and governments alike. Its symptoms of hopelessness, sadness, energy loss, sleep and appetite disruption, restlessness and despair drain its victims of their ability to work, enjoy life, and relate to loved ones. It may even rob them of their will to live.

As many as one in five women and one in eight men are at high risk of experiencing depression sometime in their lives, no matter what their race or socioeconomic status. Recent advances in medication and talk therapy have made depression more treatable than ever. But only about 10 percent of all people with depression receive adequate treatment, due to social stigma, lack of symptom awareness, poor diagnosis, incomplete treatment regimens and inability to pay.

The picture is changing, though. Greden points to recent events in the depression field, including scientific discoveries, public education campaigns, the availability of new and more cost-effective medications, media attention, improved health care training and mental health insurance parity legislation.

"Right now, the battle against depression is beginning to turn in our patients' favor, as science provides new answers, pharmaceutical and treatment research provide new options, social acceptance provides new openness and government policy provides new means for coverage," he says. "What better time to launch a comprehensive center to catalyze the momentum that we have?"

The new center takes aim at depression from all angles, using existing and new resources:

Laboratory research - Center researchers are working to characterize the genetic and neurochemical signals within the brain that lead to depression, to see the links between depression and other mental and physical health problems, and to study and improve the delivery of health care to depression patients. New tools like DNA microarray chips and advanced brain scanning techniques are speeding scientific discovery; results from research already underway at UMHS were recently presented at the Society for Neuroscience meeting in San Diego.

Clinical research - Studies designed to test new medications and treatment interventions, or to measure how well patients do under certain treatment strategies, are another major focus. U-M patients have access to the newest treatment advances through clinical trials like STAR*D, a national study for patients with treatment-resistant depression in which U-M is one of only 13 participating sites — the only site in Michigan.

Treatment - The Center's patients receive team-based, family-

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centered treatment coordinated by Care Navigators from the new Michigan Depression Outreach and Collaborative Care, or M-DOCC, program - a continuous care service designed to support long-term recovery. Patients are treated by specialists in many fields, often within the same visit, using approaches tailored to their individual diagnosis, and followed up to ensure treatments work and other health issues are being addressed.

Early diagnosis - Patients, especially those with other primary illnesses, will be more likely to have their depression diagnosed early, as center clinicians and outreach staff work with physicians in primary care and specialty fields such as cardiology, geriatrics, cancer, obstetrics and adolescent medicine. Free depression screening for the community will be available in early 2002.

Education - The education of patients, their loved ones, and the community is expanding through a variety of efforts. Workshops for patients and families are being offered beginning Jan. 21, 2002; participants will learn about depression's causes, treatments and effects, and will learn ways to form partnerships in treatment. Two new Depression Education and Resource Centers funded by a $502,000 grant from FRIENDS of U-M Health System are now available in clinical areas to give patients and families access to printed and electronic information. And conferences for health care professionals will bring experts with current knowledge in contact with those on the front lines of diagnosis and treatment.

Administrators and chairs - working effectively together

Due to a deadline problem, this article summarizing a presentation made at the AAP Fall conference in Washington, DC. was not included in the previous issue of The GrAAPvine.

by Joe Cook

Elizabeth Smith (Thomas Jefferson University) and **Kevin Johnston** (Indiana University) presented excellent summaries of their experiences in the world of chairman and administrator working together. Both had gone through the experience of a chair (or two or three or…) departing and a new chair arriving.

Liz presented a handout titled "A Descriptive Contrast Between Physicians and Administrators." The handout focused on differences in training, goals, usual work style, and ways of relating. For example, physicians have goals relating to the welfare of individual patients. Administrators have goals related to the welfare of the whole organization. Physicians mainly relate through one-on-one interactions. Administrators are accustomed to group interaction. Liz gained a great deal of insight into this relationship as she supported four different department chairs in four years!

Based on her experience, Liz believes the top qualities of a leader (i.e., chair) are: Ambition, direction and vision for the department; open communication, not just when a problem exists; consistency in dealings with faculty and staff; support for the administrator and resource allocation decisions; values opinions and input of faculty and staff; broad base of thinking and involvement regionally and nationally with professional organizations; and a willing change agent that endorses change and works to make it positive.

Kevin also gained extensive knowledge based on transition from old to new. Kevin focused on contrasting styles related to seven areas: Gaining confidence, understanding strengths and weaknesses, faculty issues, financial issues, personnel issues, private practice issues, and strategic planning. Kevin believes that to have an effective working relationship, you needed to do the following:

- **Gaining confidence** Help the chair understand areas they should focus on. Talk through assumptions and assist the chair in creating priorities.
- **Understanding strengths and weaknesses** Learn the style of communication best suited to the Chair. Are they verbal or visual? Do they like numbers or graphs?
- **Faculty issues** Assist the chair with faculty recruitment on the front-end. Explain how faculty productivity is reported.
- **Financial issues** Communication is the key to keeping the chair informed concerning division performance. Know his/her style.
- **Personnel Issues** Make it clear who will handle faculty supervision issues. Who will handle performance issues? How involved will the chair be in non-faculty hiring/firing?
- **Private Practice Issues** Have clear definitions of practice issues of faculty expectations, staff support, and risk comfort level.
- **Strategic Planning** Assist in any way possible with monitoring progress and changes to your strategic plan. Make the plan a "living" document.

The bottom line from Kevin is communication, communication, communication. You cannot develop as an effective team without effective and timely communication.

We all came away from the discussion understanding how critical the relationship is between the Chair and the administrator. Understanding HOW to communicate effectively is one of the major keys to making this relationship work!

(Joe Cook is the administrator of the department of psychiatry of the University of Arkansas).

Do we have to keep updating our policies and procedures?

by Genie Skypek, Ph.D. skypek@mindspring.com

Believe it or not, I was asked this question within the past six months. The answer is an unequivocal "Yes" but not because the Joint Commission or any other regulating body requires it.

If you are wondering about the answer to this question yourself, apply the Performance Improvement Cycle to the process of providing policies and procedures to staff, both contractual and salaried.

To remind you, the Performance Improvement Cycle, when used to develop a new process, requires that you:

1. Specify a purpose or objective
2. Design the process to achieve that objective
3. Measure (to see if the process was implemented correctly and if it achieved the objective)
4. Analyze the results of the measurements (to see if improvement is warranted, perhaps to identify 'cause' if the objective was not achieved, i.e., where was the process design ineffective)
5. Improve (redesign the process)

So, to answer our question, we need to specify the purpose or objective of Policies and Procedures. An interesting exercise for your leadership team might be to have them brainstorm a list of objectives or purposes for why any organization might have policies and procedures in writing - and why they might want to keep them up-to-date.

Purposes

* Educating staff about the organization's expectations about how they are to perform their job and what performing their job entails.
* Educating staff about the values of the organization and how those values are enacted (policies)
* Increasing the consistency with which various organizational processes are performed.

In his article, "Stress in the Workplace," Gerald Kraines states that interpersonal dependence is an important aspect of effective work environments. "Dependence refers to how much each 'organism' (worker and organization, in this case) envelops the other and supports the other's existence. The premise is that interdependence is necessary for mature functioning in groups. . . and it builds toward a common purpose. Each wants the other to succeed, trusting that its own needs will be served as well.

Therefore, each wants to create an atmosphere that fosters understanding of and meaningful responses to the legitimate needs of the other. When those conditions are met, both function optimally.

When the legitimate needs of one are denied by the other, feelings of hurt, anger and abandonment result. Organizations do this when they fail to supervise their employees adequately, follow a "sink-or-swim" philosophy, or cut off opportunities for training and promotion." (Kraines, 1992)

Certainly, a well-developed set of policies and procedures is part of an organization's responsibility in this worker-organization 'psychological contract' referred to by Kraines. Policies and procedures can say to staff that you, as an organization, are committed to providing them with guidance they need to know what your expectations are and how to meet them – the opposite of a "sink-or-swim" philosophy.

Design

Once you've decided on the purpose of your policies and procedures, you need to determine the design. Your purposes should drive your design. Thus, if you want to educate staff about expectations and practices, you will need to use an effective educational design.

An interesting question might be whether the "traditional" design of policies and procedures is based on a desire to effectively educate or, perhaps, designs that used to be effective are not as effective today – in our multimedia world. Ask your leaders how they might design a set of policies and procedures if they wanted them to be used and to be effective educational tools.

Multimedia design, sound bytes, flow charts, key word searchable and many more ideas would likely surface. In fact, actually writing policies and procedures might be fun for some among your staff if they could use their creativity in designing the presentation model, a key aspect of the design of something like policies and procedures.

The Joint Commission has not set the standard format for policies and procedures. There is no standard that requires that they be boring, difficult to use or even that one write a policy for every procedure. The focus for the Joint Commission is on achieving the purpose of policies and procedures - defined here by me as specifying expectations, practices and values, educating re: those items and achieving consistency in performance.

References:

Kraines, Gerald. "Stress in the Workplace". Directions in Clinical Psychology, Vol 2 No 1, January, 1992.

The views expressed in this article are those solely of the author. They are in no way directly representative of the official views of the Joint Commission on Accreditation of Healthcare Organizations.

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The College corner

ACMPE educational opportunities can also be fun

by David Peterson, FACMPE

Everybody's idea of fun is different and certainly one individual's idea of fun is another individual's idea of work, to say the least. But commingled with the personal and professional benefits of membership in the American College of Medical Practice Executives is stuff that is fun. As one joins and advances through the College, there is a certain rigor and challenge to the process. Once the exams have been passed, the continuing education requirements have been met and Certified Member (CMPE) status has been achieved, the fun stuff – as some would view it and all of it volunteer – begins.

Oral Examiner: The College offers oral exams throughout the year at different sites and conferences or educational events. The College seeks oral examiners to sit on a panel of three and evaluate the oral responses of candidates taking the certification exams. Effective July 1, 2002, the oral exam format will change but up until then, this volunteer opportunity exists.

Exam Proctor: Exam proctors are always needed to help assist with and monitor the candidates who are sitting for the objective portion of the certification exams. As with those serving as an oral examiner, a small stipend is offered to help offset the extra overnight stay.

Once Fellow (FACMPE) status has been achieved, in addition to the opportunities above, more fun stuff becomes available.

Essay Grader: Those volunteering to serve on a team of essay graders don't have to attend the examination session. Essay exams (the grader is blind to the candidates' names) are mailed to the grader shortly after the exams have been administered. The grader is then given a certain period of time to grade and return the exams.

Professional Papers Committee Reviewer: For those interested in committing more time to the certification and advancement process, the opportunity to join a team of professional paper reviewers exists. Acceptance of the professional paper or 3 case studies is the final step toward achieving Fellow status in the College, and because these papers and case studies are peer reviewed, professional papers committee members are sought annually, usually for 3 year appointments.

The list of fun stuff above is far from complete. As with any professional organization, the College has a number of standing committees and governance structures that have been created to perpetuate the goals and missions of the College. These committees are always seeking members who wish to volunteer and share their expertise.

One theme connecting these activities is the opportunity to add to one's own **Body of Knowledge**. The activities are certainly educational and through active participation in the College, one learns from the credentialing process, the content and, as we all know, one learns from their peers. Some would view this as work. Others view it as fun. In doing all of the above I have found them both educational and fun.

For more information on joining the ACMPE or the certification process, contact the ACMPE directly at (303) 397-7869 or contact David Peterson, FACMPE at (414) 257-7227, e-mail at peterson@mcw.edu or at the Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 9455 Watertown Plank Road, Milwaukee, Wisconsin 53226.

Even though the full implementation of HIPAA has been delayed, there are still many questions to be answered to prepare for that day. Here are some websites to help you in your preparation:

WebWatch

http://www.hcfa.gov/medicaid//hipaa/online/default.asp

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Salary limitation on grants, cooperative agreements and contracts

Release Date: January 25, 2002

Notice: NOT-OD-02-030 National Institutes of Health

The purpose of this notice is to provide updated information regarding the salary limitation as it relates to NIH grant and cooperative agreement awards. This information also applies to extramural research and development contract awards. The last notice in the NIH Guide for Grants and Contracts regarding the salary limitation was published January 11, 2001.

Fiscal Year (FY) 2002 is the thirteenth consecutive year for which there is a legislatively mandated provision for the limitation of salary. Specifically, the Department of Health and Human Services (HHS) Appropriation Act for FY 2002, Public Law 107-116, restricts the amount of direct salary of an individual under an NIH grant or cooperative agreement (hereafter referred to as a grant) or applicable contract to Executive Level I of the Federal Executive Pay scale. The Executive Level I annual salary rate is $161,200 for the period January 1 through December 31, 2001. Effective January 1, 2002, the Executive Level I salary level increased to $166,700.

Direct salary is exclusive of fringe benefits and facilities and administrative (F&A) expenses, also referred to as indirect costs. NIH grant/contract awards for applications/proposals that request direct salaries of individuals in excess of the applicable RATE per year will be adjusted in accordance with the legislative salary limitation and will include a notification such as the following:

According to the FY 2002 HHS Appropriations Act, "None of the funds appropriated in this Act for the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level I" of the Federal Executive Pay Scale.

The term "salary" means "direct salary" which is exclusive of fringe benefits and F&A expenses. "Direct salary" has the same meaning as the term "institutional base salary." An individual's institutional base salary is the annual compensation that the applicant organization pays for an individual's appointment, whether that individual's time is spent on research, teaching, patient care, or other activities. Base salary excludes any income that an individual may be permitted to earn outside of duties to the applicant organization.

Table 1 reflects the time frames associated with the existing salary caps.

Implementation of new salary limitation

- No adjustments will be made to modular grant applications/awards or to previously established commitment levels for noncompeting grant awards issued with FY 2002 funds.
- NIH competing grant awards with categorical budgets reflecting salary levels at or above the new cap(s) issued in FY 2002 will reflect adjustments to the current and all future years so that no funds are awarded or committed for salaries over the limitation.
- For awards issued with FY 2001 funds, if adequate funds are available in active FY 2001 awards, and if the salary cap increase is consistent with the institutional base salary, grantees may rebudget to

FY 1999 Awards (Executive Level III)	
o October 1, 1998 through December 31, 1999	$125,900
o January 1, 2000 and beyond	$130,200
FY 2000 Awards (Executive Level II)	
o October 1, 1999 through December 31, 1999	$136,700
o January 1, 2000 through December 31, 2000	$141,300
o January 1, 2001 and beyond	$145,100
FY 2001 Awards (Executive Level I)	
o October 1, 2000 through December 31, 2000	$157,000
o January 1, 2001 through December 31, 2000	$161,200
o January 1, 2002 and beyond	$166,700
FY 2002 Awards (Executive Level I)	
o October 1, 2001 through December 31, 2001	$161,200
o January 1, 2002 and beyond	$166,700

Table 1

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accommodate these salary levels and contractors may bill at the higher level. However, no additional funds will be provided to the FY 2001 grant award and the total estimated cost of the contract will not be modified.

- An individual's base salary, per se, is not constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to NIH grants and contracts. An institution may supplement an individual's salary with non-federal funds.
- The salary limitation does not apply to payments made to consultants under an NIH grant or contract although, as with all costs, such payments must meet the test of reasonableness and be consistent with institutional policy.
- The salary limitation provision *does* apply to subawards/subcontracts for substantive work under an NIH grant or contract.
- *Competing* grant applications and contract proposals that include a categorical breakdown in the budget figures/business proposal should continue to reflect the actual institutional base salary of all individuals for whom reimbursement is requested. In lieu of actual base salary, however, applicants/offerors may elect to provide an explanation indicating that actual institutional base salary exceeds the current salary limitation. When this information is provided, NIH staff will make necessary adjustments to requested salaries prior to award.

Inquiries

Questions concerning this notice or other policies relating to grants or contracts should be directed to the grants management or contracts management office in the appropriate NIH Institute or Center.

NIMH policy update for career awards (K-Series)

Release Date: February 8, 2002

Notice: NOT-MH-02-001 National Institute of Mental Health

This notice provides a revision and update of the most recent NIMH policy update for career awards (K-Series) that was published in the NIH Guide on June 12, 2000. This document is intended to complement the policies of the Trans-NIH K-Series program announcements (see below). Prospective applicants must follow all the instructions covered under each program announcement as well as the Research Career Award section of PHS 398 when preparing an application.

NIMH general policy on career awards

K01, K08, K22, K23 and K25 Awards: NIMH mentored career development award mechanisms (K01, K08, K22, K23 and K25) are intended to assist new investigators at stages beyond postdoctoral training to gain additional supervised experience in order to become an independent scientist. Support for the K01, K08, K22, K23 and K25 awards are limited to one three to five year term, and are usually restricted to one mentored career award per individual.

Applicants are expected to pursue research and career development activities directly relevant to the mission of the NIMH. Applications with marginal or no mental health relevance will be considered unresponsive to these programs. These applications will not be considered further and will be returned to the applicant. Therefore, it is very important that prospective applicants contact the appropriate Institute office, listed under INQUIRES, prior to preparing an application.

NIMH mentored career award recipients are encouraged to apply for independent research grant support (e.g., R03, R01 or R21) during the period of the award. However, in general, NIMH discourages awardees from applying for an NIH research grant during the initial stages of the mentored K award (corresponding approximately to the first two years of the award). Regardless of the timing, when a research grant application is subsequently submitted to the NIMH requesting support that overlaps the period of mentored K award support, the awardee must include a statement in the application which outlines how the career development and research supported through the K award will be impacted or modified should the new research application be supported. The applicant should identify how these applications (career award and research grant) relate to one another, highlighting any areas of scientific overlap. Since R01 and several other research grant applications now follow "modular" guidelines, any budgetary overlap issues will need to be resolved with NIMH staff prior to award. It should be noted that no salary for the principal investigator will be provided in the research grant during the period of career development support. Therefore, applicants are strongly encouraged to discuss these issues with the NIMH program staff prior to submitting a new grant application.

K02, K05, and K24 Awards: The early to mid-career awards, K02 and K24, are available for two five-year terms (including one competitive renewal). Investigators with peer-reviewed, independent research support may receive an initial K02 or K24 award from NIMH. However, an individual who previously has held an NIMH K01, K08, or K23 award must have NIMH research support at the time of his/her first K02 or K24 award. Eligibility for renewal of K02 or K24 awards is limited to those who are NIMH grantees at the time of award. Support from either K02 or K24 or any combination of these awards is limited

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to two five-year terms. The senior scientist award, K05, is restricted to one five year term only, and is available only to those researchers who are NIMH grantees at the time of award.

For the purpose of these policies, NIMH grantees are PIs on active R01, R24, R37, P01, P20, P30, P50, U01 and U10 grants. It should be noted that investigators whose only NIMH support has been to direct subprojects on P or U series grants, or are PIs on a subcontract on any other grant mechanism, are not eligible.

Scientists who hold a position with committed salary support for research or whose primary responsibility is administrative, must demonstrate a compelling need for a K02, K05, or K24 award.

NIMH policy on allowable costs

The unique aspects of NIMH allowable costs, specifically in the categories of salary and research support are listed below.

Salary for K01, K02, K05, K08, K23 and the Extramural period of the K22 Award: The NIMH will contribute up to 100% of the Principal Investigator's institutional base annual salary, up to a maximum of $90,000. Note that the salary allowance will be commensurate with the actual level of effort up to $90,000. The salary must be based on a full-time 12–month position and must be consistent both with the established salary structure at the institution and with salaries actually provided by the grantee institution from its own funds and or non-federal funds to other staff members of equivalent qualifications, rank, and responsibilities in the applicable department.

The NIMH Career Award programs (except the K24) require the recipients to devote a minimum of 75% of full-time professional effort to research and career development activities for the period of the award. Fringe benefits are requested separately from the salary and must be based on the salary requested in the application.

Following peer review, detailed budget information will be requested for selected applications. When this information is submitted to NIMH, it is important to note that the amount requested must reflect the actual salary effective at the start date of the potential award and will not be modified mid-year.

Beginning with competing awards made in fiscal year 2003, the NIMH will limit salary increases on career awards, to no greater than 3% per year, up to the maximum allowed, in order to comply with the NIH total cost commitment policy.

It is important to note that NIMH funded salary limitations for non-competing applications that began prior to fiscal year 2003 continue to be governed by the NIMH policies in place at the time the competing application was funded.

Salary and Research Related Expenses for K22, K24, and K25 Awards: Please note that the K24, K25 and the Intramural phase of the K22 awards are somewhat different from the other career development mechanisms covered under this policy announcement. Therefore, the applicant is referred to the K22, K24, and K25 program announcements for additional information about salary and research related expenses.

Research Development Support for K01, K08, K23 and the Extramural phase of the K22 Awards: The NIMH allows for funds up to $50,000 per year for research-related expenses outlined in each program announcement (note that $50,000 is the upper limit allowed for the first year and each subsequent year). Applicants must justify requested costs.

Research Support for K02, K05: Only K02 and K05 awardees who are engaged in predominantly theoretical work, such as modeling or computer simulation, will be eligible to receive NIMH funds up to $25,000 for expenses as outlined in each program announcement. Applicants must justify requested costs. (Note that $25,000 is the upper limit allowed for each year of the proposed project period.)

NIMH policy on change of institution

Institutions are encouraged to use these awards to help transition the awardee from mentored research to independence. NIMH realizes that new investigators often need to obtain external support and/or move to another institution in order ultimately to secure a more independent position (e.g., faculty). Therefore, it is the policy of NIMH to be flexible with regard to transfer to another institution.

Instructions for Change of Institution: An abbreviated application must be submitted by the new institution.

The transfer request must be submitted at least three months in advance of the desired effective date to allow the necessary time for staff review.

Note: NIMH will continue to allow an awardee to transfer from one institution to another for the last year of the award, with prior approval of the responsible Project Officer. The period of support requested can be no more than the time remaining within the existing original award project period. No transfer will be allowed for awards with less than six months remaining in the project period, during a period of administrative extension or after a project has terminated.

Inquiries

Consultation with NIMH staff is encouraged especially during the planning phase of the application. Prospective applicants may visit the NIMH Research Training and Career Development Website: http://www.nimh.nih.gov/grants/training.cfm to obtain additional information.

New codes for health and behavior assessment and intervention

Psychologists now have a more accurate way of billing for services provided to patients with a physical health diagnosis. As of January 1, 2002, codes for health and behavior assessment and intervention services now apply to behavioral, social, and psychophysiological procedures for the prevention, treatment or management of physical health problems.

Until now, almost all intervention codes used by psychologists involved psychotherapy and required a mental health diagnosis. In contrast, health and behavior assessment and intervention services focus on patients whose primary diagnosis is physical in nature. The codes capture services addressing a wide range of physical health issues, such as patient adherence to medical treatment, symptom management, and overall adjustment to physical illness. In almost all of these cases, a physician will already have diagnosed the patient's physical health problem.

If a psychologist is treating a patient with both a physical and mental illness he or she must pay careful attention to how each service is billed. The health and behavior codes cannot be used for psychotherapy services addressing the patient's mental health diagnosis nor can they be billed on the same day as a psychiatric CPT code. The psychologist must report the predominant service performed. Use of these codes will enable reimbursement for the delivery of psychological services for an individual whose problem is a physical illness and does not have a mental health diagnosis.

When providing outpatient care to Medicare beneficiaries, services for these patients will be reimbursed at a higher rate than psychotherapy because under current Federal regulations, the outpatient mental health limitation does not apply to these new services. Therefore, Medicare would reimburse a 45 minute outpatient health and behavior intervention for an individual at 80% of the approved amount, rather than reduce the approved amount by 62.5% and reimburse 80% of the remainder. Importantly, Federal reimbursement for these codes will come out of funding for medical rather than psychiatric services and thus will not draw from limited mental health dollars.

There are two new codes for assessment services used to identify the biological, psychological and social factors important to the prevention, treatment or management of physical health problems. 96150 is for an initial health and behavior assessment while 96151 should be used when reassessing a previously assessed patient. A reassessment may or may not be conducted by the clinician that conducted the initial assessment of the patient.

Four new intervention codes reflect services used to modify the psychological, behavioral, cognitive, and social factors affecting a patient's physiological functioning, health and well being. The codes apply to intervention services for an individual (96152), a group (96153), a family with the patient present (96154), and a family without the patient present (96155).

Because CPT code descriptors do not limit the services to any particular profession, any licensed health care professionals whose scope of practice allows them to perform services that fall within the descriptors may also bill these codes.

These codes are based on 15 minutes of services. To illustrate, a psychologist furnishing an individual with 45 minutes of intervention services would bill for 3 units.

("APA Practice Directorate Announces New Health and Behavior CPT Codes" 2002, Copyright 2002 by the American Psychological Association. Adapted with permission).

CPT coding for ECT

The Department of Health and Human Services, Office of Inspector General, issued a report in December 2001 entitled "Medicare Reimbursement for Electroconvulsive Therapy" which discusses the appropriateness of the current CPT codes for ECT.

The National Institutes of Health 1985 Consensus Conference Statement on ECT, as well as more recent studies, indicates that the administration of multiple seizures is not clinically recommended. Multiple seizure ECT (CPT code 90871) is also known as multiple monitored ECT (MMECT). In this case, the patient has one seizure induced and before regaining consciousness undergoes another session of ECT to elicit an additional seizure.

A Medicare carrier medical director advises, "in the ordinary course of administering ECT, or in order for the treatment to be effective, the seizure needs to last more than 20 seconds. If the seizure is of shorter duration, the seizure needs to be repeated until a seizure of sufficient duration is achieved. This should be coded as 90870" or single seizure ECT.

Only under exceptional circumstances, and with appropriate documentated justification, should MMECT be used and billed.

A copy of the HHS OIG report can be obtained from Jan Price at janprice@umich.edu.

What's in a Name?

Two doctors opened offices in a small town and put up a sign reading: "Dr. Smith and Dr. Jones, Psychiatry and Proctology."

The town's fathers were not too happy with that sign, so they changed it to Hysterias and Posteriors." This was not acceptable either, so they changed the sign to "Schizoids and Hemorrhoids." No go, so they tried "Catatonics and High Colonics." Thumbs down again, so they tried "Manic-depressives and Anal-retentives." Still not good, so they tried "Minds and Behinds." Nope. Nor did "Analysis and Anal Cysts," "Nuts and Butts", or "Loons and Moons" work either, so they finally settled on "Dr. Smith and Dr. Jones, Odds and Ends."

Editorial staff

Editor:
Janis Price
Associate Editors:
Radmila Bogdanich
David Peterson

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Publication deadlines

Publication deadlines are on the 5th of February, May, August and November. News items and articles are welcome and should be sent to:

Janis Price
Division Administrator
Department of Psychiatry
University of Michigan Health System
UH9C 9151
Ann Arbor, MI 48109-0120

(734) 936-4860
(734) 936-9983 Fax
janprice@umich.edu

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