THE GRAAPVINE

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Winter 2002

From the president's desk

by Warren Teeter

WOW! Wasn't our Fall Conference in San Francisco outstanding! The recipe for a successful conference is no secret. We have an Education Committee that works hard, does good planning, invites good speakers internal and external to our organization, and has excellent participation from our members. Thanks to President-Elect **Dan Hogge** (University of Utah) and his program conference committee for hitting a home run on this one. We had 34 AAP members attend. Highlights of the presentations are given throughout this newsletter.

Thank you to our board members for a very productive board meeting on Friday before the conference. Later that afternoon, **Janet Moore** (serving the role of Immediate Past President), Dan Hogge and I represented the administrators for the Intergroup Executive Committee with the American Association of Chairs of Departments of Psychiatry represented by outgoing president Daniel Winstead MD (Tulane University), Angelos Halaris, MD (University of Mississippi) incoming secretary/treasurer, Joel Silverman, MD (Virginia Commonwealth University), incoming president. Randolph Canterbury, MD (University of Virginia) and John Greden, MD (University of Michigan) were unable to attend, but we were able to catch up on our discussion on Saturday. Some of the highlights of our meeting were:

The chairs' group and administrators' group continue to show a strong interest in the two organizations having our fall conference in the same location. Next year's conference will be in Washington DC on Saturday, ***November 8.***

We plan to expand our 1½ hour collaborative lunch meeting to 2½ hours to be able to include a 1 hour round table breakout interactive discussion on topics of special interest.

We plan to link our websites so we can exchange e-mails on topics of interest to both groups

We are considering assigning a liaison administrator to each of the Chair's committees where appropriate.

Kevin Johnston (Indiana University) and his membership team continue to show outstanding results in their membership efforts. We currently have 115 members representing 81 medical schools (including three in Canada) and have added twenty new members in the past seven months.

We missed having Immediate Past-President **Alex Jordan** (University of Washington) with us at the meeting, but it is understandable with his career

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Administrators in Academic Psychiatry

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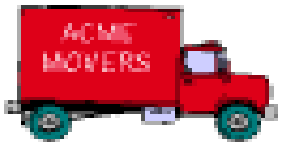

If there are new AAP members in your area, please feel free to call them and personally welcome them to our organization. One of the things that makes AAP special is its friendly members! The hospitality offered by a personal contact will surely be appreciated.

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

Sandra Ahonen
University of North Dakota
(701) 293-4113

Jeff Charlson
University of Wisconsin
(608) 262-0935

Aileen Clemente
University of Massachusetts
(508) 856-3014

Regina Cline
SUNY Stony Brook
(631) 444-2833

Brian Cushman
University of Calgary
(403) 944-1295

Robert Davies
University of Michigan
(734) 936-8269

Beth Deley
Ohio State University
(614) 293-8283

Daniel Dunham
Wright State University
(937) 276-8250

Susan Fleming
University of Arkansas
(501) 686-5483

Carolyn Forman
Mount Sinai School of Medicine
(212) 659-8838

Jane Hardee
Mercer University
(478) 301-4100

Linda Hein
University of Alberta
(780) 407-6502

Jennifer Tunget Henry
University of Louisville
(502) 852-1117

Darcy Jaffe
University of Washington
(206) 731-6639

Fidel Lakew
SUNY Health Sciences Center @ Brooklyn
(718) 270-2025

Nan Lewis
Medical College of Georgia
(706) 721-9604

Edward McDevitt
University of Medicine and Dentistry of NJ
(973) 972-5401

Frank Mucha
Columbia University
(212) 543-5801

Sharon Mueller
University of Manitoba
(204) 787-7093

Maria Sciancalepore
University of Medicine and Dentistry of NJ
(732) 235-5786

Jesse Shoemaker
Louisiana State University
(318) 675-6046

Jane Ulsafer-VanLanen
Rush Medical College
(312) 942-3480

Bruce Warren
New York Medical College
(914) 493-8198

AAP wishes good luck to the following members:

Joe Cook (U Arkansas) has left the Department of Psychiatry to assume a position at the UA Spine and Neurosciences Institute.

Lana Moore (Trover Clinic) is now Director of Paragon, an assisted living facility in Madisonville, KY.

Florie Munroe has left St. Mary's Hospital for the Yale New Haven Health System Vertical Network as the Privacy/ Compliance Coordinator.

Amy Perchick (Temple University) has accepted a promotion as Associate Director of Billing for the Practice Plan.

Newsletter archives

Have you ever wanted to find an article in a back copy of The GrAAPvine but didn't have the printed version? Very soon, you will be able to locate old articles on our website. The plan is to archive back issues, in PDF format, on the website beginning with volume 14 (last year's issues) and working back from there.

You can locate the archive at our website, http://www.adminpsych.org, then click on the link for The GrAAPvine.

Please let Jan Price (janprice@umich.edu) know if you have any suggestions for improving the online newsletter access.

2003 spring conference plans

Our Spring AAP Conference plans are in motion and we are looking forward to another wonderful opportunity for all of us to meet. The conference will be held, as in prior years, in conjunction with the MGMA/APA conference at the Marriott Marquis Hotel in Atlanta, Georgia.

We are planning an exciting conference for Administrators in Academic Psychiatry to be held on Saturday, April 26. Our plans include invited speakers, including **Karen Milner, MD**, Medical Director of the Psychiatry Emergency Service, University of Michigan and Medical Director, Washtenaw County Community Supports and Treatment Services, who will present the William J. Newel Lecture on The Academic-Public Partnership. Again this year will be a two-minute hot topic discussion that was very successful last year.

The MGMA/APA conference will be held April 27-29th. As part of the conference Psychiatry will host a breakout session on Sunday with **Sara Larch, FACMPE** as our guest speaker. (The scheduling for this breakout has changed this year from Monday to Sunday).

Please mark your calendar for our conference and we look forward to seeing you in Atlanta.

Reminders

Using the listerv

Many of our members say that the listserv is the most valuable networking tool available to us from AAP. When you become a member, Rich Erwin will automatically set your email up to send and receive listserv messages. However, you must first reply to a confirmation email message in order to activate that access. Please make sure you respond. Without that, you won't get the benefit of our collective expertise.

Once you have been activated, enter the listerv address (aap@adminpsych.org) in your email address book so that you can easily contact your colleagues.

When you receive a message and want to respond, remember to REPLY ALL or only the person asking the question will learn your answer - and we all want to become smarter and do our jobs better. If you ask someone else in your department to help with the answer, please have them respond to you so that you can send the information back out on the listserv. Only members can access the list, so if your coworker responds, the message will either bounce back (if sent to the listserv) or be read only by the originator of the message (if sent to that person only).

Following these instructions will help all of us become better administrators. If you have any questions or problems, or if you haven't received your confirmation message, please contact Rich Erwin at erwinRW@health.missouri.edu.

Updating the member database

Do you ever need to contact a colleague but don't know the phone number or email address? That's what the AAP online database is for.

Since 2000, AAP has maintained our member database electronically through the MGMA website at http://www2.mgma.com/asig/login.cfm (note the "2" after the "www").

When you become a member of AAP, Rich Erwin will set you up in the database. If you are a member of MGMA, and already have a member ID, the process is relatively quick. However, if you are not a member of MGMA, this process can take a few weeks, so be patient while they assign an ID to you. Rich will contact you with your member ID once it has been assigned. If you don't know your member ID, you can contact Rich at erwinRW@health.missouri.edu for the number.

To log on, enter your ID number and last name (capitalize the first letter) and click *Member*. Your information will be displayed. To find another AAP member, click on the *Search by Name* button at the top left. To get a listing of all AAP members, click on the *Search by Profile* button.

Please take a few minutes to update your directory information. Click on *Update Your Record*. It's important to keep this information updated and accurate since this is how people will be able to network with you. It's also where our mailing lists come from, so in order to continue to get The GrAAPvine, conference brochures and other AAP mailings, make sure we have the correct address in the directory.

The Administrators in Academic Psychiatry Fall Conference was held on Saturday, November 9 in conjunction with the American Association of Chairs of Departments of Psychiatry meeting in San Francisco, California. High winds and heavy rain didn't dampen the enthusiasm of the attendees, who were treated to opportunities to learn, to network and to socialize. This was one of the best attended Fall meetings, with thirty-five registered participants, including six new members. A very special thank you is extended to Dan Hogge and his Program Committee who planned an excellent educational program and some delicious dining experiences!

Fostering quality care - A challenge to administrators

by Richard Kennedy

In his keynote address at the Fall Conference, **Robert Okin, MD**, Chief of Psychiatry at San Francisco General Hospital, Professor of Clinical Psychiatry and Vice Chair Department of Psychiatry at the University of California, San Francisco, challenged administrators not to accept the limited role of serving solely as implementers of policy. In addition to this role, he urged them to use their positions, experience, and knowledge to influence policies and directions for the departments they serve in order to improve the conditions of mentally ill clients in their home areas and elsewhere in the world.

Dr. Okin's human rights efforts in Hungary and Mexico illustrate the possibilities of how one individual can make a difference in the conditions of the mentally ill, even under dire circumstances. After conducting an investigation into these conditions in Hungary, he and his colleague were asked to participate in rewriting that nation's mental health law. Notwithstanding the resulting improvements in Hungarian law, he was concerned that legal change was insufficient to promote tangible improvements in the lives of the mentally ill. One of the reasons for this was the relative lack of public advocacy. Such advocacy, he came to believe, required that the public see, not just hear about the conditions of the mentally ill.

For his mission to Mexico, he acted on this lesson and took a video camera to record the violations of human rights of the mentally ill in that country. He sent these videos to the New York Times, which sent its own investigative team to Mexico and published its findings in the Sunday New York Times Magazine. Subsequently ABC's 20/20 sent a team to Mexico and reported on the degrading and inhumane conditions they found. This publicity forced an agreement by the Mexican government to make crucial changes in certain institutions for the mentally ill. Dr. Okin was asked by the Secretary of Health in Mexico to make recommendations for the improvement of one of these institutions. Dr. Okin concluded the institution was broken beyond repair and recommended that it be abandoned and replaced by small group homes in the community and on public land. His recommendations were quickly accepted and immediately implemented by the government.

Dr. Okin argued that claims of national poverty could not be legitimately used by governments to excuse their mistreatment of the mentally ill. If points of leverage can be found and used by advocates, nations will find ways to implement change, just as Mexico did. He recommended the need to build alliances with other organizations such as the World Bank, the State Department, and Amnesty International.

"Fighting for the human rights of the mentally ill is not someone else's war. It is our war," he urged. "As clinicians and administrators, we are well positioned to help reduce human suffering," he said. "Involvement in this type of work is not only potentially healing to patients, but adds meaning to our own lives."

(Richard Kennedy is the administrator of the University of California, San Francisco department of psychiatry).

How Are We Doing?

By Wendy Carlton

A discussion of clinical financial indicators and benchmarking presented by **Lee Fleisher**, Vice-Chair of the Department of Psychiatry at Vanderbilt University and a fifteen year veteran in the business, struck a chord of collective interest during the morning session of the fall conference.

Lee used a cartoon with the tag line "You can't shoot first and ask questions later" to stress the importance of benchmarking for creating a frame of reference to measure how a business is doing. A benchmark is a solid immutable point whose primary meaning is a surveyor's mark on a permanent object and used as a reference in topographical surveys. In business this immutable point is a reference against which others may be measured or judged. Benchmarking can be used in many different activities (i.e. billing, office performance, days in AR, net collection ratios, physician productivity, etc.). Lee focused on billing office performance and productivity.

Some valuable sources of benchmarking data that can be useful to administrators in psychiatry are gathered and published by MGMA, UHC, and AAMC. Lee noted that it is also valuable to compare intra-

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institutional and intra-departmental data. When using surveys and other benchmarking data one must be cognizant of how FTE information is used. FTE is not used consistently in different information sources and can drastically change the comparator data. UHC, AAMC and AAMC all use a different ratio for clinical FTE benchmarking. Another consideration is the importance of using more than one benchmark whenever possible, or to use ranges. Benchmarking against oneself (intra-departmental) is often valuable and can be done to measure the effect of a practice change over time. This can be a valuable tool when dealing with the inevitable problem of change resisters. Benchmarking for a given period can show improvements over time that helps an administrator overcome the resistance of change.

Key billing performance benchmarks are net collection rate, percent of denied claims, accounts receivable over 120 days and days in AR. Benchmarking data for these areas is easily found through MGMA, UHC and AAMC.

Net collection rate is current month collections divided by the average of the net charges for the most recent three months. Net charges are gross charges less insurance contractuals. MGMA shows net collection rate benchmark percentages as 96.68% for private multi-specialty groups and 83.79% for academic medical centers.

Denied claims should be measured by number of claims as well as percent of billings. It is critical to capture the denial codes; if you don't know the reason for the denial, you can't improve the process. The top reasons for denials include incorrect registration information, wrong diagnosis, duplicate claim, non-covered service, and patient liability. It is valuable to sort denials by payor to identify problems with a particulate payor. The issue can then be addressed at a higher level.

Days in Accounts Receivable (AR) is a commonly used benchmark in all practice areas. The formula commonly used to determine days in AR is total AR divided by (12 months gross charges divided by 365). UHC/ AAMC currently shows an average of 83.80 for academic practices and 65.34 for private practice. A focus on time of service collections can significantly increase receivables and limit days in AR.

Lee noted that collections per RVU can be tricky because it is affected by contract payments and payor mix and should only be used as an interdepartmental comparator.

Common productivity benchmarks are gross charges and worked RVUs. Gross charges for Psychiatry academic faculty are $185,218 per FTE and $311, 973 for private practice faculty. The trend in academic medicine is to assign a value to all activities done by academic faculty in order to accurately measure the real level of contribution. Productivity ratios can be used but with careful consideration of the measure of FTE.

In spite of all the potential pitfalls, benchmarking is a valuable, even essential tool for administrators in order to measure practice effectiveness and ensure success. Lee offered the 10-step model of benchmarking that includes the following steps:

1. Understand your own process/ performance
2. Identify benchmarking target,
3. Plan project
4. Identify partners
5. Collect data
6. Determine gap
7. Establish goals
8. Develop action plans
9. Implement plan and monitor results
10. Recalibrate the benchmark and go at it again.

(Wendy Carlton is the administrator of the Oregon Health Sciences University department of psychiatry).

Developing an investment strategy - The hows and whys of rebalancing a portfolio

by Warren Teeter

Erin Lander, Individual Consultant, a Registered Representative for TIAA-CREF, presented a very informative educational program relevant to all of us who have investments or want to understand investments. After the rocky road many of us have been over during the past two years, the timing could not have been better for us to have this program to help us refocus on our investment goals.

Ms. Lander emphasized that it is important to:

- Establish financial goals and put them in writing;
- Be diversified in our asset allocation;
- Know our asset classes and risk tolerance;
- Understand our investment selections; and
- Understand our investment companies and where to look for research in evaluating a company.

What does risk mean to an investor? There are inflation risks, market risks, foreign investor risks and market timing risks. The timeframe for your goals should determine the type of risk you are willing to accept. Short-term goals (1-3 years) generally call for the most conservative investment strategies with fewer risks while with intermediate-term (3-10 years) and long-term goals f (10+ years) you can be more aggressive.

There are different types of asset allocations for investments, and it is important to diversify among equities and non-equities. All have different returns with different volatilities. For example, if someone invested $1.00 in

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1926 and withdrew it in 2001, they would have received the following appreciation: $1.00 would be worth $7,860 if invested in a small company stock fund, $2,279 if invested in a large company stock fund, $51 if in government bonds, $17 if in treasury bills and would be worth $10 with inflation only. With this in mind, Ms. Lander reminded us that stocks prices are 30-40% lower than they were two years ago so now is a good time to buy. It's important that we consider now, and periodically, rebalancing our asset class mix, since these asset values can change over time. It's hard to time the market, so dollar cost averaging (buying an equal amount each month) of a fund is strongly recommended by all financial advisors.

Investors and fund managers want to maximize returns with minimal risks. What is your risk tolerance ? Are you conservative, moderately conservative, moderately aggressive, or aggressive? Also, keep in mind that there are tax advantaged investing (401K, IRA's, etc.), indexing (S&P 500 funds) and active management (buying individual stocks). There are growth and value funds and asset allocation funds, which combine stocks, bonds and money market funds. It was interesting to note that from 1970-2001, the least risk allocation with the best return was 28% stocks and 72% bonds. The highest risk allocation with the best return was 100% stock.

It is important to consider a managed portfolio that has professional management, diversification, managed risks and returns, minimal investments within reason, and low-cost management fees. It is also important to compare expenses charged to you by a company to manage your funds. If you had invested $10,000 thirty years ago in the same investment, but your management fees were 1.96% per year, you'd have $31,716 today. If the fee was 1.26% per year, you'd have $36,262. But, if you had been with a company that only charged a 0.4% annual management fee, you'd have $59,300.

Ms. Lander pointed us to investment related web sites we can use to review fund performances. *Morningstar.com* is the easiest to understand. Other good sites are *Bloomberg.com* and *Lipperweb.com.*

Personally, I must relate that " a major national consumer reporting magazine" gave TIAA-CREF an excellent review and rated it in its' top category for its' higher than average returns and very low management fees. Their website is *tiaa-cref.org* and their phone is 1-800-842-2776.

(Warren Teeter is the administrator of the Wake Forest University department of psychiatry).

Healthcare systems and financing Issues for the academic psychiatry department

by Jim Landry

The AAP fall conference luncheon and presentation was held in conjunction with the American Association of Chairs of Departments of Academic Psychiatry. This year's speaker was **Barry Chaitin, M.D.**, Professor and Co-Chair, The Department of Psychiatry and Human Behavior at University of California, Irvine.

Dr. Chaitin is a member of the American Psychiatric Association's Council on Healthcare Systems and Finance and in his presentation he addressed the committee structure of the APA, and the focus of each of these committees.

Dr. Chaitin indicated that we are in an era in the healthcare industry where we are experiencing the beginning of the end of managed care. Managed care organizations (MCO) are requiring higher premiums and higher out of pocket expenses for subscribers. MCO's currently absorb roughly 30% of the healthcare dollar. There is inadequate funding at the federal level to ensure appropriate care. Only 3% of healthcare premium dollars are spent on psychiatric services, while 160 million covered lives have psychiatric carve outs in their health plans.

The tragedy of September 11th put great focus on the psychiatric community, and the reality of psychiatric mental illness was front and center in the psyche of Americans. There was/is renewed interest in the business community regarding mental illness, especially in regards to posttraumatic stress disorder. Psychiatric professionals are now being included in disaster preparedness planning, and major companies are reviewing their psychiatric policies for employee access.

The APA Committee on Managed Care is advocating the utilization of residencies in MCO plans (under supervision) to provide additional access and treatment to MCO subscribers. Dr. Chaitin also cautioned that we should be cautious when entering into a relationship with an MCO in this time of transition. He pointed to the current issue of an MCO on the verge of bankruptcy.

Historically, academic medical centers (AMC) have provided a safety net for the uninsured and underinsured. The challenge is how to keep providing the same level of care with reduced Medicare and Medicaid reimbursement. Furthermore, with disproportionate share dollars evaporating, this could have a major impact on AMCs, as this is a major source of discretionary funding from AMC hospitals to the medical school and its clinical departments. The untimely death of Senator Paul Wellstone has sidetracked efforts in securing federal mental health parity legislation.

Within the next two years the Medicare reimbursement for

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psychiatric services will change from cost base to DRG. It remains to be seen what the impact on academic psychiatry departments will be.

In closing, Dr. Chaitin set forth challenges that face academic psychiatric departments:

- How to support educational and academic mission, when faced with unfunded mandates,
- Participation in the safety net,
- Retirement and retention of faculty,
- Need for a new paradigm – omnibus healthcare enterprise versus dedicated teaching, and
- Dealing with hospital administration.

Dr. Chaitin's remarks were followed by a panel discussion. Panel members were **John DiGangi** (University of Massachusetts) and **Nish Patel** (Mayo Clinic) from AAP, and **Peter Buckley, M.D.** and **David Mzarek, M.D.** from the AACDP.

(Jim Landry is the administrator of the Tulane University department of psychiatry).

Successful development and operation of an integrated delivery network

by Kevin Johnston

Managed Care, or "Integrated Delivery Network" (a much more palatable description), was the focus of a talk by **Jack Denbow**, recently retired Executive Director of the Jefferson Behavioral Health Network (JBHN). The full title of his talk was "First Steps in the Development of an Integrated Delivery Network and mistakes I would hope not to make again," which he described as "implementation to operation." Mr. Denbow's healthcare leadership experience is extensive in the Philadelphia area along with past healthcare consulting on a national level.

In 1997, JBHN was a partnership coordinated by Mr. Denbow between four healthcare systems in the Philadelphia area, representing four organizations, nineteen facilities, 560 IP beds, five crisis centers, twenty partial stay locations and forty OP locations. The original intent was to utilize an existing entry point (Belmont) for contracting coverage of the lives, but with Aetna as the primary contractor and unwilling to contract with Belmont, JBHN was established. Aetna contracted with JBHN to manage 50,000 lives. The primary problems to start were:

- Low PMPM
- Limited Medicare experience
- Poor geographic coverage with the credentialed provider network
- Lack of commitment to JBHN
- Limited subcontractor/delegate experience
- Unfavorable mix of clinical capacity

The organization obtained outside assistance to develop organizational documents, which was a five-month process. Organizationally, an LLC was created with each partner providing start-up funds. Simplistically, a Board of Managers headed the organization, with an Executive Director and Medical Director reporting to the Board of Managers. The Medical Director coordinated Quality Management, Outcomes and Credentialing with operational activities handled by the Executive Director. With this leadership, a mission statement was developed. Operationally, key system elements, continuum of care, geographic coverage, competitive rates, contract vehicle, system access and appropriate care, were defined and refined. This definition and refinement was handled through an Operating Steering Committee, with subcommittees for Provider Relations, Clinical Operations, Quality Assurance and Information Systems.

Mistakes they resolved over time were:

- Full time financial director was necessary
- Part time IS support was necessary for data base administration
- Spend no more than 7 minutes per call (initially above 20 minutes)
- Hire the right person for each job
- Should have worked at getting all inpatient hospitals at the same level of care with step down options
- Admitted patients to some hospitals where no contract existed
- Should have involved all practice plan partners and faculty foundations from all partner hospitals
- Did not understand existing Family Practice referral structure (education sessions later provided information on joining along with how and when they would be paid)

The bottom line was that corrective actions were implemented and the network development was considered a good direction since the lives (100,000 now) would have gone to other plans. Patient recruiting was reduced with increased hospital revenue. More importantly, in the final analysis, the system is considered reliable, ethical and respected.

(Kevin Johnston is the administrator of the Indiana University department of psychiatry).

Panel Discussion – Regulations, rules and compliance

by Elaine McIntosh

At the recent AAP Fall Meeting in San Francisco, AAP members **Pat Sanders Romano** (Albert Einstein College of Medicine), **Steve Blanchard** (University of Iowa), and **Jim Landry** (Tulane University) gave a three part presentation on HIPAA implementation, compliance issues, and pharmacy guidelines for donations.

Pat presented a comprehensive discussion entitled *HIPAA…is not a four letter word*. Pat outlined the five key provisions of HIPAA of privacy, security, transactions and codes, identifiers, and enforcement. Privacy creates a floor of standards (procedures and protocols) to protect a patient's right to his or her medical records and other personal health information. Security establishes minimum administrative, technical, and physical safeguard requirements to prevent unauthorized access to health information. Transactions and codes establish uniform standards to govern how health information must be formatted (codes) and exchanged electronically (transactions). Identifiers are unique alphanumeric numbers to identify providers, group health plans and health plan sponsors. Enforcement will utilize fines ranging from $100 to $250,000 per incident and criminal penalties including jail time.

Additionally, Pat highlighted some important provisions of the HIPAA regulations. Providers should disclose only that amount of Protected Health Information (PHI) necessary to meet the intended purpose. Signed consent by a patient is required to release medical records to third parties. Authorization is required for all other uses such as marketing and release of information to an attorney. Patients must be provided with notice of their privacy rights. Business Associate Agreements are required for vendors who have access to PHI. A Business Associate Agreement is not required with an entity who must also be HIPAA compliant. Pat completed her presentation by comparing the HIPAA regulations and the federal regulations for confidentiality of alcohol and drug abuse patient records (42 CFR Part 2). In general, the more restrictive regulation should be applied.

Steve outlined the current focal points of the Office of the Inspector General as medical necessity of inpatient psychiatric care, the reporting of adverse outcomes of seclusion and restraint to the Centers for Medicare and Medicaid Services (CMS), and the performance of services by non-physicians outside their scope of practice. Tools that can be used to identify problem areas in clinical practices are internal audits, analysis of your records, and help lines where callers identify areas of ambiguity or noncompliance. Issues on the horizon are new directions for JCAHO accreditation beginning in 2004, pharmaceutical company regulations, public scrutiny of patient safety, and new privacy regulations associated with HIPAA.

The PhRMA Code of Interactions with Healthcare Professions served as the format for Jim's presentation on the pharmaceutical code of ethics. The Code was notated with comments from Pfizer. One of the primary purposes of the Code is to address public perceptions. Utilization of the Code is voluntary. With regard to CME support, funding should be given to the program sponsor, not to faculty. Pharmaceutical time at CME programs needs to be limited relative to education time. Pharmaceutical representatives should not select the residents who will receive gifts or support.

To conclude the presentation, Jim made the following recommendations:

- Funding should not be distributed to faculty or residents without department chair approval.
- Books and other tangible gifts should be given to the department residency program, not to individual residents.
- The presence of pharmaceutical representatives in clinical areas needs to be reviewed in regard to compliance with HIPAA regulations.

(Elaine McIntosh is the administrator of the University of Nebraska department of psychiatry).

President's desk

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transition from psychiatry to vascular surgery. We will continue to depend on Alex as an advisor to us officially until January 1 at which time Janet Moore will fill the role as Immediate Past-President. Alex promises to spend some of his social time with us at the Spring conference.

I look forward to seeing many of you at our Spring, 2003 conference in Atlanta in conjunction with the MGMA Academic Practice Assembly conference. We will have a board meeting on Friday April 25, the AAP Educational Conference will be on Saturday, April 26, and the APA conference runs from Sunday, April 27 until early afternoon Tuesday, April 29. Dan Hogge and his conference planning committee are well on their way to organizing an outstanding conference. Please contact Dan at *Dan.Hogge@hsc.utah.edu* if you have any questions about the meeting.

The board and special committees will be working on our goals and strategic planning over the next six months. Please email me at *wteeter@wfubmc.edu* or phone (336) 716-3544 if you have any questions or suggestions regarding AAP.

Warren

The College corner

ACMPE update from 2002 MGMA annual conference

by David Peterson, FACMPE

Consistent with this issue of fall conference updates, I would like to offer two observations from the MGMA's 2002 Annual Conference held in October. The first observation involves the committee process related to the professional papers requirement to achieve Fellow status in the American College of Medical Practice Executives (ACMPE) and the second observation will relate to the keynote address on "College Day" at the conference.

First, I have the privilege of serving as Team Leader for one of the 5 teams comprising the Professional Papers Committee. The essential charge of this committee is to review and evaluate topics/outlines and manuscripts submitted by candidates seeking Fellow status. At the annual meeting, I spent a number of hours with colleagues from around the country in the Professional Papers Committee meeting. At the end of these sessions, I continually walk away impressed by the dedication of the committee members and their desire to maintain the quality and professionalism of the body of work that is submitted; and help, coach and mentor Certified Members who have submitted manuscripts with the goal of achieving Fellow status.

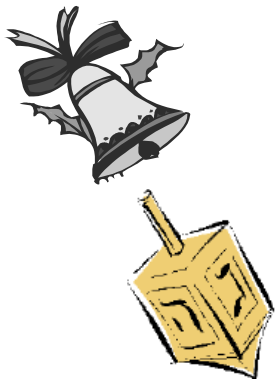
Many Certified Members dread this final step toward Fellow status and procrastinate taking it. To be sure, if done rightly, it is a significant amount of work. But, I suspect that if all Certified Members were able to see the faces and hear the words behind "the Committee," most Certified Members would be assured that they are beginning this final step with a supportive, albeit sometimes constructively critical, Committee and group of professionals behind them. Between the Committee members themselves, the ACMPE staff and mentorship programs, the College has a significant support network and resources in place to assist Certified Members through this final step. At the end, most members find that it has been a personally and professionally gratifying step to take.

And second, in previous columns I have noted that one can measure the value MGMA places on the ACMPE by the fact that it has dedicated an entire day of the annual conference to the College. For the 2002 "College Day," the speaker of the general session was W. Robert Wright, Jr. FACMPE who spoke on the topic, "Legacies and Perspectives: Professions in Medical Group Management." In one segment of the 75 minutes or so that Bob spoke, he highlighted portions of the book he coauthored titled "Trials to Triumph: Perspectives of Successful HealthCare Leaders."

The book is a compilation of the thoughts, observations and experiences of scores of current leaders in the healthcare field. Bob prefaced his remarks by saying that the hard, quantifiable skills necessary to be a successful leader were baseline skills that were "a given." But beyond the "hard skills," the lessons from these leaders are often the simple ones and include such things as being respectful of one another and listening closely to the physicians and patients.

A tape of Bob's remarks can be ordered through MGMA. You can order it online at *www.mgma.com*. The book is published by Healthcare Administration Press and can be found online at *www.ache.org/hap.cfm*. Both items are worth a look.

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, 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.



Have a joyous holiday season and a happy and healthy new year.

NIH transitions to providing electronic progress report due date information

NOTICE: NOT-OD-02-066
National Institutes of Health (NIH)

NIH continues to transition the notification of Non-Competing Grant Progress Reports from a hard copy mailing of preprinted electronic PHS 2590 and PHS 416-9 face pages to an electronic format. The last hard copy mailing of preprinted face pages was mailed in late June for those progress reports with November 2002 start dates. Beginning with December 2002 start dates and beyond; e.g., those progress reports due on/after October 1, 2002, grantees will need to access a website to determine which progress reports are due.

Now available at http://era.nih.gov/userreports/pr_due.cfm, the NIH Office of Extramural Research has launched a website of Non-competing Progress Report due date information. Users search the website using an IPF (Institutional Profile File) number, a unique number that NIH uses for tracking and reporting on grant awards to grantee organizations. Users who do not know their IPF number may link to a query system that allows them to retrieve that information. The system currently lists institution name, grant number, Principal Investigator name, progress report due date, and whether the project is in the last year Institutes/Centers as well as the Agency for Health Care Research and Quality and is sorted in due date order. New records will be added on/around the 30th of each month so users are encouraged to check the report monthly. Grantee officials should plan to review this list at least once a month. Several months of "due" information will be in the query at all times and records will drop off of the list as NIH receives the progress reports.

This new website is one of two ways due date information will be made available to grantees. The second way will be through the NIH Commons. When this option becomes available, details will be published in the GUIDE.

Progress reports should continue to be mailed directly to the NIH awarding Institute/Center. A list of Institute/Center mailing addresses for progress reports is found at http://grants.nih.gov/grants/type5_mailing_addresses.htm.

Questions concerning this query should be addressed to the eRA Helpdesk email at Commons@od.nih.gov. Questions concerning submission of progress reports should be directed to the specific NIH Institute/Center.

This notification is an update to: 1) the July 10, 2001 NIH Guide notice entitled Revised PHS 398 and PHS 2590 Now Available; 2) the January 7, 2002 notice entitled Use of Non-Competing Grant Progress Report (PHS 2590) Face Pages; and, 3) the May 2, 2002 notice entitled Update On The Transition To Electronic Non-Competing Grant Progress Report Notification.

Electronic FSR submission is changing as of 12/31/02

NOTICE: NOT-OD-03-008
National Institutes of Health (NIH)

The current system used to electronically submit financial status reports to the NIH is scheduled to be turned off on December 31, 2002. This system is part of an NIH legacy system that is in the process of being decommissioned. The new system that will take its place is the FSR module of the NIH Commons version 2. It will be deployed on November 1, 2002 and be in limited use until November 18, 2002 at which time it will be opened up to all users of the current system. To be able to use the new FSR module, recipient institutions will need to register in the NIH Commons V2. All of the institutions that were registered users in version 1 of the NIH Commons will automatically be registered for version 2. To register before December 6th, contact the Commons helpdesk at (866) 504-9552; As of December 6th, registrations will be processed directly through the NIH Commons web site (http://commons.era.nih.gov/). The steps involved are: 1. Complete the online institution registration form 2. Print signature form, obtain necessary signature and fax back to NIH 3. Reply to the email address verification message sent by the NIH 4. NIH processes the registration 5. Confirm the IPF assignment for the registration is correct 6. Receive account information from the NIH 7. Create and maintain additional accounts at the institution Institutions not registered by December 31, 2002, will need to submit FSRs in paper form until they are registered. We understand that this is a very short timeline for this transition, but it is necessary in order to avoid technical problems caused by the legacy system. NIH will make every effort to ease the transition as much as possible. Please contact the Commons helpdesk (commons@od.nih.gov or (866) 504-9552) with any questions about how to use the FSR module or the registration process.

Ask the experts

Editor's note: This is a summary of a question I recently asked on the listserv concerning combined psych/med inpatient units. Our colleagues are our best resource for information, and the active use of the listserv demonstrates how valuable we think our collective expertise is. I'm hoping to make this a "semi-regular" column, so please consider taking a few minutes to summarize the thoughts you've been able to glean from our experts on your most pressing issues.

by Jan Price

At a recent retreat of the Hospital Services Division of the University of Michigan Department of Psychiatry, I was asked to look into the feasibility of the development of a combined psychiatry/medical inpatient unit. Over the past several years, we have seen the medical complexity of our psychiatric inpatients rise dramatically, often requiring ongoing medical intervention while on our unit. We currently have a psychiatry-specific inpatient unit, with medical consultation provided when requested. This consultative coverage is often spotty, depending on the medical service and the individual physicians rounding. Additionally, psychiatric nurses are being called upon to treat these medically complex patients while at the same time dealing with the psychiatric disorders that brought them to our unit in the first place.

I received several responses that fell on all sides of the continuum. Not surprising, however, were the consistent responses about the difficulty in obtaining adequate reimbursement.

Mayo and Iowa have some double boarded faculty that serve this patient population. At both facilities, attending and resident staff from both Psychiatry and Medicine round daily. All other respondents have consultants as needed. Since many of the consultation requests are for specialty services, the effectiveness of a General Medicine physician assigned to the unit seems debatable. Medical nursing care is provided by the psychiatric nurses.

The financial issues are stickier. Payment varies from insurer to insurer and is likely dependent on whether the unit is designated as a psychiatry or a medical unit, whether the primary diagnosis is psychiatric or medical and who is considered the primary provider and who is the consultant.

Harborview Medical Center of the University of Washington, in addition to their regular psychiatry units, has a psychiatric ICU, consisting of 14 private rooms, where the most complex medical patients are housed. The rate for these beds is higher than the acute bed rate. Patients needing transfer from a medical unit to one of the psychiatry units must fit their criteria for medical stability. To ensure appropriate nursing resources are available, the approval of the Inpatient Psychiatry Director must be obtained, as much as 48 hours in advance of the transfer. Patients who require two emergent medical transfers off inpatient psychiatry should have at least 48 hours of medical stability and approval by the Inpatient Psychiatry Director and Medical Director before a transfer back to psychiatry.

(Jan Price is the division administrator for the Hospital Services Division of the University of Michigan Department of Psychiatry).

It's time for AAPs to pay your 2003 dues! Remember, membership has it's advantages:

- § Subscription to *The GrAAPvine*, AAP's quarterly newsletter
- § Notification of conferences and reduced registration fees
- § Participation in the AAP listserv
- § Friendship with some of the nicest people in academic medicine - or anywhere!

Coming attractions

April 26, 2003	**AAP Annual Educational Conference** Atlanta Marriott Marquis Atlanta, Georgia
April 27-29, 2003	**APA Annual Educational Conference** Atlanta Marriott Marquis Atlanta, Georgia

1. A bicycle can't stand on its own because it is two-tired.
2. What's the definition of a will? It's a dead giveaway.
3. Time flies like an arrow. Fruit flies like a banana.
4. A backwards poet writes inverse.
5. In democracy it's your vote that counts. In feudalism it's your count that votes.
6. She had a boyfriend with a wooden leg, but broke it off.
7. A chicken crossing the road is poultry in motion.
8. If you don't pay your exorcist you get repossessed.
9. With her marriage she got a new name and a dress.
10. Show me a piano falling down a mine shaft and I'll show you A-flat minor.
11. When a clock is hungry it goes back four seconds.
12. The man who fell into an upholstery machine is fully recovered.
13. A grenade thrown into a kitchen in France would result in Linoleum Blownapart.
14. You feel stuck with your debt if you can't budge it.
15. Local Area Network in Australia: the LAN down under.
16. He often broke into song because he couldn't find the key.
17. Every calendar's days are numbered.
18. A lot of money is tainted. It taint yours and it taint mine.
19. A boiled egg in the morning is hard to beat.
20. He had a photographic memory that was never developed.
21. A plateau is a high form of flattery.
22. The short fortune teller who escaped from prison was a small medium at large.
23. Those who get too big for their britches will be exposed in the end.
24. Once you've seen one shopping center you've seen a mall.
25. Those who jump off a Paris bridge are in Seine.
26. When an actress saw her first strands of gray hair she thought she'd dye..
27. Bakers trade bread recipes on a knead to know basis.
28. Santa's helpers are subordinate clauses.
29. Acupuncture is a jab well done.
30. Marathon runners with bad footwear suffer the agony of defeat.

Very Pun-ny!!

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Visit the AAP website at:
http://www.adminpsych.org

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:

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