Vol. 16 No. 1
Winter 2003

The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

As the plane circled to land and I stretched to see some of our nation's most famous landmarks I quietly remarked to myself that I was excited and obviously anxious for another AAP conference in Washington D.C. Of course, I was not surprised that we had such a great conference. We experienced one of the best conferences ever for our organization and we certainly were the major benefactors of the presentations and discussions. The conference was absolutely powerful and well attended by over forty members!

We extend to President-Elect **Kevin Johnston** (U Indiana) and all the program committee our appreciation for going the extra mile and making this conference exceptional. There is no question that all the months of planning and collaboration for this conference paid off with huge dividends. The first Norman MacLeod Fall Lecture, presented by Martin Lazoritz M.D, will set a precedent for many years to come. Dr. Lazoritz, from the University of Florida, was delightful and we had a wonderful dialogue with him regarding our financial and operational responsibilities.

This year we enjoyed two concurrent sessions during the morning session. This allowed the participants to select an area of interest and engage in a topic of discussion that would meet more of their professional needs. I encourage you to take the time to read in this newsletter the articles devoted to summarizing the presentations and speakers that were a part of this conference. The success of our program was evident in our collaborative interactions and the professional environment we enjoyed.

We've had the pleasure of meeting three times now for our Fall Conference in conjunction with the American Association of Chairs of Departments of Psychiatry (AACDP). There is no question that we are the recipients of a great relationship that allows us to share and exchange ideas and professional knowledge. I want to express my appreciation to Member-at-Large **Jim Landry** (Tulane U), joining with **Dr. Joel Silverman** (Medical College of Virginia) and other representatives to spend their conference time in the morning to discuss the Institute of Medicine report, "Research Training in Psychiatry Residency: Strategies for Reform." (see page 13). The opportunity to engage with the chairs

Continued on page 3

Comings and goings

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

Susan Cambria
Dartmouth-Hitchcock Medical Center
(603) 650-6404
susan.a.cambria@dartmouth.edu

Stephen Kiser
Brown University
(401) 444-1919
stephen_kiser@brown.edu

Mary Jo Laudermilch
Penn State U
(717) 531-6385
mlaudermilch@psu.edu

Cynthia Overton
Howard University
(202) 806-6611
coverton@howard.edu

Denese Shervington, MD
Meharry Medical College
615 327-6606
dshervington@mmc.edu

Jan Stevenson
Emory University
404 727-5892
jan_stevenson@emoryhealthcare.org

Mischelle van Thiel
University of Calgary
403 944-1298
mischelle.vanthiel@calgaryhealthregion.ca

AAP wishes good luck to the following member:

William Fussinger (U Cincinnati) who has left his position with Psychiatry in his combined Psychiatry/Emergency Medicine/ Otolaryngology.

Karen Jones (UTexas-Houston) has left Psychiatry for Ophthalmology/Radiology.

Karen Strider (George Washington U) who is leaving her institution to become a stay-at-home mom!

Meeting the new members

Steve Kiser has been in his position a little over a year. Previously he was at UMass Boston for 10 years, where he worked in the Research Administration Office and also as a department administrator. He got married this summer, and he reports that he and Karen have no children (yet!).

Steve says the biggest professional challenge he faces currently is changing the culture from one of solely compliance to one of service and compliance. He joined AAP because he thought it would be a good forum for professional development, give him the opportunity to meet other academic medicine psychiatry administrators and share knowledge and experience.

In his spare time, Steve is an avid reader/baseball/humor enthusiast, and he and Karen love to camp. Prior to entering the world of academic administration, he worked as a stand up comic/comedy writer and in the funeral business!

Denese Shervington, MD has been in her present position since Sept 1, 2003. Prior to this, she served as Medical Director for the Louisiana Office of Mental Health, Region 1. She was also an Assoicate Clinical Professor of Psychiatry at Louisiana State University Medical Center. Her late husband, Walter W. Shervington M.D, was also a psychiatrist.

Denese says that her biggest challenge on the job is developing a research infrastructure,especially in the area of mental health disparities.

She is a student of yoga, and this takes up much of her spare time. She also writes and has published a non-fiction book, "SoulQuest: A Healing Journey for Women of the African Diaspora" and a novel, "Three Women."

Prior to joining the Department of Psychiatry at University of Calgary, **Mischelle van Thiel** spent 5 years at Mount Royal College in Calgary, first as a Director in Continuing Education and most recently as the Registrar and Director of Admissions. Prior to that, she was the Manager, Continuing Professional Development for the Association of Professional Engineers, Geologists and Geophysicists of Alberta (APEGGA).

Mischelle has been married for almost 17 years to husband, Hans. They have two sons, Adam,14, and Jordan,10. She is currently working towards a second Masters' degree and applying to the U of C for PhD studies commencing Fall 2004. She is a dedicated fitness buff, who runs 5 km daily, does tai chi and pilates and is working towards a black belt in tae kwon do. She loves reading non-fiction, biographies and anything on comparative religious philosophy, art history or theoretical mathematics.

Her biggest job challenge is getting to know everyone (and remembering their names!) and getting up to speed quickly on the pressing issues. Thankfully, she says, she has a great team to support her.

President's desk

Continued from page 1

and help formulate initiatives for this report was timely and fortuitous. Also, I would like to extend a special thanks to **Lucille Meinsler**, Executive Assistant of AACDP, for her caring and helpful attitude. She has so willingly assisted us over the years in making sure our collaboration with AACDP is smooth and complete.

Our strategic goals this year are focused on taking our plan (see our AAP website http://www.adminpsych.org) and updating it so that we know it provides us with relevant direction and organizational tools. Over the past five years we have accomplished many goals thanks to the dedication of our members. Under the direction of Member-at-Large **John DiGangi** (U Massachusetts), the board is reviewing and finalizing future objectives and goals (see article on page 4). One of the greatest hazards of strategic planning is to have a well-written document that just sits on the shelf. My challenge is to make sure we implement a document that will accomplish our association's mission and objectives. We are fortunate to have a board and a membership who are committed to these principles. We have made great progress and I know my job is much easier because of your support. I am excited when I see our members involving themselves and helping us to promote the AAP organization. Please take the opportunity to visit our website and consider how you can be involved in helping us fulfill our goals.

Each year a few of our board members meet with the executive board members of AACDP to discuss and review any strategic issues or opportunities that are meritorious to us as a group. We reviewed important programs and ideas that bind us together and effectively make us more successful. As I mentioned, during our luncheon Dr Joel Silverman, Dr. John Greden, and Jim Landry were very kind to take the opportunity to give details of the Institute of Medicine Report. These are the types of interactions that allow us to more successfully identify common issues and provide opportunities to join in group projects. We look forward to the opportunity over coming years to work together and strengthen our relationship.

Please note that our AAP Spring Conference will be held at the Sheraton Towers in Seattle, Washington May 1, 2004 in conjunction with the annual MGMA Academic Practice Assembly Meeting which follows from May 2-4. We are pleased for this opportunity to continue our educational programs and I'm sure you'll soon hear more about this great event.

And, if you want to plan far in advance, our next AAP Fall meeting will be November 5-6, 2004 in Boston, Massachusetts.

Lastly, the continuity of an organization is dependent on a leader who provides direction and is able to guide us thru transitions in the organization. I wanted to express our deepest appreciation to Immediate Past President **Warren Teeter** (Wake Forest U) for providing us excellent leadership and friendship. Warren has always attended AAP meetings and has been very instrumental in helping us to manage changes in our board and committee structures. He has coordinated the revision of our board orientation manual and he will be heavily involved in the selection of our next board. Our meetings would not be the same without his great leadership.

In closing, Michael Useem once said: "If people are too intimidated or too reluctant to help their leaders lead, their leaders will fail." I know I will never fail because of the great members of AAP. We are fortunate to enjoy a cadre of well-educated and knowlegable members who are willing to contribute. To each of you I wish the best during the holiday season and success in your own professional and personal lives.

Dan

Condolences to the family and friends of Steven Papp (Columbia University) who passed away in July 2003.

Your board has been busy!

Membership report

by Elaine McIntosh, Membership Director

The Membership Committee has conducted two major projects in the past few months. The first was to send out recruitment letters to chairs without an active AAP member representing their department. With the help of **Jan Price** (U Michigan), the form letter was drafted and attached to the Fall GrAAPvine. This project recruited four new members to AAP.

The second project was to contact approximately seventy members who had not previously attended an AAP conference and encourage these members to attend the November 8 conference in Washington D.C. The project was a great success with many first time attendees at the conference. Thanks go out to **Jackie Rux** (Medical College of Wisconsin) who headed up this project and her committee, **Janice McAdam** (U Kansas), **Joanne Menard** (U Washington, and **Buddy Sanders** (Baylor U).

AAP currently has one hundred twenty-seven members representing ninety-eight departments of psychiatry. Since the beginning of this administration's year in April, there have been seven new members and two prior members who have returned to AAP. Please refer to the Comings and Goings column in this and past issues for the names, and feel free to drop a welcome note or call!

Strategic planning

by John DiGangi, Member-at-Large

The current AAP strategic goals for 2003-2004 are listed on the web site at www.adminpsych.org. As was decided at the recent Fall Board meeting, **Dan Hogge** (U Utah), and **Kevin Johnston** (Indiana U), will be working on the goals for 2004-2005 and the Strategic Planning committee will work on the long range (three year) Strategic Plan for the period 2004-2007. At our 2004 Spring Educational conference Kevin will present the updated plan and annual goals. At the 2004 Fall Educational meeting, Kevin and the new President-Elect will update members regarding progress of the plan. The strategic planning committee is comprised of the following members: **John DiGangi** (U Massachusetts) Chairperson, **Rich Erwin** (U Missouri), **Lee Fleisher** (Vanderbilt U), **Joe Thomas** (U Michigan), **Radmilla Cassidy** (Southern Illinois U), **Jan Price** (U Michigan), and **Steve Blanchard** (U Iowa). Watch for updates and notices on the AAP listserv regarding the progress of the strategic planning process.

Two areas of specific interest and focus will be benchmarking using mini-surveys of specific data useful for administrators and managers and the access to these benchmarks/mini-survey data from a central depository or database. The strategic planning committee will be working on these two tasks and report at the Spring Conference in Seattle in May 2004.

WATCH THE MAIL --
DUES NOTICES ARE COMING!

Online database

by John DiGangi, Member-at-Large

The AAP Board, at their meeting in Washington, DC, discussed the membership database information and its current and future use. Processes for updating the data and keeping it current; methods and systems for allowing access to the data by AAP members; use of the data by Membership Director, Treasurer, and other Board members; and other concerns were discussed at length. The plan was defined with a due date to accomplish the following tasks before the Spring 2004 meeting. **John DiGangi** (U Massachusetts) and **Rich Erwin** (U Missouri) will be working together to accomplish these tasks:

1. Send AAP members a request to update their AAP membership information on a biannual basis in the months of November and March.
2. Coordinate the three existing data sets into one.
3. Provide AAP board members access to the database.
4. Provide AAP members access to the membership data either on a CD or on paper. Distribute that information at the Spring 2004 meeting and annually thereafter.
5. Notify members that the AAP board will not sell or distribute membership information to anyone outside of the organization.

Watch the listserv for updates on the progress of these tasks.

Job postings on the listserv

by John DiGangi, Member-at-Large

The AAP Board voted to allow job postings to the listserv. The following guidelines will be distributed to members on the listserv, posted on our web site, and introduced in this article for *The GrAAPvine*. There will be no charge to AAP members as this is a benefit of membership but members must adhere to the guidelines listed below. After lengthy discussion the board also voted to allow recruiters/ headhunters to access our listserv with advertisements for professional positions in Psychiatry departments, but also only under specific rules.

Guidelines for posting on the Listserv:

1) Only Administrative Management, professional job openings available in the AAP member's department(s) and/or affiliate sites will be allowed.
2) The AAP member will be required to email the President-Elect (the name and email address is listed on the back page of every *GrAAPvine*) with the posting request on the form provided. Once the request has been reviewed and approved, the President-Elect will send the posting out to the AAP listserv for the member.
3) Non-AAP members (ie., recruiters) may be allowed to post jobs on the listserv by providing AAP with an unrestricted educational grant of no less than $500 for a one time opportunity to post an advertisement. Non-AAP members will be directed to the President-Elect who will inform them of the guidelines, provide them with the advertisement format, accept the advertisement and grant funding, and finally place the ad on the listserv after receipt of payment.
4) If a member of the AAP listserv posts a job without authorization, the President-Elect will inform them in writing of the infraction and let them know they will be removed from listserv in the event of a second occurrence. These guidelines will be sent out to the listserv on a quarterly basis as a reminder to AAP members and will be posted on the AAP web site.
5) The President-elect makes the final decision on allowing an advertising request to be posted. He/she should seek consultation from the AAP board if there is any doubt that maybe a specific situation and/or request does not warrant approval.

"Excellent meeting…I'm impressed with the talent of my colleagues." "The day was very informative and helpful discussions on very relevant topics." "I am very glad I came and will look forward to our next meeting." These were some of the comments following a wonderfully successful Fall Educational Conference held on November 8 in Washington, DC. Forty-one participants, including seven new AAP members attended the program held jointly with the American Association of Chairs of Departments of Psychiatry. This year, the Program Committee, led by President-Elect ***Kevin Johnston****, developed a "track" format allowing attendees to select from concurrent sessions on research, education and clinical issues. There were additional general sessions for all participants, including the inaugural Norman MacLeod Fall Lecture, presented by Martin Lazoritz, MD of the University of Florida School of Medicine. Special thanks must go to Kevin and the Program Committee as well as to all of the members generous enough to give of their time to write the following sessions summaries.*

Norman MacLeod Fall lecture

Faculty clinical productivity and successful business practices

by Joe Thomas

The inaugural Norman MacLeod lecture was given at the Fall AAP meeting held in Washington D. C. on November 8, 2003 by **Dr. Martin Lazoritz,** Associate Chair for Clinical Operations and Medical Director, Department of Psychiatry, University of Florida College of Medicine University of Florida College of Medicine.

Dr. Lazoritz was entertaining, thought-provoking and very interesting. He said that in his current role his goal is to "predict the future so systems of care can be developed to meet future demands." Dr. Lazoritz reviewed the changes in delivery of care from fee-for-service to managed care and the practice and financial implications of those changes.

Currently, we are all faced with an increase in self-pay patients, a decrease in psychotherapy and an increase in medical management with shorter

visits. In order to meet the demands that these changes bring, we must find ways to increase efficiency and decrease cost. He gave examples of practice being utilized at the University of Florida to overcome many of the challenges faced by Psychiatry.

Dr. Lazoritz pointed out that quality sells but that we need to show that we have high quality and for this we need outcome data. We must also make it easy for patients to get into our system. In many academic institutions today, revenue from clinical contracting is exceeding the traditional on-site clinical revenue. He challenged us to always look for the "obvious that people don't see" and capitalize on those opportunities. In marketing our programs, we should "just say yes" to opportunities and develop the systems to take advantage of the opportunities.

To be successful, we must know "who we are," what is our mission, what products we can offer, who are our customers, what is our service area and what are our sources of funding.

Dr. Lazoritz stayed with us for the remainder of the day and for our evening dinner. His perspective, comments and questions during the remainder of our program was also extremely helpful to the assembled group.

(Joe Thomas is the administrator of the University of Michigan department of psychiastry).

Clinical trial program development

by Jeff Charlson

Debbie Pearlman (Yale University) and **Dan Hogge** (U Utah) presented us with two very informative presentations on the benefits and risk considerations of building a Clinical Trials Program. Some of the risks to identify and manage are regulatory/ compliance, IRB, billing compliance, patient safety, and finance (particularly cash flow and early study terminations) and accounting.

Debbie reviewed the phases of drug and device trials. Phase one trials seek to find a safe dosage and involve typically 15-30 subjects. Phase two trials are designed to prove efficacy and may involve 100 or less subjects. Phase three is the largest pre-market clinical trial that could involve thousands of subjects and seeks to compare a new device/ treatment to an existing standard.

Both Dan and Debbie stressed the point that fees are very negotiable with sponsors and you should strive to negotiate the deal that optimizes not only the best total anticipated payment, but also

provides advantageous payment timing and provisions for up-front payments and cancelled study

payments.

Dan presented some budgeting templates that were developed at Utah to help with proper cost identification and tracking. The system at Utah also computed a Profit and Loss statement for each of the projects and provided per subject detail as well. Debbie and Dan presented the group with many helpful handouts/checklists/budget templates used to help manage their clinical trials projects.

These presentations generated a significant and lively discussion with many AAP members sharing hints and traps to avoid. For institutions that want to get clarification about what clinical services can be charged to a study subject's insurer, the general consensus was to not make generalizations but talk to your compliance officer and perhaps even get a written opinion from CMS. Other members suggested looking into media placement consulting to optimize subject recruitment advertising.

It is very clear that developing a clinical trials program can provide many benefits. However, there are many risks to be managed and an organized approach is key to achieving these benefits.

(Jeff Charlson is the administrator of the University of Wisconsin department of psychiatry).

Clinical contract management

by Cynthia Smith

Tony Bibbo (U Maryland) and **Marti Sale** (U Kentucky) co-led a discussion on contract management. Tony described his approach as basic "Blocking and Tackling" of contract management. The strategy he uses is to determine the financial threshold

that is acceptable to the department and then compare current contracts to this threshold. Tony determined the outpatient cost per visit per hour and used that figure in a break-even analysis to calculate the hourly revenue required contracts. Using this figure as the benchmark, Tony

Continued on page 8

Continued from page 7

compared reimbursements from other payors to determine which contracts to retain and which ones might be discontinued. He has also calculated a table of Suggested Hourly Rate Guidelines for Outside Services Provided by Faculty. This table shows the hourly rate by salary range required to break even. Future plans are to use these tools to evaluate opportunities, expand only where financially intelligent to do so, and explore other potential growth areas such as telepsychiatry and services at other hospitals within the University of Maryland system.

The University of Kentucky has 47 contracts totaling 65% of clinical revenue. The physician/clinician time is the only prohibitive factor for contracts. The physicians/clinicians are given clinical targets that imply some contractual work. If clinical targets are not met, salary can be reduced.

Marti negotiates all contracts. She has a very centralized approach to managing the contracts. An accounting clerk processes the contract billing on a monthly basis. Marti's suggestions are that psychiatry departments should negotiate their own contracts, physicians/clinicians should have clinical targets, and look for the balance between contractual obligations and inpatient/outpatient care.

(Cynthia Smith is the administrator of the Washington University (St. Louis) department of psychiatry).

Integrating family practice with psychiatry

Pat Sanders Romano, Executive Director, Psychiatry, Albert Einstein College of Medicine, led a discussion on a topic which continues to be a major interest to many academic psychiatry and primary care departments. Pat gave an overview of how the program at Albert Einstein College of Medicine (AECOM) evolved from the mid-1980's by linking services for treatment of substance abuse services for treatment of addictive diseases with primary care patients in outpatient clinics, to the current day era of a network of 12 community-sited programs in the Bronx, NY providing comprehensive on-site care to include general primary care, HIV-related primary care, TB screening, OB/GYN, prenatal care, disease management, psychiatric care, dental services, and an array of drug treatment services. Substance abuse treatment often is the link

between the patient and these two important dimensions of treatment: primary care and mental health services. Consolidating primary and psychiatric care into one location enhances geographic access to care, and integrates care to provide treatment of the "whole person." It also develops on-site expertise in complex medical management issues, and reaches a high concentration of patients with or at high risk for drug-use related conditions.

The integration of primary care and psychiatric care does have barriers to overcome, including the challenge of providing efficient services, and the financial challenges of non-billable interdisciplinary, integrative work in treating substance abusers. Potential cultural clashes can be improved by a clearly defined mission statement, combined basic and clinical research opportunities, combined teaching opportunities, and by recruiting double boarded MD's (for example, boarded in Psychiatry /Family Medicine or Psychiatry/Internal Medicine). The linkage has also been enhanced by the Substance Abuse Consultation and Referral Service (SACRS), which is a hospital based team of internist and psychiatric social workers to optimize inpatient care of drug users.

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

Conflict management

by Dan Hogge

Is conflict in the workplace a good thing or a bad thing? Do you know what type of conflict manager you are? Can you pick a strategy that will fit the type of conflict? According to **Lee Fleisher** (Vanderbilt U), a successful manager needs to recognize, understand, and develop skills that will provide the appropriate approach to conflict resolution.

A self-administered questionnaire allowed the conference attendees to assess how they think they normally respond to conflict. The quiz provided thought provoking questions that were geared to help us understand our own negotiating behaviors.

After scoring our exam, Lee defined and explained the negative and positive aspects to conflict. If we fail to recognize these aspects and don't effectively deal with these issues we will fail to glean the value that can come from channeling our energy towards a reasonable solution.

There are generally four types of conflict: A win or lose situation; a collaborative scenario; a mixed situation; and a low interdependency situation. Each situation has a different level of conflict intensity and each require different levels of compromise and collaboration. Lee explained that many of these conflict situations can be observed thru indicators like our body movement, expressions, statements, a lack of respect, and candor.

Lee encouraged us to review five different forms of reaction

styles and their characteristics. Each of these styles has a place in negotiating conflicts and we should learn their applicability.

1) Competing- A tough position to pursue one's own position with whatever power needed to win.
2) Accommodating-The opposite of competing and neglect your own concerns.
3) Avoiding- Does not pursue either position to avoid any conflict.
4) Collaborating- Both assertive and cooperative.
5) Compromising- The goal is to find an expedient solution.

Each of these styles can be beneficial to our management style but on the opposite side of the spectrum, if we overuse or underuse these techniques a person can feel the impact. For example, an overly accommodating person can be seen as weak or not having much self-respect. On the other hand, an individual who underutilizes the technique can be as been very rigid or unreasonable. Choosing an appropriate approach obviously is not easy but understanding the potential impact is critical.

Good social and people skills are very important as we approach a solution for conflict resolution. Lee reviewed the importance of separating people from the problem, establishing goals, never assuming what others think, never placing labels on people, forgeting the past, and focusing on interests not positions.

Lastly, Lee explained how negotiations can become positional based on wrong assumptions. To avoid these stumbling blocks we should negotiate from a position of common ground and mutual interests. If we clarify the "real problem" we can be satisfied and successful in our negotiations.

How do we uncover what the interests are and find a common playing field? Lee outlined questions that are helpful to ask: What is the real problem? What concerns do you have? What are your fears concerning this? What exactly do you want from me? If we offer the opportunity to an individual to explain his position then we are more likely to successfully find a reasonable and correct answer.

Obviously, searching for a joint solution is the goal. If we enter negotiations having remembered some of these critical components of conflict management techniques we are likely to find the solutions that best fits the issue. Generating as many options as possible and searching for viable trade-offs can lead to a mutually beneficial solution and will help lead us to the best outcomes.

(Dan Hogge is the administrator of the University of Utah department of psychiatry).

Take two minutes

by Jim Landry

One of the more popular segments at our conferences is the "Take Two Minutes" session. This session provides a forum for members to ask a question and get responses from our peers around the country as to how issues are handled at other universities. What follows is a recap of the questions and responses from this session. I would like to thank **Brenda Paulsen** (U Arizona) for assisting me in this session by recording the questions and answers.

Jan Price (U Michigan) led off the discussion by asking if anyone pays incentives for inpatient work (not weekend call). **Howie Gwon** (Johns Hopkins U) responded that when a faculty member leaves and there is a gap of faculty coverage for a unit, members of the remaining faculty receive incentive for coverage until new faculty is hired. **Jim Landry** (Tulane U) stated that the hospital provides funding for medical directorships and clinical directors. Each faculty member is responsible for finding his or her own coverage.

Dan Hogge (U Utah) had a faculty member who assumed the practice of another who was not compliant with regard to documentation. Consequently, the audit has been expanded. Dan's question was whether this happened at other universities and who helped resolve the issues – lawyers, compliance office, etc. **Lee Fleisher** (Vanderbilt U) stated that they have a central compliance office, and when an issue was detected the monies were refunded, and the quality

assurance office was involved. One member suggested that the review not be expanded, but refund monies per the sample. Dan noted that Utah required a retrospective audit. **Margaret Moran** (Medical College of Ohio) stated that her faculty is charged $75 an hour for an audit and non-compliant charges refunded; all bills are held until the compliance office is satisfied.

Tom Tantillo (Children's Hospital of Philadelphia) inquired if a faculty member is supposed to have 75% of his time available clinically, what are the expectations if he does not perform that much time in clinic. **Kevin Johnson** (Indiana U) stated that productivity is based on revenue not sessions. **Jim Landry** stated that the first year salary is guaranteed, but after that if revenues are not generated, salaries are reduced. Tom asked if faculty pick patients with the best reimbursement. Kevin responded that they are not allowed to pick and choose. **Radmilla Cassidy** (Southern Illinois U) stated that productivity is RVU based. **John DiGangi** (U Massachusetts) stated that RVU's determine percentage of clinical salary. If they exceed RVU production, they are eligible for incentive pay. There is no down side for salary if they do not meet the RVU goal. Tom then asked, "If they do exceed their goals do they get a piece of what's left over if the department has losses?" **Charles Boyd** (U Alabama) stated that if the department is in a deficit position then there are no physician incentives paid.

Cindy Smith (Washington U) wanted to know if anyone provided hospitalist-type services to private psychiatrists? Cindy is looking into a hospitalist model for physicians covering for community physicians who are in inpatient units. **Elaine McIntosh** (U Nebraska) stated that sometimes the community doctors don't always take patients back. Currently they only have a 10-bed unit, so there is no capacity. **Lee Fleisher** stated that they use a hospitalist model, but most community doctors like to follow their own patients. **Debbie Pearlman** (Yale U) explained that in her program, inpatients are covered by community and hospitalist physicians. Their community providers do not want to come into an inpatient unit.

Cindy was also interested if anyone was involved in palliative care. If so, who pays and is it financially self-supportive. **Charles Boyd's** program has psychiatrists and internal medicine doctors. The program was big about five years ago, but now is a money loser. Services are moving over to internal medicine. **Howie Gwon** stated that if other departments offer to pay full salary for services – take it!

Tony Bibbo (U Maryland)

Continued on page 11

Continued from page 10

was interested to know if we had noticed severity of medical needs increasing for psychiatric inpatients, and what did we do about medical consults. **Jan Price**, felt that the severity had increased noting that patients are medically more ill. For medical needs they use consults, but are looking at developing a clinical nurse specialist model. There is no medical doctor on the unit. **John DiGangi** stated that the hospital funds an internist and a nurse practitioner that is psychiatrically trained. Contracts are for bundled day rates. Medicare is billed for professional component. **Howie Gwon** uses a hospitalist for medical needs. They discharge to medical unit for billing purposes.

Liz Smith (Thomas Jefferson U) is faced with obtaining consent for each medication. Liz wanted to know if anyone else had to do this. **Jan Price** explained that the Michigan Mental Health Code requires inpatients to have signed informed consent. Outpatients only need consents if they are Medicaid patients. **Patrice Guild** (Thomas Jefferson U) said that the State now requires the doctor to explain medication on the inpatient unit. Jan Price further added that the mental health code does not apply to outpatients in Michigan.

Debbie Pearlman inquired if anyone still used NPs and LPs? Yale stopped using them because they are not cost effective. **Tom Tantillo** stated that under a hospital system they are cost effective. **Howie Gwon** agreed. Maryland is still using mid level providers under the hospital system.

Warren Teeter (Wake Forest U) stated that with mental health centers closing, Medicaid patients are flooding the University inpatient unit. At Wake Forest they have to accept Medicaid patients even if they are not emergencies. Warren is currently negotiating with BCBS for "reserving" 5 beds. No one else would be able to access the beds so there is some financial protection. **Cindy Smith** has a situation where she has a wait list from the ER and other units in the hospital. They want to take wait list patients instead of the non-insured emergency patients. **Jan Price** thought that if an emergency room patient was well enough to be on a wait list, they were not sick enough to be admitted. In Cindy's case the hospital states that the occupancy rate was too low while doctors are saying they can't find beds – ICU vs. step-down. **Margaret Moran** holds one bed for emergency and local crisis on their adolescent unit. Their worst payer is managed care. **John DiGangi** is looking at the same bed reservation system as Warren. John felt that a separate unit that is just BCBS may be needed for legal reasons. Also, each of the physicians is limited to the number of patient beds, so then they do not have to take more patients if there is a bed available.

Beth Deley (Ohio State U) wanted to know if most inpatient doctors only work inpatient or do they do everything. **Kevin Johnson** felt inpatient doctors only work inpatient, and that outpatient doctors do a little of everything including research. **Tony Bibbo** stated that adult inpatient only do inpatient, but burn out. **Jan Price's** faculty work 5-7 months on inpatient and outpatient doctors cover weekend and holidays. Quality of care on weekends is poor. Doctors don't want to discharge patients they haven't been following so length of stay is longer than necessary. Jan's division is looking at having a core group of inpatient specialists, not necessarily full time. Beth was curious as to what Jan's faculty did with the remainder of their time. The balance of time includes research, administration, etc. The faculty finds that when they are on the inpatient unit they can't do anything else.

Susan Fleming (U Arkansas) does not have an inpatient unit. From a financial perspective would we recommend a unit? **John DiGangi** stated "size matters – if the unit is too small it won't be effective." John felt to be cost effective, 20-25 beds were needed on an adult unit. **Tom Tantillo** suggested looking at marketing conditions – What are payers willing to pay? Some payers will pay $500 a day, but your expenses could be more. **Kevin Johnson** stated that it was lucrative to have an inpatient faculty member who did inpatient research.

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

It wasn't all work and no play!

Institute of Medicine report
"Research training in psychiatry residency – Strategies for reform"

by Jim Landry

The Institute of Medicine recently released a draft of a report entitled, "Research Training in Psychiatry Residency – Strategies for Reform." The following is the abstract from that report:

"The neural and behavioral sciences have advanced tremendously in recent years, and there has been a concomitant increase in public awareness of mental disorders. Psychiatrists are on the front line of treating mental illness. Some psychiatrists also serve as patient-oriented researchers, advancing psychiatric care through investigation aimed at helping those with or at risk for mental disorders. Unfortunately, the number of psychiatrist-researchers does not appear to be keeping pace with the unparalleled needs that currently exist in clinical brain and behavioral medicine. The need is especially acute in child and adolescent psychiatry. In this context, the National Institute of Mental Health asked the Institute of Medicine (IOM) to convene a committee to study research training during psychiatric residency. The IOM committee was charged with considering (1) the goals of psychiatric residency training, (2) programs that train researchers successfully, (3) obstacles to efficient research training, and (4) strategies for overcoming those obstacles.

"The committee found that significant influences on research training span three major conceptual categories: regulatory, institutional, and personal factors. Cutting across these factors are the ubiquitous and overlapping issues of time and money, and the competing demands of patient-care activities. A considerable time investment – 2 to 4 years- beyond core clinical training is typically required for successful research training. Therefore, the committee concluded that more and better residency-based research training may have the important and dual benefits of optimizing the length of training for, and solidifying research career interests of, greater numbers of junior psychiatrists.

"Regarding regulatory factors, a review of the psychiatry residency accreditation requirements led the committee to conclude that these requirements should be modified to afford more training time for research experiences and general research literacy. Institutional factors of greatest importance were found to be supportive leadership and the involvement of research faculty as residency educators and mentors. A review of personal factors revealed motivation and drive, family demands, gender, and race as important factors relevant to research training in psychiatry. This finding led the committee to conclude that a more diverse group of trainees needs to be persuaded that research careers in psychiatry are worthwhile. Greater financial incentives (through stipend supplements or debt repayment) and more aggressive promotion of the benefits of participation in psychiatric research are recommended as strategies to enhance trainee recruitment.

"In addition to time and money, overarching themes of this report are that residency-based research is limited because of the demands of clinical training, and thus that successful research training typically requires the linkage of residency to postresidency research fellowships. There is little evidence to support any particular approach to training patient-oriented investigators. Given that the existence of a large research effort (i.e., many investigators and substantial funding) is the most salient feature of successful programs, child and adolescent psychiatry divisions and small programs in general will likely require outside collaborations to develop a critical mass of resources for effective research training. Finally, while there are numerous efforts under way to enhance research training in psychiatric residency, the committee recommends the formation of a national coordinating body to develop, implement, and evaluate strategies toward that goal."

Response to the IOM Report

"A 1989 survey found that only 15 percent of psychiatrists **who are faculty at U.S. medical schools** spent more than half of their professional time engaged in

Continued on page 14

Continued from page 10

research (Pincus et al., 1993), and more recent surveys conducted in 1999 and 2000 showed that fewer than 2 percent of **all** U.S. psychiatrists consider research their dominant activity (AAMC, 2002b)." This statistic is cause for great concern for the future of psychiatric research. The IOM report is challenging us to ensure that there is a next generation of psychiatric researchers.

In an effort to draft a response to the IOM report, **Joel Silverman, M.D.,** President of the AACDP held an executive session of the AACDP on Saturday, November 8, 2003 and invited stakeholders from various organizations to participate in an initial meeting to draft a response to the IOM. The stakeholders included representatives of several organizations, including Institute of Medicine Report Committee; American Association of Chairs of Departments of Psychiatry; National Institute of Mental Health; National Institute on Alcohol Abuse and Alcoholism; American Psychiatric Association; American Association of Child & Adolescent Psychiatry; Residency Review; Association for Academic Psychiatry; American Board of Psychiatry and Neurology; American Association of Directors of Psychiatric Residency Training; Administrators in Academic Psychiatry. (For a complete list of the representatives to the committee, contact Jim Landry at jlandry1@tulane.edu).

The initial recommendation of the committee is to request NIMH to empower the AACDP as the coordinating body to develop, implement, and evaluate strategies toward the goal of increasing psychiatric research.

As this discussion unfolds, our role as administrators needs to be focused on finding ways to fund a research component of our residency training programs. We need to look at traditional sources, but more importantly we need to be creative and develop new streams of revenue that have not been previously tapped.

Finally, following is the "Summary of Recommendations" from the IOM Report for your review.

Summary of Recommendations

Topic	Number	Recommendation	Obstacle Addressed
Longitudinal perspective	2.1	Foster coordinated multiyear research training experiences.	Research opportunities are fragmented across the multiple levels and years of training.
Regulatory	3.1	Increase the flexibility of training requirements.	Clinical requirements are excessive and prevent tailored training.
	3.2	Require research literacy.	Many training programs lack research education components.
	3.3	Require researcher membership on regulatory bodies.	Researchers are not sufficiently involved in setting expectations for training curricula and achievement of competencies.
Institutional Factors	4.1	Encourage executives to invest in mental health research.	Resources to support research training are limited; stigma works against optimal mental health care funding.
	4.2	Encourage research faculty involvement.	Researchers often are not involved in direct resident training.
	4.3	Create patient-oriented research training curricula.	Curricula are needed that incorporate research training across the range and time constraints of residency programs.
	4.4	Support emerging programs.	Resources to move programs to the next level of research training are scarce.
Personal Factors	5.1	Increase financial compensation to trainees.	Education debt and low compensation deter the choice of a research career.
	5.2	Develop strategies to attract trainees to patient-oriented research.	Trainees have pessimistic views of research careers and can be uninformed about research opportunities.
	5.3	Develop women researchers.	Talent is underutilized.
	5.4	Develop international medical graduate researchers.	Talent is underutilized.
	5.5	Develop minority researchers.	Workforce diversity is lacking; talent is underutilized.
Overaching Recommendation	6.1	Establish a national coordinating effort.	Monitoring data are lacking, and there is no centralized plan for research training.

Requirement of DUNS number

NOTICE: NOT-OD-03-055
National Institutes of Health (NIH)

Effective October 1, 2003, use of the Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number will be required when applying for Federal grants or cooperative agreements. (See June 27, 2003 Office of Management and Budget Federal Register Notice http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2003/03-16356.htm).

A DUNS number must be included in every application for a new or competing continuation grant or cooperative agreement. The identifier will be used for tracking purposes, and to validate address and point of contact information. The DUNS number will be required whether an applicant is submitting a paper application or using the NIH Commons or Grants.gov to submit the application.

Applicant and grantee organizations should verify that they have a DUNS number or take steps needed to obtain one as soon as possible. Organizations that do not have a DUNS number can receive a DUNS number at no cost by calling the dedicated toll-free DUNS number request line at 1-866-705-5711 or URL http://www.dunandbradstreet.com. The requirement for a DUNS number applies to all organizations that apply for NIH grants and cooperative agreements. Non-affiliated Individuals who apply for a grant or cooperative agreement are exempt from this requirement.

NIH has developed a Question and Answer sheet to provide additional guidance for the grantee community on this new requirement. It is located at http://grats.nih.gov/grants/duns_qa.doc.

For further information on this new Federal-wide requirement please contact: Sandra R. Swab, Office of Federal Financial Management, Office of Management and Budget, at 202-395-5642, or e-mail sswab@omb.eop.gov.

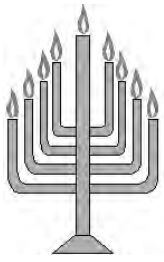
Notice regarding change of receipt dates for cutting edge basic research awards (CEBRA) for NIDA, PAR-03-017

NOTICE: NOT-DA-03-005
National Institute on Drug Abuse

Effective with the October 1, 2003 receipt date, the Cutting Edge Basic Research Awards (CEBRA) applications will be accepted for only two receipt dates per year – October 1 for the May Council and February 1 for the September Council. The CEBRA program announcement was published on October 30, 2002 at http://grants.nih.gov/grants/guide/pa-files/PAR-03-017.html.

Direct any questions about this notice to Jackie Porter, Office of Extramural Affairs National Institute on Drug Abuse/NIH/DHHS 6001 Executive Boulevard, Room 3158, MSC 9547 Bethesda, MD 20892-9547 at (301) 443-2755 or email jporter@mail.nih.gov.

May the joy of this holiday season Last the whole year through.



Update of the PHS 398, 2590 and 416 forms

NOTICE: NOT-OD-03-062
National Institutes of Health (NIH)

In response to comments and suggestions from the research community on how NIH can continue to improve the application forms to make them more user-friendly, NIH has made several formatting enhancements to the PHS 398, 2590 and 416 forms. Applicants who are experiencing difficulties with earlier versions of the forms are encouraged to use the recently updated forms. If you have not encountered problems, and you downloaded the forms to your personal computer, you may continue using the set of forms previously posted.

The forms are now more compatible with existing software and Microsoft Word (MS Word) files. In addition, forms links in the instructions have been updated to reflect these changes. Institutions may want to link to the PHS 398 Forms and Instructions page rather than maintaining copies of forms on internal web sites, to be sure the most current forms are available for applicants.

A complete listing of all of the changes is available at http://grants2.nih.gov/grants/guide/notice-files/NOT-OD-03-062.html.

NIH will continue to inform the public of notable changes to the documents and forms through the "NIH Guide" and the "NIH Forms and Applications Page" (http://grants.nih.gov/grants/forms.htm.) Applicants are urged to always check the PHS 398 and PHS 2590 websites to download the most current versions of the instructions and forms prior to submission of an application to NIH.

For other inquiries, please do not hesitate to contact grantsinfo@nih.gov or 301-435-0714.

Publication of the revised NIH grants policy statement (Rev. 12/03): Policy changes, clarifications, and enhancements

NOTICE: NOT-OD-04-009
National Institutes of Health (NIH)

The National Institutes of Health (NIH) is pleased to announce the publication of the revised NIH Grants Policy Statement (NIHGPS, rev. 12/03). The NIHGPS (12/03) is applicable to all NIH grants and cooperative agreements with budget periods beginning on or after December 1, 2003. This revision supersedes, in its entirety, the NIH Grants Policy Statement (03/01) as a standard term and condition of award. However, the March 2001 NIHGPS continues to be the standard term and condition for all NIH grants and cooperative agreements with budget periods that began between March 1, 2001 and November 30, 2003. The NIHGPS provides both up-to-date policy guidance that serve as NIH standard terms and conditions of awards for grants and cooperative agreements, and extensive guidance to individuals that are interested in NIH grants. The NIHGPS (rev. 12/03) incorporates NIH policy changes since March 2001, public policy changes, policy clarifications, as well as document enhancements. Sections of the revised policy statement have been rewritten to provide clarity; however, the overall policies in these sections have not changed. The document is available in both HTML and PDF formats at http://grants.nih.gov/grants/policy/nihgps_2003/index.htm. Links to the 10/98 and 3/01 NIHGPS will remain the same. NIH will publish interim grants policy changes through the issuance of NIH Guide Notices. Each change will be described, including its applicability and effective date; and the necessary language to implement it as a term or condition of award provided. amount charged in access of the Federal share of costs for the project period (competitive segment)."

Additional questions about the NIHGPS may be directed to the NIH Division of Grants Policy at (301) 435-0949 or the Grants Management Specialist that is identified on the NIH Notice of Grant Award.

CMS outlines appeal process for intermediaries

The Centers for Medicare & Medicaid Services recently handed down guidelines for appeals processing. Intermediaries and carriers should use the priorities set out by CMS in Aug. 22 program memorandum AB-03-133 when "the budget amount is insufficient to adequately perform the required functions" for appeals, CMS says. In general, intermediaries should use a first-in, first-out method to process appeals and manage workload; however, during times of limited resources it may become necessary to prioritize the processing of appeals to more efficiently manage the workload. Contractors are able, however, to establish their own set of priorities differing from the CMS recommendations.

Topping the appeals priority lists are implementing decisions from a variety of bodies ranging from administrative law judges and the Departmental Appeals Board down to medical review. At the bottom of the priority list are forwarding hearing files that don't contain the necessary documentation in the required timeframes. That means if you don't have all your documentation in order when you file your appeal, you may not receive consideration from your intermediary any time soon.

To see the memo, go to www.cms.gov/manuals/pm_trans/AB03133.pdf.

CMS consolidates Medicare coverage policies

A centralized database of national and local policies affecting the coverage of medical services for Medicare beneficiaries is now available. The Medicare Coverage Database includes national coverage decisions, national coverage analyses and final local medical review policies (LMRPs)—replacing all policies previously posted on http://www.lmrp.net/. Part of the new initiative requires Medicare carriers to update all local policies posted to the database and monitor them for accuracy. The database is available online at http://www.cms.hhs.gov/mcd.

MGMA News

MGMA™ Medical Group Management Association

CMS Launches New Practice Administration Homepage

The Centers for Medicare & Medicaid Services (CMS) announced a new "Practice Administration Information Resource" web page during the MGMA 2003 Annual conference in Philadelphia. This new web page was developed by the MGMA Government Affairs Department in conjunction with CMS. The practice administration home page includes links to Medicare payment, billing, coding, enrollment, participation and much more. MGMA members can use this web page to simplify navigation throughout the CMS web site. You'll find the new site at http://www.cms.hhs.gov/providers/pair/.

The college corner

Erwin's perseverance pays off with board certification

by David Peterson, FACMPE

It is a great pleasure to announce that **Richard Erwin Jr. CMPE**, Manager, Business & Fiscal Operations for the Department of Psychiatry in the School of Medicine at Columbia University of Missouri, recently achieved Board Certification in the American College of Medical Practice Executives (ACMPE). By achieving his boards, Rich has advanced to **Certified Medical Practice Executive (CMPE**) in the College and is now positioned to continue his advancement to **Fellow** status **(FACMPE)** in the College.

Board certification is awarded when a candidate has met the continuing education requirement and passed the 3 part exams: the objective exam, essay exam and presentation requirement. Having already passed 2 parts of the exams, Rich passed the essay portion of the exam that was offered in Chicago early this year which allowed his advancement to certified status.

According to Rich, it was the belief that the credential would add to his professional body of experience that helped him persevere through the exam process. Says Rich, "I stuck with it to know for self-justification of what I do and to prove to myself that I could do it. I am only the third person here [at Columbia] to ever get it [certified status] and currently the only one here."

Rich Erwin

Rich's next step in the College advancement process is to work toward Fellow status. Certified candidates working toward Fellowship in the College must successfully write a peer-reviewed professional paper or three case studies. Rich recently attended a seminar offered by the College to help clarify the Fellow process, but he isn't yet sure what his topic will be and whether it will take the form of a paper or 3 case studies.

An AAP member new to the College is **Carol Thomas**, Business Administrator for the Department of Psychiatry at the University of Louisville. According to Carol, "the main reason that I decided to join was to the make the commitment to sustained continued education in our field. The educational programs that I have attended through the MGMA have been excellent and the variety of topics covered allows me to focus on areas that are directly related to my responsibilities. I always bring back several useful and innovative ideas that can be integrated into our clinical programs. I have found that given my diverse duties as department and clinical practices administrator, it is easy to get caught up in the day-to-day activities and to put continuing education at a lower priority than I should. I believe that the commitment to ACMPE certification to enhance my skills and knowledge base is also my commitment to our department and its mission."

Another AAP member who recently joined the College is **Jennifer Tunget**, Assistant Business Administrator in the Department of Psychiatry at the University of Louisville.

Professional advancement, fulfillment and continuing education are common denominators that link College members. Congratulations to Rich for his successful completion of his boards and to Carol and Jennifer for their start in the process.

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) 456-8990, email at peterson@mcw.edu or at the Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wisconsin 53226.

Coming attractions

NCURA: Financial Research Administration V
February 29-March 2, 2004
"Maximizing Our Assets"
San Diego, California
http://www.ncura.edu/conferences/frav/

American College of Mental Health Administration
March 10-13, 2004
"Regaining Relevance: Reinventing Behavioral Health"
Santa Fe, NM
http://www.acmha.org/

National Association of Psychiatric Health Systems
March 14-16, 2004
"Making Vision a Reality"
Washington, DC
http://www.naphs.org/AnnMeeting/index.html

Administrators in Academic Psychiatry Spring Conference
May 1, 2004
Seattle, WA

Academic Practice Assembly Annual Conference
May 2-3, 2004
Seattle, WA

Medical Group Management Association
October 3-6, 2004
San Francisco, CA
http://www.mgma.com/education/annconf/

Academic Practice Assembly/
American Assoication of Chairs of Departments of Psychiatry Fall Conference
November 5-6, 2004
Boston, MA

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

CONGRATULATIONS . . .
to John DiGangi on completing his Bachelors degree.
Way to go, John!

HHS issue guidance regarding services to limited English proficient persons

On August 8, 2003, the Department of Health and Human Services (HHS) published a revised Guidance to Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient (LEP) Persons. The original Guidance was published in 2000, following an Executive Order entitle "Improving Access to Services for persons with Limited English Proficiency." Under that order, federal funds recipients (hereafter "recipients") must not "restrict an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service . . . under the program." Specifically, for healthcare providers, LEP persons must have available to them the same services as any other persons.

Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may fit the definition of limited English proficient and may be eligible to receive language assistance with respect to services they may receive.

All recipients are required to take reasonable steps to ensure meaningful access to their programs and activities by LEP persons. While designed to be a flexible standard, the starting point is an individualized assessment that balances the following four factors:

• *The number or proportion of LEP persons eligible to be served or likely to be encountered by the program*. The recipient should determine the number or proportion of LEP persons from a particular language group served in the eligible service population. When calculating this number, the recipient should consider whether the minor children their programs serve have LEP parents or guardians with whom the recipient may need to interact.

• *The frequency with which LEP individuals come in contact with the program*. Recipients should assess the frequency with which they have or should have contact with an LEP individual from different language groups seeking assistance. The more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed. In applying this standard, recipients should take care to consider whether having enhanced language services for LEP persons could increase the frequency of contact with LEP language groups.

• *The nature and importance of the program, activity or service provided by the program to people's lives*. The more important the recipient's service or program, or the greater the possible consequences of the contact to the LEP individuals, the more likely language services are needed. Thus, emergency room services are of greater consequence than a tour of a hospital's facilities.

• *The resources available to the recipient and costs*. A recipient's level of resources and the costs that would be imposed on it may have an impact on the nature of the steps taken to comply with Title VI.

The HHS Guidance defines both oral (interpretation) and written (translation) services. All recipient provided languages services must be provided at not charge to the LEP individual. For recipients concerned with costs, volunteer interpreters are a reasonable alternative. Family members may be appropriate in situations where the service provided is of a routine nature. However, in aa case where the nature of the service becomes more complex, depending on the circumstances, the recipient should make a determination as to the competence of the person to interpret.

The plan ultimtely developed by the recipient should incude ways in which language assistance willl be provided. It should define the types of services available; how to provide notice to LEP persons of the availability of language service; how to provide notice to LEP persons of the availability of language services; how staff can obtain these services; how to respond to LEP callers, in person individuals and written communication; and how to ensure competency of interpreters and translators. These plans should be monitored and updated as necessary as new needs arise.

The goal for Title VI enforcement is to achieve voluntary compliance. HHS provides outreach through its several agencies, cincluding Centers for Medicare and Medicaid Services (CMS). Complaints will be investigated, with a report of the determination and information on the steps necessary to achieve compliance. If matters cannot be resolved informally, federal assistance can be terminated.

Information about LEP requirements, as well as the full Executive Order and Guidance, can be found at www.lep.gov.

OIG sets new work plan for FY2004

The Office of Inspector General has set forth its Work Plan for fiscal year 2004, which began Oct. 1, 2003, is essentially a compendium of the agency's anticipated activities for the coming year. The plan lists dozens of new audits and investigations in the works, including several that could impact psychiatry practices and hospitals.

Following are selected provisions that might be relevant to practices of AAP members.

To see the entire work plan, go to <http://oig.hhs.gov/publications/docs/workplan/2004/Work%20Plan%202004.pdf>.

Consecutive Inpatient Stays

We will examine the extent to which Medicare beneficiaries received acute and postacute care through sequential stays at different hospitals. Although Medicare allows care in different facilities according to the beneficiary's needs, payments may be denied when one or multiple stays constitute an attempt to circumvent the prospective payment system. We will analyze claims to identify questionable patterns of inpatient and long-term care. *(OEI; 03-01-00430; expected issue date: FY 2004)*

Medical Necessity of Inpatient Psychiatric Stays

This review will determine the extent that any improper Medicare payments for inpatient psychiatric stays were due to medical necessity or coverage issues. Prospective payment system-exempt psychiatric units and specialty hospitals received over $2.8 billion for Medicare inpatient stays in 2000. Medical reviews of outpatient psychiatric services provided by prospective payment hospitals and specialty psychiatric hospitals found very high rates of unsupportable or unallowable services (58 percent and 42 percent, respectively). We will also assess the ability of controls to detect improper payments for inpatient psychiatric services. *(OEI; 00-00-00000; expected issue date: FY 2005)*

Claims for Residents of Institutions for Mental Diseases

Our review will determine whether States improperly claimed Federal Medicaid funds for 21- to 64-year-old residents of private and county institutions for mental diseases. Our prior work found that some States did not comply with Federal regulations prohibiting Federal funding for services provided to such patients. We will also determine if improper claims were made for residents of institutions for mental diseases who were under age 21. *(OAS; W-00-03-31005; various reviews; expected issue date: FY 2004)*

Outpatient Alcoholism Services

We will determine whether providers were reimbursed for improper claims for outpatient alcoholism services. Medicaid reimbursement is available for outpatient alcoholism services provided in hospital-based or free-standing clinics. Prior work identified significant noncompliance with Federal and State regulations. In several States, we will conduct reviews at the providers that receive the largest amounts of Medicaid reimbursement. *(OAS; W-00-04-31079; various reviews; expected issue date: FY 2004)*

Payments to Psychiatric Facilities Improperly Certified as Nursing Facilities

We will determine whether psychiatric facilities have been improperly certified as nursing homes and quantify any resulting inappropriate Medicare and Medicaid expenditures. Medicare is prohibited by statute from certifying any nursing facility that is "primarily for the care and treatment of mental diseases." We will identify nursing facilities that operate primarily as psychiatric facilities, examine their State certification, and determine the amount of any inappropriate Medicare and Medicaid reimbursement. *(OEI; 00-00-00000; expected issue date: FY 2005)*

A mild-mannered man was tired of being bossed around by his wife so he went to a psychiatrist. The psychiatrist said he needed to build his self-esteem, and gave him a book on assertiveness, which he read on the way home.

He had finished the book by the time he reached his house. The man stormed into the house and walked up to his wife. Pointing a finger in her face, he said, "From now on, I want you to know that *I* am the man of this house, and my word is law! I want you to prepare me a gourmet meal tonight, and when I'm finished eating my meal, I expect a sumptuous dessert afterward. Then, after dinner, you're going to draw me my bath so I can relax. And, when I'm finished with my bath, guess who's going to dress me and comb my hair?" "The funeral director," said his wife.

Editorial staff
Editor:
Janis Price
Associate Editors:
Radmila Cassidy
David Peterson

The GrAAPvine is published quarterly and distributed to the members of Administrators in Academic Psychiatry as part of the membership in AAP.

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