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Fall 2004

The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Kevin Johnston, CMPE

With constant challenges for each of us to make our organizations successful, AAP members continue to offer a wealth of knowledge, allowing us to help each other address those challenges. This past Educational Conference in Seattle provided many opportunities, through networking and formal presentations, and I was able to bring back many new concepts and information to apply at Indiana University. The team of **Joanne Menard, Jim Landry, Chris Williams, Jackie Rux, Pat Sanders Romano** and **Elaine McIntosh** provided great direction and support to the planning and success of this conference. We are so appreciative of your contributions. It does not stop there, as many of our presenters were AAP members, showing that there is significant knowledge within our organization.

I realize finances in most institutions are very tight, but I encourage you to find the funds to make it to Boston for our Fall Education Conference, November 6th. You will certainly find many benefits through the networking and presentations that you can take back to your institution. You may also have managers or directors who can certainly benefit from membership in AAP and attendance at educational conferences. Reserve the date now on your calendar and piece together those funds to cover the cost.

This past year has truly been a growing period for AAP as Dan Hogge led us to better direct our organization strategically. With John DiGangi's attention to detail in revising a draft of the detailed Strategic Plan for 2004-2007, and the Board's extensive time reviewing and finalizing the details, we have very good direction. You can review the details at our web site, http://www.adminpsych.org/, but some primary goals to accomplish during 2004-2005 are:

- Provide Fall and Spring Education Conferences
- Further enhance our electronic communications
- Develop and implement a benchmarking survey
- Actively recruit new members, insuring a formal welcome and orientation
- Develop a "buddy system" for new members
- Develop an "intake sheet" to capture and share member talents and specialties

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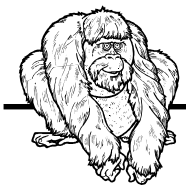

Comings and goings

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

Best of luck to **Ed McDevitt** of University of Medicine and Dentistry of New Jersey, Newark, who is leaving to become the CEO of Sacred Heart Hospital of Allentown, PA.

President's message

(Continued from page 1

- Implement strategic collaboration with other national organizations who have related interests
- Create a more formal link with AACDP and determine specific collaborations
- Continue strong leadership by Board members

Your Board of Directors, listed on the last page, represent a strong cross section of varied institutions. Please don't hesitate to contact any of them or myself for any question or request. We are an all volunteer organization, so I would also encourage you to contact one of them to offer to help in a capacity where your skills and talents can shine.

In closing, I just received an e-mail from a cousin that reminded me of the need to insure there is a good balance between the personal and professional life. It states to invest your time wisely, remembering that FAMILY stands for:

Father(F) and(A) Mother(M) (I) Love(L) You(Y).

Bizarre Boston history

You know about the Boston Tea Party. You know about the Battle of Bunker Hill (but, did you know it was actually fought on Breed's Hill?). You know about the Boston Massacre. You know about the Boston Pops Orchestra. But, did you know these somewhat less familiar tidbits of Boston history?

Ether memorial

William Morton, a dentist, first used ether in an 1846 operation at Massachusetts General Hospital. (The Mass. General Ether Dome, where Morton applied the gas, is still around and open for public viewing when it's not used for lectures).

In the Public Garden near Arlington Street is a statue of the "Good Samaritan" metaphorically comforting the afflicted with some ether. At the time sculptor John Quincy Adams Ward began working on the statue, it wasn't clear Morton was the true inventor so the statue isn't a likeness of Dr. Morton.

The Great Molasses Flood

On Jan. 15, 1919, twenty-one people, a dozen horses and at least one cat died when drowned in a flood of molasses. A 58-foot-high, 90-foot-wide cast-iron tank holding 2.2 million gallons of molasses burst, sending a 15-30 foot high tsunami of the thick brown liquid down Commercial Street at 35 m.p.h., destroying houses, commercial buildings and a part of the elevated railroad.

It took over six months to remove the molasses from the cobblestone streets, theaters, businesses, automobiles, and homes. Water from Boston Harbor had to be pumped onto the gooey mess because plain water did nothing to remove it.

Cinnamon raisin bagels

Moe Eagerman, who for many years was almost synonymous with Boston bagels, claimed to have invented the cinnamon raisin bagel (or "baigel" as he always spelled them) in the 1960s.

The Pledge of Allegiance

In 1892, a socialist and preacher named Francis Bellamy created the Pledge of Allegiance for *Youths' Companion*, a national magazine for young people published in Boston. Bellamy was also a chairman of a committee of state superintendents of education in the National Education Association. As its chairman, he prepared the program for the public schools' quadricentennial celebration for Columbus Day in 1892. He structured this public school program around a flag raising ceremony and a flag salute - his 'Pledge of Allegiance.'

(Mostly excerpted from Bizarro Boston *at www.**boston**-online.com/bizarro.html).*

Fall education conference planning well underway

Marketing and business development to be theme

by Pat Sanders Romano

The Democrats have left, and Boston is now gearing up for the AAP Fall Education Conference. So don't forget to save November 6 on your calendar for a conference that promises to be enlightening and fun! Brochures and conference registration materials will be sent to members via the listserv in mid-September.

The Education Committee is actively working to organize an exciting program with the theme: ***Marketing and Business Development***. We are looking forward to our second annual MacLeod Fall Lecture, and to continuing the tradition of having two tracks: Clinical and Research. "Take Two Minutes" has become a popular feature in past programs and this year we plan to expand the time available for this session.

To develop the tracks, we are interested in finding members who could share their experiences in outcomes research, patient satisfaction and in funding for research. We would also welcome any member who would like to make a presentation at this conference on the theme. As a past presenter, I can tell you that it is quite enjoyable and educational to participate. Please email me at promano@aecom.yu.edu if you would be interested in contributing.

Quincy Market

This year, once again, we are running our conference concurrently with the Fall meeting of the American Association of Chairs of Departments of Psychiatry (AACDP). We will join the Chairs for lunch and will be their guests at their evening cocktail reception.

We will be staying at the Wyndham Boston, which was built in 1928 as Boston's first skyscraper. The hotel is the ideal blend of old and new; a recent renovation enhanced the 1920's art deco and added modern comforts and conveniences. It is ideally located so that you can take advantage of charming attractions like Quincy Market, Post Office Square and The New England Aquarium. You'll find plenty of shops and historic buildings to explore. Our room rate is $159 per night, which is amazingly reasonable for Boston. Please call 1-800-996-3426 to make a reservation and reference the AACDP meeting. Join *Wyndham ByRequest* (no charge to you) for extra benefits during your stay.

While we are in Boston, we are planning a Friday night pre-conference dinner meeting at a local restaurant for all those interested and their guests. Our Saturday dinner will once again be a pleasant event were we can relax and enjoy each other's company. The cost of Saturday's dinner will be part of the conference registration fee. More information will be contained in the brochure. We are considering several typically Boston restaurants, so think seafood and Italian.

Please save November 6th, make your reservations, and think New England in the fall!

(Pat Romano is administrator of the deparmtent of psychiatry at Albert Einstein College of Medicine and president-elect of AAP).

With deepest condolences

The Board of Directors and the membership of AAP extend our sincerest condolences to the family of Pat Sanders-Romano, who lost her mother on July 25, 2004.

Academic practice self-assessment tool

By Darrell L. Schryver, DPA
Principal, MGMA Health Care Consulting Group

Academic practices have achieved success with an organizational philosophy that incorporates the entities' mission with sound business and administrative principles.

Up until the mid-'90s, academic practice organizations were designed to allow academic departments to practice relatively independently in an environment that provided for the financial security and economic strength of the institution, flexibility in adapting to the health care industry and the collegial environment of an academic practice. Now, however, with today's academic health care industry in the midst of tremendous change, academic practice organizations must demonstrate not only teaching and clinical quality, but also quality of administrative and management systems through the efficient implementation of operational support processes.

Managing an academic practice organization involves unifying the diverse cultures of management and the clinical provision of care, teaching and research, coalescing academic and management perspectives and visions while responding to unique market needs that affect the academic organization's financial viability.

The following is a brief self-assessment tool to help academic organizations evaluate performance and identify improvement opportunities. For more information, call toll-free 877.ASK.MGMA (275.6462), ext. 877 or e-mail consulting@mgma.com.

I. Strategy, culture and governance

- Have strategic initiatives been developed as part of a formal strategy?
- Has a planning process been initiated that identifies the direction of the academic entity?
- Are the goals and objectives of the academic entity consistent with, and support, the overall mission and goals of the sponsor institution?
- Are the objectives of the teaching, research and clinical activities functionally integrated and supported?
- Are providers appropriately represented in governance and decision-making?
- Were providers full participants in the planning process?

II. Business planning and financial control

- Has a formal business/ operations plan been developed that incorporates the strategic initiatives as part of the plan?
- Does the business plan include quantifiable objectives in the areas of administrative/ management services, accounting/financial services, marketing/organizational growth, etc?
- Has a financial strategy been developed that presents a pro forma budget and financial statement with descriptions of revenue, expenses and capital expenditures?
- Does the plan focus on its action or tactical components? Is the plan clear and concise? Is it flexible and able to respond to inevitable changes?
- Are contracts (e.g., managed care, research, off-campus service delivery) coordinated, monitored and centrally administered?
- Are the costs per clinical service (direct and indirect) identified?
- Do financial reports present data necessary to manage the entity, or are they simply adopted from the supporting organization and not applicable to an academic clinical enterprise?

III. Physician/Provider compensation

- Are the academic organization's operational/ management support services efficient and can they support the direction and initiatives as established in the business/operations plan? Specific systems reviewed should include information technology, financial systems and management reporting, human resources support, compliance and coding.
- Are the economic realities of administering an academic enterprise understood and communicated throughout the organization? How are they communicated? How is the communication documented?
- Has benchmarking been conducted to identify the appropriate resources to allocate to teaching, research and clinical services? Who/what are the outliers? Why?
- Has the academic entity established a formal compliance program?

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- Does the compliance program clearly demonstrate the organization's intent and are its operations/behavior designed to comply with regulatory requirements, specifically in detecting, correcting and preventing billing and documentation errors and omissions?

IV. Marketing and business development

- Has the academic enterprise formally assessed its marketplace and identified additional revenue producing opportunities (e.g., outreach programs, satellite operations, community centers, external faculty contracting)?
- Has the academic entity established competitive tactics within its marketplace?

Competitive tactics are generally defined as a function of providing outstanding services to patients, including good communication systems, patient flow and physician response to non-clinical patient needs.

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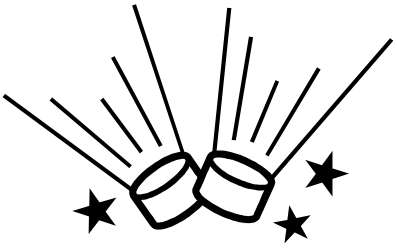

Coming attractions

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

Administrator in Academic Psychiatry/
American Association of Chairs of Departments of Psychiatry Fall Conference
November 6, 2004
Boston, MA

National Association of Psychiatric Health Systems
April 17-19, 2005
Washington, DC

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

Academic survey report just released!

From costs and compensation to individual production and overall performance, knowing where your academic practice stands against peer organizations is the first step in taking it to the next level. Rely on us for critical data to make decisions.

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We put it together. You put it to use.™

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Bridging the physician-administrator communication gap

By Thomas C. Royer, MD

Teamwork between physicians and practice administrators is critical for addressing and resolving practice issues. Only together can they effectively manage the revenue cycle; control supply and pharmacy costs; and balance productivity and staff numbers. Building on this operational foundation, they can increase access and efficiency and drive business to the facility.

However, the style physicians are trained to use in providing care to patients is often not ideal for working with administrators. In some cases, this difference creates miscommunication and mistrust that polarizes physicians and practice leaders. Rather than working together on the practice mission, these two groups exist in a state of friction enhanced by governmental regulations and reimbursement methodologies.

Clear communication is the key to bridging the gap. Practice leaders must employ communication tools that create physician-administrative collaboration instead of conflict:

- Outlining how the practice's operational challenges necessitate teamwork. Physicians are an essential component to practice business success and must recognize both their importance and the role they need to play.
- Expressing understanding of physician behaviors, not criticism. Show physicians that you know why they do what they do and have realistic expectations for any requested changes.
- Involving physicians in leadership. This ensures that physicians receive timely information about why a practice needs to change and have a say in that process. Practices also benefit from physician expertise when physicians are involved in governance or in committees that consider clinical process improvements (such as revenue cycle supply chains).

Creating the communication bridge is a continual process of developing new communication tools focused on the physicians' needs, improving old tools that have worked and repeating key messages as new physicians join the ranks.

Physician leadership is necessary – not optional – for group success. A fellow physician will understand the perspective of physicians when leadership gives direction or outlines necessary change. Physicians are more likely to listen to and follow requests from another physician. There should be the expectation that appointing a physician on the leadership team must be accompanied by the physician's willingness to work with administrative leaders.

Leadership should use ongoing written and oral communications to keep its group focused on these values. These messages reiterate to staff members and physicians alike that physician input, support and flexibility are integral to the system's success. And these messages work. The group should experience improved clinical quality, service delivery, business literacy and group reputation within the community.

Creating the communication bridge is a continual process of developing new communication tools focused on the physicians' needs, improving old tools that have worked and repeating key messages as new physicians join the ranks. Leaders believe that their legacy – whether as physicians, administrators or both – is to train those who come after them.

(Adapted from MGMA Focus On: Human Resources, January 2004. Thomas C. Royer, MD, is an MGMA member and CEO, Christus Health, Irving, Texas).

Revision to NOT-MH-04-007 Inactivation of PA-03-039 - NIMH Small Grants Program

NOTICE: NOT-MH-04-008 National Institute of Mental Health (NIMH)

The purpose of this addendum to Notice NOT-MH-04-007 is to clarify the final receipt date for previously reviewed applications under PA-03-039. (See The GrAAPvine Summer 2004 p. 18 for original article). Revisions to applications that were previously reviewed under PA-03-039 will be accepted until May 1, 2005, rather than March 1, 2005, to accommodate AIDS-related applications.

Direct your questions about this notice to: Jean G. Noronha, Ph.D. Referral Officer Division of Extramural Activities National Institute of Mental Health 6001 Executive Boulevard, Room 6154, MSC 9609 Bethesda, MD 20892-9609 Rockville, MD 20852 (for express/courier service) Telephone: (301) 443-3367 FAX: (301) 443-4720 Email: jnoronha@mail.nih.gov

Centralizing the receipt of progress reports for all NIH insitutes/centers effective October 1, 2004

NOTICE: NOT-OD-04-054 National Institutes of Health (NIH)

As NIH continues towards its goal of end-to-end electronic research administration, business practices are being revised to improve efficiency and service to the grantee community. Effective with non-competing progress reports due on/after October 1, 2004, NIH is centralizing receipt and initial processing of all NIH non-competing progress reports. The new centralized mailing address for all NIH Institutes/Centers (IC) will be announced in a separate NIH Guide Notice issued after September 1, 2004. As part of this centralized activity, all progress reports will be scanned and stored in the eRA Enterprise system. As a result, the scanned images will also be available to grantee institutions through the eRA Commons.

Progress reports that are due before October 1 should continue to be mailed directly to the NIH awarding IC. Those addresses can be found at: http://grants.nih.gov/grants/type5_mailing_addresses.htm.

This new business process affects only non-competing progress reports currently mailed directly to NIH ICs. It does not change the Center for Scientific Review mailing address used for all new and competing grants nor that process. The new non-competing process will use a unique address.

It should also be noted that this change is only for progress reports received by NIH ICs. Progress reports for grants to other DHHS agencies that use the PHS2590 should continue to use the mailing addresses noted for those agencies.

For additional information concerning this change contact:

Office of Policy for Extramural Research Administration
Office of Extramural Research
National Institutes of Health
Tel.: 301-435-0938
E-mail: grantspolicy@mail.nih.gov
FAX: 301-435-3059

Professional courtesy addressed in new Stark rule

The Stark II, phase II regulation took effect July 26. As part of this rule, group practices are required to modify their professional courtesy policies to minimize the risk of possible referral incentives. Professional courtesy policies include a variety of arrangements in which group practices offer free or discounted services (including insurance-only billing) to physicians, employees and/or their families and others.

The Stark II, phase II rule creates a new exception that permits groups to apply professional courtesy policies as long as the policy meets the following requirements:

- The policy is in writing and approved by the group's owners;
- It is offered to all physicians and/or staff in the group or in the local community without regard to referrals or other business generated between the parties;
- It is not offered to physicians or others who are eligible for Medicare or Medicaid unless the physician demonstrates financial need;
- It covers the type of medical services and items normally provided by the practice;
- If coinsurance amounts are waived or reduced, the provider notifies the insurer; and
- The arrangement does not violate the federal anti-kickback statute.

ICD-9 Codes may be released twice yearly

The ICD-9 codes are still coming out in annual updates, but the Centers for Medicare & Medicaid Services has proposed moving to a twice-yearly update as mandated in the Medicare Modernization Act, according to a CMS official.

If this happened, most likely the second update would take effect in April and wouldn't include any hospital procedure code updates, the source says. The new schedule could take effect as soon as next April, according to the proposal published in the May 18 Federal Register. "The April updates would be those primarily related to new technology, and not necessarily everything that was presented at our October meeting," the official said.

This year's update includes 171 new ICD-9 codes, according to the CMS official. It also changes some code descriptors. In particular, it changes some codes from the mental health chapter to bring the descriptors in line with the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.

Medicare listserv available for psychiatric facilties

Inpatient psychiatric facilities are one of the latest latest health care organizations to join the Medicare listserv community.

On May 24, the Centers for Medicare & Medicaid Services unveiled a series of new listservs that will allow these previously unserved providers better access to relevant Medicare and provider information online.

To sign up for the psychiatry listserv mailing list, go to www.cms.hhs.gov/mailinglists and enter your name and email address at the top of the page. Click on the IPFPPS-L radio button in the "Subscribe" column in the list of CMS mailing lists. You will receive a welcome email. Follow the instructions in that message to confirm your subscription.

Grace period eliminated for 2005 codes

The Centers for Medicare & Medicaid Services (CMS) recently announced that the 90-day grace period granted for providers to use old codes in Medicare billing will be eliminated for the 2005 update cycle. This will apply to International Classification of Diseases – 9th Revision (ICD-9) codes, HCFA Common Procedure Coding System (HCPCS) codes and Common Procedural Terminology – 4th edition (CPT-4) codes. Agency officials explained that this policy change is due to a Health Insurance Portability and Accountability Act (HIPAA) mandate that all medical codes sets used in HIPAA-compliant transactions be current as of the date of service. Medicare claims received with discontinued ICD-9 codes will be rejected for dates of service after Oct. 1. Claims with discontinued HCPCS or CPT-4 codes will be rejected for dates of service after Jan. 1, 2005.

CMS will update ICD-9 codes this spring in the proposed changes to the inpatient hospital prospective payment system rule. The agency releases new, revised and discontinued HCPCS and CPT-4 codes in October. Updated code sets for ICD-9 and HCPCS can be accessed from the CMS Web site. Providers are encouraged to purchase a coding manual with the revised CPT-4 codes from the American Medical Association.

To access the carrier communication announcing this change for ICD-9 codes: http://www.cms.hhs.gov/manuals/pm_trans/R95CP.pdf.

To access the carrier communication announcing this change for HPCSC and CPT-4 codes: http://www.cms.hhs.gov/manuals/pm_trans/R89CP.pdf.

(Reprinted from MGMA Washington Connexion™ February 20, 2004).

Written inquiries to Medicare carriers now require written responses

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) included many reforms advocated by the Medical Group Management Association that affect the administration of the Medicare program, including the requirement for written responses to inquiries. Effective June 21, 2004, Medicare contractors must respond in writing to provider-written inquiries in a "clear, concise and accurate manner" within 45 calendar days of receiving the request.

The Centers for Medicare & Medicaid Services (CMS) recently published a program transmittal detailing this requirement. Medicare contractors must maintain a correspondence quality-control program containing written policies and procedures, designed to improve the quality of written responses. This program has a number of requirements for contractors:

- They must take substantive action, or send an interim or final response, as a result of all provider correspondence within 45 calendar days of receiving the inquiry;
- Every contractor must have the flexibility to respond to provider inquiries by phone within 45 calendar days. If the contractor cannot reach the provider by phone, it shall develop a written response within 45 calendar days of the inquiry; and
- Contractors shall ensure that e-mail responses use the same guidelines that pertain to written inquiries (i.e., timeliness, accuracy, clarity, tone, level of understanding).

(Reprinted from MGMA e-Connexion June 22, 2004).

Revised audit process for Medicare claims

In compliance with the Medicare Prescription Drug, Improvement and Modernization Act (MMA), the Centers for Medicare & Medicaid Services has instructed local contractors to handle Medicare claim appeals differently and clarify the reasons for decisions reached by the appellate board. The MMA renames first-level claim appeals as "redeterminations." Appeal decision letters issued after Oct. 1 shall clarify the claim status and will include:

- Information on the rationale for an appeal outcome;
- A summary of relevant clinical and/or scientific evidence used to make the decision;
- Directions on obtaining more information regarding the redetermination; and
- Instructions on how to take the claim to a higher level of appellate review.

The full Carrier Transmittal can be found at http://www.cms.hhs.gov/manuals/pm_trans/R97CP.pdf.

Provider appeals process joins the 21st century

The rules will be changing the next time you take a squabble with your fiscal intermediary to the Provider Reimbursement and Review Board. In a proposed rule published in the June 25 *Federal Register*, the Centers for Medicare & Medicaid Services revises, updates and clarifies various provisions of its reimbursement appeal rules.

As they stand now, the principal provisions are about 25 years old. CMS says extensive litigation over important regulations -as well as an impressive 10,000-case backlog before the board - prove that streamlining is long overdue.

Some of the areas targeted for change:

- definitions of reimbursement, provider and entities that review intermediary determinations or decisions by such entities;
- time period and deadlines;
- hearing rights for providers and non-providers;
- "good cause" extensions;
- intermediary hearing officer jurisdiction;
- group appeals;
- judicial reviews;
- quorum requirements;
- subpoenas;
- board authority in a hearing decisions; and
- reopened procedures.

To see all the proposed revisions, go to http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/pdf/04-13246.pdf.

Reprinted from Medical Newswire July 9, 2004. Copyright 2004, Eli Research/The Coding Institute. Reproduced with permission.

Medicare interest rate calculation

The Centers for Medicare and Mediaid Services is changing its method for calculating interest on incorrect payments by Medicare to providers, suppliers and other health care entities.

The final rule, published Friday, July 30, 2004 in the Federal Register, also applies to Medicare Secondary Payer (MSP) recoveries.

Under previous rules, a partial period of interest owed, even one day, is considered a full 30-day period for calculating interest. The new rule no longer considers partial periods as full periods. Interest will be charged for each 30 days that expire after the overpayment was due.

o *Example: A physician receives a demand letter and repays the overpayment in full on the 45th day. Under the previous regulations, the physician would have to pay interest for two 30-day periods. Under the new rule, the physician would pay interest for only one 30-day period.*

A health care entity will have the first 30 days to pay the amount without interest being assessed. For MSP recoveries, the provider or other entity will have the time specified in the letter from CMS, either 30 or 60 days, to pay the debt without any interest being assessed.

The college corner

ACMPE is about goal setting

by David Peterson, FACMPE

As the classic Gershwin song put it, it is summertime and the living is easy so I thought I would write about a colleague of mine here at the Medical College of Wisconsin (MCW) who just completed his **American College of Medical Practice Executive (ACMPE)** board exams and has begun developing an idea and outline for his professional paper. He has passed the exams hurdle, was just awarded **Certified Medical Practice Executive (CMPE)** status and is hoping to achieve **Fellow (FACMPE)** status by this time next year.

For Kenneth C. Mace, MA, CMPE, Administrator for the Department of Family & Community Medicine, seeking board certification has been all about goal setting. Says Ken, "I joined the ACMPE to achieve board certification, seeking an objective measure of my abilities, earning a credential to differentiate myself from the other 19,000 members of the Medical Group Management Association, expanding my skill set and helping others excel in the medical practice management field."

Ken believes that by passing the boards, he has validated his 20 years of experience in the field and that he has "obtained a credential which speaks to setting and achieving a higher standard for myself." Taking the exams forced Ken to "think broader and learn new skills and techniques along the way, plus I would be forced to think methodically about my own skills and knowledge 'package' and my own deficits (or 'opportunities for improvement') and strengths to share with others." Finally, Ken used the process as a way to push himself "to set higher standards of professionalism for the young managers around him."

The methods he used to prepare for and achieve this goal were a review of the ACMPE's Body of Knowledge, reviewing publications and finally signing up for the test exam the ACMPE offers online. After passing the online test exam, Ken sat for and passed the two components of the boards offered in Seattle. The third component, two professional presentations, was completed independently. Upon completing this component of the exams, Ken says he "was forced to think about what he had learned, and not just what the audience learned from his presentations."

The next step for Ken is developing an idea and outline for a professional paper. He has set as his goal to achieve Fellow status in time for the MGMA Annual Conference to be held in the fall of 2005. Methods he is using to achieve this next goal include a review of articles and abstracts that have been approved and published in the *ACMPE Executive View*, the development of a survey in support of his professional paper with the idea of achieving outline approval in the fall of 2004, survey distribution and compilation in the winter and paper development and submission in the summer of 2005. On the way to success, it's all about goal setting and Ken's path is clear.

Closer to the AAP home but stretching from coast to coast, **Roxanne Morganthaler** (U Washington) and **Pat Sanders Romano** (Albert Einstein College of Medicine) are working on taking the next steps toward passing the board exams and Certified Medical Executive status. **Jim Landry, CMPE** (Tulane U) has begun drafting an outline for a professional paper as he takes the next steps to achieve his goal of Fellow status.

Summer offers a great opportunity to think about goals for the coming year. Evidenced by the organization's growing membership and interest in the boards, many consider the ACMPE a premier organization through which to achieve some professional goals.

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.

Have you ever been in therapy? No? You should try it. It's like a really easy game show where the correct answer to every question is: "Because of my mother."

A man who thinks he's George Washington has been seeing a psychiatrist. He finishes up one session by telling him, "Tomorrow, we'll cross the Delaware and surprise them when they least expect it." As soon as he's gone, the psychiatrist picks up the phone and says, "King George, this is Benedict Arnold. I have the plans."

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

Administrators in Academic Psychiatry

2004-2005 Board of Directors

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Kevin Johnston
kjohnsto@iupui.edu
(317) 274-2375

President-Elect
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promano@aecom.yu.edu
(718) 430-3080

Treasurer
Brenda Paulsen
bpaulsen@u.arizona.edu
(520) 626-2184

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(402) 354-6360

Membership Director
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steve-blanchard@uiowa.edu
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Members at Large
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(508) 856-2799

Jim Landry
jlandry1@tulane.edu
(504) 584-1975

Jackie Rux
jrux@mcw.edu
(414) 257-7239

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