Vol. 17 No. 1
Winter 2005

The GrAAPvine

Inside this issue

20th Administrators in Academic Psychiatry

During 2005, AAP celebrates its 20th birthday! We've got special things planned for The GrAAPvine leading up to this celebration and lots of festivities and goodies planned for our conferences, so watch for it all!

From the president's desk

by Kevin Johnston, CMPE

With the holidays fast approaching, it seems that there should be time to pause, regroup and prepare for the challenges of 2005. That pause for me, and I know many of you, as I heard at the AAP Education Conference in November, is difficult to find, though we all know personal rejuvenation is so important for our mental health.

Thanks so much to **Pat Sanders Romano** (Albert Einstein Medical College) and her Education Committee, who coordinated such a diverse and thought provoking conference. With speakers from outside AAP, which was much different than many previous conferences, we received perspective that helped us think about solutions and issues in a different way. I know **John DiGangi** (U Massachusetts) provided significant support in finding and scheduling these speakers. It was wonderful being able to network, face to face, with so many other administrators and hear some of the ways others cope and determine ways to resolve problems. Even though our institutions and structures can vary so much, we are still able to use ideas we hear from peers.

If you have never attended a conference or have not become involved in one of the AAP committees, I encourage you to attend and become involved. Your professional and personal development will surely be enhanced by what you receive. Don't hesitate to contact me and ask where you can get involved or tell me what you'd like to be involved in. The degree of involvement is usually not extensive, but you can guide that

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Comings and goings

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

Patricia Barkey
University of Massachusetts
(508) 334-0535
barkeyp@ummhc.org

Gregory Brownstein
Tufts University
(617) 636-3032
gbrownstein@Tufts-NECM.org

George Como
Montefiore Medical Center
Albert Einstein College of Medicine
(718) 920-6215
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Elaine Haigh
Rhode Island Hospital
Brown University
(401) 444-5488
ehaigh@lifespan.org

Sandra Hodges
University of Cincinnati
(513) 558-4711
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John Mills
Wright State University
(937) 223-8840
john.mills@wright.edu

Lorraine Montalbano
Albert Einstein College of Medicine
(718) 904-4408
lmontalb@aecom.yu.edu

James Puricelli
Loyola University
(708) 216-5336
jpuricelli@lumc.edu

Welcome back to:

Karen Roe
VA Medical Center
New York University
(212) 951-5417
Karen.Roe@med.va.gov

AAP wishes good luck to the following members:

William Fussinger
University of Cincinnati

Joel Sherr
Loyola University

AAP buddies

One of the most wonderful things about AAP is the collegiality and welcoming friendliness of our members. We have established a buddy system, pairing up "oldtimers" with newcomers to our organization and/or our conference. Being a buddy means meeting with your new member either at the dinner the night before the conference or at the beginning of the conference and making introductions. Buddies do just what comes naturally for AAPs - making people feel welcome.

Jennifer Wood (Oregon Health Sciences University), a new member at our conference in Seattle, said "I wanted to let you know that your buddy system really works and that if I were going to [Boston], I'd volunteer. In Seattle, it was because of the friendly people who made me feel welcome and included that I was so impressed with AAP. . . . When the group figured out I was new, they adopted me. It was great! I look forward to seeing everyone the next time I am able to attend an AAP function."

Consider being a buddy at the Spring conference in New York - or whenever you're asked. It's easy, it's painless, and most of all, it could be the start of a wonderful friendship!

Congratulations!

Margaret Moran has recently completed all of the requirements for her Masters in Business Administration.

Dave Peterson was elected ACMPE Professional Papers Committee Chairman.

Website includes *GrAAPvine* table of contents

Have you ever tried to look for something in a past issue of *The GrAAPvine* but just didn't know where to start looking? We're making it at least a little easier for you to search for major articles in each issue on the website.

Go to http://www.adminpsych.org/graapvine.htm and use either the topic index or the table of contents to view article titles. Then click on the issue number to get you to the newsletter and your article.

Bylaws amendments passed

Several changes to the bylaws were approved at the Fall business meeting. These changes created three new standing committees: Strategic Planning, Benchmarking, and Strategic Collaboration and Governance and assigned member-at-large positions to specific committees. An additional change created a fourth member-at-large position.

The *Strategic Planning Committee* will work with the President and President-Elect to develop the long and short term goals of the organization.

The *Benchmarking Committee* will recommend, develop and carry out relevant survey projects and report results to the membership.

The *Strategic Collaboration and Governance Committee* will investigate collaborations and determine appropriate inter-organizational committees with other psychiatry organizations.

President's message

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yourself. As encouragement to visit our web site, please review the committees as they are listed at http://www.adminpsych.org/ which also will soon include the revised bylaws as approved by membership attending the November business meeting, held during our conference.

With a new directive to establish benchmarking as a priority, we are thankful that **Lee Fleisher** (Vanderbilt U) has agreed to guide this committee. Your Board has made this directive an important focus for the coming years. As you hear more from Lee and his committee, please take the time to respond and make the results truly representative of all our institutions.

As we approach our 20th birthday for AAP, we are so thankful to **Jan Price** (U Michigan) for her leadership and guidance in reminding us of our history and coordinating the celebration that will move us forward for many more years. New York City's Times Square, the location of our Spring Education Conference, is an ideal place for you to help celebrate our 20 years. Plan to be there.

In closing, I encourage each of you to rejuvenate and find growth opportunities in 2005. AAP membership and involvement can certainly provide some opportunities for your professional development and personal growth.

Have a happy and healthy holiday.

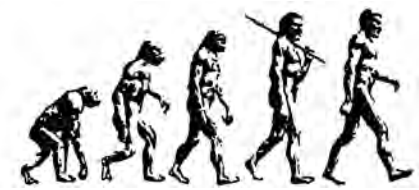
Kevin

What's more fun than a barrel of monkeys?

A room full of AAPs, of course! Make sure you get to NY in time for all the festivities planned for our 20th birthday. We're planning a real New York dining experience both Friday and Saturday nights, a birthday party during the Saturday program (with gifts and a birthday cake!) and a pre-dinner reception (with entertainment) on Saturday evening. Sound like fun? Mark your calendars for April 15-16 for the AAP conference. By the way, there'll be a NY adventure too!

The evolution of AAP

This article was originally published in 1995, when Administrators in Academic Psychiatry was 10 years old and we've updated it with the last 10 years of our development.



In the late 1970's and early 1980's, a small but growing group of psychiatry administrators attending the annual educational conferences of the Academic Practice Assembly (APA) found that the meetings' content did not always address the issues confronting psychiatry. Consequently, the psychiatry administrators gathered informally during APA meetings to exchange ideas and information. Led by **Bill Newel** (then of U Wisconsin), the administrators began to think about the creation of an organization devoted to the management of academic psychiatry and, in 1985 at the APA conference in Dallas, organized the first psychiatry breakout session, attended by twenty-one psychiatry administrators, to discuss the formation of a formal group.

In the fall of 1985, a steering committee met in Chicago to draft bylaws and plan the implementation of the new organization under the umbrella of the Academic Practice Assembly. Joining Bill Newel on the committee were **Doris Haley** (Washington U), **Glen Kiger** (then of Medical College of Virginia), **Norm MacLeod** (then of U Michigan), **Judy McElroy** (U Arizona), **Steve Valerio** (then of U Maryland), and **Mary Wood** (then of SUNY Stony Brook). In April 1986, at the APA conference in West Palm Beach, Bill Newel was elected its first president.

From the outset, AAP programs have been offered during the APA conference. For the first three years (West Palm Beach, San Diego, and Boston), breakout sessions were held during the APA educational conference. Then, in 1989, when the APA first provided financial support for pre-conference programs, the organization held its first all day educational program in New Orleans. Since then, a full day program has been offered prior to the Academic Practice Assembly conference.

In 1990, the first AAP midwest regional conference was held. Although billed as a midwest conference, attendees have always included representation from throughout the United States. Beginning with the 8th annual fall meeting in 1997, the conference moved from a midwest location to Boston, Massachusetts and was no longer called the midwest regional conference. In 2001, AAP began what has been a fruitful collaboration with the American Association of Chairs of Departments of Psychiatry, holding simultaneous fall conferences with some shared sessions and social gatherings.

In 1993, the William J. Newel Lectureship was created to honor AAP's first president. Bill and his wife, Pat, joined the conference attendees for the presentation of a plaque commemorating Bill's "professional management in psychiatry through his vision of a network of psychiatry administrators and for his key role in organizing and leading AAP in its early years." The first Newel Lecture was presented at the fifth annual AAP educational conference in Tarpon Springs, Florida.

At the Spring 2003 conference, the Norman MacLeod Fall Lectureship was announced, honoring Norm for his "devotion and dedication to AAP and to its mission." The inaugural MacLeod Lecture was presented in Washington, DC in November 2003.

From a small group of twenty-one administrators in 1985, AAP has seen steady growth, finally exceeding 100 members in 1991. Part of the reason for this growth is the eagerness of the organization to provide a wide range of educational and networking opportunities. Besides educational programming, AAP offers its members a variety of other services. In 1989, with Norm MacLeod at the helm, the inaugural issue of The GrAAPvine was published. Issued quarterly, the newsletter provides information of general interest to psychiatry administrators as well as news about Administrators in Academic Psychiatry and its members.

Recognizing that networking with other administrators is of prime importance to its members, AAP has developed a website and an email listserv, under the leadership of **Rich Erwin** (U Missouri) facilitating networking opportunities. Time and again,

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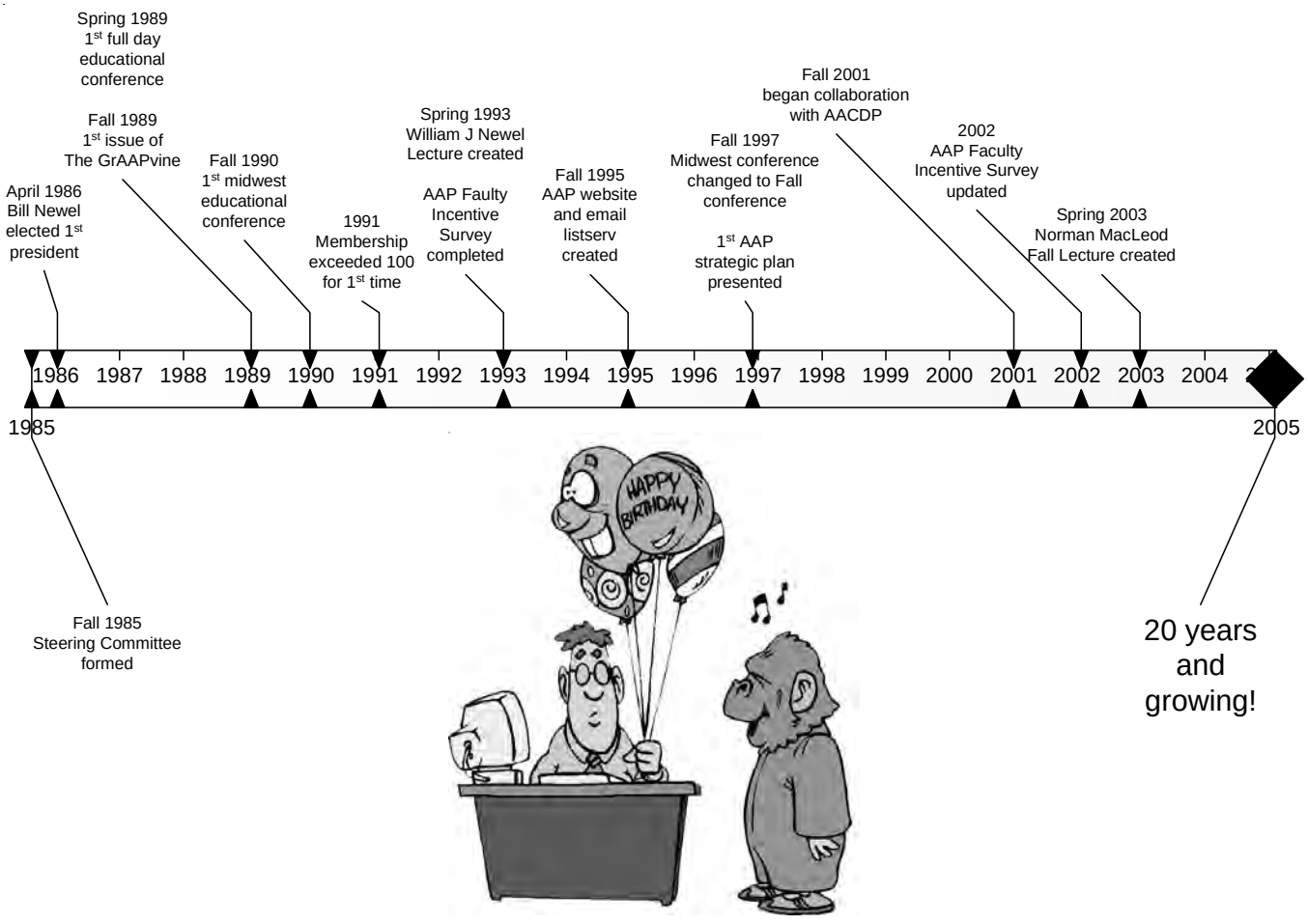
members have said that the listserv is the most valuable tool AAP offers, providing opportunities to contact the entire membership for help with those thorny issues we all face daily.

The "AAP Faculty Incentive Survey Report," spearheaded by **Donna Devine** (U Washington) was completed and distributed to members in 1993 with a follow-up survey, led by **Radmila Bogdanich** (Southern Illinois U) completed in 2002. The purpose of the initial survey was to "gather information that can provide a sense of where a department stands in relationship to others, to suggest possible ramifications of a certain plan structure on plan results, and to offer examples of plan features which one might wish to consider for inclusion in one's own departmental plan."

The first AAP Strategic Plan was presented at the Fall 1997 meeting. Developed by **Ed Comer** (then of Wright State U) and his committee, the plan provided a work plan and a framework for growth for several years. The plan has recently been updated, thanks to the dedication and leadership of **John DiGangi** (U Massachusetts).

During the 2001-2002 presidency of **Alex Jordan** (U Washington), and thanks to **Janet Moore** (Michigan State U) and her committee, AAP saw a complete rewrite of the By-Laws and a reorganization of the Board of Directors, creating several standing committees and defining specific roles for the members-at-large.

As we move ahead in the coming years, the organization can be proud of its history and the dedication of its leaders and can surely look forward to continued growth and leadership in the field of psychiatry administration. So, let's sing a round of "Happy Birthday to You" to AAP and wish us many, many more years of success!



Conference Highlights

A group of over 30 members attended the Fall conference in Boston, Massachusetts on a delightful weekend in early November. Kudos to President-Elect ***Pat Sanders-Romano*** *and her Program Committee for an excellent, balanced program around the theme of Marketing and Business Development. Attendees heard presentations on such diverse topics as inpatient and outpatient program development and international business development. Of course, the ever-popular "Take Two Minutes" gave members an opportunity to share ideas and help solve problems in an informal setting. As an added benefit of the conference, jointly held with the American Association of Chairs of Departments of Psychiatry, there was a luncheon presentation on the new Medicare Inpatient Prospective Payment system and it's impact on academic departments of psychiatry. And thanks to* ***John DiGangi****, the group was treated to two evenings of wonderful food and camaraderie, because no AAP program would be complete without time spent with friends!*

The Norman A. MacLeod Lecture

Business development - The chair's perspective

by Paul McArthur

Dr. Paul Summergrad provided a review of his perspectives on the role of chairs of psychiatry in business development activities since assuming the role at Tufts. He pointed out that the scope of departmental activities varies by nature of external relationships specific to each department as well as by relationships with the dean. Some departments have broad

Paul Summergrad, MD

responsibilities for hospital services involving connections to state or other public sector entities while others are at arm's length from public services.

Discussion covered revenue sources data, including information obtained via the 2001 AAP survey showing fund distributions and profitability of services for 51 of the 125 medical school psychiatry departments. Critical to the success of a department is the chair's pivotal role in developing diversified sources of revenue.

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Department relationships with state governments are frequent, with 55% having a special relationship with state agencies and 55% listing contracts or grants that fund faculty salaries or residency line items.

The nature of the department's practice plan and specific agreements with the dean and teaching hospitals are critical to determining opportunities for income from patient care activity, external consultations and contracts. In recent years, most hospitals have experienced a decline in clinical revenue margins and pressures on psychiatric payment rates have increased. The marginal contribution of psychiatric services is lower than most other medical services and Medicare's final ruling on Psychiatry PPS reimbursement structures will have a major impact on financial opportunities for hospital services. True private or self-pay practice, such as forensic and professional consultation, is most profitable for practices. Inpatient care and research provide components of positive contribution margin, while clinic, consultation and emergency services, all essential to clinical and academic missions, generally have negative margins.

Dr. Summergrad pointed out that in the national payor market, mental health services have been commoditized through carve-outs, with a resulting 50% reduction in the amount of premium dollars allocated to behavioral health. Payors have been successful in reducing behavioral health benefits. As managed behavioral health plan enrollments have increased, behavioral health costs have decreased. In comparison with other medical specialties, the government funds a disproportionately large share of mental health services.

In turning to the chair's role, Dr. Summergrad emphasized that communication, both up and down, is essential to establishing a stable financial base for a department. Regular updates about developments on the clinical operations side are key. The chair must be clear about key leadership expectations of the dean and hospital and assess departmental strengths and weaknesses in the context of primary and secondary goals of affiliated health systems and the medical school. The chair needs to establish a leadership group capable not only of assessing opportunities but also of implementing change. Also important is that physicians become concerned about the success of the practice plan.

Other areas discussed by Dr. Summergrad included key benchmarks and understanding of billing and overhead structures, productivity determinations, and philanthropy and future neuroimaging opportunities. In conclusion, Dr. Summergrad emphasized that if a department's core business plan isn't stable, it will be difficult to focus on other missions.

(Paul McArthur is the administrator of the University of Rochester department of psychiatry).

Planning new service delivery programs in the land of managed care

Christina Nesbeda

William O'Brien, MSW, Executive Director, University of Massachusetts Memorial Behavioral Health System and Director, Integrated Behaviors Health Service, presented an overview of managed care, how to obtain leverage in a managed care environment, and described two innovative programs that illustrate successful adaptation to this environment.

William O'Brien, MSW

Mr. O'Brien provided information about the origins of managed care and the impact it has had on how providers and services are contracted and reimbursed. The need to revise how services were delivered and how providers were compensated was evident early on. Managed care initially focused on certain key variables which included who gets the care; what kind of care and how much care do they get; who provides the care; and what is the cost. This

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created increased competition for contracts and "took the bottom out of the market."

New approaches to service delivery and compensation were needed. Mr. O'Brien provided information on how institutions and providers needed to understand program service variables and look for leverage in the marketplace. His outline of how to leverage both internal resources and outside players is quite valuable and applicable in more ways than just a response to managed care; it appears to have value for many types of program development and marketing. Looking at leverage involves "looking at your bench." What do you have to offer? What are your strengths? What are the costs of the services? Can you bill for the services? Can the services be provided within the existing clinical and administrative structure of your institution? Who are the key stakeholders? What are their needs and expectations?

Mr. O'Brien then presented two programs that illustrate program development and implementation in the managed care environment. The Neuropsychiatric Disabilities Unit is a 10-bed inpatient unit for individuals with mental retardation and a psychiatric diagnosis. Historically, the goal was to provide services as close to home as possible and programs were based and accessed geographically. The result was "360 degrees of dissatisfaction." Willing providers were not necessarily the most qualified and managed care had many limitations. UMass Memorial worked to establish collaboration among the financial and clinical stakeholders and held focus groups with key parties (the state Department of Mental Health, providers, families, and insurers). The state Department of Mental Retardation had leveraged Medicaid and created specialty units across the state, which were "better but not good enough." UMass Memorial reviewed its services, its academic, research and clinical missions, and worked with the key stakeholders to craft a program that met the needs of all parties while doing so in a manner that was fiscally responsible to the institution. Defining what everyone wanted, how to provide it, and how to pay for it were the main themes in the development phase. Highly qualified personnel were recruited and state and private payors were leveraged to fund services. A concept of "we" was fostered among all key stakeholders which continues in the present. Once the program was established and running, unanticipated issues with the payor mix were identified which caused fiscal concerns. These issues were addressed with payors and new rates were negotiated. The success of these negotiations was based in both the demonstrated quality of the clinical services provided and the early work done with all stakeholders in the development of this model. This unit continues to run successfully with a waiting list for services and highly competitive lengths of stay.

Another program, the Massachusetts Child Psychiatry Access Project (MCPAP), grew out of a problem with children's lack of access to child psychiatry services due to both insurance and provider availability issues. UMass Memorial looked closely at the problems, primarily from a clinical perspective, in conjunction with the New England Partnership for Improvement of Behavioral Health Services and Outcomes for Children and Families, and started by defining the need. Children were on numerous psychotropic medications without psychiatric intervention or services; many pediatricians treating children discharged from hospitals on psychiatric medications were unsure of how best to manage them; and while some pediatricians were comfortable managing these children, many desired an "assist" but were unsure how to obtain what they needed. Limited access to child psychiatry services was identified as a key problem.

The next step focused on developing initial partnerships. A demonstration grant was awarded to UMass by Medicaid to see if reorganizing child psychiatry practices could create improved access. This pilot program (TCPS – Targeted Child Psychiatry Services) essentially established a consultation service for pediatricians that guaranteed a participating pediatrician immediate access to a child psychiatrist during regular working hours for a real time consultation, with the ability to have a child seen in a timely manner. This was a pediatrician only referral program, available to a limited number of pediatricians during the pilot study. Evaluation and treatment services were provided to children as needed; however, the child was referred back to the community with the pediatrician as the primary provider as soon as possible. The

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demonstration grant provided funding for all costs.

Based on the success of the pilot study, the next step was to identify and secure permanent funding for the model. Medicaid agreed to fund the program via a capitated rate agreement, which also allows for fee for service billing with a reconciliation process in which the provider can retain some of the billable revenue. Negotiated rates for MCPAP are based on costs for all services provided, including consultation, referral, and training collaboration. This allows the psychiatrist to focus on the care needed versus just billable services. At this time at UMass Memorial, 1.0 FTE psychiatrist (spread over three individuals for scheduling purposes) support 120 pediatricians in the community with approximately 200,000 children in their care. This model is expanding to six locations across the state under Medicaid funding. Depending on the success of this project, the current state Executive Office of Health and Human Services contribution to cover non-Medicaid expenses will migrate to a first time partnership among private and public payors. The costs will be borne by all payors proportional to the number of covered lives. This is an innovative funding mechanism for a new and seemingly successful model of providing psychiatric services.

In summary, Mr. O'Brien provided valuable information regarding how to approach new program development possibilities, identify needs and services, obtain buy in from key stakeholders, and implement programs. This approach was not only successful for the two programs he presented but is applicable to many other types of program development activities.

(Christine Nesbeda is an administrator of the University of Massachusetts department of psychiatry).

Maintaining and growing an outpatient community mental health center

by Patrice Guild

Thomas Betzler, MD, Executive Director CMHC of Albert Einstein College of Medicine, presented an informative and energetic talk about his role in the creation of the Sound View Throgs Neck (SVTN) Community Mental Health Center, established in 1967 and located in the Bronx, New York.

Dr. Betzler started his talk by giving us a historical overview of mental illness in the US. Attempts to categorize mental illness started as early as 1840 with one category, "Idiocy/Insanity" listed by the Census Bureau. By 1880, the Census Bureau listed 7 categories and by the 1920's there were 10 categories for psychosis, nine categories for psychoneuroses and seven categories for disorders of character, behavior and

Thomas Betzler, MD

intelligences. The increase of disorders grew greatly and in 1994, 410 disorders were listed in the APA-DSM IV. He continued his talk with a detailed historical summary of interventions in psychiatry dating from the 1840's through today.

The paradigms for treating mental illness have shifted. As the number of psychiatric diagnoses and treatment strategies increased, patients with mental illness moved from a state hospital setting to a community outpatient setting. This change in care paralleled the current legislation of the time. The 1946 Mental Health Act established the National Institute for Mental Health and the Community Mental Health Construction Act of 1966 established public funding for the creation of Mental Health Centers. In 1990, the Americans with Disabilities Act protected individuals with mental illness by prohibiting discrimination and requiring that services be provided in the most integrated setting that was appropriate to the needs of the disabled individual. Further legislation gave patients with mental illness the right to treatment (1974) and the right to treatment in the least restrictive environment (1967,

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1975 and 1979). In 1999, the Supreme Court held that states were required to place persons with mental disabilities in a community setting rather than institutions.

The burden for caring for the mentally ill was now up to the individual states and the social community. The social issues that affected the community were addiction, MICA, HIV, domestic violence and psych issues, forensics, polypharmacy, child abuse and neglect issues and crisis management. SVTN strongly believes in the importance of a community health center staying focused on the social community. Their objective is to bring treatment close to home for emotionally troubled individuals and to promote the mental health of all community residents. As the community changes SVTN recognizes that their center must also change to meet those needs.

The success of SVTN is due to a number of changes instituted by Dr. Betzler. Changes were made to the information systems, involving productivity analysis, billing and patient demographics. An inservice was held on treating co-morbid issues and the focus shifted to incident-based illness. Specifically, the task of scheduling was taken out of the hands of the physicians and is now controlled by the clinic. The length of visit time was reduced from 1 hour to 30-45 minutes. Productivity of all staff is analyzed and reviewed weekly. As a result, the number of open cases, number of visits and number of programs offered has increased dramatically.

In summary, the SVTN Mental Health Clinic is a productive, vibrant member of the social community in which it is located. It offers two outpatient adult programs, two outpatient children and adolescent programs, a continuing day treatment program, an on-site program for schools, an alcohol program, a program for mentally ill chemical abusers and a geriatric program. The program at SVTN is committed to providing treatment with competent, professional staff and to provide services to all community members with respect and dignity. "Mental health, like our physical health, requires care and nurturing in order for each of us to maximize our academic, vocational, social and spiritual potential." This is the commitment of the successful Sound View Throgs Neck Community Mental Health Center.

(Patrice Guild is the outpatient services manager of the Thomas Jefferson University department of psychiatry).

One world, one medicine: International healthcare business development

by Dan Hogge

"Every citizen of the world should have access to quality health care in their own community." In a world fraught with so many issues and problems, and yet to aspire to such a hopeful concept is definitely inspiring. **Norman MacLeod**, Vice-President for Business Administration, Harvard Medical International (HMI) presented a summary of the Harvard business strategy for contributing to this noble medical mission.

Mr. MacLeod explained that with the Harvard brand identification and a clear commitment by the Harvard Medical School they have successfully started a healthcare program that is not only profitable but shares a premiere healthcare system with the rest of the world.

Norman MacLeod

After years of start-up losses, this past year's revenue has provided $4.0 million dollars in support to the HMS faculty and students and generated a contribution to HMS of $1 million in unrestricted funds. Natural by-products of this commitment has been the establishment of a center of academic and clinical excellence, an enhancement of faculty and student awareness and interaction with the global healthcare system, the creation of a partnership with world leaders, and a focus on improving access to high quality, cost effective healthcare.

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HMI has mobilized the resources of the institution as a whole to create a strong network of international partners to promote medical education through these long-term contractual relationships and the creation of communities for collaboration and learning. The approach taken with each potential client is to complete a full assessment of their local needs and priorities and then dovetail the concept of "best practices" with technology that is appropriate for each respective entity. If a strong healthcare system for the world is ever to built, a cadre of highly educated and motivated professionals is needed. The concept is basic but builds on good communication, a referring physician network, and supportive medical staff organizations.

Mr. MacLeod explained that business opportunities of this magnitude bring a number of risks and challenges that can change the business model quickly and the key to success is based on understanding the client's needs and knowing how, when, where, and what to propose. Issues of great importance to HMI include how the Harvard name is used and how contracts are written for exclusivity. Even with these legal instruments, abuse is often difficult to control and contracts must be monitored diligently. Financial terms and other issues have changed over the years to accommodate and insure that the client is fulfilling their part of the agreement in return for a quality product.

In the final part of the presentation, Mr. MacLeod discussed one of HMI's most successful opportunities now being developed in the Emirate of Dubai. After discussing and seeing the changes in this region, their vision of developing an integrated academic health center campus to serve the greater Middle Eastern region seems very realistic and exciting.

HMI's new approach in healthcare holds promise of bringing excellent healthcare to the citizens of the world and a commitment and vision of establishing a network for access, education, and quality to the most essential of all basic needs of mankind, healthcare.

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

Take two minutes

by James Rodenbiker

What are models for paying for Consult Liaison services?

Somehow, departments must find a way for the hospitals to contribute to the payment of C/L services. Clinical revenues alone usually are insufficient, given that many patients have no insurance and never pay for the service. To get the hospital to contribute, it may be necessary to threaten to terminate the service. Better yet, meet with the hospital administration and show them how C/L can reduce LOS, thus reducing costs. It is also effective to get other disciplines (those who refer to the C/L service) to voice support for the service.

How to obtain better allocation of Dean's funding?

Most Dean's offices have a formula for dispensing their dollars, and some of the formulas are rather rigid. Sometimes these formulas run out of money, and then it is up to the department to make ends meet. Any changes in the formula are best phased in over several years, so departments can adapt and find other funding. Many using the MBM model are suggesting that it has reduced the funding from the Dean's office.

Has anyone contracted with a hospital to pay a faculty doctor via RVUs?

Not many hospitals or departments have developed this yet. However, to do so there will need to be a way to determine a base amount for the RVU. And, once the base amount is determined, a conversion factor will need to be added to the formula.

Are the Medicaid teaching rules waived?

Since every state Medicaid system has different rules, there is no standard answer. UMass bills fees under the hospital, and the hospital returns a portion of these fees to the department. It was agreed that it will be a hardship to most departments if Medicaid takes on the same rules as Medicare, thus not allowing outpatients to be seen without

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direct supervision by a faculty physician.

Are we making a profit with clinical trials?

It was suggested that negotiations for more reimbursement from pharmaceutical companies can prove successful. However, because so many SSRI patents are expiring, in addition to other reasons, funding for this type of research is decreasing a bit. To get more dollars, it is best to have a research manager negotiate funding, rather than the PI. Competition from community mental health centers is also reducing some of the trials available to teaching institutions. Also, if there is a balance at the end of the clinical trial, departments need to find appropriate methods to use this money, or risk that it will be used by another entity of the university.

(James Rodenbiker is the administrator of the Creighton University department of psychiatry).

New Medicare inpatient prospective payment system

As part of the luncheon with the American Association of Chairs of Departments of Psychiatry, we heard a presentation by **Kenneth F. Nolan** and **Steven M. Mirin, M.D.** of Best Practice Management, explaining the provisions of the new Medicare prospective payment system for inpatient psychiatric facilities, to start January 1, 2005, in a four year phased implementation.

Mr. Nolan began the presentation with an explanation of the calculations going into the reimbursement to hospitals for care of Medicare patients. Payments will be based on a federal per diem base rate of $575.95 to which several adjustors will be applied. Adjustments for both rural and teaching hospitals will be given, with a regional wage index applied to $417.73 of the base rate, which is equal to the labor share portion of the per diem.

Additional adjustments will be made for hospitals in Alaska and Hawaii, for patients receiving ECT (applied for each treatment day), length of stay, patient age, DRG and comorbidities.

The length of stay adjustments decrease from a high of 1.19 (or 1.31 for hospitals with an emergency department) for the first day to 0.92 for stays longer than 21 days. One important aspect of the length of stay factor is that a readmission to any hospital within three days of discharge counts as the same stay and payment will be based on continuation from the last day of the previous admission. A second aspect is that CMS did not include any adjustment for hard to place patients awaiting discharge or for patients who are holding for commitment proceedings.

Fifteen DRGs will be used to adjust payments, with a baseline DRG adjustment factor of 1.00 for psychosis, and a range of .88 (for Alcohol/Drug Abuse or Dependence without Rehabilitation Therapy without Complication) to 1.22 (for O.R. Procedure with Principal Diagnosis of Mental Illness).

CMS has included seventeen comorbid conditions which will adjust the final payment. It is important to remember that the patient must be treated for the comorbid condition while on the psychiatric unit in order to benefit from the adjustment.

Dr. Mirin continued the presentation by stressing the importance of good preparation and planning for the change to come.

He outlined several key tasks psychiatric hospitals must undertake in preparing for prospective payment. First, analyze the fiscal impact of the change, both during the transition phase and beyond. What portion of your inpatient business is Medicare? What is your case mix? What are the key drivers of cost? What are the margins for Medicare patients in different levels of care and what will they be under PPS?

Next, review procedures and practices concerning clinical documentation, coding, billing and cost structure. Does your documentation, coding and billing accurately reflect patient complexity and the treatments rendered? Make sure that all psychiatric and medical comorbidities are documented. Are there components of costs not currently billed for? What should your cost allocation strategy be during the 3-year phase in period?

Finally, reassess the fiscal viability of clinical programs and make changes where appropriate. Is your array of services and case mix financially sustainable? Dr. Mirin recommends controlling access to multiple levels of care to help shorten LOS and provide continuity of care. Are there changes you can make to improve financial performance and still sustain your clinical and academic mission?

Dr. Mirin ended with a caution to recognize that change is both difficult and unpopular and that a consensus strategy for meeting the challenges and making needed changes is important. He recommends implementing a plan as quickly as possible and not in a piecemeal fashion.

The college corner

Making Fellows: The work of the ACMPE professional papers committee

by David Peterson, FACMPE

At this fall's annual meeting of the Medical Group Management Association in San Francisco, I had the privilege of accepting the Chairmanship of the **American College of Medical Practice Executive's (ACMPE** or the **College)** Professional Papers Committee. Because this Committee's work is to review all professional papers or case studies that have been submitted for partial fulfillment of the criteria necessary for advancement to Fellow status in the College and because 4 of our AAP board certified colleagues are at this stage of advancement, I thought it would be helpful to describe the work of the Committee and take some of the mystery out of the professional paper/case study review process. Our 4 colleagues ready to take the final step toward Fellow status are: **Rich Erwin, CMPE** (Missouri), **Kevin Johnston, CMPE** (Indiana), **Jim Landry CMPE** (Tulane) and **Joe Thomas, CMPE** (Michigan).

The Professional Papers Committee is made up of 6 teams of 4 Fellows each (one of whom is a Team Leader) and each of whom have successfully passed a "reviewer test." Committee appointments are generally for 3 years. By accepting appointment to the Committee, each member has agreed to voluntarily devote what will eventually total over 100 hours per year of committee work to review and provide feedback on the professional paper and case study submissions from prospective Fellow candidates. The teams are thoughtfully chosen and assembled by dedicated staff in the Denver offices of the ACMPE. The Denver staff balances each team with seasoned and unseasoned reviewers, taking into consideration each team member's experience, the specialty represented and the team member's geographic location. Thus, each team brings a broad wealth of experience, geographic market perspective and dedication to the profession of medical practice leadership.

Mentors are also part of the Professional Papers Committee and become part of the support network available to candidates as they navigate, for what most becomes, the final step toward Fellow status. Mentors are Fellows and have to have been past members of the Committee. This year the Committee has 3 mentors devoted to helping candidates through the submission process.

The criteria necessary for a submission to qualify as either a professional paper or case study are quite different. Briefly, professional papers describe a health care management topic or theory and provide a considerable degree of breadth and depth. Professional papers will invariably include a bibliography and often contain original research, exploring a theory or idea and arriving at a conclusion that is supported by a combination of research, extensive literature review or survey data. Case studies, in comparison, are academically less rigorous but provide a wealth of "real-world" information regarding a problem or issue the medical practice executive has encountered and successfully addressed. A case study includes a description of the problem, what would occur if the problem were not addressed, alternative solutions to the problem, how the alternatives were evaluated, the process of implementing the chosen alternative and finally, lessons learned from the experience along with advice for colleagues.

To successfully complete the professional paper or case study requirement, one professional paper must be accepted while three case studies must be accepted. If the Committee's work approaches anywhere near the volumes last year, the teams will review almost 200 outlines, revised outlines, manuscripts and revised manuscripts.

It was indeed a pleasure to meet for several hours in San Francisco with the sixteen dedicated professionals from around the country who could attend the meeting along with the ACMPE professional papers committee support staff. I can say with complete confidence that the group will work hard to preserve the integrity of the body of knowledge that is built through the paper and case study submissions while providing constructive review and feedback to candidates as they navigate this final step toward Fellow status.

(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.).

Lawmakers pass mental health / criminal justice bill

The Senate gave final approval on October 11, 2004 to a bill to address the growing numbers of people with mental illnesses in the criminal justice system.

The Mentally Ill Offender Treatment and Crime Reduction Act (S. 1194), introduced by Representative Ted Strickland (D-OH) and Senator Mike DeWine (R-OH), was approved unanimously by the Senate after House lawmakers also unanimously approved the bill last week.

"The criminal justice system is being overwhelmed by a wave of adults and children with mental health needs," said Laurel Stine, director of federal relations at the Bazelon Center for Mental Health Law. "S. 1194's passage is a crucial step toward promoting effective alternatives to needless and harmful incarceration."

Sixteen percent of all adult inmates in U.S. prisons and jails have a mental illness, according to a landmark 1999 Department of Justice report. In fact, 70 percent of people with mental illnesses in jails are there for nonviolent offenses.

S. 1194 would authorize $50 million in federal funding for grants to states to support pre- and post-booking interventions, including crisis intervention teams and law enforcement training, mental health courts and other court-based approaches, reentry and transitional programs.

The bill establishes one-year planning grants and five-year implementation grants that would require states to increase their share of funding for the program in later grant years.

"More work must be done to address the criminalization of mental illness, but S. 1194 is a solid foundation for reform," said Stine. "This bill will help keep people with mental illnesses from being inappropriately incarcerated and support their efforts to live more successful lives in the community."

S. 1194 will now be sent to the White House, where advocates believe President Bush will sign the bill into law.

(The Bazelon Center is a national legal advocate for the rights of people with mental disabilities. For more information, see www.bazelon.org).

Overtime rules change affects RNs, PAs, and other medical professionals

Many salaried medical professionals working in medical group practices that required an advanced degree to fulfill their position requirements are exempt from overtime pay under a revised labor regulation. Effective Aug. 23, the regulations modify the categories of salaried professionals who are ineligible for overtime compensation. For medical professionals to qualify under the regulations, they must meet the following requirements of the learned professional employee exemption:

- The employee must be salaried at a rate of $455 or more per week;
- The employee's primary duty must be the performance of work requiring advanced knowledge, defined as work that is predominantly intellectual in character and that includes work requiring the consistent exercise of discretion and judgment;
- The advanced knowledge must be in a field of science or learning; and
- The advanced knowledge must be customarily acquired by a prolonged course of specialized intellectual instruction.

Among the several categories of employees affected, the new exemption will affect the following salaried medical professionals in psychiatry practices:

- Registered nurses (RNs) licensed with the state;
- Physician assistants (PAs) certified by the National Commission on Certification of Physician Assistants who successfully completed four years of academic study by an accredited program.

Licensed practical nurses, lab technicians and other similar salaried health care professionals generally do not qualify. These employees rarely require an advanced academic degree for entry into their occupations and therefore do not fall under the learned professional employee exemption.

(From MGMA Washington Connexion September 10, 2004).

NIDA Policy Update for Career Development Awards (K Awards)

NOTICE: NOT-DA-05-001
National Institute on Drug Abuse (NIDA)

Purpose

This Notice regarding the National Institutes of Health (NIH) Career Development Program Announcements (K Awards) is intended to provide additional information for potential applicants on the unique aspects of National Institute on Drug Abuse (NIDA) career development programs. This supersedes the one dated August 5, 1999. The NIH program announcements addressed in this Notice are the following:

- PA-00-019: Mentored Research Scientist Development Award (K0l)
- PA-00-020: Independent Scientist Award (K02)
- PA-00-021: Senior Scientist Award (K05)
- PA-00-003: Mentored Clinical Scientist Development Award (K08)
- PAR-02-076: Mentored Clinical Scientists Development Program Award (K12)
- PA-00-004: Mentored Patient-Oriented Research Career Development Award (K23)
- PA-04-107: Midcareer Investigator Award in Patient-Oriented Research (K24)
- PA-02-127: Mentored Quantitative Research Career Development Award (K25)

The guidelines and procedures outlined in NIH program announcements must be followed closely when an application is being prepared for submission to the NIDA, Particular attention should be paid to the purpose of each award mechanism, its eligibility requirements, and its review considerations.

Note: This policy is effective and applicable only to new, competing applications submitted after February 1, 2005.

Additional Information for NIDA Applicants

The *Research Objectives* section of each program announcement should be followed carefully during the preparation of an application. Note especially that differences exist among various NIH Institutes regarding allowable costs. The unique aspects of NIDA allowable costs, specifically in the categories of salary (all Ks) and research development support (K01, K08, K23, K25), are listed below.

Salary (K01, K02, K05, K08, K12, K23, K24, K25)

Effective October 1, 2004 this policy applies to all new (type 1), competitive renewal (type 2), and noncompetitive renewal (type 5) applications. The NIDA contribution to the principal investigator's salary is geared to institutional base salary outlined in Table 1.

Research Development Support (K01, K08, K23, K24, K25)

NIDA allows for funds up to $50,000 per year for research-related costs as outlined in each program announcement—examples include supplies, equipment, technical personnel, travel, and statistical services. [Note: This new amount is effective only for new, competing applications received after October 1, 2004).

Research Support (K02, K05)

For the K02 and K05 awards, NIDA allows for funds up to $25,000 per year for those applications from individuals who are engaged in predominantly theoretical work, such as modeling or computer simulation, as outlined in each program announcement.

Renewals

K01, K08, K23, K25 Awards: Support for the K01, K08, K23, K25 awards are limited to one term of 3 to 5 years and are further restricted to one mentored career award per individual.

K02 and K24: The Independent Scientist Award (K02) and Midcareer Investigator Award in Patient-Oriented Research (K24) are renewable one time only.

Institutional Base Salary	NIDA Contribution
Up to $48,000	100% of institutional base salary
$48,001 to $64,000	$48,000
$64,001 and over	75% of institutional base salary, up to cap of $90,000

Table 1

Enhanced public access to NIH research information

Notice: NOT-OD-04-064
National Institutes of Health (NIH)

The National Institutes of Health (NIH) is dedicated to improving the health of Americans by conducting and funding biomedical research that will help prevent, detect, treat and reduce the burdens of disease and disability. In order to achieve these goals, it is essential to ensure that scientific information arising from NIH-funded research is available in a timely fashion to other scientists, health care providers, students, teachers, and the many millions of Americans searching the web to obtain credible health-related information. NIH's mission includes a long-standing commitment to share and support public access to the results and accomplishments of the activities that it funds.

Establishing a comprehensive, searchable electronic resource of NIH- funded research results and providing free access to all, is perhaps the most fundamental way to collect and disseminate this information. The NIH must balance this need with the ability of journals and publishers to preserve their critical role in the peer review, editing and scientific quality control process. The economic and business implications of any changes to the current paradigm must be considered as the NIH weighs options to ensure public access to the results of studies funded with public support without compromising the quality of the information being provided. The NIH has established and intends to maintain a dialogue with publishers, investigators, and representatives from scientific associations and the public to ensure the success of this initiative.

NIH intends to request that its grantees and supported Principal Investigators provide the NIH with electronic copies of all final version manuscripts upon acceptance for publication if the research was supported in whole or in part by NIH funding. This would include all research grants, cooperative agreements, contracts, as well as National Research Service Award (NRSA) fellowships. We define final manuscript as the author's version resulting after all modifications due to the peer review process. Submission of the final manuscript will provide NIH supported investigators with an alternate means by which they will meet and fulfill the requirement of the provision of one copy of each publication in the annual or final progress reports. Submission of the electronic versions of final manuscripts will be monitored as part of the annual grant progress review and closeout process.

NIH considers final manuscripts to be an important record of the research funded by the government and will archive these manuscripts and any appropriate supplementary information in PubMed Central (PMC), NIH's digital repository for biomedical research. Six months after an NIH supported research study's publication—or sooner if the publisher agrees—the manuscript will be made available freely to the public through PMC. If the publisher requests, the author's final version of the publication will be replaced in the PMC archive by the final publisher's copy with an appropriate link to the publisher's electronic database.

As with NIH's DNA sequence and genetics databases, this digital archive in PMC is expected to be fully searchable to enhance retrieval and can be shared with other international digital repositories to maximize archiving and to provide widespread access to this information. It is anticipated that investigators applying for new and competing renewal support from the NIH will utilize this resource by providing links in their applications to their PubMed archived information. This practice will increase the efficiency of the application and review process.

NIH trusts that the up to six month delay to public archiving in PMC recommended by the policy will not result in unreasonable or disproportionate charges to grantees. As with all other costs, NIH expects its grantees to be careful stewards of Federal funds and to carefully manage these resources. We will carefully monitor requested budgets and other costing information and would consider options to ensure that grantees' budgets are not unduly affected by this policy.

Determining full-time professional effort for career awards

NOTICE: NOT-OD-04-056
National Institutes of Health (NIH)

Almost all NIH supported career development awards (Ks) require that recipients devote a specified minimum percentage of their full-time professional effort (in most cases 75%) to the goals of the career award. In addition, policy requires a full-time appointment at the applicant organization, with salary based on a full-time, 12-month staff appointment.

NIH has previously defined this requirement as encompassing the entirety of the professional commitments of the investigator, both within and outside the applicant institution. Although designed to protect the investigator's time for research and career development, this definition recently has been cited as problematic because investigator appointments are becoming increasingly complex.

In an effort to address these concerns and to foster more consistent treatment across all NIH Institutes and Centers, the following policy regarding the determination of full-time professional effort will now be applied to all K awards:

A career award recipient meets the required commitment of total professional effort as long as: 1) the individual has a full-time appointment with the applicant organization; and 2) the minimum percentage of the candidate's commitment required for the proposed Career award experience is covered by that appointment. Please note that a candidate may propose a career award experience that involves sites beyond the applicant institution or organization, provided that the goals of the total experience are encompassed and supported under the appointment with the applicant organization.

This policy also applies to individuals who hold additional appointments with an independent clinical practice plan, the Veterans Administration or other organizations. Assuming a full-time appointment with the applicant organization, a candidate meets the professional effort requirement of the career award as long as the minimum percentage required for the proposed Career award experience is supported by the appointment at the applicant organization. Responsibilities outside of the applicant organization appointment are not restricted but also cannot be used to meet any minimum effort requirement.

The following example is illustrative:

An investigator has a full time appointment at a university and a half time appointment with another organization (VA or independent clinical practice plan). Under this new policy, the investigator can be supported because the university and candidate can commit at least 75% of the full time appointment to the award.

The purpose of this policy is to clarify this requirement to ensure that the criteria for proposing and charging effort on career awards are consistent with the other NIH funding mechanisms. We also expect that this clarification will expand the pool of eligible candidates for NIH career awards.

This revised policy applies to all existing Career Development Award announcements for all applications and resubmissions submitted on/after October 1, 2004.

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

Get well wishes go out to Jackie Rux, who is recovering from recent surgery.

NIH announces updated criteria for evaluating research grant applications

Notice: NOT-OD-05-002
National Institutes of Health (NIH)

Background
The goal of the NIH Roadmap is to accelerate and strengthen biomedical research enterprise. During consultation with the extramural scientific community that led to the development of the NIH Roadmap process, it was frequently mentioned that the criteria used to evaluate research grant applications were not placing appropriate emphasis on some important types of biomedical research (see http://nihroadmap.nih.gov/). The Roadmap Trans-NIH Clinical Research Workforce Committee proposed a modification of the NIH Peer Review Criteria for investigator-initiated research grant applications that would better accommodate interdisciplinary, translational, and clinical projects. The updated review criteria were adopted at the August 5, 2004 meeting of the Directors of the NIH Institutes and Centers. According to the schedule shown below, the updated criteria will replace the review criteria adopted on June 27,1997.

Implementation
These updated review criteria will be effective for research grant applications received on or after January 10, 2005 that fall into the following categories:

- Investigator initiated research grant applications;
- Investigator initiated research grant applications submitted in response Program Announcements (PAs) whether published before or after this announcement;
- Solicited research grant applications submitted in response to Requests for Applications (RFAs) will continue to use the review criteria described in the RFA.

Note: RFAs published before this announcement will continue to use the existing review criteria. RFAs published after this announcement will use the newly updated criteria (shown below) as a framework for the development of review criteria specific to the RFA.

Beginning with reviews in the summer of 2005, reviewers will be instructed to use the updated review criteria (shown below) as the basis for evaluating research grant applications and for assigning a single, global score for each scored application. The score should reflect the overall impact that the project could have on the advancement of science. The emphasis on each criterion may vary from one application to another; and an application need not be strong in all categories to be judged likely to have a major scientific impact.

Future RFAs and PAs, which will be published in the NIH Guide to Grants and Contracts, will incorporate and employ these updated criteria as the basis for evaluating all research applications.

Updated NIH Criteria for the Evaluation of All Research Applications

The goals of NIH supported research are to advance our understanding of biological systems, to improve the control of disease, and to enhance health. In their written critiques, reviewers will be asked to comment on each of the following criteria in order to judge the likelihood that the proposed research will have a substantial impact on the pursuit of these goals. Each of these criteria will be addressed and considered in assigning the overall score, weighting them as appropriate for each application. Note that an application does not need to be strong in all categories to be judged likely to have major scientific impact and thus deserve a high priority score. For example, an investigator may propose to carry out important work that by its nature is not innovative but is essential to move a field forward.

1. Significance Does this study address an important problem? If the aims of the application are achieved, how will scientific knowledge or clinical practice be advanced? What will be the effect of these studies on the concepts, methods, technologies, treatments, services, or preventative interventions that drive this field?

2. Approach Are the conceptual or clinical framework, design, methods, and analyses adequately developed, well integrated, well reasoned, and appropriate to the aims of the project? Does the applicant acknowledge potential problem areas and consider alternative tactics?

3. Innovation Is the project original and innovative? For example: Does the project challenge existing paradigms or clinical practice; address an innovative hypothesis or critical barrier to progress in the field? Does the project develop or employ novel concepts, approaches, methodologies, tools, or technologies for this area?

4. Investigators Are the investigators appropriately trained and well suited to carry out this work? Is the work proposed appropriate to the experience level of the principal investigator and other researchers? Does the

Continued on page 17

Continued from page 16

investigative team bring complementary and integrated expertise to the project (if applicable)?

5. Environment Does the scientific environment in which the work will be done contribute to the probability of success? Do the proposed studies benefit from unique features of the scientific environment, or subject populations, or employ useful collaborative arrangements? Is there evidence of institutional support?

NOTE: Requests for Applications (RFAs), which are published in the NIH Guide to Grants and Contracts, may list additional elements, relating to the specific requirement of the RFA, under each of the above criteria. Additional Review Criteria: In addition to the above criteria, the following items will continue to be considered in the determination of scientific merit and the priority score: **Protection of Human Subjects from Research Risk:** The involvement of human subjects and protections from research risk relating to their participation in the proposed research will be assessed (see the Research Plan, Section E on Human Subjects in the PHS Form 398). **Inclusion of Women, Minorities and Children in Research:** The adequacy of plans to include subjects from both genders, all racial and ethnic groups (and subgroups), and children as appropriate for the scientific goals of the research will be assessed. Plans for the recruitment and retention of subjects will also be evaluated (see the Research Plan, Section E on Human Subjects in the PHS Form 398). **Care and Use of Vertebrate Animals in Research:** If vertebrate animals are to be used in the project, the five items described under Section F of the PHS Form 398 research grant application instructions will be assessed.

Additional Review Considerations **Budget:** The reasonableness of the proposed budget and the requested period of support in relation to the proposed research. The priority score should not be affected by the evaluation of the budget.

Inquiries

For more information, including a side by side description of the changes, and frequently asked questions, see the OER: Peer Review Policy and Issues website (http://grants.nih.gov/grants/peer/peer.htm#documents).

Feedback and comments regarding the criteria may be left at grantsinfo@nih.gov.

Inquiries regarding this notice may also be directed to:

Anthony M. Coelho, Jr., Ph.D. Review Policy Officer OD/OER/OEP National Institutes of Health 6701 Rockledge Drive, Room 3533 Bethesda, MD 20892 Telephone: (301) 402-7543 Email: CoelhoA@od.nih.gov

NIH announces new address for centralized receipt of progress reports due on/after October 1, 2004

Notice: NOT-OD-04-063
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. This Notice updates Notice OD-04-054 published July 23, 2004. As stated in that Notice, 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) is now:

Division of Extramural Activities
Support, OER
National Institutes of Health
6705 Rockledge Drive, Room 2207, MSC 7987
Bethesda, MD 20892-7987 (for regular or US Postal Service Express mail)
Bethesda, MD 20817 (for other courier/express mail delivery only)
Phone Number: (301) 594-6584

Reminders:

1) 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.
2) This change is only for progress reports received by NIH ICs. Progress reports for grants to other DHHS agencies that use the PHS2590 or the 416-9 should continue to use the mailing addresses noted for those agencies.

For additional information concerning this change see Notice OD-04-054 or 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

Final 2005 impact chart released for physician payment rates

The Centers for Medicare & Medicaid Services released the much anticipated revised final rule which included a 1.5 percent increase as mandated by the Medicare Prescription Drug, Improvement and Modernization Act. The Agency also provided a chart showing the impact of the revisions to codes and the payment update on providers by specialty and type.

2005 Medicare Physician Fee Schedule Impact Chart as anticipated in the Nov. 15, 2004 Federal Register

This information is taken from tables 38 and 42 of the rule, which details the impact of the final changes on total allowed charges by physician, practitioner and supplier category.

Impact of physician fee schedule changes on total Medicare allowed charges by physician, practitioner and supplier subcategory including the effect of the physician fee schedule update

Specialty	Medicare Allowed Charges ($ in millions*)	Coding and RVU Changes	Physician Fee Schedule Update	Total
Physicians				
Psychiatry	1,109	0%	1.50%	1%
Practitioners				
Clinical psychologist	494	0%	1.50%	1%
Clinical social worker	317	0%	1.50%	1%
Nurse practitioner	556	-1%	1.50%	0%
Physician assistant	414	0%	1.50%	1%

***Calculation includes additional injection payments and monies added by a one-year demonstration project.*

Dues notices are coming!

Watch your email and get your membership renewed soon.

And, please make sure your name is included on the invoice.

MGMA Smart Pack

The MGMA Smart Pack is a collection of practice management articles from *MGMA Connexion™*, *MGMA e-Connexion™*, *MGMA Directions* and professional papers from the American College of Medical Practice Executives (ACMPE). Each packet addresses a management performance domain from the ACMPE Body of Knowledge for Medical Practice Management.

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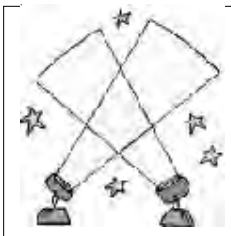

Coming attractions

Administrators in Academic Psychiatry Spring Educational Conference
April 16, 2005
New York, NY

Academic Practice Assembly Educational Conference
April 17-19. 2005
New York, NY

Medical Group Management Association Educational Conference
October 23-26, 2005
Nashville, TN

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

The Board of Directors
and the membership of
Administrators in Academic Psychiatry
extend our deepest sympathy to
John and Debbie DiGangi
on the recent loss of Debbie's father.

Psychiatrists in Training

The aspiring psychiatrists were attending their first class on emotional extremes. "Just to establish some parameters," said the professor to the student from Massachusetts, "What is the opposite of joy?"

"Sadness," said the student.

And the opposite of depression?" he asked of the young lady from Illinois.

"Elation," said she.

"And you sir," he said to the young man from Texas, "how about the opposite of woe?"

The Texan replied, "Sir, I believe that would be giddy-up."

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

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