Vol. 19 No. 1
Winter 2006

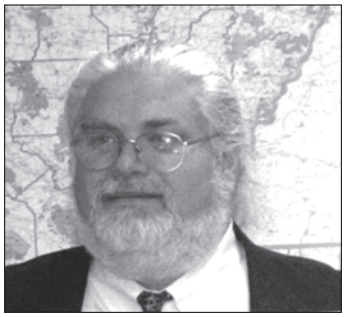
The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Jim Landry



Kudos to **Elaine McIntosh** (U Nebraska) and the education committee for planning an amazing fall conference. A special thanks goes out to **Brenda Paulsen** (U Arizona) for being AAP's site coordinator – arranging for the beautiful resort and networking dinners.

I want to remind everyone that the spring education conference will be held on April 21, 2007 in Boston, in conjunction with the Academic Practice Assembly annual meeting, April 22-24. Please save the date and make your plans now to join us. Suggestions for topics and speakers for the spring conference should be directed to Elaine.

Recently, **Paul MacArthur** (U Rochester) resigned as a Member-at-Large of the Board of Directors for personal reasons. Paul remains a valued member of AAP. **Margaret Moran Dobson** (U Toledo) was selected by the Board to fill Paul's unexpired term. Please join me in welcoming Margaret, and wishing her well in her new position.

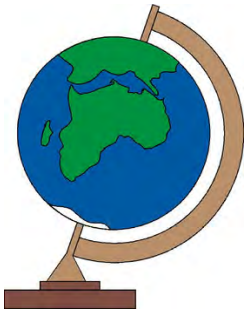
Past President **Pat Romano** (Albert Einstein SOM) is the chair of the nominating committee, charged with presenting a slate of candidates for board vacancies to be voted on at the annual business meeting (held in Boston in the spring). Serving on the board is very rewarding, and a way to give back to an organization that gives so much. I would encourage each of you to consider serving on the board. Please contact Pat if you have interest in a leadership position in our organization – share your talents!

Starting around Thanksgiving we hear Christmas carols playing all around us. One of my favorites has a line that says, "I want everything for Christmas" – maybe it's the kid in me that believes this is a wonderful concept! However, in our personal and professional lives we can't have everything; we must negotiate for what we want. And this reminded me of the "orange theory" of negotiation.

At an APA conference several years ago there was a senator from Nebraska who spoke on negotiations. One of his examples was that of splitting one orange between three parties, without cutting the orange into pieces. The lesson was that in conducting successful negotiations it is important for stakeholders to understand the needs and wants of the others in order to successfully negotiate and create a win-win-win outcome. The

Continued on page 2

Comings and goings



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

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

Shiyoko Cothren
Penn State University - Hershey Medical Center
(717) 531-7945
scothren@psu.edu

Mary Ogozalek
Robert Wood Johnson Medical School - Camden
(856) 541-6137
ogozalek-mary@cooperhealth.edu

Barbara Rood
Michigan State University
(517) 353-4985
barbara.rood@ht.msu.edu

Board update

Due to an illness in his family, **Paul McArthur** (U Rochester), Member-at-Large for Strategic Planning and Governance, has resigned his position. **Margaret Moran Dobson** (U Toledo) has been appointed to complete Paul's term of office through Spring 2007. The position will be open for nominations and election at the Spring Business Meeting in Boston, Massachusetts on April 21, 2007.

We are all thinking of Paul and his family during this difficult time.

Associate membership

The following former members have been granted associate membership in AAP:

Doris Chimera - University of Texas Medical Branch - Galveston
Howie Gown - Johns Hopkins University

Associate membership may be awarded to any former member asking in writing for that status. Associate members have all rights and privileges of active members except that they may not vote or hold office.

President's message

Continued from page 1

successful negotiation of dividing the one orange entailed determining that one party wanted just the skin, one party wanted just the pulp, and one party wanted just the seeds. No party needed the whole orange – only parts of the whole would maximize the needs of all parties.

This past week I saw this theory played out in real life with a project my department was trying to implement throughout southeast Louisiana for children and adolescents with PTSD. It took seven major stakeholders, representing various areas of the university, to get in the same room and hash out a solution that was a win-win-win for everyone. It was truly amazing to participate in this process, especially watching the layers peel back as each stakeholder began revealing what part of the "orange" was important to their area. We all negotiate in our personal and professional lives and the obvious lesson is that we don't have to have everything to get what we want.

In closing, I would like to thank each of you not only for the contributions each of you makes to AAP, but for your contributions to your university community and the patients we serve. Wishing everyone a happy holiday season, and hoping for mental health parity in the New Year!!

Jim

Discussions of pricing and compensation on the listserv

Recently, there was a question of faculty and staff compensation on the listserv. Just prior to that discussion, a similar question was raised on an MGMA email list and MGMA suppressed responses due to concern over a violation of federal law. MGMA's explanation follows:

MGMA, like our members, operates in a regulated environment and is constantly balancing the needs of our members with the regulatory requirements of our industry. This is especially true of our email forums where members are encouraged to seek advice and exchange information with their group practice colleagues. Although the federal government recognizes the value of sharing information among our members, it has also recognized that exchanges of certain types of information have potential to violate antitrust laws. In 1996 the U.S. Department of Justice and the Federal Trade Commission issued antitrust guidance to the health care industry in a document, entitled "Statements of Antitrust Enforcement Policy in Health Care." That statement can be read in its entirety at <http://www.usdoj.gov/atr/public/guidelines/0000.htm#CONTNUM_49>. Statement #6 of this document establishes a "safety zone" within which providers can exchange price and compensation data. It states that the Department of Justice and Federal Trade Commission "will not challenge, absent extraordinary circumstances, provider participation in written surveys of (a) prices for health care services (including billed charges for individual services, discounts off billed charges, or per diem, capitated, or diagnosis related group rates), or (b) wages, salaries, or benefits of health care personnel, if the following conditions are satisfied:

1. *the survey is managed by a third-party (e.g., a purchaser, government agency, health care consultant, academic institution, or trade association);*
2. *the information provided by survey participants is based on data more than 3 months old; (In fact the document later states that "exchanges of future prices for provider services or future compensation of employees are very likely to be considered anticompetitive.") and*
3. *there are at least five providers reporting data upon which each disseminated statistic is based, no individual provider's data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.*

In providing a forum for the exchange of information among our members, MGMA has always felt that it is in the best interest of our members to comply with the conditions set forth for the safety zone, to the extent feasible. Because exchanges of specific prices, wages, salaries and benefits information in the email forums cannot substantially comply with this safety zone, MGMA cannot enable these exchanges. Nonetheless, in recognition of the value to our members of candid, real-time information exchanges, and in order to provide constructive guidance to participants who wish to share economic information on the email forums within legal bounds, a set of "Frequently Asked Questions" is available by clicking on: http://www.mgma.com/about/email-faq.cfm These FAQ's are presented for educational purposes only, and each participant remains responsible for conforming to legal requirements.

Therefore, so that the AAP listserv is in compliance with Stark regulations, please refrain from asking questions of either faculty and staff compensation or procedure pricing. If there is a desire for this information specific to psychiatry practice and MGMA aggregate survey data is not sufficient, the Benchmarking committee may entertain requests for a survey to be conducted.

Taking MGMA surveys just got a whole lot easier!

MGMA surveys are now on-line! You can use your own personalized web portal to participate in surveys on compensation, costs and revenue, specialty-specific topics and more. It's much easier to start and stop the surveys, enter your data and receive ranking reports. The new user-friendly portal includes:

- One-click definitions
- Faster submission
- Easy save and return to the survey feature

Look for questionnaires in the mail or find the latest deadlines and surveys on-line at

http://mgma.com/pm/info.aspx?tid=7618&cid1=9198&cid2=194&cid3=192&cid4=9196.

And, you'll receive these benefits for participating:

- Obtain free customized ranking report benchmarking your practice against its peers.
- Obtain free copies of the survey reports in which your organization participated.
- Qualify for discounts on the *Cost Survey Report* and/or *Physician Compensation and Production Survey Report* CDs.
- Enhance your understanding of your practice's most critical performance characteristics.

Coming attractions

Administrators in Academic Psychiatry Fall Conference
April 21, 2007
Boston, MA
www.adminpsych.org

Academic Practice Assembly/Medical Group Management Association
April 22-24, 2007
Boston, MA
www.mgma.com

Medical Group Management Association
October 7-10, 2007
Philadelphia, PA
www.mgma.com

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 executive suite

Stewards of a quasi-public good

by David Peterson, FACMPE

Lots of us just returned from annual conferences. Many attended the AAP's Fall Conference in Tucson, some may have attended the MGMA/ ACMPE Annual Conference in Las Vegas, and others most certainly have found some type of venue to continue their professional education. These types of activities allow for a sort of professional renewal, providing an opportunity to escape the daily office pressures of the immediate, to listen to informed speakers, to mingle with colleagues from around the country, to think, hopefully, about the bigger picture and to step back and see the forest instead of the trees.

One of the standing-room-only breakout sessions at the MGMA/ACMPE annual conference helps illustrate the value of thinking about the bigger picture as short-term solutions are considered to address a problem or achieve a goal.

The session involved a case study of an academic system moving from physician-based clinics to hospital-based clinics, with the overall object of capturing more revenue through hospital facility fees. The session was full of content, spreadsheets and charts describing the stakeholder winners and losers as the system shifted to the hospital-based model. Needless to say, there were more winners than losers, and the academic system – the enterprise - experienced an overall financial gain from the administrative switch. [Interestingly, *Psychiatry was exempted* from the switch to this hospital-based model, remaining a physician-based practice because of the "complexity" of the specialty and "contractual, mental health carve-outs," to name two.]

The switch from a physician to a hospital-based model is one many organizations are pursuing, some more directly than others, and the move described in the breakout session certainly addressed a goal of maximizing revenue – "revenue trees," so-to-speak.

At the end of the session, I asked the speaker if the enterprise was concerned about adding a new cost to an already stressed healthcare system - the national "cost forest" - and was there concern about the inevitable "push-back" from payer stakeholders that could arise due to this additional cost. The speaker acknowledged that some push-back from payers would likely occur – eventually.

It seems the push-back has already begun, evidenced by AAP President **Jim Landry's** (Tulane U) listserv alert to the AAP membership regarding a *USA Today* article (11/16/06; http://www.usatoday.com/money/industries/health/2006-11-15-hospital-pricing-usat_x.htm) describing class-action lawsuits over the lack of disclosure of the additional costs of hospital-based clinics.

To reinforce a hopefully all-too-obvious point: Short-term solutions to an immediate problem may have unintended consequences in the long term, and taking a step back to think about the long-term consequences may help avoid the creation of a new short-term problem. In fact, economist Thomas Sowell, in his book *Applied Economics: Thinking Beyond Stage One*, has labeled this type of thought "second stage" thinking.[1] Forests and trees.

As stewards of a quasi-public good, it is important to remember to look at the forest as well as the trees. National conferences contribute to this ability to reflect. They contribute to the healthcare executive's continuing professional education and development, ultimately helping him or her make more informed decisions as the problems of the immediate are addressed back in the office.

In addition to these conferences, membership in *The American College of Medical Practice Executives (ACMPE)* helps provide an additional set of tools to help the medical practice executive distinguish forests and trees. In this 50th year of the ACMPE, 85 individuals who were elevated to *Fellow* status (exceeding the target of 50 set for this year) would agree.

For more information on joining the ACMPE or the board certification and fellowship 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.

Endnotes

1. Sowell, Thomas. 2004. *Applied Economics. Thinking Beyond Stage One*. Perseus Books Group: Cambridge, MA. p. 5.

*Blue cloudless skies and unseasonably warm weather greeted all of the attendees of the 2006 Fall conference in Tucson, Arizona. President-Elect and Program Chair **Elaine McIntosh** (U Nebraska) and her committee, and especially her "point person on the ground" **Brenda Paulsen** (U Arizona), planned an informative program on a variety of topics relevant to psychiatry academic administrators. We welcomed six first time attendees - perhaps the most ever. Do you think this perfect location might have had something to do with it?*

The Norman A. MacLeod Lecture
Shared departmental governance

by Dan Hogge

Daily governance plays a major role in our lives and **Alan Gelenberg, MD,** Professor and Department Head of the University of Arizona Department of Psychiatry, described the changes and process their department has undergonesince 1989 as they moved towards a shared governance structure.

Dr. Gelenberg related this story: A man told his friend there was shared governance in their family and that he was responsible for the "major" decisions in the family, and his wife was responsible for the "minor" decisions. The man said the decisions he made were around issues such as when will they go to the movies, but the decisions she made were the family budget, where their children attended school, and family trips. Telling this story perfectly illustrated in a humorous fashion how sometimes there is an imbalance in who makes important decisions even though we may think otherwise.

From a fiscal perspective, Dr. Gelenberg focused on a fundamental premise that a department cannot prosper unless there is a margin. An unidentified source once said, "No Margin, No Mission," and in tandem Dr. Gelenberg said, "No Market, No Margin." In academia there is no clearer message than that our educational, research, and clinical missions may all fail if we do not create a market for our services and ultimately a profit margin from these services. This concept is a key factor in how a department governs its operation.

To illustrate the evolution of governance Dr. Gelenberg described their department since 1989. A department retreat with the assistance of administrator **Brenda Paulsen** allowed them to discuss and design an effective model for their shared governance. In concept, shared governance requires all "major" decisions to be agreed upon by faculty but that unanimity can create inertia which can be bad for business when decisions are to be made quickly. To mitigate this dilemma they agreed upon a benchmark of $5,000 as the dollar amount that will trigger a faculty vote. Less than that amount does not require faculty approval. A finance committee affords the department the ability to provide additional management and control for major decisions.

As a leader, Dr. Gelenberg has retained the right of veto for all decisions when he feels that the wellbeing of the department may be at risk. He feels it is his obligation to make a reasonable attempt to contact all faculty on a shared governance issue. The solicitation of comments and thoughts are critical for a good decision but sometimes the timeliness of the decision can impact how well he is able to gather comments and suggestions.

Personally, Dr. Gelenberg said that he favors shared governance because of the buy in from faculty on decisions. Also there are no longer comments like "it's the chair's money (department funds), so I don't care," but more "it's our collective money and the decisions are important." Additionally, there is the value of multiple eyes and thoughts on an

Continued on page 7

Continued from page 6

issue and how it can validate or change important decisions.

He emphasized that ultimately the success of shared governance requires two important components. First, there must be a high level of trust within the group; and second, there must be a shared vision of the mission and values of the department. In the absence of trust or when there is divisiveness or a dysfunctional matrix the concept is suicidal or ineffective. Certainly an organization can take on this type of antipathy and create a very hostile environment if these core values are not addressed.

Dr. Gelenberg's presentation was insightful and stimulating and it was clear there is a high level of trust and professional relationship between him, the faculty, and his administrator, thereby creating a wonderful environment for collegiality and a solid structure for a successful shared governance. *(Dan Hogge is the administrator of the University of Utah department of psychiatry).*

The darker side of physician practice

By James Rodenbiker, MSW

Dan Shapiro, PhD, Associate Professor, University of Arizona Department of Psychiatry, presented an enlightening and informative lecture that provided significant data to suggest that many physicians are not coping well with the pressures they face. He cited several data sources indicating that practicing medicine is a high risk profession. For example, 30% to 60% of all physicians are depressed at some point in their career. Moreover, depressed mood in medical students ranges from about 4% to 24% at any given time. Thirty-five percent of physicians report an increase in alcohol use, with 3% to almost 20% drinking more than five drinks per night. In addition, the suicide rate among physicians is higher than the population at large, with female physicians having 2.5 times higher suicide rates than the general female population. Moreover, 20% of all medical students report having suicidal ideation at some point in time during their medical education.

It was interesting to note that according to Dr. Shapiro, 48% of all young doctors would not again choose the medical profession! The majority are less satisfied with their role as a doctor, and as a result do not care for themselves very well.

What then are the dynamics behind the dissatisfaction in the medical profession? Dr. Shapiro cites three primary reasons: First, the practice environment has changed with more to know and more people (not just patients) to satisfy. Second, doctors are working harder and longer than in previous generations. And finally, the paperwork part of the job has become burdensome and takes doctors away from patient care. In addition, Dr. Shapiro stated that doctors trained under a "medical model" suffer more than those who receive training via the "healing model." The medical model encourages doctors to believe they will be able to "cure all," and when they cannot, they cope by "stuffing" their emotions. They become very self critical which can lead to depression, but it also can be manifested by developing addictions to food, alcohol, sex, spending, etc. Other maladaptive coping includes anger outbursts, withdrawing, or becoming controlling when there is no reason to control. Dr. Shapiro commented that doctors are like a massive ship that is sinking; they don't know they are sinking until it is too late.

While physicians are well trained, experience is the equalizer. Until the physician has several years experience, they will not have seen many of the situations they are confronted with during their initial years of practice. Moreover, most adverse incidents and malpractice claims involve physicians who are less than four years removed from their residency. Despite the "darker side" of physician

Continued on page 8

Continued from page 7

experiences, Dr. Shapiro related how he helps physicians learn to process the stress of practicing medicine. He currently has a practice that is almost exclusively devoted to treating physicians. Frequently he treats physicians who have had something go wrong with a patient resulting in an adverse event and sometimes a malpractice suit. When a physician comes to him for treatment his method is to have the physician write a letter to the patient on whom the adverse event happened. Most begin writing immediately, although some struggle to write, but eventually they all will write. After writing about the event they need to read it aloud. This serves to get the stuffed feelings into the open, where they can be discussed and processed.

What then should practices, medical schools, hospitals, etc. be doing to manage these risk to our physicians? Senior physicians and management must model and demand self care during physician residencies. In addition, we should be modeling commitment and coping to our residents and young physicians, and we should be observant of physicians' behavior so we can intervene early. Finally, there should be a referral system set up in collaboration with the risk management entity of the practice, so when a physician is identified as needing assistance, the referral will go smoothly. This, in turn, will help to ensure a better recovery and outcome of all who are involved. *(James Rodenbiker, MSW is the administrator of the Creighton University department of psychiatry).*

Hot topics in women's mental health: Focus on perinatal depression

By Pat Sanders Romano

Women, in general, exhibit higher lifetime prevalence of depression, and it is most pronounced during child bearing years. **Marlene P. Freeman, MD**, Associate Professor of Psychiatry, Obstetrics & Gynecology, and Nutritional Sciences at the University of Arizona Health Sciences Center, focused her presentation of *Hot Topics in Women's Mental Health* on the epidemiological and treatment implications of perinatal depression.

Mental illness, a chronic recurring disorder, is the leading cause of disability in the US and Canada in 15 to 44 year olds; and depression is the leading illness causing disability in women in this, the child bearing, age group.

It is ideal to anticipate the mental health treatment needs of depressed patients who become pregnant, however most (50-60%) pregnancies are unintended/

mistimed, and two-thirds of American women will have at least one unintended pregnancy in their lifetime. Therefore it is critical that mental health practitioners "plan" that any woman of reproductive age will get pregnant. Commonly, both the practitioner and the patient experience terror and panic when faced with a pregnancy.

There are reasons for concern. Depression in pregnancy is a common problem, with 10-15% of women experiencing significant depressive symptoms; untreated depression may negatively affect maternal weight gain and infant birth weight, and increase the risk of prematurity. Furthermore there is a high risk for relapse for major depression during pregnancy. In a 2006 study of depressed pregnant women, a total of 43% relapsed, with 26% of those who continued medication relapsing, and 68% of those who discontinued medication relapsing.

Yet, there are very few published studies on antidepressant drug efficacy in pregnancy or the effects on newborns. Further clouding the issue are the "costs" of untreated depression and bipolar disorder on fetal and neonatal health. Among the negative effects of maternal depression on a child is insecure attachment, behavioral problems, cognitive function, and increased risk of abuse or neglect.

Dr. Freeman, based upon her practice in women's mental health, makes the following suggestions: For moderate to severe depression —*Treat!* Practitioners need to

Continued on page 9

Continued from page 8

consider the role of antidepressants and discuss the risks and benefits with the mother; use the lowest effective doses; consult with experts; and for mild depression consider non-medication alternatives.

Among the nonmedical alternatives that are being looked at by Dr. Freeman and her colleagues is the use of Omega-3 fatty acids in mood disorders. Epidemiological evidence, based upon cross-national analyses, demonstrates higher per capita seafood consumption is related to a lower prevalence of major depression, perinatal and postpartum depression, and bipolar disorder. Pregnancy and lactation depletes the mother's supply of Omega-3 fatty acids, and studies have found that women's intake of Omega-3 fatty acids is inadequate. With the FDA advisory that pregnant women limit their intake of fish to 12 oz. per week and avoid fish high in mercury, the recommendation is to use Omega-3 supplements. Omega-3 supplements do not contain mercury.

Prenatal supplemental Omega-3 intake has other significant benefits during pregnancy and lactation, including protection against cerebral palsy, decreased risk of preeclampsia, increased birth weight, more mature patterns in the baby's sleep and wakefulness, and possible effect on IQ.

Current trials are underway to study supplemental Omega-3 in conjunction with supportive therapy for perinatal depression. There are limitations however with Omega-3 supplements. The dose is currently unclear for depression treatment, food supplements are not regulated with the same vigilance as pharmaceuticals, and the supplements are usually not covered by insurance.

Dr. Freeman concluded by noting that women need and deserve more evidence-based treatment information and with a quote from the Lawyers Collective (1995*): "A society is judged by the way it treats its women and children."*

(Pat Romano is the administrator of the Albert Einstein School of Medicine department of psychiatry).

Mind-body medicine

by Ellen Francis

Mark Gilbert, M.D., Director, Consultation/ Liaison, Department of Psychiatry and Mind-Body Medicine Skills Group Program at AHSC, University of Arizona, discussed the Mind-Body Medicine Group Program where "heart and soul find health" and "physical, psychological, emotional and spiritual components of health care are intertwined . . . balancing education and interpersonal support in a healing environment." The program uses mind-body medicine to serve patients with a diagnosis of chronic and/or life-threatening illness. Meditation, relaxation, nutrition, exercise, humor, spirituality and faith, ritual

and more are included. Using small group workshops, patients are taught to increase awareness through use of self-care techniques, and to discover ways to "celebrate all of the seasons of life" despite illness or stress. He explained that mind-body medicine includes combining aspects of neurological, hormonal, psychological and belief systems. It teaches patients to be more resilient but does not promise cure or remission.

He addressed the concepts of optimism versus hope, with hope being related to meaning and purpose. Giving patients a purpose for living influences their survival; and meaning and purpose are related to spirituality, which Dr. Gilbert defined as being whatever gives a human being solace that connects them outside of themselves. He presented research that shows that belief systems and social supports may directly influence healing, and that social connection is a big protector of health. The research he described

Continued on page 10

Continued from page 9

suggests that relationships and group support matter, as does giving patients an active role in their health care.

He also presented conclusions drawn from ongoing research of the physiology of mind and body interrelatedness. He showed how reactions in the central nervous system and the sympathetic nervous system affect the immune system, that psychological stress affects cells in ways that are measurable. He gave examples of research involving bereaved spouses, spouses of cancer patients with lower levels of social support, and of caregivers of demented and chronically ill patients, showing the effects of stress (fight/flight responses), of elevated cortisol, and of decreased Natural Killer (NK) cell activity. Other examples he gave showed that emotionally negative stressors delay wound healing, and that patients with emotional repression have been shown to have poorer immune responses and in some studies greater recurrence and higher mortality from cancer. He showed through examples of research that healing is aided by social support, purposeful life, interconnectedness, increased empowerment and confidence.

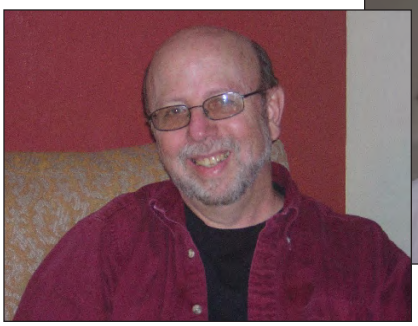
He pointed out the need for more research, expanding the populations studied, testing the interventions empirically, and recognizing the limits of drawing general conclusions about the effects of interventions on a mix of people with different personality types and backgrounds.

How do we apply this to our psychiatry departments at our own academic medical centers? He said that medical schools tend to teach about disease, not about health. He quoted a definition of health as a life lived well and fully, involved with other people, with self-exploration of the emotions, the mind, the body, and the spirit. He advocated teaching of self-awareness as a mandatory component in training programs for healing professionals, and including it in order to teach residents to be more compassionate. He encouraged teaching it to residents and medical students, and eventually to faculty, so it will become part of usual treatment. We can take the message back to our faculty, and in the areas where we can exercise our influence, we can support requests to add mind-body studies to the curriculum. The programs tend to be in the realm of the physiologist, immunologist, naturopath and chaplain. We can encourage their inclusion in psychiatry. We can refuse to be so sophisticated in the ways of economics and management that we can't believe in our brain's ability to take care of our body.

He concluded by telling us it is not just that we are mortal, but that our job is to open up, to help ourselves and others to find the center of calm within, in the midst of all the pressures and concerns of life, and to push out.

(Ellen M. Francis, M.B.A., is the clinical department business administrator of the University of Oklahoma Health Sciences Center department of psychiatry).

Conference pix



Ed Kagan

Joe Ricci

Sarah Thomas

Steffie Patterson

Staff development: Defining a culture

In these days of downsizing and staff reduction, the importance of team oriented, stable staff

cannot be overstated. According to current literature, employees ask four questions when coming to work: What do I get? What do I give? How do I belong? How can I grow? The topic of staff development affects each of these questions.

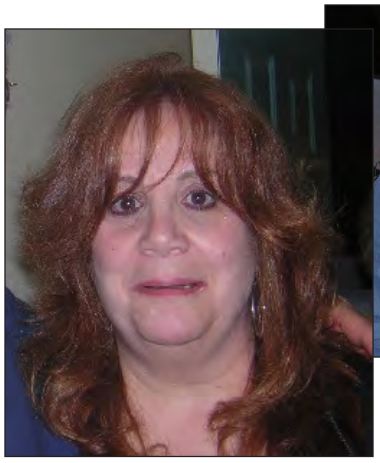
Using a case study approach, **Janice McAdam**, (Kansas U) and **Margaret Moran-Dobson** (U Toledo) illustrated examples of moving to empower employees in their respective departments. Using various tools such as Myers-Briggs, *Seven Habits of Highly Effective People, Who Moved my Cheese?* and discussions of varied communication styles and patterns, they were able to improve staff skills, job fit, and satisfaction.

A common technique in staff development programs at both institutions is the Gallup approach to strength based management. By increasing awareness of employee strengths though listening for yearnings, watching for satisfactions and rapid learning, looking for glimpses of excellence, and monitoring total performance for excellence, managers are able to develop areas of talent and interest into strength, rather than expending valuable energy attempting to correct weaknesses. When weaknesses are identified, staff can be encouraged to manage them by getting a little better at it, designing a support system, or complementary partnering.

The triad of manager, faculty supervisor, and employee customary with many academic department staff presents its own special challenge. Including faculty in the distribution of the impressive

statistics available regarding the advantages of engaged vs. disengaged employees should help convince them of the value of this approach.

With disengaged employees costing companies hundreds of millions of dollars in lost workdays, high turnover rates, poor productivity, and high healthcare costs, developing a highly engaged workforce is a sound investment. *(Janet Moore is the administrator of the Michigan State University department of psychiatry).*



Lorraine Montalbano

Jim Landry and Elaine McIntosh

The ladies of the Board

Billing code changes

The descriptors for inpatient consultation codes 99251-99253 delete the word "initial" to account for the fact that last year's CPT update deleted the follow-up inpatient consultation codes.

CPT 2007 adds 199 new codes and deletes 105 old codes. These include some HCPCS and Category II and III codes. It also makes corrections to the descriptors of dozens of other codes.

As with last year, there's no grace period for the new codes which go into effect January 1, 2007.

UB-04 to replace UB-92 for inpatient paper claim forms

The Centers for Medicare & Medicaid Services (CMS) announced that all providers who bill Medicare fiscal intermediaries, including regional home health intermediaries, using the UB-92 paper form must begin using the new paper form (UB-04) by May 23, 2007. CMS will no longer accept the UB-92, even as an adjustment claim, after May 22. Providers may begin using the new form on March 1.

The UB-04, which is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements, incorporates the National Provider Identifier, taxonomy and additional codes. While most of the data-usage descriptions and allowable data values have not changed on the UB-04, many UB-92 data locations are different. In addition, bill-type processing will change. Providers are encouraged to ensure that their billing staffs are aware of this new, uniform, institutional provider bill form for paper claims.

Access additional information on the UB-04 form can be found at http://www.cms.hhs.gov/Transmittals/downloads/R1104CP.pdf.

CMS clarifies hospital death reporting requirement

Recently, the Centers for Medicare and Medicaid Services (CMS) sent a letter to state survey agency directors reiterating their policy regarding the responsibility and process by which hospitals report to CMS patient deaths associated with restraint and seclusion.

The Patients' Rights Interim Final Report, published in 1999, requires that a hospital must report to CMS any patient death that occurs while the patient *is restrained* or *in seclusion for behavior management*. It also requires reporting *where it is reasonable to assume that a patient's death is the result of restraint or seclusion used for behavior management*.

The rule requires that hospitals must report directly to their CMS regional office (RO) any such deaths **prior to the close of business on the business day following the day of the patient's death**.

The Interim Final rule has specific timeframes within which the hospital, CMS, state agencies and accrediting bodies must comply.

Within two days of receipt of the report, an evaluation will begin. If there is evidence that the death did, in fact, involve seclusion or restraint use for behavior management, a full investigation is commenced. The investigation is carried out by the state agency with notification to the CMS central office, the hospital's accrediting agency and to the appropriate State Protection and Advocacy Group. Within five days the investigation must be completed with findings reported to the CMS regional office.

Medicare discharge notice final rule is released

The Centers for Medicare & Medicaid Services released a final rule in November on its Medicare discharge notice policy that is significantly less burdensome than its April 2006 proposed rule. CMS will require hospitals to issue a revised version of the Important Message from Medicare (IM) that fully explains patients' discharge rights. Rather than issuing a second and different notice 24 hours before discharge as was proposed, hospitals will issue the IM within two days of admission, answer any questions, and get the signature of the patient or his or her representative on the notice. Hospitals will be required to provide a copy of the signed notice before the patient leaves the hospital, but not more than two days before the departure. For short stays, this means that the copy of the notice need be provided only once. CMS will be developing the revised notice text, but before submitting it to the Office of Management and Budget for public comment and paperwork clearance, the agency intends to test it with beneficiary focus groups. The rule becomes effective July 1, 2007. The American Hospital Association (AHA) had submitted comments saying that the earlier proposal was overly burdensome and duplicative because hospitals already inform Medicare beneficiaries of their discharge rights through the IM. The AHA also said that the proposed policy would have the unintended consequence of unnecessarily extending Medicare patient stays an extra day in the hospital because hospitals often cannot predict the exact date of discharge one day in advance.

(Reprinted from www.ahanews.com, November 27, 2006).

New resource center on psychiatric advance directives

The Department of Psychiatry of Duke University Medical Center and the Bazelon Center for Mental Health Law have recently launched the National Resource Center on Psychiatric Advance Directives (NRC-PAD), at http://www.nrc-pad.org. The NRC-PAD offers mental health consumers, family members, clinicians and policymakers timely information about PADs, including:

- Introduction to PADs
- Forms to complete PADs
- Links to state statutes
- Educational webcasts
- Discussion forums
- Frequently-Asked-Questions
- Past and up-to-date research

The NRC-PAD will be a key gathering place for stakeholders to learn about psychiatric advance directives and how to complete these legal documents. The NRC-PAD aims to assist in implementing laws that support patient self-determination and high-quality mental health care.

Twenty-two states have created specific forms for PADs, available through the NRC-PAD. The resource center also links to healthcare directive forms for the remaining states, or consumers can use the Bazelon Center's template for a PAD at http://www.bazelon.org/issues/advancedirectives.

(Reprinted from Bazelon Center News at http://www.bazelon.org/newsroom/2006/7-17-06-NRCPAD.html).

Faculty charged 100% to sponsored programs - Another compliance risk?

by Jerry Fife

Add to your list of compliance concerns faculty that are charged 100% to sponsored programs. Why should you be concerned and where are the regulations that address this? Are these new regulations? This article will discuss recent audit findings and alternatives for properly recognizing faculty effort related to proposal writing, committee assignments and teaching assignments.

Background

A recent university audit by the Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) assessed cost disallowances for faculty that were charged 100% to sponsored programs while writing sponsored program proposals. The basis for these disallowances is derived from the Office of Management and Budget (OMB) Circular A-21 which states in Section F.6. (a)(2): "Salaries and fringe benefits attributable to the administrative work (including bid and proposal preparation) of faculty (including department heads), and other professional personnel conducting research and/or instruction, shall be allowed at a rate of 3.6 percent of modified total direct costs." This language is contained in a section of A-21 describing the treatment of costs for developing the departmental administration pool while developing an F&A proposal. This language has been in A-21 since 1986. Unfortunately, for a host of reasons some universities may have failed to account for this effort and this latest audit report serves as a reminder that this should be taken into account when providing effort reporting guidance. Most universities have informed faculty of this requirement but some may not have monitored this for faculty that have charged 100% to sponsored programs. Which proposals should be considered? Obviously new proposals fall into this category and institutional funding must be provided to account for this effort. It is important to realize that it is not acceptable to argue that faculty effort devoted to proposal writing occurs during personal time and needs not be included in the calculation of effort. Proposals such as NIH non-competing continuations where the proposal is a progress report can legitimately be direct charged to the project. Where things become grey are in proposals like NIH competing continuations where a portion of the proposal is a progress report and the remainder is proposed work. In this instance, the progress report portion is chargeable to the project and the remainder should be considered departmental administration and charged to university sources.

In addition, the audit also found instances where faculty charged 100% to sponsored programs but taught courses during a portion of their time. Although not a part of the audit findings, serving on university committees and not accounting for effort on sponsored programs for which faculty are named as an investigator with no effort also represents a compliance risk.

Mitigating the Risk

Before describing possible solutions to mitigate risk it is important to recognize that taking these corrective actions will not be an easy task, regardless of the approach. It may create a funding issue at the department or school level and while this is not a valid reason for non-compliance, it will complicate the resolution of the compliance risk.

Understanding the magnitude of this risk is the first step in mitigating this compliance risk. This is done by running reports from your institution's effort or payroll system to determine how many faculty are being paid 100% from sponsored programs. It is also important to determine which faculty will be included in the report. In addition to traditional tenure track faculty, many research universities have research faculty positions that are not eligible for tenure. Although some research faculty may not be involved in proposal writing it is advisable to include these positions in your assessment because it is likely that some do engage in proposal writing. If your institution included research faculty in the 3.6% allowance in the development of the departmental administration pool for your institutions F&A proposal then this must be considered in mitigating this risk. Once you have completed a report of faculty charged 100%, you will need to work with your institutions research leadership to develop a plan for reviewing and reducing the percentage charged for those faculty involved in proposal writing. Many research universities have already developed monitoring processes that periodically review the effort of faculty charged greater than some predetermined percentage. Most seem to be

Continued on page 14

Continued from page 13

reviewing faculty charged greater than 90% although some are reviewing at lesser percentages. These reviews may include discussions with appropriate departmental officials or faculty depending on how your university operates. The discussions should be aimed at determining if adjustments in effort should be made to account for proposal writing.

How should the effort be adjusted for faculty charged 100% that are involved in proposal writing? This will depend on multiple factors and there is no clear guidance. If the 3.6% has been claimed for faculty as a part of your institutions F&A rate calculation then auditors may argue that the reduction should be at least 3.6% for all faculty included in this calculation. Since the 3.6% is an allowance it was intended to cover a reasonable amount for this activity spread across all faculty in the calculation. Stated another way, some faculty would be expected to be over the 3.6% while others would be under. A reasonable approach is to consider the amount of proposal writing that occurred during the effort certification period and account for the effort accordingly. Faculty teaching of regular undergraduate and graduate courses must be accounted for in faculty effort and included as a part of faculty effort as instruction. Faculty charged 100% to sponsored programs should not be teaching courses unless the course is approved as a part of a sponsored instruction project. Also, faculty charged 100% to sponsored projects should not be serving on university committee(s) as these activities should be included as university funded activities and included as a part of the institutional base salary.

What about those instances where a faculty member provides guest lectures, teaches a course that requires an insignificant amount of effort or serves on a university committee that only meets a few times in accomplishing its mission? Again, there is no clear guidance for these situations. The safest compliance position is to count these activities; however, it may be difficult to obtain faculty recognition of these activities when considering effort. A-21 recognizes the concept of reasonability in effort reporting. Therefore, a good strategy for dealing with these types of activities is to carefully define by policy that effort which is considered insignificant for effort reporting purposes. Care should be taken during monitoring of effort to ensure that these types of activities are questioned and documented so that a clear audit trail is created. Instances where faculty are listed as an investigator with no effort also need to be considered in mitigating compliance risk. To understand why these projects need to be considered it is important to review a clarification to A-21 which was dated January 5, 2001.

The portion dealing with effort reads "In addition, most Federally-funded research programs should have some level of committed faculty (or senior researchers) effort, paid or unpaid by the Federal Government. This effort can be provided at any time within the fiscal year (summer months, academic year, or both). Such committed faculty effort shall not be excluded from the organized research base by declaring it to be voluntary uncommitted cost sharing. If a research program research sponsored agreement shows no faculty (or senior researchers) effort, paid or unpaid by the Federal Government, an estimated amount must be computed by the university and included in the organized research base. However, some types of research programs, such as programs for equipment and instrumentation, doctoral dissertations, and student augmentation, do not require committed faculty effort, paid or unpaid by the Federal Government, and consequently would not be subject to such an adjustment."

It is clear from this statement that faculty effort must be assigned to most federally funded research projects. Although not stated, if this concept applies to federal programs it would not be surprising to see auditors extend this to non-federal programs and these should be considered when monitoring faculty effort.

Conclusion

Effort reporting has been the focus of many audits and many compliance efforts over the past few years. Many articles have been written on this topic during this time and this article has covered one small and sometimes overlooked area. Taking the steps as outlined above is yet another step in ensuring compliance in effort reporting.
(Jerry Fife is the NCURA Immediate Past President and serves as the Assistant Vice Chancellor for Research Finance, Vanderbilt University).

This article is reprinted from the July/ August 2006 NCURA Newsletter, with permission of NCURA—the National Council of University Research Administrators.

The back page

Bubba went to a psychiatrist. "I've got problems. Every time I go to bed I think there's somebody under it. I'm scared. I think I'm going crazy."

"Just put yourself in my hands for one year," said the shrink. "Come talk to me three times a week, and we should be able to get rid of those fears."

"How much do you charge?"

"Eighty dollars per visit, replied the doctor."

"I'll sleep on it," said Bubba.

Six months later the doctor met Bubba on the street. "Why didn't you ever come to see me about those fears you were having?" asked the psychiatrist.

"Well, eighty bucks a visit three times a week for a year is an awful lot of money! A bartender cured me for $10. I was so happy to have saved all that money I went and bought me a new pickup!"

"Is that so! And how, may I ask, did a bartender cure you?"

"He told me to cut the legs off the bed! Ain't nobody under there now."

Thanks to Jackie Rux

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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:

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