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Summer 2007

The GrAAPvine

Inside this issue

Administrators in Academic AP Psychiatry

From the president's desk

by Elaine McIntosh

The conference in Boston on April 21st was perfect—a great learning experience, a wonderful group of members coming together for an inspirational networking opportunity, delicious New England cuisine, and beautiful weather all sprinkled with fun. I want to thank the members of the Education Committee who so willingly and ably planned and coordinated this conference. It was this committee's team work and willingness to go the extra mile that made my job as Education Committee Chair much, easier. Any and all calls for help were answered by the committee members with enthusiasm. The Education Committee for this conference included **Marti Sale** (U Kentucky), Member-at-Large for Education; **Steve Blanchard** (U Iowa); **John DiGangi** (U Mass); **Rich Erwin** (U Missouri); **Dan Hogge** (U Utah); **Jim Landry** (Tulane); **Janice McAdam** (U Kansas); **Margaret Moran Dobson** (Medical University of Ohio); **Brenda Paulsen** (U Arizona); **Jan Price** (U Michigan); **Pat Sanders Romano** (Albert Einstein COM); and **Narri Shahrokh** (U California Davis).

Special thanks to John DiGangi and his associates, **Tina Nesbeda** (U Mass) and **Pat Barkey** (U Mass), for their work as the Boston site team. Their efforts in organizing all the events in Boston, helping with gifts, local speakers, presentation handouts and many other details is much appreciated. I also want to especially thank Jim Landry and Pat Sanders Romano for their frequent consultative service and cheerful coaching of the Education Committee during the past year of planning the Fall 2006 and Spring 2007 conferences.

On behalf of AAP, I want to express thanks to Jim Landry as the 2006-2007 AAP President and the Board of Directors for their commitment and leadership during the past year. The 2006-2007 Board of Directors, in addition to Jim, included (Pat Sanders Romano, Immediate Past President; Elaine McIntosh (U Nebraska), President Elect; **Debbie Pearlman** (Yale U), Secretary; Janice McAdam, Treasurer; Steve Blanchard, Membership Director; **Hank Williams** (U Washington), MAL for Benchmarking; Marti Sale, MAL for Education; **Joanne Menard** (U

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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:

David Allen
University of Alabama Birmingham
(205) 996-6172
barton@uab.edu

Amanda Baker
Eastern Virginia Medical School
(757) 446-7189
bakerae@evms.edu

Mario Harding
Denver Health Medical Center (Colorado U)
(303) 436-5682
mario.harding@dhha.org

Carley Holland
Vanderbilt University
(615) 936-5693
holland.carley@vanderbilt.edu

Yongku Kwon
SUNY Downstate MC at Brooklyn
(718) 270-2588
yongku_kwon@downstate.edu

Annmarie Lucas
University of Michigan
(734) 232-0352
acap@med.umich.edu

Kimberly Russell
Oregon Health and Science University
(503) 494-6166
jasperla@ohsu.edu

AAP wishes the best of luck to the following members:

Marion Greenup (NYU) who is becoming the VP for Administration of the Simons Foundation.

Mike Nemcek (U Minnesota) who is retiring after 39 years in Psychiatry. All the best for a well deserved retirement.

And the winner is . . .

Each year, AAP recognizes outstanding service to the organization by presenting several awards. This year, the Rising Star Award, given to new members who have made a contribution by serving on a committee, writing an article for the newsletter, or in some other way participating in the operation of AAP, was presented to **Pat Barkey** (U Massachusetts) for her assistance in organizing the Boston conference.

The Board of Directors Award, given in recognition of a significant current contribution to AAP, was awarded to **Brenda Paulsen** (U Arizona) for leading the planning of the 2006 fall conference in Tucson, Arizona, from finding the host hotel to arranging speakers to setting menus, and a myriad of other tasks necessary for a smooth experience for our members.

The President's Award for long-term commitment and contributions to the organization was presented to **Rich Erwin** (U Missouri), for his ongoing management of the website and listserv as well as for many other contributions in the past.

President's message

Continued from page 1

Washington) MAL for Membership; and **Paul McArthur** (U Rochester)/Margaret Moran Dobson, MAL for Strategic Planning. This Board's service in the past year has continued and enhanced AAP's foundation of education and professional networking for administrators in psychiatry. I know each member of this Board would agree that serving on the AAP Board of Directors is some of the most rewarding work they have done in their careers.

One of the primary tasks at the Annual Business Meeting was to elect a new Board of Directors for the 2007-2008 year. The following slate of officers was unanimously elected to represent AAP: Jim Landry, Immediate Past President; Elaine McIntosh, President; Steve Blanchard, President Elect; Debbie Pearlman, Secretary; Janice McAdam, Treasurer; Tina Nesbeda, Membership Director; Hank Williams, Member at Large for Benchmarking; Narri Shahrokh, Member at Large for Education; **Lindsey Dozanti** (Case Western Reserve U), Member at Large for Membership; and Margaret Moran Dobson, Member at Large for Strategic Planning.

Among the highlights of the Spring Conference Annual Meeting was the Membership Committee report presented by Steve Blanchard. There are five new members since the beginning of 2007 with the current total AAP membership at 123 representing 96 institutions. Great work Steve, Joanne, and other Membership Committee members.

Hank Williams presented the Benchmarking report. Hank has worked diligently over the past several months to kick off the AAP benchmarking program. He has already sent out some preliminary surveys via the listserv to gauge topic interest and has received impressive response results. Hank will be attending a benchmarking meeting specific to academic psychiatry at Ohio State University in July. He is quickly becoming our member expert on benchmarking. You will be hearing more from Hank in the near future.

Also announced at the meeting, Pat Sanders Romano, Jim Landry, Margaret Moran Dobson and the 2007-2008 Board will begin updating the AAP Strategic Plan over the next few months. This is an exciting project which will provide structure and a methodology to continually improve and grow the organization.

Plans are already underway for the Fall 2007 conference at Deer Valley, Utah (just "up the hill" from Park City). Our site member for this conference is **Dan Hogge** (U Utah) and he has already made some exciting arrangements for a great conference experience. The format has been changed somewhat. Instead of a Saturday conference, we have planned a Thursday/half-day Friday conference on October 4th and 5th. This will give members an opportunity to schedule some sightseeing and relaxation time during Utah's beautiful fall season over the weekend if so inclined. This would be a great location to bring your family for some time together before settling in for winter. If you are lucky enough to get Columbus Day off, the conference time frame is just prior to Columbus Day Monday. (Information about the conference site can be found on page 4). We will again be planning great presentations for this conference. If you have recommendations for speakers or ideas for pertinent topics, please forward these on to the Education Committee Chair, Steve Blanchard. The Board is excited to receive feedback regarding this new weekday format for our conference. So let us know via the listserv what you think. Or better yet, plan to attend the conference and then let us know if this format would be a good idea for future fall conferences.

As administrators of academic psychiatry departments, the AAP membership is an elite core of experts. Your individual talents and experience provide a wealth of information that you can share through AAP's many networking outlets—the listserv, The GrAAPvine, survey responses, committee and Board participation, and attendance at conference. In whatever way you choose to participate in the organization, your contribution makes AAP stronger and of greater value to our membership. I invite you to contact a Board member or any other member to volunteer and become involved. Know that your contributions will be very welcome and you will be professionally and personally rewarded with an information-rich network of peers and friends.

Elaine

Fall conference plans in the works

The AAP Fall Conference will be held October 4 and 5, 2007 in Deer Valley, Utah. The conference facility is a condominium resort, The Chateaux of Silver Lake, and can be viewed at the following website: http://www.chateaux-deervalley.com/resort.php/CHATEAUX/OVERVIEW. The special conference rate is $129 per night. Deer Valley is adjacent to Park City, Utah and can be reached by plane from Salt Lake City. Thanks to **Dan Hogge** (U Utah) who has been hard at work making arrangements and coordinating logistics. This promises to be a great location for our AAP conference.

The particulars for this conference are slightly different than past conferences. While we have historically had our Fall conference on Saturday, this year we will have a 1 1/2 day meeting

beginning on Thursday morning and concluding at noon on Friday. There will be a networking dinner at the Deer Valley resort on Wednesday evening before the conference. The Thursday dinner will be in Park City.

This change in schedule gives you an opportunity to do some sightseeing after the meeting and if you have Columbus Day off you may want to consider extending your stay through the weekend. Conference lodging rates are available three days prior to the beginning of the event and three days following.

The program for the conference is still under development. There is a great deal of interest in benchmarking and measurement of psychiatry's value and activity. Another topic members have expressed interest in is chair recruitments. We are planning for the discussion to provide a perspective from both the chair and the administrator points of view. If there is a another topic you would like to see covered at the Fall conference, or other conferences, please contact Steve Blanchard at steve-blanchard@uiowa.edu or (319) 356-1348.

While we're on the subject of conferences, looking ahead, the Spring conference will be held in Orlando at the Disney Contemporary Resort. The date for that meeting will be March 29, 2008 and will be held prior to the MGMA/APA conference.

Your 2007-2008 board of directors

The 2007-2008 AAP Board of Directors was approved at the Spring Conference business meeting in Boston. The members of the Board welcome your comments and questions as well as your participation, so please feel free to contact any one of them. All email addresses and phone numbers are printed on the back page of The GrAAPvine.

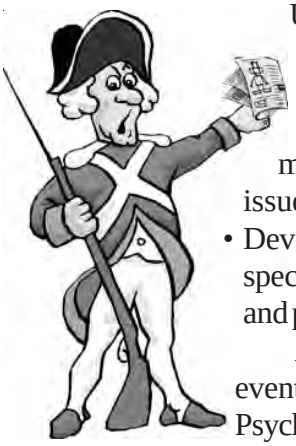
President	Elaine McIntosh	University of Nebraska
President-Elect	Steve Blanchard	University of Iowa
Immediate Past President	Jim Landry	Tulane University
Secretary	Debbie Pearlman	Yale University
Treasurer	Janice McAdam	Kansas University
Membership Director	Tina Nesbeda	University of Massachusetts
Member-at-Large *Strategic Planning/Governance*	Margaret Moran Dobson	University of Toledo
Member-at-Large *Membership*	Lindsey Dozanti	Case Western Reserve University
Member-at-Large *Education*	Narriman Shahrokh	University of California - Davis
Member-at-Large *Benchmarking*	Hank Williams	University of Washington

The surveys are coming, the surveys are coming!

Watch for those AAP surveys in your email in the coming weeks and months! And please respond!

Why?

The essence of benchmarking is learning from the best practice of others. Our ability to compare administrative services, performance, quality, and outcomes of care can facilitate change, ensuring quality control and continuous service improvement.



AAP is building a roadmap to provide financial, clinical, and performance benchmarks for its membership over the next several years. The goal is to develop new data for Psychiatry administrators to augment existing studies and literature on best practices for our field.

Initial steps by AAP include:

- A review of current benchmarking efforts by other relevant organizations, such as Medical Group Management Association (MGMA), University HealthSystem Consortium (UHC), and Association of American of Medical Colleges (AAMC);
- Establishing priorities among the membership to develop a "roadmap" of issues for study during the next 2-3 years; and,
- Developing and executing one or more specific studies per year, and their publication and presentation to the membership.

AAP members will also be participating in events such as the Ohio State University Psychiatry Benchmarking Forum in July.

The success of this endeavor will only be as good as the response of the membership, so please be sure and respond when you receive a questionnaire from AAP in your email.

If you have questions, suggestions, or want to help, please contact Hank Williams at hankwil@u.washington.edu.

A compensation system self-assessment tool: 12 questions for better results

MGMA™ Medical Group Management Association

This self-assessment tool, available at the mgma homepage (www.mgma.com) can help physicians and administrators assess their group's compensation system. It is designed to promote an objective understanding of the existing system and highlight some of the "hot button" issues that influence physician perceptions and satisfaction with compensation systems.

Print out the tool and respond to the questions. When you're done, review the answers section to learn what your answers might mean.

For additional information about compensation systems, MGMA offers *Physician Compensation Plans: State-of-the-Art Strategies,* where you can find innovative approaches, plans, and a step-by-step guide to assess or modify an existing physician compensation plan or develop a new state-of-the-art plan for your practice. Strategies for academic practices are included. Find information at http://www5.mgma.com/ecom/Default.aspx?tabid=138&action=INVProductDetails&args=939.

The executive suite

Six sigma degrees of freedom

by David Peterson, FACMPE

Most of us are at least casually familiar with the Six Sigma process developed by Motorola, made widely popular by General Electric and championed nowadays by a host of companies, including hospitals. Briefly, Six Sigma can be loosely termed a quality improvement process that allows "defects" to occur in a production process no more frequently than "6 standard deviations from the mean." The goal is to minimize "defects" – however they are defined – and improve quality through a 5 step process of Design, Measure, Analyze, Improve and Control. In short, it is a process striving for "near perfection." [1,2]

In a specialty such as psychiatry where pennies count, budgeting techniques and forecasts need to strive for "near perfection" as positive budget margins or minimal goals of financial breakeven are targeted. This view was reinforced by the anecdotal comments I heard from our colleagues at the AAP Spring Conference and certainly in one of the presentations by U Mass. As Thomas Manning often repeated in his presentation titled "Commonwealth Medicine: Applied Knowledge in Public Service," no margin, no mission. As we all know, squeezing a margin out of a labor-intensive specialty with virtually no procedures is challenging and requires the academic psychiatry administrator to actively and creatively manage revenues and expenses throughout the year.

If a deficit can be labeled a "defect," then moving toward Six Sigma tolerances in a world of pennies leaves little room for error.

Mr. Joseph Naughton-Travers of OPEN MINDS further reinforced the need to closely evaluate financial performance and offered some tools in his presentation titled "Analyzing Your Organization's Profitability by Service Line and by Contract." His review of process improvement techniques also added some ways to improve efficiencies and the bottom line.

Operating in a world with Six Sigma degrees of freedom requires a broad skill set that the **American College of Medical Practice Executives (ACMPE)** has defined in its **Body of Knowledge**. The **Body of Knowledge** is comprised of:

- Business and Clinical Operations
- Financial Management
- Governance and Organizational Dynamics
- Human Resources Management
- Information Management
- Planning and Marketing
- Professional Responsibility

- Risk Management

Expertise in each of these domains helps the administrator evaluate the bottom line, identify ways to improve it and add value to the practice. The ACMPE board certification process can help the practice administrator acquire and prove expertise in these areas, helping add to the pennies that contribute to the bottom line, working toward that state of near perfection.

For more information on joining the ACMPE or the board certification and fellowship process, contact the ACMPE directly at 877.275.6462 ext. 889 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.

Footnotes

1 "Six Sigma," http:/en.wikipedia.org/wiki/six_sigma (retrieved May 3, 2007).

2 "Six Sigma – What is Six Sigma?," www.isixsigma.com/sixsigma/six_sigma.asp (retrieved May 3, 2007).

Newel lecture: Mentoring and professionalism

by Janice McAdam

The Newel Lecture, "Mentoring and Professionalism," was presented by **Douglas Ziedonis, MD, MPH**, Professor and Chair of the Department of Psychiatry at University of Massachusetts Medical School. Upon arrival at UMass as a new chair, Dr. Ziedonis started an initiative of faculty and staff development for the gamut of personnel: a diverse group of residents, interns, medical students, women faculty, junior faculty mid- to late-career faculty, and staff from all areas including administrative, support, financial, and research.

Dr. Ziedonis believes mentoring is important to include in any development initiative for retention and career development. The enhancement of employee success, job satisfaction, and turnover rate is a beneficial career development tool and a link to personal, departmental, and institutional mission, values, and goals.

A professionalism training program was important at UMass to provide an environment free from unprofessional, inappropriate, disruptive, and abusive conduct. The new chair looked to see if a problem existed or if unacceptable behavior is tolerated or even rewarded. Beyond that, professionalism is one of the six general competencies for residents in accordance with the ACGME Outcome Project. ACGME guidelines for professionalism are to demonstrate a commitment to carrying out professional

responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Dr. Ziedonis explained that mentoring requires one to reflect on one's own life to understand what qualities matter, what approaches are effective for you, and what you have learned. If you want to be a mentor, establish personal and professional mission, values, and goals. All mentoring is not done at the same level of intensity. He identified the following characteristics of a good mentor: approachable, shares information openly, good communication skills, trustworthy, provides accurate and appropriate feedback, technical expertise, motivating, encouraging, positive, empowering, allocates time to mentoring, and sensitive to needs of others.

According to Dr. Ziedonis a mentor is someone who can guide your development and give you support and feedback. He suggested that when selecting a mentor you should seek someone with skills to challenge your performance and skill level with the shared goal of establishing a desired career path.

A mentor is not just a role model, but being a role model is part of being a mentor. Do not try to be a mentor if you do not have the time commitment or have the culture or comfort to be a mentor. If you are still developing you own skills and striving to achieve your own goals, Dr. Ziedonis suggested that are not ready to be a mentor.

As a mentor you need to know your mentee in order to acknowledge similarities and differences. There are certain parameters to know and understand such as the mentee's goals and the formality of the mentor relationship and structure. Mentors should be available to their mentee, respectful, focused on the mentee, able to track progress and give feedback. A mentor should not promote his/her own agenda, use the mentee as "free labor," take credit for the mentee's accomplishments, or make a clone of themselves.

Dr. Ziedonis included in the mentoring process relationship building, goal setting, knowledge and skill building, observation, analysis, providing feedback, action planning, and review. Mentees need to be motivated and proactive. If you find your mentee is not motivated, think about what has worked for you in motivation, determine what factors you see that lead you to believe that the individual is not motivated and then assess your own goals and styles to make sure you are both on the same track. An increase in the desire to change can be aided through motivational interviewing

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and feedback. He gave strategies for motivational interviewing. The strategies to use are open ended questions, listening reflectively, summarizing what you hear, affirming, and eliciting change talk that are self-motivational statements. Eliciting change talk will allow for discovery of the mentee's goals, strategies, and skills, and then provide for advice and instruction. When the mentee's reaction is elicited for credibility and self-efficacy, feedback is started.

Dr. Ziedonis stated that feedback is an important part of the mentoring relationship. Feedback offers changes, assessment of the process, empowerment of the mentee, and comfort level considerations. When giving feedback one should think about daily and weekly "positive feedback sandwiches" – positive comment, identify problem, positive solution. The feedback sandwich, as Dr. Ziedonis explains, conveys respect and support by making comments relate to the task and not the person. Focus your feedback on specific behaviors and support by examples. Feedback should encourage openness and be timely. When feedback sessions fail, the mentee will not receive any benefit and start to shut down from the process. He suggested you think of the message you are sending during feedback sessions.

According to Dr. Ziedonis, professionalism is the conduct, aims or qualities that characterize a profession or a professional. More than doing a particular type of job, professionalism is more about being a particular type of person and "professing" openly that you are that type of person. Professionalism includes aspiring to altruism, accountability, excellence, duty, honor, and integrity and respect for others. Dr. Ziedonis also looks to the point of view of patients and peers. From the patients' point of view professionalism is competency, availability, being on time, being a good listener, cordial and respectful, following through, and being communicative, empathic, and reassuring. A colleague's perspective of professionalism is being competent, well, self-aware, able to cope with stress, and able to get along with others. He also warned about challenges to professionalism: abuse of power, arrogance, greed, misrepresentation, impairment, lack of conscientiousness, and conflict of interest.

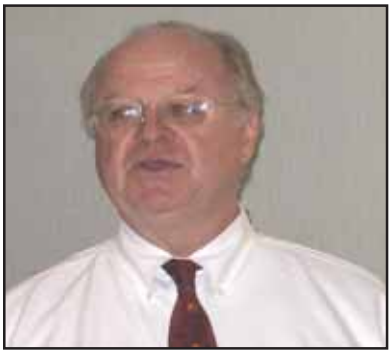
At UMass the program for professionalism took a proactive approach requiring leadership to be fully engaged. There have been leadership education programs and workplace professionalism programs, including individual coaching. Leadership values were defined by asking staff "What is important to you?" Some examples of the replies were improving through teamwork and systems thinking, embracing accountability, collaboration, promoting human dignity and respect, and maintain integrity. It is how these values are projected that will impact and improve performance.

(Janice McAdam is the administrator of the Kansas University department of psychiatry).

Commonwealth medicine: Applied knowledge in public service

by Margaret Moran Dobson

Thomas D. Manning, MA, CAGS, Deputy Chancellor for Commonwealth Medicine, University of Massachusetts (UMass) Medical School provided an overview of the development and current services provided by Commonwealth Medicine. Commonwealth Medicine had its origins within the University of



Massachusetts School of Medicine and has evolved into a multi-state organization offering services and programming to public-sector health systems.

About eight years ago, the UMass practice plan privatized in order to improve responsiveness. The state legislature formally recognized this relationship by ruling that the school (UMass) will not compete with Commonwealth Medicine. This allows Commonwealth to continue to act

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quickly in response to community needs and maintain a level of autonomy.

UMass and Commonwealth have jointly benefited from early investments in three areas, all of which have provided returns, both in terms of growth and learning: Donations and fund-raising; technology; and community mental health.

The investment in community mental health was supported by research which indicated a need for 80,000 to 100,000 annual visits in order to support a substantial program in ambulatory research. Ownership and operation of community mental health centers has provided this volume, in turn yielding increased research activity.

Commonwealth Medicine has also invested in the Department of Psychiatry's development of expertise in areas of mutual benefit. For example, Commonwealth was operating Psychiatric clubhouses, but encountering difficulty with funding sources due to a lack of demonstrated outcomes. Commonwealth assisted the UMass Department of Psychiatry with development of a research program to measure the outcomes and effectiveness of psychiatric clubhouses. The research, in turn, assisted Commonwealth with clubhouse program expansion.

Commonwealth also assisted the department with negotiation of the Dean's tax allocation to provide a reinvestment of these funds back into the department. Another example of Commonwealth's support of the University is it's assistance in obtaining State funding of $7.8 million for the medical school, $4 million of which went directly in to basic science research.

Key to the success of Commonwealth has been an organizational structure that blends University leadership with external advisors. In addition, separate entities have been created when indicated by business necessity. Examples of separate entities are out-of-state ventures and pharmacy management programs.

Commonwealth has thirty-two different sites within the State of Massachusetts, and has relationships with twenty other states. Examples of out-of-state services include technical assistance with drug utilization review, Medicare appeals and school-based claiming of public funds for special needs children.

Commonwealth reinvests in academic research, education and health policy through funding and support of public health related programs such as the Shriver Center for Developmental Disabilities Evaluation and Research, the Center for Adoption Research, and minigrants to encourage public sector work. Commonwealth also reinvests in the academic mission through educational programs related to workforce development, especially in correctional health, mental health and public health related programs. This organization serves as an excellent example of an outgrowth of a typical university-related function which has developed into a valuable public service entity.
(Margaret Moran Dobson is the administrator of the University of Toledo department of psychiatry).

Functional magnetic resonance imaging: Bridging the science between animal and human research

By: Dan Hogge

Craig Ferris, PhD, Director of the Center for Comparative Neuroimaging at the University of Massachusetts Medical School.has revolutionized the research of mental illness with the development of a highly sophisticated method for functional imaging of awake animals. With the acquisition of a magnetic resonance spectrometer the center has opened

the study of brain activity to many disciplines with opportunities for young scientists to participate in new discoveries.

The technology of the actual display of brain activity has dramatically changed over the last thirty years. Dr. Ferris reviewed how the ability to segment the brain into twelve hundred sections has allowed the science of displaying brain activity to explode. Current research includes the use of mice,

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rats, marmosets, and rhesus monkeys.

Present research allow the scientists to introduce various environmental changes into the lives of the animals to research maternal behavior, stress, drug abuse, aggression, fear and anxiety, and other drug discoveries. For example, a nursing rhesus finds more satisfaction in motherhood than using cocaine. However, as the pup grows older the cocaine brings more satisfaction to the mother.

Dr. Ferris then discussed various studies in aggression and how the introduction of an intruder causes stress and aggression in the male resident. The researchers then did 3-D modelling of whole brain activity of mice when Prozac and SRX251 is introduced. The clarity of the models was exceptional and demonstrated how the introduction of these factors can cause a great deal of change in the brain activity of these animals.

Other studies he discussed briefly included the brain activity of rats involved in the use of recreational MDMA or "ecstasy" and other physiological impacts on the animals during this MDMA use. One of the interesting results showed that the adolescent females were more vulnerable to MDMA than their male counterparts.

Dr. Ferris was clear in summarizing that animal imaging does have its limitations. Nonetheless, the progress of MRI imaging will continue to have a profound impact on the study of mental illness and related diseases. If the next thirty years are similar to the previous thirty years in this field, the implications are invaluable in researching cause and effect relationships in our environment and visually displaying information that has previously never been seen or understood well.

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

The next generation: Integrated mental and physical health care

By Dan Hogge

Perhaps the best way to capture Dr. Kathol's presentation is to reiterate the point he made in his closing remarks. He stated that the current system of treating mental health and physical health problems in separate and distinct units is ineffective. The key to improving our current system is an integrated care model that if developed correctly can reverse these poor outcomes and improve substantially the delivery of care.

We have all struggled with how to provide concurrent and coordinated medical and behavioral health care in an efficient and effective manner that benefits the patient both physiologically and financially.

Dr. Kathol systematically presented empirical evidence noting several factors that lead us to the conclusion that at any given general hospital there are on average between 30-60% of the patients who have a mental disorder along with their medical illnesses. In such a condition the findings validate the statement that 65% of all our health care costs are incurred by these complex patients with significant complications. Interestingly, depression and generalized anxiety disorder both dominate the utilization of primary care physicians and hospital care.

How do we reconcile this dilemma and move forward? Dr. Kathol suggests that we do that with an effective program that integrates the treatment, improves the number of depression-free days, and reduces the associated health care dollars. Likewise, he noted that in the treatment of panic disorders and substance abuse, integrated care is cost effective and reduces the recurrence or relapse of the illness.

Solutions to such difficult

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problems include some core ingredients. For a hybrid system to work the units must include:

- Co-location of the mental health and medicine unit with well trained personnel and a set up for the patient's convenience
- Total health provider accountability for all clinical conditions
- An absolute unhampered communication among the providers
- A common clinical documentation system
- A uniform billing to a single payer.

The process to integration is slow and difficult. The ability to integrate the purchasers, health care plans, providers, and patients demands a great deal of coordination and cooperation. Health plans have been slow to negotiate and accept the value of integrated systems. However, progress has been made with a number of third parties and as the system recognizes the value and cost savings to the institution the market will respond.

In the end, no one can force this change to occur. The ability to merge and coordinate care between mental health and medical needs is just a small but critical part of our healthcare system. There is no question but that reimbursement for mental health must be on a par with general medical health benefits and be on the same radar screen as other disciplines.

Universal health care is coming and the ability to control its costs will provide mental health and medicine integration a unique opportunity but it must be timely. Otherwise, the current problems we face now may well persist into the next quarter century.

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

Analyzing your organization's profitability by service line and contract

by Jeffrey Charlson

Joseph Naughton-Travers, Senior Associate of the OPEN MINDS group, introduced useful graphical tools to analyze the mix of services or success of contracts within our organizations. These 4-quadrant bubble diagrams were presented with a variety of parameters, measuring mission advancement, revenue, unit cost, business unit profitability, or service profitability. Bubble sizes within these quadrants typically represented the overall cost of a program or service and could be used to simultaneously present a program's size and the extent to which it was profitable and contributed to mission success.

The charts were a useful tool to bring together these elements for analysis and to promote a good basis for strategic planning activities. The driving reason for strategic planning is the basic premise that we do not have unlimited resources, and therefore our planning must be strategic to optimize these resources.

As these tools were initially used in the finance world to analyze companies within a give industry sector, Naughton-Travers urged us to apply them to look at our organizations as we would manage our stock portfolios.

He also introduced the idea that data may not be in the most useful format to use as a tool for performance improvement, and stressed the utility of activity based cost management. Typical financial reports manage dollars and expense categories (i.e. "Labor" or "Supplies") and the shift to activities (i.e. "Receive and Process Claims" or "Produce Reports") is essential for evaluating operational effectiveness, identifying outsourcing opportunities, and pricing decisions.

After the framework for good decision support data has been created, Naughton-Travers reminded us of some points to focus upon for good process improvement. If you follow people's tasks and how and where the paper flows, you should get some easy improvements. Typical areas to look at in behavioral health operations might include centralized scheduling and intake, improved applications of technology, and medical records systems. Medication management improvements could yield improvements in reduction of medication related visits and better integration with case management functions.

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

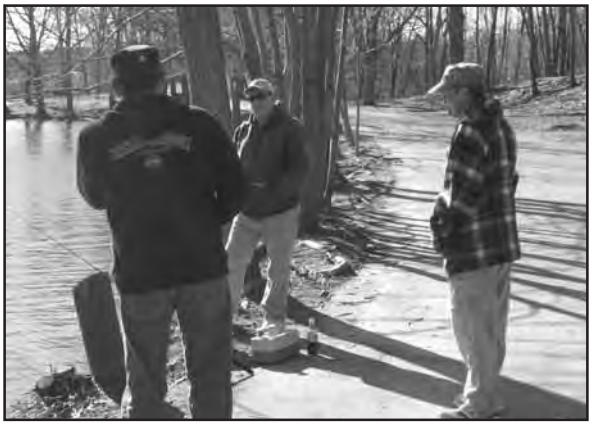
Boston photo album

Buddy and Beverly Sanders and Elaine McIntosh at dinner

Self portrait of new member Laura Collins

John DiGangi driving the Duck

Gloria Dunne and Lorraine Montalbano relaxing



Dan Dozanti, John DiGangi and Dan Hogge "gone fishin'"

New members Julia Slater and Kimberly Russell enjoying the Boston sights

Take two minutes

Facilitated by Patricia Barkey
Summary provided by Lindsey Dozanti

Who is using telemedicine technology and what has your experience been? **Warren Teeter, Wake Forest University**

Narriman Shahrokh, University of California – Has been using telemedicine for 10 yrs UOC is also spending approximately $1Billion distributed among 5 campus; PRIME program to rural sites and a lot of that money will be used for telemedicine programs. Fortunate to negotiate programs for physician time. It's been quite successful. With more providers UOC would have done more. This is for consults services only. They are getting push from correctional facilities but have decided not to do this at this time.

Radmila Bogdanich, Southern Illinois University – We are doing lots of CME telepsychiatry activities with our Division of Developmental Disabilities, and have international affiliations going with Egypt and France at this time. We have a grant from the School's Rural Health Initiative that is funding part of the base salary of a child psychiatrist who is developing a consultation clinic project in southern Illinois. There is only one child psychiatrist south of Springfield and the area is tremendously underserved. We have developed a coalition of primary care providers, the psychiatrist, and counselors and social workers who are all involved. We have developed a research component to the project where we will be assessing the impact of the PCP's comfort level with treating psych patients both before and after. We are not billing for services, but are collecting insurance information on the patients involved and do plan to bill down the line, so that the project can become self sustaining.

Roxanne Morganthaler, University of Washington - We have an adult contract where we provide consults only for a fixed per hour fee, may move to direct service, which is really wanted by that rural site. We have a child contract with a mental health center in Alaska where we do provide direct service both on site and via telemedicine. This center bills third party payors for our services and keeps the payments so I don't know how successful they have been with getting reimbursed for the telemedicine services. For the rural Washington site, the UW provider offers consultation to the care team that includes case managers and midlevel providers. There is a hospital and nursing home attached to this agency so she does geropsychiatry consults for the providers there and sometime the PCP attends. Due to this being on / near an Indian reservation, chemical dependency counselors are also involved.

***Tulane is thinking of opening a Geropsych unit. Does anyone have data source for the cost and/or problems of opening a Geropsych unit*?** **Jim Landry, Tulane University**

Steve Blanchard, University of Iowa - Suggests if you go with exempt unit it could be a problem. If you blend services Medical/Psych it could work for you financially.

Margaret Moran, University of Toledo – Suggests with PPS you have to be careful with diagnostic screening

Pat Romano, Albert Einstein – Suggests documentation will be key with cormobidities.

Does anyone bills for group therapy services provided by hospital employed staff? Jan Price, University of Michigan

Lindsey Dozanti, University Hospital Case Medical Center - Advised they used to bill for services but following an internal review were advised to discontinue billing due to them being included on the hospital's cost report.

His department has gone from paying an 18% Deans Tax to what was referred to as a "Utilization Tax" of 34%. He asked if anyone else had experienced a significant increase? **Warren Teeter, Wake Forest University -**

John DiGangi, University of Massachusetts - Deans Tax is at 30% and is known as the "corporate taxes" in our health system (which is a private, not for profit, Medical Group Practice Plan). UMass is different, as the Medical Group Practice is split from the (State) Medical School and are two separate corporate entities. In our Medical Group Practice Plan, it's the fringe benefit and malpractice expenses that are going up. Billing costs are based on

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transactions and number of providers so everyone is paying proportionally.

Doug Ziedonis (our new Chair) had Charlie Nemeroff from Emory consult to us the other day and he advised the need to determine whether you want to be in the red or black. He suggested that in certain cases you get subsidies to run services, therefore, sometimes being in the red is not a bad thing as long as you can make your case that it's a mission driven service and they keep subsidizing your physician services.

Jim Landry, Tulane University – They pay a Dean's Tax based upon collections.

Joe Thomas, University of Michigan – Suggests it is important to clarify what they are paying as direct vs. Deans Tax as you could be comparing apples and oranges.

Radmila Bogdanich, Southern Illinois University – The AAP Benchmarking Survey demonstrated some University Dean's Tax went as high as 51 percent.

Margaret Moran Dobson, University of Toledo – Certain costs were passed on and others were per head. She also has observed with an orthopedist as President they have moved some costs and there were more per head with smaller transactions going up. This was a problem Psychiatry, Radiology and other PCP were facing.

Deb Pearlman, Yale University – The Dean's Tax was transaction based and that Psychiatry was the highest but it no longer works that way.

An Electronic Medical Record (Epec as the Vendor) is being implemented at U Maryland. Have others gone through this and what they be facing down the road? **Tony Bibbo, University of Maryland**

Narriman Shahorokh, University of California – They are going live in January 2008 and she will provide an update as it was rolled out.

Jeff Tapper, Northwestern University - They are going live May 1st for outpatient services only. He stated that within the practice the process had been fairly smooth to this point and that confidentiality questions are being addressed. He stated that a decision had been made to allow diagnosis, medications, allergies, and labs to be shared and that psychotherapy notes would not be shared. He thinks everyone is comfortable with that and advised integrating into the process of care such as when to put information into the system will be done at the end of day.

Jan Price, University of Michigan – Reminded the group that they went live in 1995 and everything was behind a firewall and protected except for diagnosis, treating physician and medications. No notes were available outside the department. In December 2005 U of M dropped the firewall and they have not had any problems. She also noted that patients were advised that the firewall was being dropped.

Roxanne Morganthaler, University of Washington - Uses Cerner for inpatient and outpatient. They have asked the residents to be vague on their notes and that cancer patients do not want their notes via an EMR.

Steve Blanchard, University of Iowa – Records have been integrated forever whether it's paper or electronic. They also have a homegrown EMR and have advised providers to be vague. They are going to EPEC and have been impressed with the process. They have a steering committee for both inpatient and outpatient. He advised that substance abuse records require a special release.

Elaine McIntosh, University of Nebraska – Advised they have a substance abuse program that is grant funded and therefore records are kept separate. She also advised there was no firewall with psychiatric records.

Lindsey Dozanti, University Hospital Case Medical Center – An EMR was being implemented "enterprise wide" which would include inpatient, outpatient, community/ system hospitals as well as PCP community/system offices. The vendor selected was Eclipses and several Steering committees had been organized. The design and clinical data repository sessions have begun. Timeframe for design, testing and full implementation is 2010.

Maryland is celebrating its Bicentennial and several departments are interested in writing a book. The have found a writer but wondered if anyone has been part of this type of process? **Tony Bibbo,**

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University of Maryland

Jim Landry, Tulane University – They prepared an overview on the "Living History" and have it on CD. They used internal people and included generic history of the department.

Jan Price, University of Michigan – U of M has a historian within the department that worked on their Centennial.

Steve Blanchard, University of Iowa - Their Chair wrote the Department's history.

Lindsey Dozanti, University Hospital Case Medical Center – Chair wrote the Department's history for the 50th year celebration of the building that was built for Psychiatry. They also obtained photos and numerous materials announcing the grand opening of the building as well as other text from the hospital archival department. This data was also on CD and distributed to attendees of the celebration event.

(Pat Barkey is the academic business manager for University of Massachusetts department of psychiatry. Lindsey Dozanti is the administrator of the Case Western Reserve University department of Psychiatry).

Clarification of CMS provider number nomenclature

Following the implementation of the National Provider Identifier (NPI), the Medicare/Medicaid Provider Number will continue to be issued to certified providers/suppliers and used on all survey and certification and patient assessment transactions.

In order to distinguish its role from that of the NPI, the Medicare/Medicaid Provider Number has been renamed the Centers for Medicare & Medicaid Services (CMS) Certification Number (CCN).

By law, the NPI will become the only acceptable provider identifier on Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standard Transactions (i.e., claims, remittance advice, eligibility inquiries, prior authorization and referral, and claims status).

However, post NPI implementation, the Medicare/ Medicaid Provider Number will continue to be issued to certified providers/suppliers and used to verify Medicare/Medicaid certification on all survey and certification and resident/patient assessment transactions. All applicable forms, data entry fields, systems, and manuals are being revised to reflect this new name and the role of the CCN versus the NPI. In some activities, both numbers will be used.

Effective immediately, 'CCN' will replace the term 'Medicare/ Medicaid Provider Number' in survey and certification, assessment-related activities, and communications. This terminology change should be explained in those instances. When the NPI is called for on any form or transaction, it should be provided, if available. When the Medicare/ Medicaid Provider Number (also known as the Online Survey, Certification, and Reporting (OSCAR) Number; Medicare Identification Number; or provider number) is requested, the CCN should be provided.

Honorable mentions

Thank you to everyone who has helped this year to get the newsletter out. Your commitment to AAP make this newsletter and this organization valuable tools for professional development!

Radmila Bogdanich
Jeff Charlson
Lindsey Dozanti
Ellen Francis
Dan Hogge
Jim Landry, CPME
Janice McAdam
Elaine McIntosh
Margaret Moran Dobson
Dave Peterson, FACMPE
Jim Rodenbiker
Pat Sanders Romano
Hank Williams

NIH announces changes to eRA Commons, particularly the electronic streamlined non-competing award process (eSNAP) Function

Effective 4/28/2007, users of the eRA Commons will note a variety of changes throughout the system, particularly in the eSNAP function.

Changes to Institutional Profile Assurances/Certifications

The Assurances/Certification section within the Institutional Profile has been revised to reflect all assurances included in NIH applications and progress reports; specifically Prohibited Research, Select Agent Research and PI Assurance have been added, others have been edited to reflect current terminology. Institutional Officials submitting eSNAP progress reports will be required to update the institutional profile to indicate their compliance with these additional assurances. Grantees are reminded that if an institution is not in compliance with any of these assurances at the time of an eSNAP submission, additional information concerning this issue must be included as part of the "Other Attachments" in an eSNAP submission. Institutional Signing Officials are strongly encouraged to update the Assurances/ Certifications section within the Institutional Profile immediately to avoid any potential delay of eSNAP submissions.

Changes to eSNAP

eSNAP has been revised to bring it current with the OMB-approved changes of the PHS2590 approved in April 2006 and announced to the community in the NIH Guide Notice OD-06-058.

SNAP Questions & Checklist

1) Section Name: The name of this section has been changed to "*SNAP and Other Progress Report Questions and Checklist*"; 2) Select Agents Research: Separate check boxes have been added to specifically capture any changes in Select Agent Research; and, 3) Multiple PI Leadership Plan: Separate checkboxes have been added to specifically capture any changes in the previously submitted Multiple PI Leadership Plan. Grantees are reminded that any explanations for changes in Select Agent Research and/or Multiple PI Leadership Plan are to be included in the actual Progress Report (*Upload Science*).

Change in Business Process: Measuring Effort Devoted to Projects

Transitioning to the SF424 Research and Related (R&R) introduced a new business practice for measuring effort devoted to a project—person months. Personnel working on projects now indicate effort by indicating the number of calendar, academic, and/or summer months. To keep a consistent business practice in place for all applications and progress reports, eSNAP has been revised to reflect this new effort measure in two areas: 1) PI Effort, found on the *Edit Business/Org Info* screen; and, 2) effort for all Key Personnel on the *Edit Business/Key Personnel* screen.

Any edits to the Key Personnel section will require that the user convert annual effort to person months for all Key Personnel listed. Frequently Asked Questions for Person Months and a Conversion Calculator Tool are available at: http://grants.nih.gov/grants/policy/person_months_faqs.htm.

Principal Investigator (PI) Assurance Changes to the PHS2590 included the removal of an actual PI signature on the face page submitted to NIH and instituted in its place an Institutional Assurance requirement for the organization to secure and retain this assurance for all PIs at the organization. Since eSNAP already includes a PI sign-off as part of the electronic routing process, it was determined that this sign-off function could be used as the institutional system of record for the institutional PI assurance. The PI sign-off will be recorded by the system to be retrievable via a new report (see below).

New PI Assurance Report: Institutions need to be able to provide documentation of PI assurances upon request. To accommodate this requirement, a new PI Assurance Report has been created.

Assurance Language: The assurance language used in the sign-off process for PIs has been revised to reflect current policy. In those cases where an Institution delegates eSNAP submit authority to a PI, the assurance language has been modified to appropriately reflect this delegated authority. Note, at this time eSNAP accommodates only a single PI assurance. For those progress reports involving Multiple PIs, this individual is the contact PI only. For now, it will remain the institution's responsibility to secure and retain signatures of the other PIs.

Miscellaneous Enhancements

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Other improvements to eSNAP functionality include: 1) the ability to save and complete an eSNAP in a single action; and, 2) the ability for those with the AO or SO role to now Add/Change files previously accessible only by the PI; i.e., Research Accomplishments and Other File attachments. Although not yet required, grantees are strongly encouraged to use eSNAP for electronic submission of progress reports for all grants awarded under the SNAP authorities.

Other eRA Commons Changes

Pre-populated Progress Report Face Page (PHS 2590)

This continues to be available in Commons *Status*; however, it has been modified to reflect the PHS2590 interim form changes announced in April 2006. Note however, for progress reports involving Multiple PIs, the 2nd page of the Face Page (Face Page-continued) is not available at this time. This is expected to be available in June 2007.

Delegation of PI Status Access to Assistant for Electronic Application Review

PIs now have the ability to delegate to any commons-registered individual with an ASST role the ability to view the status of electronically submitted applications. This new menu choice is found in *Admin/Account/ Delegate Status*. Once in the *Delegate Status* screen, users will see a list of all the individuals registered with the ASST role and can manage the ability to "Delegate" and "Remove" delegation for those individuals. Once this delegation has been granted, the individual with the delegated authority will be able to view and access the list of applications associated with the PI. Individuals can have this authority delegated to them by more than one PI. Please note, that the view these delegated individuals now has is equivalent to that of a signing official (SO View) and as such does not include access to confidential information; e.g., summary statements and priority scores.

Person Profile/Reference Letters

For electronically submitted applications that involve separately submitted confidential reference letters (e.g., NIH Director's Pioneer Award), a feature has been added to electronically monitor the submission of these letters. This monitoring feature appears within the Person Profile where a Reference Letter menu choice now appears. This feature lists only data items appropriate for monitoring the submission of reference letters but does not provide access to the actual documents.

Other enhancements to the eRA Commons are described in the Release Notes posted at: http://era.nih.gov/commons/index.cfm.

Coming attractions

American Medical Group Association
September 27-29, 2007
New Orleans, LA
www.amga.org

Administrators in Academic Psychiatry Fall Conference
October 4-5, 2007
Deer Valley, UT
www.adminpsych.org

Medical Group Management Association
October 28-31, 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!)

Analyze This...

A man walked into a bar and ordered a glass of white wine. He took a sip of the wine then tossed the remainder in the bartender's face.

Before the bartender could recover from the surprise, the man began weeping. "I'm really sorry. I keep doing that to bartenders. I can't tell you how embarrassing it is to have a compulsion like this."

Far from being angry, the bartender was sympathetic. Before long, he was suggesting that the man see a psychoanalyst about his problem. "I happen to have the name of a psychoanalyst," the bartender said. "My brother and my wife have both been treated by him, and they say he's as good as they come." The man wrote down the name of the doctor, thanked the bartender and left. The bartender smiled, knowing he'd done a good deed for a fellow human being.

Six months later, the man was back. "Did you do what I suggested?" The bartender asked, serving a glass of white wine.

"I certainly did," the man said. "I've been seeing the psychoanalyst twice a week." He took a sip of the wine then threw the remainder into the bartender's face.

The flustered bartender wiped his face with a towel. "The doctor doesn't seem to be doing you any good," he spluttered.

"On the contrary," the man said," he's done me a world of good."

"But you just threw the wine in my face again!" The bartender exclaimed.

"Yes," the man replied, "but it doesn't embarrass me anymore!"

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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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