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The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Elaine McIntosh

I hope you have marked you calendars for the upcoming AAP fall conference on October 4-5 (Thursday and Friday) at Deer Valley, Utah. This conference will be an information-packed day and a half conference covering topics on perspectives of a new chair, research, contracting with government agencies, and other pertinent topics, as well as an opportunity to network with other academic administrators from around the country. The resort where the conference will be held is in a beautiful setting, just up the mountain from Park City, the site of the 2000 Olympics. The conference registration fee is $175 and includes program materials, two breakfasts, lunch on Thursday and dinner in Park City Thursday evening. There will also be an administrator's networking dinner at the resort on the Wednesday evening prior to the conference. For more details about this conference, you can read the article in this issue.

The AAP Board of Directors will be meeting on October 3. The BOD will be covering the general association business but the focus of the meeting will be on reviewing and updating the AAP strategic plan that will continue to guide the direction of our organization. If you have ideas and suggestions on ways that AAP could serve our membership more effectively, I invite you to share your ideas with the committee responsible for updating the strategic plan. The committee includes **Margaret Moran Dobson** (U Toledo), Member at Large for Strategic Planning; **Jim Landry** (Tulane U); **Pat Sanders Romano** (Albert Einstein College of Medicine); and **Elaine McIntosh** (U Nebraska).

The Board will also continue to discuss the progress of the development of academic psychiatry benchmarking. The membership of AAP have indicated a need for this information and **Hank Williams** (U Washington), as Member at Large for Benchmarking, has put a great deal of effort into developing a benchmarking initiative that will be ongoing. Several AAP members attended a meeting in July sponsored by Ohio State University Department of Psychiatry on benchmarking academic psychiatry. You can read more about the content of this meeting as well as ideas that have developed as a result in the article beginning on page 4.

I recently participated in a presentation to my department's faculty, staff,

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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:

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A Park City primer

Parley's Park was established around 1850 as a toll stop for prospectors moving westward to strike it rich in the California gold rush. Following the completion of the transcontinental railroad in Promontory, Utah, laid-off workers settled in Parley's Park, raising the population to 164.

In 1868, silver was discovered in the area and with the resultant boom, the town was renamed Parley's Park City, which was soon shortened to Park City. In 1872, the Ontario Mine opened and just a short time later, George Hearst, father of William Randolph Hearst, purchased it for $27,000. The mine earned over $50 million in its lifetime.

The silver boom created a population boom as well, and in 1896, the year Utah became a state and less than 50 years after the town was established, Park City had a population of over 7000.

In 1898, three quarters of the city burned down, but was rebuilt in less than a year and a half. The first business to reopen was a saloon!

Skiing finally arrived in Park City in 1906, when a telephone lineman spent the winter on skis troubleshooting telephone lines. The first ski jump was built on a mine dump in 1930 but more people came to the area to watch the skiing than to participate.

Following some very lean times for the mines, one of the mining companies investigated diversifying and opening a ski resort, and in 1963, the Treasure Mountain Resort was built.

In 1978, the area was without a working mine in over 100 years and by 1982, mining was officially over in Park City. But art filled the void in the form of galleries and the United States Film and Video Festival, now better known as the Sundance Film Festival.

In 2002, Salt Lake City was awarded the 2004 Winter Olympics, and more than 40% of the events were held in Park City at the Utah Olympic Park, Deer Valley, and Park City Mountain Resort.

Fall conference in Utah

The Fall AAP Conference will be held Thursday and Friday, October 4 and 5, 2007 in Deer Valley, Utah, adjacent to Park City. Deer Valley and Park City were part of the Winter Olympics complex and our conference venue, The Chateaux at Silver Lake, is a luxurious condominium hotel with a full-service day spa. The conference facilities can be viewed at the following web site: http://www.deervalleylodging.com/resort.php/DVL/PROPERTYLIST?propertyId=262. Lodging rates are $129 per night. Flight arrangements should be made to Salt Lake City, Utah. Ground transportation is available through the resort complex and arrangements can be made on the hotel reservation form sent via the listserv. If you need a lodging reservation form, one is included with this newsletter or contact Steve Blanchard (steve-blanchard@uiowa.edu).

Different this year, the conference will begin on Thursday morning and conclude at noon on Friday. There will be a networking dinner on Wednesday evening at the Deer Valley facility. The Thursday dinner will be in Park City at The Windy Ridge. If you have the Columbus Day holiday off, you may want to consider extending your stay into a long weekend. Conference lodging rates are available three days prior to the beginning of the event and three days following. Thanks to **Dan Hogge** (U Utah) who has being doing the ground work with arrangements for lodging and meals.

The program will feature a keynote address by the new chair of the Utah Department of Psychiatry, **William McMahon, MD**, who will speak to us about the role of the administrator as an extension of the chair. Thursday afternoon will feature a presentation on contracting clinical services and will end with the always popular "Take 2 Minutes" discussion, so come prepared with questions. Friday's session will focus on benchmarking and the measurement of psychiatry's value and activity. A program brochure and registration form will be sent soon via the listserv to all members. If you need one, contact Steve Blanchard

Looking ahead, the Spring Conference will be held in Orlando, Florida at the Disney Contemporary Resort. The date for that conference will be March 29, 2008, prior to the MGMA Academic Practice Assembly meeting. Suggestions for topics for the Spring Conference should be sent to Steve Blanchard.

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!)

Academic psychiatry benchmarking project underway

For two very full days in July, a group of AAP members and Ohio State University faculty and staff met in Columbus, Ohio for a discussion of the development of benchmarking measures for academic psychiatry departments. **Toni Ansley**, Administrator, and **Radu Saveanu, MD**, Chair of the OSU Department of Psychiatry, challenged by their institution's leadership to demonstrate how their department's financial health compares to other academic psychiatry departments, realized that this information didn't exist anywhere specifically for psychiatry. In order to make the meeting meaningful, the forum expanded beyond financial metrics alone to include operations, staffing, quality, staff and patient satisfaction, and faculty productivity and compensation.

Day one, which dealt primarily with operational issues, began with an introductory review of benchmarking, including the mistakes made when doing it (see sidebar). A presentation by **Avni Cirpili, RN, MSN**, OSU Harding Hospital Chief Nursing Officer, discussed inpatient staffing and the measures currently available to determine appropriate staffing levels while accounting for census and acuity. An exercise allowed participants to consider the

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Avoid these 10 benchmarking mistakes

1. **Confusing benchmarking with participating in a survey**. Benchmarking is the process of finding out what is behind the numbers. A survey may tell you where you rank, but it won't help improve your position.
2. **Thinking there are preexisting "benchmarks" to be found**.
3. **Forgetting about service delivery and customer satisfaction**. The cost of providing service is not the only statistic to consider. Take a "balanced scorecard" approach
4. **The process is too large and complex to be manageable**. Avoid trying to benchmark a total system. Select one or two processes that form a part of the total system.
5. **Confusing benchmarking with research**. Collecting information to take ideas from is research, not benchmarking.
6. **Misalignment**. Make sure that the issue you benchmark is aligned with the overall strategy and goals of your organization.
7. **Picking a topic that is too intangible and difficult to measure**. Choose a topic that is easily observed and measured.
8. **Not establishing a baseline**. Analyze your own process before going out to observe others.
9. **Not researching benchmarking partners thoroughly**. Choose those you will benchmark against carefully so that you don't waste your time or theirs.
10. **Not having a code of ethics and contract agreed with partners**. Make clear what you are seeking to learn from your benchmarking partners, how you will treat the information, who will have access to it, and for what purposes it will be used.

(Adapted and reprinted with permission. Benchmarking PLUS, Level 6, 443 Little Collins Street, Melbourne, VIC 3000, Australia. Tel +61-3 (03) 9600 2186. Email: info@benchmarkingplus.com.au).

Continued from page 4

elements that affect staffing for Hours Per Patient Day and to develop benchmarking questions that could be asked across departments.

Jay Kasey, Chief Operating Officer of OSU Health Systems, next discussed balanced scorecards. These scorecards allow organizations to align their vision and mission with customer requirements by providing data to manage and evaluate business strategies, monitor operational efficiency improvement, build capacity, and communicate progress to all employees. In order to develop a meaningful scorecard, performance measures should be developed that reflect the overall business strategies of the organization. Scorecards should filter down to each organization's units, making sure that they are meaningful to the unit. Following this presentation, the group developed several metrics felt to be important for comparison across departments.

The remainder of the day was spent discussing satisfaction surveys. After an introductory presentation by Toni, a group breakout developed a brief draft tool for measuring staff satisfaction.

A presentation by **Kenneth Yeager, Ph.D., LISW, ICDC**, Assistant Professor and Director of Quality and Operational Improvement for OSU Harding Hospital, discussed the difficulties and benefits of doing inpatient satisfaction surveys in psychiatry. The most important correlate of patient satisfaction is patient perception of care, so whatever tool is selected must take this into account. Dr. Yeager shared OSU Harding's results which demonstrated a higher correlation between satisfaction and nursing care than with physician care. Because surveying inpatient satisfaction is generally a function assumed by the hospital, the group will not be recommending a separate survey tool. However, there are very few psychiatry specific tools, and Dr. Yeager thinks that the Press-Ganey tool will become the industry standard for psychiatry satisfaction, even though it has been found to have a higher level of patient confusion than other instruments.

Day two was focused on financial structures, and began with a sharing of the various faculty compensation models used by the participants. Models were as varied as the departments represented, using measures of productivity, billing, RVU's or some combination.

Mission based reporting (MBR) is a decision-making process that is mission driven -- in a healthcare setting using the tripartite missions of clinical care, research and education. Toni gave a presentation that focused on using MBR for measuring physician productivity and determining compensation. The group reviewed a sampling of compensation models to determine areas within education, research and administrative responsibilities on which to benchmark.

The second day ended with a discussion of next steps. Members of the group will examine the MGMA, University Hospital Consortium, and Facility Practice Solution Center surveys already in use for data currently available. An investigation of what might be available through the AAMC Group on Business Affairs will also be conducted. Then, a comparison of these surveys with the questions we determined important will be made. It was agreed that any efforts to survey academic psychiatry departments should be done under the umbrella of AAP, both to lend credence to the process and to hopefully ensure a higher response rate. Finally, because survey tools currently exist, members of AAP should be encouraged to participate in these external surveys as they arise, providing more reliable results and because the statistical tabulation can be completed more easily than AAP could do. Toni will summarize the meeting results which will be used at future meetings of the benchmarking group.

14 recommendations to prevent no-shows

by Kathleen Quinn, MBA, RN

Patients who fail to keep appointments without notice - "no shows" - adversely affect patient access and clinical revenue. The University of California - San Francisco (UCSF) Medical Center experiences an estimated 67,000 no-shows annually, which have a conservative financial impact of $7 million.

When a patient fails to keep an appointment and does not give notice, it's not possible to offer the slot to another patient, even that day.

The problem of no-shows has no single solution. The reasons and the rates for no-shows vary greatly among practices. However, the approaches we describe for our academic medical center can be applied in any practice setting.

1. **Establish a cancellation line** - Put a cancellation option on the automatic telephone-call distributor that routes to voice-mail around the clock. A staff member must check voice-mail regularly and cancel appointments in the scheduling system, making slots available to other patients.
2. **Send reminder letters** - These are sent to patients with three or more missed appointments in a 12 month period.
3. **Put up "good citizen" signage** - Signs are posted on elevators and in other key locations saying "We know that things come up and sometimes you can't keep a scheduled appointment. When that happens, please let us know as soon as possible so we can offer your appointment to another patient. Call our cancel line 24/7 at ###-####.
4. **Use a training bulletin** - The bulletin reminds employees that they can view a patient's no-show history in the scheduling system for the last 12 months. Managers can determine, based on a defined number of no-shows, whether another intervention is appropriate.
5. **Automatically generate letters from the scheduling system** - Each practice can tailor letters to no-show patients from the UCSF scheduling system, e.g., "Our records indicate this is the third appointment you have failed to keep. Please call us at least 24 hours in advance if you cannot keep an appointment."
6. **Revise-shorten the automated reminder message to a "quick listen"** - Because some patients would hang up on a lengthy reminder message, we shortened it considerably.
7. **Overbook the schedule to cover for no-shows** - This is relatively easy to implement but more difficult to sell. Provider buy-in is critical. Practices can start conservatively and over book by half of the no-show rate or some other portion. This option does not reduce the number of no-shows - it simply replaces the revenue.
8. **Create "standby" appointments for patients with a history of no-shows** - This offers the opportunity to increase revenues by seeing more patients and may reduce the no-show rate. Revenues outweigh staff expenses to adjust master schedules and monitor flow, but increased staff time should not be considered.
9. **Use open-access scheduling** - Open access scheduling requires resources to reduce the backlog of demand, such as locum tenens to increase sessions in the short term and analytical support to predict and monitor demand. Open access works better when a practice doesn't require preparation for patients' visits. This method may have a detrimental effect on continuity clinics - those scheduled for medical residents to care for a defined subset of patients - so academic practices need to consider the impact on the teaching program.
10. **Remind staff to look for existing appointments before offering another** - This is necessary in case the patient is calling to reschedule an appointment or has forgotten an appointment made at checkout.
11. **Discharge from practice, based on a defined number of no-shows** - Most patient dismissal policies consider no-

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show behavior but don't state a level of tolerance. [UCSF] recommends that five no-shows in a 12 month period trigger a review to see of discharging a patient from the practice is clinically appropriate.

12. **Define no-show criteria** - In our scheduling system, a missed appointment can only be classified as a no-show if the appointment time has passed. Our no-show rate does not capture patients who cancel with such short notice that we can't put another individual in the slot. A training bulletin on this topic ensures consistency across practices.
13. **Have provider discuss no-show behavior with patient** - Having a nurse or physician talk briefly with patient who have a history of no-shows may effectively convey the importance of keeping appointments.
14. **Create a no-show report** - The report lists upcoming appointments of patients with histories of no-shows. The practice can them employ preventive measures, such as reminder calls, reminder c cards and overbooking those appointment slots.

Both patient access and clinical revenue incentives prompt a medical practice to decrease no-show rates. . . . There is no single, easy fix to this complicated problem, but employing a variety of measures, customized to your practice, will decrease the no-show rate, improve access and boost revenue.

(Excerpted from "It's no-show time!" MGMA Connexion, July 2007, by Kathleen Quinn, MBA, RN, administrative director, University of California - San Francisco department of orthopaedics.

Use of "tamper-proof" prescription pads mandated on Oct. 1

In the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, Congress included Section 7002(b) which states, "Effective Oct. 1, 2007, Medicaid outpatient drugs will be reimbursable only if nonelectronic written prescriptions are executed on a tamper-resistant pad."

[It is expected] that the Centers for Medicare & Medicaid Services (CMS) will send a letter to state Medicaid directors regarding state implementation of this federal requirement. State insurance commissioners will likely have the ultimate implementation authority through a state definition of tamper-proof prescription pad. California, Florida, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Mississippi, New Jersey, New York, Pennsylvania, Texas and Wyoming already have laws requiring varying levels of tamper-proof prescription pads. These states variously require prescription pads to be written in triplicate; require pads to contain chemicals that reveal efforts to alter the paper; or require pads to display serial numbers so pharmacists can match the physician' orders.

It is unclear whether this new federal requirement will apply to all drugs or just narcotics. Although the law's intent is to prevent patients from obtaining drugs illegally, the rapidly approaching start date leaves little time for education and compliance for pharmacists, physicians and the 55 million Medicaid beneficiaries.

MGMA and other national provider and pharmacy organizations have raised concerns with CMS about the short implementation time, but the agency has no regulatory authority to delay the start date mandated by Congress.

(Reprinted from MGMA Connexion, August 6, 2007)

President's message

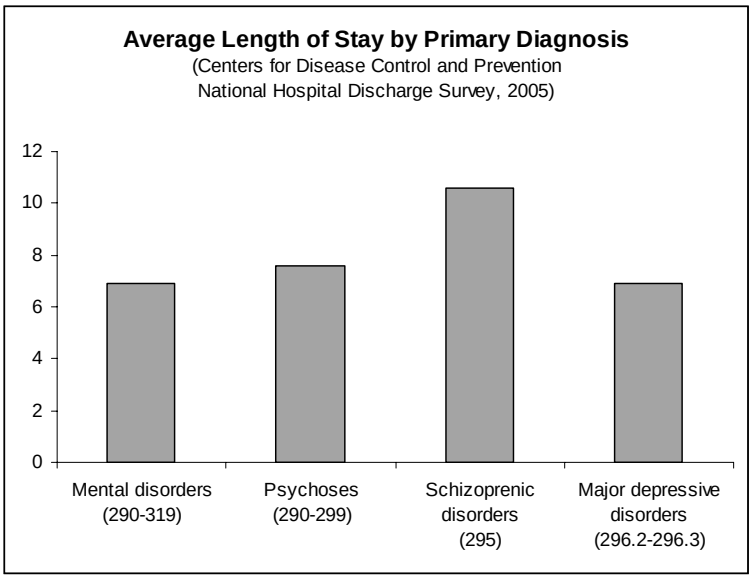
Continued from page 1

residents, and medical students on understanding your personal style and how to effectively communicate with colleagues with different personal styles. This presentation was a take off of the Myers-Briggs personality test but we presented a much more streamlined survey that can be accessed at www.goer.state.ny.us/Train. The survey takes only five minutes to complete, gives an immediate response to the survey results, and makes recommendations on how to effectively communicate with other personality types.

In working on this project, it occurred to me that it is very important for administrators in academic departments to be flexible in their communication style. We communicate with a myriad of people with very different personalities during the course of a day. Our roles change drastically from one interaction to the next depending on whether we are communicating with faculty, staff, residents/students, university officials, or external contacts. My conclusion at the end of this presentation was that all of us need to have a well honed tool box of communication skills that include but are not limited to diplomacy, flexibility in personal communication styles, good verbal skills, ability to listen and understand others' perspectives, effective body language, and the ability not to take things personally.

Effective communication is just one aspect of our positions. Membership in AAP has been so very beneficial to me in my career because is provides a forum for the development of the many skills that administrators must possess and an opportunity to network with individuals in a similar role. I hope you will consider attending the fall conference at Deer Valley as another opportunity to build your skills as an administrator—and to have some fun with academic psychiatry colleagues.

Psychiatry by the Numbers



What's new?

The 'Housewife' Will See You Now

Two quality solutions to a city's therapist shortage

From time to time, The GrAAPvine *features innovative and interesting programs in academic departments of psychiatry. These programs might ignite an idea for other departments as well. If you have a program you'd like featured, let us know.*

The path that Lois Feinblatt and Ellen Halle have chosen for the past 36 years is one some women dream about while they sort socks in a steamy laundry room. Even the way it came about has a fabled feel to it. In 1966, word got out about an unusual Hopkins program to train mature women as "auxiliary psychotherapists" as a fix for Baltimore's shortage of community psychiatry professionals. The project mirrored an earlier NIMH model.

As then-head of Psychiatry Joel Elkes told the Baltimore Sun, "We're tapping a great reservoir of talent represented by intelligent married women in their 40s. They've become experts in family management just as their families are leaving home." Those chosen, he said, would be college graduates with "psychological awareness, minimal defensiveness and an ability to empathize."

So just as the program appeared, Halle and Feinblatt fit right in. The two women, both college graduates in English literature, had seven non-cookie-cutter children between them, had managed active households and had "served sentences" on social service boards. Married to prominent, successful men, they were accomplished and worldly in the best sense. Feinblatt had worked a decade for the city's Department of Welfare.

Acceptance, however, wasn't a snap. Some 40 others were as eager, Halle says, especially new psychologists wanting clinical experience. "We survived an avalanche of interviews," says Feinblatt. The women also role-played and dealt with hypothetical patients. For a month, their every word was weighed by clinicians rapier-sharp to nuance in speech and thought. "It was both intense and dramatic," says Halle, who remembers it vividly. "But because I'm not a competitive person," adds Feinblatt, "it was also somewhat terrifying."

For the next two years, the two spent 40 hours a week in study, gaining an intensive clinical education. Rooming together on campus made them fast friends. And training under the area's finest psychoanalysts and psychiatrists served them, and the community, well. Then came a third-year internship.

"The program wasn't without controversy," says Halle. The trainees were called "the housewives" behind their backs by green-eyed residents put off after seeing women their mothers' age develop a quick rapport with their patients. It also stung when, in grand rounds, the chief of medicine asked "the housewives" not to ask questions, please.

A dedicated lot, all eight of the Hopkins trainees graduated, most taking jobs throughout the city. The program proved wonderfully relevant.

Ultimately, Halle and Feinblatt earned master's degrees and certification as licensed clinical professional counselors. At first they worked in private or group practices, but then, in 1970, Hopkins' Chester Schmidt thought they'd fit well in the new Sexual Behaviors Consultation Unit he was co-heading with fellow psychiatrist Jon Meyer.

In the days of Masters and Johnson, when human sexuality clinics dotted the country, the SBCU was one of few tied to a major medical facility. Its reliance on scientific rigor brought respect that lasts today.

"From the beginning it's been a place where patients learn about themselves," adds Feinblatt, "where they're made to feel comfortable." First interviewing patients, then adding to their evaluations, the women soon became instructors in psychiatry. They were sought out as therapists, and still are today.

They also weathered the clinic's three phases: first, after the discovery that women could be orgasmic—a time that couples' appointments surged, says Feinblatt. Then they began to see men whose impotence, in part, followed from demands of the first phase. Now, says Halle, disorders of desire are more common: "We've identified the functional-but-disinterested patient."

Through that, says Schmidt, "Lois and Ellen have kept a broader, psychodynamic view of mental health. They know how and why our patients do what they do. Their observations are invaluable. They have a depth of understanding that our medical students can't touch."

This story was first published in the winter 2007 issue of the Johns Hopkins Medicine newsletter Brainwise. Reprinted with permission.

The executive suite

Proving ground for academic medicine

by David Peterson, FACMPE

Google™ "psychiatry" and "canary in a coal mine" and the over 10,000 search results range from psychiatry and overcrowded emergency rooms to psychiatry and children (along with many obscure results in this quasi-Boolean search). If one is "feeling lucky," the first hit will likely be an article from the *Archives of General Psychiatry* regarding cognitive markers and Alzheimer disease. To be sure, most of the results describe *clinical* canaries in a coal mine under the premise that certain psychiatric symptoms or behavior may be early signals of other medical illnesses. But some of the results of such a search suggest that psychiatry could be a *financial* canary in the coal mine, serving as a signal of what may be in store for the rest of academic medicine.

With the economic landscape changing for the academic medical field through pressures in continually declining reimbursements, scarcer resources and the increasing need for creative clinical practice management to name a few, it is no wonder that psychiatry could be viewed as a financial bellwether for the field. These pressures are not new to those in psychiatry and a peek into the discussions on the AAP listserv, for example, shows that strategies for a psychiatry department's survival in a changing, often fragile, environment include establishing community partnerships; working creatively with the public sector; developing service contracts with outside agencies; weaving multiple funding sources into a coherent program; carefully managing scarce resources; skillfully negotiating with hospital leadership; and savvy managed care contracting, to name a few.

The list could go on, but one could posit that the execution of many of these strategies extends psychiatry more deeply into the community than some of the other medical specialties and results in a psychiatry department with heightened sensitivity to changes in the medical marketplace, creating the proverbial financial canary in the medical practice coal mine. And, it is these very strategies, so frequently employed by administrators in academic psychiatry, that administrators in other clinical departments will likely need to embrace as the medical marketplace continues to change.

These strategies noted above loosely correlate to the list of attributes for the "new academic world" that Dr. Darrell Kirsch, President & CEO, AAMC, presented at the Academic Practice Assembly meeting in Boston. These attributes are:

- Mutual goal setting and shared accountability,
- Interdependence across individuals and systems,
- Group process and consensus,
- Professional diversity and adaptation, and
- Creative pathways that balance service and scholarship.[1]

The notion that psychiatry could be a proving ground for academic medicine is not new. A former Senior Associate Dean for Clinical Affairs, uniquely positioned to make such a pronouncement, once stated that if one can manage a department of psychiatry, one can mange any clinical department or program. The career tracks of some former AAP members bear this out, many of whom have moved on to managing departments of medicine, cancer centers and even an international healthcare program, to name a few. To reinforce this notion, some chairs of departments of psychiatry have moved on to become deans of medical schools.

So, to catch a glimpse of what the future could hold for academic medicine, perhaps one need look no farther than to an academic department of psychiatry.

A proving ground for the management of the business of medicine is the credentialing and board certification process offered to administrators through the **American College of Medical Practice Executives (ACMPE)**. This process helps hone the skill sets necessary to navigate and stay nimble in an ever-challenging medical marketplace. For those who want to further develop the skills necessary to recognize and manage the early warning signs that can signal change, a journey to www.acmpe.com is worth the trip.

(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).

Endnotes

1 "Transforming Academic Medicine: The Leadership Opportunity", Kirsch Darrell G. MD, MGMA-APA presentation, April 22, 2007.

Suggested reading

"Visualizing the Future: Technology Competency Development in Clinical Medicine, and Implications for Medical Education" Malathi Srinivasan, M.D., Craig R. Keenan, M.D., Joel Yager, M.D. *Academic Psychiatry*, Vol. 30, No. 6, November-December 2006, pps. 480-490

We all know that medical practice continues to evolve at a very quick pace. Part of this evolution is based on the vast amount of in-depth knowledge scientists continue to cultivate. Other factors include the changing marketplace, globalization, outsourcing of jobs and the need to provide more cost effective health care with improved quality. Finally, technological advances are driving constant change and enhancements to communication methods. It is clear that these changes are already having a significant impact on the practice of medicine and the education of future students and residents.

The authors of this article do an excellent job of describing the past, present and a probable future scenario of how health care has been and will be delivered. They point out, however, that it is very difficult to predict paradigm shifts based on our current knowledge of technology since the field is advancing so quickly, coupled with the fact that "current social/economic/political trends" are equally unpredictable. The authors discuss how the advancement of new technology in medicine is influenced by the need for "accessibility, affordability, accountability and affability."

The authors provide a wonderfully descriptive futuristic scenario of how a physician in India treats a citizen in the U.S. and how they overcome issues of confidentiality, insurance, billing, patient education, continued patient monitoring/continuity of care, cultural issues, and patient satisfaction. The on-call physician answers a video conference call from a patient 8,500 miles away who is insured by an international health network. The physician accesses the patient's electronic health record. The patient is sitting in a "local med-terminal" where vital signs are performed automatically by various built-in pressure gauges and the physician is able to perform an MRI-type scan to diagnose the possible problem. Since the patient completes a satisfaction survey, he/she receives a discount on his/her co-pay. This was fascinating reading - you'll have to read the entire article for the in-depth description.

This article also includes detailed appendices which outline the past, present and future of medicine in the areas of:

- Characteristic communication
- Diagnosis
- Therapy
- Information management
- Continuing education
- Quality control and location
- Medical economics
- Critical characteristics of medically-related technologies that influence the likelihood for adoption by medical profession and society and related competencies
- Fields of evolving knowledge
- Relationship of some technology-related competencies to ACGME Core Competencies
- Competencies related to use of technology in medical education and patient education

As our group practice struggles with implementation of an electronic medical record, I marvel at the seeming complexity of this relatively simple technology and recognize that we are just taking a "baby step" towards quantum change in health care.

(This article was reviewed by Radmila Bogdanich, administrator of the Southern Illinois University department of psychiatry).

Common errors to avoid with NIH electronic submissions

by Hank Williams

October is another major submission date for NIH proposals, and electronic submission is here!

With the electronic submission of grant applications, here are a few common errors to avoid, courtesy of NIH:

Invalid or Missing eRA Commons Username

The assigned eRA Commons Username must be entered in the field called "Credential, e.g. agency login" for anyone assigned the PD/PI role. This field is located on the R&R Senior/Key Person Profile(s) component of the grant application. The field is not marked as required on the application form (federal-wide form and not all agencies need this field), but is required by NIH as indicated in the application instructions in the SF424 (R&R) Application Guide.

The eRA Commons Username is used to link the submitted application to the PD/PI records in the Commons system. Without this information, the system cannot determine where to display application status or store the assembled application image.

Missing Organization Name for Senior/Key Person

The Organization field of the R&R Senior/Key Person Profile(s) component is required by NIH for all Senior/Key Persons listed. This information is used by NIH staff to determine such issues as conflict of interest with potential reviewers.

PDF Issues

NIH requires all text attachments to be in PDF format.

Senior/Key Person Effort on SF424 R&R Budget Form Must be More Than Zero

The effort included on the SF424 R&R Budget form calendar months, academic months, or summer months fields must be greater than zero for Senior/Key Persons listed. Use either calendar months or a combination of academic and summer months. For information about calculating person months, see http://grants1.nih.gov/grants/policy/person_months_faqs.htm.

Federal Identifier Format

The Federal Identifier field of the SF424 R&R cover component should be filled in as follows:

If "Type of Application" is "New", you can leave the Federal Identifier field blank on the first submission attempt. However, the Federal Identifier field becomes a required field when submitting a Changed/Corrected application to address errors/warnings. When submitting a Changed/Corrected "New" application, enter the Grants.gov tracking number of the previous submission attempt (e.g. GRANT00123456). If you are unable to find the tracking number, enter "N/A." If "Type of Application" is "Renewal," "Revision" or "Resubmission," enter the IC (Institute/Center) and serial number of the prior application/award number. The IC code is a two-letter code immediately following the activity code/grant program. The six-digit serial number follows the IC code. For example, the IC and serial number for application number 3R01CA123456-04S1A1 is CA123456.

How To Submit A Corrected Application

If your application had errors and did not make it through the eRA Commons application checking process (i.e. validations), you must correct the error(s) and submit a changed/corrected application to Grants.gov before your application can proceed further.

Here are the steps to take:

1. On the first page of the SF424 (R&R) application form, check the Changed/Corrected application box in the Type of Submission field located in box 1.
2. Once the Changed/Corrected box is checked, box 4, the Federal Identifier, becomes a required field. If you are submitting a "New" project application (including corrected submissions for "New" applications), enter the Grants.gov tracking number of the previous

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submission attempt (e.g. GRANT00123456). If you are unable to find the tracking number, enter "N/A". For "Renewal," "Resubmission" or "Revision" applications, the Federal Identifier field should contain the IC and serial number of the prior application/award number (e.g. CA123456).

3. If after the submission deadline, include a cover letter with an explanation of your changes and why the application is late. Include information from any previous cover letter(s) since that information is not retained. The cover letter must be in PDF format and attached to the PHS Cover Letter component of the application.
4. The entire Changed/Corrected application must be submitted through Grants.gov.

NIH requiring mandatory use of the electronic Financial Status Report system in the eRA Commons beginning October 1, 2007

by Hank Williams

If you are directly involved in the submission of NIH Financial Status Reports, the rules are a little different starting October 1, 2007.

NIH requires all domestic and foreign Financial Status Reports (FSRs) due on or after October 1, 2007 to be submitted using the electronic FSR system located in the eRA Commons. This includes all initial FSRs being prepared for submission and any revisions being submitted or resubmitted to NIH. This requirement does not affect other Federal agencies and how they may handle FSR's. The eRA Commons web-based FSR system allows participants to view information on currently due and late FSRs and to submit FSRs electronically to the NIH.

For those institutions not already registered in the Commons, registering in the eRA Commons allows your faculty and staff to take advantage of the electronic submission and retrieval of grant information. Only an individual with signatory authority for the institution or organization in grant-related matters can register an institution. This individual is known as a Signing Official (SO). To register in the eRA Commons, open the NIH eRA Commons homepage and click on the Grantee Organization Registration link. Follow the step-by-step instructions. The institution is registered when the information is completed, submitted (by pressing the Submit button) and confirmed by the NIH. An account with the SO role is created along with the institution registration.

Once an institution is registered, the SO can log into eRA Commons, create individual user accounts and designate the roles associated with each account. Roles provide the authority within eRA Commons to perform specific tasks. The FSR role allows institutional or organizational staff to process FSRs for submission to the NIH electronically. An account for an individual can include multiple roles, including the FSR role; however, an account with only the FSR role assigned can only perform FSR tasks.

Additional resources concerning the FSR system including a User Guide and an on-line demonstration can be found on the eRA Commons Support Page: http://era.nih.gov/commons/

Reminder: Unless the Grants Management Officer of the awarding Institute or Center approves an extension, grantees must submit a final FSR, final progress report, and Final Invention Statement and Certification within 90 days of the end of grant period. Failure to submit timely and accurate final reports may affect future funding to the organization or awards under the direction of the same PI.

A psychiatrist returned from a conference in Park City, where the attendees went skiing in their spare time.

Her husband asked her, "How was the meeting?"

She replied, "Fine, but I've never seen so many Freudians slip."

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