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Spring 2008

The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Steve Blanchard

There has been a lot of change since I last prepared this column. President Obama has won the 2008 election and been installed into office. The economy has gone into a steep dive which undoubtedly is affecting every one of you and your programs. The Iowa winter has been harsh with record cold temperatures resulting in school closures, not because of snow, but because of the dangers associated with such extreme temperatures. Since we have had temperatures above freezing in the last few weeks, I am beginning to anticipate spring.

I am certain that budget issues are your primary concern these days. What size budget reduction will occur because of reduced revenues for state governments? I have heard from a number of you about the challenge of maintaining your clinical, teaching and research missions as you face very significant budget reductions both this fiscal year and going into next year.

I do want to encourage that we maintain our vigilance as the regulations for implementing the mental health parity legislation are developed. It will be imperative that these regulations be critiqued by academic centers to see that care for patients will be advanced at teaching medical centers as well as community treatment settings.

During the last few months, the Task Force working to improve the AAP web site and listserv has been making progress; although it seems largely to be a process involving moving ahead two steps and back one. Requests for bids were submitted to three vendors; two responses were received. Both estimates were well beyond the budget capacity of AAP. The Task Force and the Board have reevaluated priorities regarding electronic communication to our members. The listserv is still considered the number one priority and one of the most valued services available to AAP members. The

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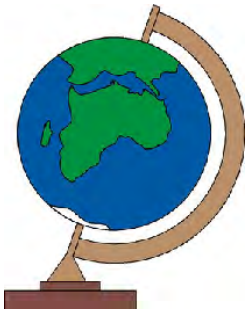
Comings and goings



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:

Janet Namini
Northwestern U
(312) 695-2195
jnamini@nmff.org

AAP wishes the best of luck to the following members:

Wendy Carlton (U Miami)

John DiGangi (U Massachusetts) See below

Randolph Siwabessy (U California-San Francisco)

The following former members have been granted Honorary status:

John DiGangi

Brenda Paulsen

A fond farewell

After 21 years in the Department of Psychiatry at University of Massachusetts, Academic Health Center, I found myself reassessing my priorities and desiring a move to another job. Rebalancing my work life and taking care of my health were the main priorities. After careful consideration, I applied for and was offered a job in the UMass Memorial Medical Group Finance and Budget office. I accepted the offer and started in the new job on December 29, 2008. I anticipate in this new role I'll be able to utilize my budget, finance, and management skills for the greater good of the UMass Memorial Clinical System and in the process find the balance I'm looking for.

I am sincerely indebted to all the great mentors, teachers, and downright nice people I have had the privilege of knowing and interacting with in the AAP organization. Much has been accomplished in the AAP in the 20 years I've been a member. I know that you all will continue to stick together, help each other learn, and continue to accomplish great things in the future.

That's it for now....I will miss all of you and all the fun we had when we were together. Be happy and healthy!

John DiGangi

Address change

Please update your membership directory to reflect the following change:

Anna John
Administrator
U Colorado, Denver
Department of Psychiatry
13001 E 17th Place
Campus Box F546
Aurora, CO 80045

Her email remains the same.

Appreciating your staff

Talent moves to where it's appreciated. In fact, 79% of those who quit their jobs cite lack of appreciation as the main reason. But appreciation does more than keep people engaged. It reveals hidden talents and inspires people to grow as well. It transforms managers into leaders people want to follow. Here are a few suggestions that don't cost anything but can make a real difference.

- Give recognition for specific achievements.
- Write or make a personal thank you note when an employee goes above and beyond.
- Establish a "Behind the Scenes" award specifically for those whose actions are not usually in the limelight.
- Drop in at the first meeting of a special project team and express your appreciation for their involvement.
- Send a letter to all team members at the conclusion of a project, thanking them for their participation.
- Call an employee to your office to thank them - don't discuss any other issue.

(Excerpted from UMHS Recognition Committee suggestions)

Coming attractions

National Association of Psychiatric Health Systems
March 16-18, 2009
Washington, DC
www.naphs.org

Administrators in Academic Psychiatry Spring Conference
April 18, 2009
Los Angeles, CA
www.adminpsych.org

MGMA Academic Practice Assembly Annual Conference
April 19-21, 2009
Los Angeles, CA
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!)

On location in Beverly Hills

When AAP goes to Los Angeles in April, you'll have the opportunity to sightsee around Beverly Hills and Rodeo Drive. Lots of movies were filmed in the area - here are just a few. See if you can find these locations!

Pretty Woman was filmed on location at the Beverly Wilshire Hotel. Did you ever wonder what store Julia Roberts was snubbed in, in *Pretty Woman*? Well, it was a woman's clothing store named Boulmiche, located just a few steps west of Rodeo, at 9501 Santa Monica Blvd.

A bum played by Nick Nolte moved into a house in Beverly Hills in the 1986 comedy ***Down and Out in Beverly Hills***, and changed the lives of Richard Dreyfuss & Bette Midler. You'll find this home at 802 N. Bedford Drive (at Lomitas Avenue, two blocks west of Rodeo Drive)

The ***Beverly Hills Cop*** series with Eddie Murphy was, of course, filmed in the city. One of the buildings he looks at is the Beverly Hills Hotel. Also known as "the Pink Palace," the hotel is a landmark, built back in 1912. The city of Beverly Hills literally grew up around the hotel - a magnet for celebrities and heads of state. You'll find the hotel at 9641 Sunset Blvd, in Beverly Hills, where the north end of Rodeo Drive meets Sunset. One of the Beverly Hills mansions that Eddie looks at can be found on the north side of Sunset Blvd, between E. Elm Drive (on the west) and N. Palm Drive (on the east) - and between both ends of the U-shaped Mountain Drive. It's about two miles east of the Beverly Hills Hotel. If you've seen 1994's ***Beverly Hills Cop III*** you'll recognize the Beverly Hills Civic Center, the gorgeous mission-style complex which includes one of the best-looking police stations and city halls anywhere, located at 450 N. Rexford Drive, Beverly Hills. The civic center was also featured in the 1993 movie version of ***The Beverly Hillbillies*** (in the scene where the Clampetts were arrested), and in 1994's ***Color of Night*** starring Bruce Willis.

Remember the scene in 1993's ***Indecent Proposal*** where real estate agent Demi Moore shows millionaire Robert Redford through an empty gothic mansion? That was shot inside the historic Greystone mansion in Greystone Park (at 905 Loma Vista Drive). Nicholas Cage had to break into the house after his girlfriend locked him out in ***National Treasure: Book of Secrets***. Other movies filmed in and around the Doheny mansion and gardens of Greystone Park include ***The Big Lebowski, Ghostbusters II, The Witches of Eastwick, All of Me, The Loved One, The Disorderly Orderly, Forever Amber***, *and* ***Dynasty, The Movie.***

Spring conference features some "stars" of psychiatry

The 2009 Spring Educational Conference of the Administrators in Academic Psychiatry (AAP), will be held Saturday, April 18, at the Hyatt Regency Century City Plaza in Los Angeles, California.

Friday evening, April 17, AAP conference attendees and their guests are invited to an informal opening night networking dinner with colleagues. A continental breakfast begins Saturday's activities, then the day's agenda, concluding with the AAP dinner. Sunday morning, April 19, there will be an AAP networking brunch for attendees and their families. Following Sunday's brunch, anyone interested can join the annual Sunday adventure, details to be revealed at the conference.

This year's conference features a strong slate of innovative leaders in the field of psychiatry. Also on Saturday will be the ever popular Take Two Minutes, the AAP annual business meeting, presentation of awards, and election of officers and board members.

Our speakers this year include:

David Feinberg, MD, Chief Executive Officer and Vice Chancellor of the UCLA Health System. Dr. Feinberg is Board Certified in Child and Adolescent Psychiatry. He served as medical director for the UCLA Medicine faculty practice group, and of the Resnick Neuropsychiatric Hospital until he became CEO of the Health System in June 2007.

Michael Gitlin, MD, Medical Director for UCLA Medicine Faculty Practice Group and Director of the Adult Division. He also has an amazing reputation as an authority in Mood Disorders.

Carole A. Klove, RN, JD, CHRC, Chief Compliance and Privacy Officer for UCLA Medical Sciences. Her role as compliance office for the UCLA Health System spans the School of Medicine, Research, Hospital System and Professional Services, and focuses on both the research and clinical sides of Psychiatry.

James Rosser, LCSW, Program Director of Continuing Care at the Semel Institute of UCLA's Resnick Hospital. Mr. Rosser is also the Administrative Director of the Borderline Personality Disorder Program.

If you haven't registered, go to the AAP website at www.adminpsych.org and download the registration form, email Hank Williams at hankwil@u.washington.edu, or call 206-616-2069.

Call the Hyatt directly for reservations (800-233-1234) and identify yourself as an attendee of the Medical Group Management/Academic Practice Assembly conference. MGMA has reserved a block of rooms until March 30 at a rate of $215/night for single or double occupancy plus state/local tax. After that date accommodations are on a space available basis.

It's not too late to join us for this fun time of learning. Contact us today!

Penn closes inpatient unit; creates Pennsylvania Psychiatric institute

by Shiyoko Cothren

On April 1st, 2008, the doors opened at the Pennsylvania Psychiatric Institute (PPI). This new, not-for-profit organization is a collaborative endeavor between Penn State Hershey and PinnacleHealth System. The PPI will be the focus of new, expanded clinical, educational and research initiatives for Penn State Psychiatry.

Economic Realities

The economic realities are clear to those of us in psychiatry. Margins on inpatient psychiatry just cannot match those of medical inpatient beds or surgical suites *(see sidebar Page 7)*. The Hershey adult unit consisted of 20 beds along a runway-like, 1970's designed unit surrounded by surgical suites and recovery areas. There was simply no room in this location to grow and the cost to relocate and renovate within other areas of the hospital was prohibitive. Our Child Unit was 16 beds with only 4 private rooms. As many patients simply could not have roommates, this limited our average daily census. In addition, while the clinical space was attractive and well maintained, it was simply too small to host age-appropriate activities for children in different age ranges. The PPI collaboration not only allowed the medical center room to expand much needed PACU space but also allowed inpatient psychiatry to grow to meet the needs of the community and our training and research programs.

Growth Strategy

The PPI opened with 74 beds divided into a 16-bed child and adolescent psychiatry unit, a 14-bed highly acute adult unit, a 24-bed adult psychiatry unit and a 20-bed geriatric psychiatry unit. In addition, a dedicated ECT suite and a Triage and Evaluation Center formed part of the construction.

During the initial stages, attorneys from both organizations and a consulting firm played key roles in establishing a member agreement. An independent consultant developed the pro forma to ensure that a neutral third party was receiving revenue information from each organization. Internal workgroups composed of key leaders from both organizations were developed to ensure all issues were vetted and identified. Physicians and staff met early with architects to design functional yet flexible units should patient populations change over time.

To maintain the integrity of the academic program, all physicians remained or became (as was the case for three PinnacleHealth employed psychiatrists) Penn State Hershey faculty. All nursing and support staff from Penn State Hershey and PinnacleHealth Psychiatry became employees of the new joint venture. The Vice Chair for Clinical Services at Penn State Hershey was also identified as the Medical Director, again providing continuity for training and research programs.

Challenges

A consultant was engaged to serve as the "voice" of the joint venture and to monitor progress on milestones. Workgroups formed to draw expertise from both organizations. With a clear goal in mind, it was truly inspiring to watch how well these teams accomplished their tasks.

There were many operational challenges in creating a new, free-standing psychiatric hospital. Payor contracting, licensure and CMS certification were among the most critical issues as they took much longer to accomplish than anticipated. Human resource issues were significant as three cultures were brought together: the Hershey staff, PinnacleHealth staff and those

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newly hired to PPI.

Every employee was ensured a position in the joint venture. As we were increasing the number of staffed beds in the community, the PPI actually needed to hire more staff. The majority of Penn State Hershey staff chose to work at the PPI while some found positions in other areas within the hospital and a smaller number chose employment elsewhere.

The joint venture concept received mixed reviews from faculty at first. Some felt devalued while others felt encouraged by the commitment and capital that was being infused into the project. Our department has experience in video psychiatry and has used this video conferencing technology for the past 4 years to connect the hospital to the outpatient clinic for meetings and educational events. This same technology was installed at the PPI to ensure that all residents and faculty could remain "connected." Video conferencing now forms part of the everyday communication between and among our administrative and clinical sites and has greatly improved past fears that the department would become fractured due to being spread out over various locations.

Lessons

I somehow thought that my own position in the department would become easier without any inpatient responsibilities; however, the coordination with an entirely new organization has been an enormous task. I am looking forward to working with the CEO of the PPI so that we can streamline things a bit with the faculty.

I believe the key to the success of the joint venture was the shared vision between Penn State Hershey and PinnacleHealth. PinnacleHealth leaders were equally dedicated to education, eager to help support research endeavors, and both organizations were focused on improving services for the community. I often tell people of a breakfast meeting that I attended during the early days of discussion on a possible joint venture. I found that by closing my eyes and not looking at who was speaking, I couldn't tell who was from the community health system and who was from the academic health center based on their comments and concerns about the process. While there are certainly financial gains to be had in combining these two programs, at the end of the day in order for these investments to be made there needed to be a true belief that providing high quality mental health services, providing training opportunities and furthering scientific research was simply the right thing to do.

(Shiyoko Cothren is the administrator of the Penn State University department of psychiatry).

U Colorado - Denver closes inpatient unit

The University of Colorado Hospital closed it's inpatient unit at the Anschutz Inpatient Pavilion in Aurora in order to create additional medical/ surgical beds. With long waits and boarders in the emergency room, hospital administrators decided that, although psychiatry was a clinically valuable service, it was not financially viable to keep it open. The 22-bed unit had an average occupancy of 73%.

The Department of Psychiatry will maintain (and possibly enhance) it's outpatient services. The residency training program is not expected to be negatively affected by the closure.

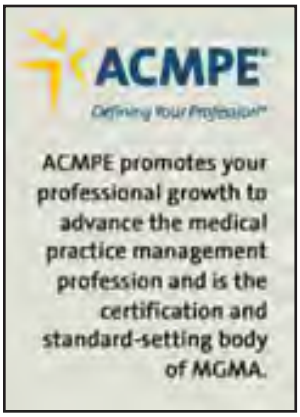
Simple truths

by David Peterson, FACMPE

Conveying messages and information accurately, succinctly, understandably and convincingly is always important, but seldom more important than nowadays. Often, some of the most complex ideas can be stated in the most simple of terms. Never one to waste a word – written or spoken – columnist and author George Will stated recently on one of the morning talk shows that "it is the nature of bubbles that they burst." From those nine words and given the context of today, one can tell that 1) he was referring to the financial crisis, 2) there was a bubble, 3) it burst, and 4) no surprise, it was supposed to. It doesn't get much plainer or accurate than that.

Simple truths are a useful tool that can be used to describe complex thoughts or actions. Some leaders refer to them as the "30 second sound bite," others label them "the elevator speech," (the goal of which is to package the speech in such a way that it is understandable and deliverable between building floors and before the intended audience exits the elevator on the next floor). In an age of limited time and limited attention spans, the elevator speech can help keep important messages moving (pun intended) through an organization in an effective way.

To be sure, it is important to ensure that the "truth" is both "simple" and "true" – a simple truth in itself. Many simple truths taken at face value and perpetuated by repetition are simply not [true]. For example, in his acclaimed and bestselling book, *The Ascent of Money*, economist and historian Niall Ferguson describes the history of money and its influence on the development of countries, economies and world events. He exposes the fallacy of some "conventional wisdoms" - simple truths - including the commonly accepted truth that homes are a good financial investment when compared with other investment instruments.[1]



One accurate, simple truth in health care that is universally accepted is the value of continuing education. The medical specialty boards require it and the profession(s) accept and respect it. The **American College of Medical Practice Executives (ACMPE)**, the credentialing body for the medical practice executive, offers continuing education and sets standards for the its members through its *Body of Knowledge*. The ACMPE's logo states this simply and succinctly.

Membership in the Administrators in Academic Psychiatry (AAP) is one way psychiatry administrators (and their academic departments) illustrate their commitment to this simple truth. A complimentary way to show this commitment is though a membership in the ACMPE. The AAP members listed on the next page, representing about 15% of the total AAP members, have this dual membership.

Finally, it is again important to express appreciation to the AAP leadership and extend a nod to The GrAAPvine's editor, **Jan Price** (U Michigan) for the newsletter space they allow this column along with the opportunity to promote the ACMPE, continuing education, professionalism and other perspectives on medical practice management.. The simple truth is that this newsletter – or

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column - would not exist were it not for their commitment and support.

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 Niall Ferguson, *The Ascent of Money: A Financial History of the World* (New York: Penguin Group, 2008), 281-282.

AAP members with dual membership in ACMPE

Name	Organization	ACMPE Status
David Allen, RN MSHA	University of Alabama – Birmingham	Nominee
Beverly Bowen	HSCIC – Lubbock School of Medicine	Nominee
Lindsey Dozanti	Case Western Reserve University	Nominee
Richard Erwin, CMPE	University of Missouri	Certified
Bill Gaupp, CMPE	Baylor College of Medicine	Nominee
Mario Harding	Denver Health Medical Center	Nominee
Judith Hyer, RN BSN	Texas A & M University	Certified
Patricia Kersey	Mayo Clinic College of Medicine	Nominee
James Landry, CMPE	Tulane University	Certified
Steve Mueller	University of Texas Medical Branch	Nominee
Florie Munroe, CMPE	Health Quest	Certified
Larry Peters	New York University	Nominee
David Peterson, FACMPE	Medical College of Wisconsin	Fellow
Andrea Rahlf	University of Illinois – Chicago	Certified
Patricia Sanders Romano	Albert Einstein College of Medicine	Nominee
Randolph Siwabessy	University of California – San Francisco	Nominee
Jeffrey Tapper	Northwestern University	Nominee
Marietta Taylor, FACMPE	Bassett Healthcare	Fellow
Carol Thomas	University of Louisville	Nominee
Joseph Thomas	University of Michigan	Certified

Some NIH electronic transactions postponed

by Hank Williams

The NIH transition to electronic submission of applications for Individual National Research Service Awards (Fs) originally scheduled to occur April 8, 2009 has been postponed due to Grants.gov related delays.

Until a new transition date is confirmed, these applications should continue to be submitted on paper PHS416-1 application forms.

NIH plans to require electronic submission of applications via Grants.gov using the SF424 (R&R) forms for Individual Research Career Development Award Programs ("K"s) - with the exception of K12s – have not changed.

This change was effective with the February 12, 2009 submission date.

Applications previously submitted in paper that are being resubmitted as amended applications must submit electronically.

Stay better informed on NIH listserv

NIH has established two electronic mailing lists (listservs) to provide periodic updates on the electronic submission of grant applications and the eRA Commons, the online interface where research organizations and grantees can receive and transmit information about the administration of biomedical and behavioral research grant applications and awarded grants.

These listservs provide a direct source for timely updates for interacting electronically with NIH. The electronic mailings can help alert you to:

- Critical situations that may arise, particularly around high-volume receipt dates
- Changes to electronic submission deadlines due to system failures (e.g., extension of application correction or viewing windows)
- New features and functionality
- Scheduled service interruptions
- Known issues and workarounds
- Other items of interest

To subscribe/unsubscribe to the listservs, visit http://era.nih.gov/about_era/get_connected.cfm

President's message

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old platform for the listserv is no longer available and must be replaced. The Google option has not worked well as evidenced by the number of members joining this service. The Task Force is exploring new options with a reduced scope of work and other vendors. The goal is to have this project moving forward toward completion by the time of the April meeting. Thanks to **Jim Landry** (Tulane U), **Elaine McIntosh** (U Nebraska), **Rich Erwin** (U Missouri), and **Margaret Dobson** (U Toledo) for their work on this issue.

I am sure that you have received the announcements about the Spring meeting being held in Los Angeles on April 18, 2009. The Board of Directors will meet on Friday, April 17; the education session will occur on Saturday, April 18. This meeting precedes the MGMA Academic Practice Assembly meeting which begins on Sunday, April 19. President-Elect and Education Chair **Hank Williams** (U Washington), Member-at-Large for Education **Narri Shahrokh** (U California-Davis), and **Ruth Irwin** (U California-Los Angeles) have been working to develop a great educational program. Special thanks to Ruth who has been the person on the ground facilitating arrangements for speakers and our all important networking dinners. Please email Hank Williams at hankwil@u.washington.edu or Membership Director **Tina Nesbeda** (U Massachusetts) at christina.nesbeda@umassmed.edu to let them know your intentions about attending the Los Angeles meeting. This will help with advance planning for the event.

The annual business meeting for AAP will take place as part of the spring meeting. New officers and Board members will be elected. Elaine McIntosh is Chair of the current Nominating Committee. If you have an interest in serving AAP in some manner as a member of the Board, please let Elaine know at emcintos@unmc.edu .

I hope to see many of you at the spring meeting. I am confident that we can continue to learn from one another as we deal with the current challenges. Thanks to all of you who volunteer to help make AAP successful and useful.

Guide to entering the real world

An administrator's course for psychiatry residents and fellows

by Pat Sanders Romano

Four years ago I noticed an article in an APA Matrix about providing guidance to residents in career choice. Since I am, by training, a Vocational Rehabilitation Counselor, and since I had experience working with both physically and emotionally disabled clients, I figured working with residents would be a "piece of cake." Little did I know….

I began with grandiose plans to administer the Myers-Briggs® Personality Inventory, to offer group and individual sessions, including counseling and mock interviews, only to come to the realization that I have another full time job!

So, the first year I presented one session to the PGY-4's in May. It was fantastic fun for me. For them, I'm not so sure. First of all, there was no way I could cover what needed to be covered in an hour and half. And, despite the fact that the information was all new to the residents, the significant feedback from them was that it was too little, too late.

I had several discussions with the Training Director and Coordinator and we decided to try three one-hour sessions with the PGY-4's in the fall and the PGY-3's in the spring. I expanded my curriculum to include CV/ Interview Preparation; How to Evaluate and Negotiate a Contract; Business Planning/Introduction to Business Management; and Budgeting.

Format and Curriculum

I developed the four modules and then searched the web for samples and resources. The best sources were the NJEM Career Center, the AMA web site and interestingly, ABOUT.com. I also searched my department files for sample CV's, cover letters and thank you letters. Each module was prepared in PowerPoint with hard copies for a binder I prepared for the participants. The binder also included samples and reading materials.

The first module presented is "Maximizing Career Options." We talk about why physicians change positions, how to determine what the best practice venue is for each individual, how to prepare a CV, how to prepare cover letters, how to obtain letters of reference, and interview skills. I encourage the residents to send me a draft CV after the session or any time in the future. I have generally gotten about a 50% response. This year I am planning to make preparation of a CV as an assignment. The material from this module always spills over into the second session.

The second module is "Practical Tips for Evaluating and Negotiating Contracts." We discuss not only employment contracts but the type of contracts they may encounter in practice. The level of anxiety in this session is very high, and was not dispelled when I advise them to always consult with an attorney before signing a contract. The AMA has excellent materials on contracts, has a Model Physician Employment Agreement, and a network of legal and business advisors. These are only available to AMA members, though.

The third module is "Developing Your Personal Business Plan." I use the business plan model to show them how to develop their thinking and research on their careers. By using that model, I am able to do a bit of Business Basics 101 (forms of business organization, governance, personnel issues, service line(s), facilities issues, regulatory compliance, and financial management). This is a huge module that I have had to rush through. I am hopeful by giving them a "taste," especially during

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the PGY-3 year, I can get into more depth with the 4's and fellows.

"Budgeting" is the 4th module. I have never had enough time to cover the material, but I do include it in the course binder. Maybe someday.

Conclusions—What I Have Learned

It was far too much to cover. My initial concept was that when the PGY-3's took the course again as 4's I could do a very brief summary and move on to the topics not covered. It didn't work -- in part because the majority of the residents have never been in the "real world," and are hungry for all of the information they can get.

The first year that I taught the PGY-3's they appeared bored. When I presented the same material to this class in the fall when they were 4's, the enthusiasm was amazing and they approached the material as though it was fresh. When I asked them what happened, they indicated that the topic made them very anxious as 3's. But, they thought it was important to expose the residents as 3's to give them a basic introduction. The early fall sessions with the 4's have become very participatory and a challenge for me. Many of their questions, especially on specifics, required my doing additional research and finding new sources of information.

The only experience I have had to date with the Child Fellows was difficult. There were only two in the group and there just wasn't much interaction. I will be meeting with a new class this year, because I skipped last year, so we will see.

Probably, the most successful aspect of this was my encouraging the participants to submit draft CV's and cover letters for my edits. Not only did it give us more of an attachment to each other, I was able to cite examples to the group in later sessions.

I get the same feedback every year: "We wish we could have more of this." Oh, and my track record: The Department has hired several of the previous participants!

Pat Sanders Romano is the administrator of the Yeshiva University Albert Einstein College of Medicine department of psychiatry.

Web Watch

Bazelon Study of State Medicaid Services

Following the Rules is a new report by the Bazelon Center summarizing federal Medicaid policy as of November 2008 with respect to community mental health services covered under the Clinic, Rehabilitation and Home- and Community-Based Services (Section 1915(i)) categories of the law. It also presents the results of a review of official state Medicaid policies for these service categories. The report focuses on community-based services and does not discuss services in hospitals, residential treatment centers for children, group homes or other congregate-care or institutional settings. The report is available for purchase from the Bazelon Center's online store; a PDF version is free via www.bazelon.org/pdf/FollowingRules.pdf.

HHS modifies HIPAA code sets (ICD-10) and electronic transactions standards

The U.S. Department of Health and Human Services (HHS) recently announced two final rules that will facilitate the United States' ongoing transition to an electronic health care environment through adoption of a new generation of diagnosis and procedure codes and updated standards for electronic health care and pharmacy transactions.

The first rule adopts two medical data code sets as Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards for use in reporting diagnoses and inpatient hospital procedures in health care transactions (ICD-10 final rule). The standards adopted under this final rule will replace the ICD-9-CM code sets, developed nearly 30 years ago, with greatly expanded ICD-10 code sets.

The second final rule adopts updated versions of the standards for certain electronic health care transactions, under the authority of HIPAA (5010/D.0 final rule). The updated versions replace the current versions of the standards and will promote greater use of electronic transactions. The final rule also adopts a standard for Medicaid pharmacy subrogation transactions, a process through which State Medicaid agencies recoup payments for pharmacy services in cases where a third party payer has primary financial responsibility.

HHS' proposed rules, published on August 22, 2008, proposed earlier compliance dates for the transition to the ICD-10 code set and the updated versions of the transactions standards, but a large majority of public comments stated that more time would be needed for effective industry implementation. The final rules accommodate these concerns. Under the transaction standards final rule, covered entities must comply with Version 5010 (for some health care transactions) and Version D.0 (pharmacy transactions) on January 1, 2012. Covered entities must comply with the standard for the Medicaid pharmacy subrogation transaction (Version 3.0) on January 1, 2012. However, for Version 3.0, small health plans have an additional year and must comply on January 1, 2013. The ICD-10 code sets rule sets the compliance date at October 1, 2013.

Relationship between the ICD-10 code set and the version 5010 translation standards

The new version of the standard for electronic health care transactions (Version 5010 of the X12 standard) is essential to the use of ICD-10 codes because the current X12 standard (Version 4010/4010A1), cannot accommodate the use of the greatly expanded ICD-10 code sets. Accordingly, HHS closely coordinated the development of the final rules, and the rules are being announced simultaneously.

Background on ICD-10

The ICD-10 final rule concurrently adopts the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for diagnosis coding, and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding. These code sets will replace the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Volumes 1 and 2, and the International Classification of Diseases, Ninth Revision, Clinical Modification (CM) Volume 3 for diagnosis and procedure codes, respectively. Covered entities that use these code sets include health plans, health care clearinghouses, and health care providers who transmit any health information

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in electronic form in connection with a transaction for which HHS has adopted a standard.

Electronic transactions involve the transmission of health care information for specific purposes. Code sets are collections of codes that are used to identify specific diagnoses and clinical procedures in claims and other transactions.

The ICD-10-CM code set is maintained by the National Center for Health Statistics (NCHS) of the Centers for Disease Control and Prevention (CDC) for use in the United States . It is based on ICD-10, which was developed by the World Health Organization (WHO) and is used internationally. The ICD-10-PCS code set is maintained by CMS.

Rationale for adopting ICD-10

ICD-9-CM is the current code sets standard adopted by the Secretary of HHS under HIPAA. ICD-9 is used by all covered entities to report diagnoses and inpatient hospital procedures on health care transactions for which HHS has adopted a standard. Shortcomings of ICD-9 include:

- ICD-9 is outdated, with only a limited ability to accommodate new procedures and diagnoses;
- ICD-9 lacks the precision needed for a number of emerging uses such as pay-for-performance and biosurveillance. Biosurveillance is the automated monitoring of information sources that may help in detecting an emerging epidemic, whether naturally occurring or as the result of bioterrorism;
- ICD-9 limits the precision of diagnosis-related groups (DRGs) as a result of very different procedures being grouped together in one code;
- ICD-9 lacks specificity and detail, uses terminology inconsistently, cannot capture new technology, and lacks codes for preventive services; and
- ICD-9 will eventually run out of space, particularly for procedure codes.

Adoption of the ICD-10 code sets is expected to:

- Support value-based purchasing and Medicare's anti-fraud and abuse activities by accurately defining services and providing specific diagnosis and treatment information;
- Support comprehensive reporting of quality data;
- Ensure more accurate payments for new procedures, fewer rejected claims, improved disease management, and harmonization of disease monitoring and reporting worldwide; and
- Allow the United States to compare its data with international data to track the incidence and spread of disease and treatment outcomes because the United States is one of the few developed countries not using ICD-10.

Background on the 5010 electronic transaction standards

HIPAA requires the Secretary of HHS to adopt standards that covered entities must use in electronically conducting certain health care administrative transactions, such as claims, remittance, eligibility, claims status requests and responses, and others. Covered entities include health plans, health care clearinghouses, and certain health care providers. The Transactions and Code Sets final rule published on Aug. 17, 2000, adopted standards for the statutorily identified transactions. Modifications to some of the standards adopted in that first final rule were made in a subsequent final rule published on Feb. 20, 2003. Covered entities must use only the standards that have been adopted by HHS, and are not permitted to use newer versions of the standards until they are adopted by HHS.

The current versions of the standards, the Accredited Standards Committee X12 Version 4010/4010A1 (Version 4010/4010A1) for health care transactions, and the National Council for Prescription Drug

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Programs Version 5.1 (Version 5.1) for pharmacy transactions, are widely recognized as outdated and lacking certain functionality needed by the health care industry. The final rule replaces the current versions with Version 5010 and Version D.0, respectively.

Version 5010 (Health care transactions)

The new version of the HIPAA standards - Version 5010 - includes structural, front matter, technical, and data content improvements. Because the updated version is more specific in requiring the data that is needed, collected, and transmitted in a transaction, its adoption will reduce ambiguities. Version 5010 also addresses a variety of currently unmet business needs, including, for example, providing on institutional claims an indicator for conditions that were "present on admission." Version 5010 also accommodates the use of the ICD-10 code sets, which are not supported by Version 4010/4010A1.

Both regulations are on display today at the Federal Register and may be viewed at http://www.archives.gov/federal-register/public-inspection/index.html.

Both regulations were published on January 16, 2009, and may be viewed at http://www.gpoaccess.gov/fr/browse.html. Click "Go" next to where 2009 appears in the year selection box for "Back Issues (HTML Only)."

Children's health Insurance expanded with mental health parity

On February 4, President Obama signed legislation renewing and expanding the State Children's Health Insurance Program (SCHIP) and for the first time extending critical mental health parity benefits to millions of recipients. Earlier in the day the House approved the bill, H.R. 2, by a vote of 290 to 135; the Senate passed it by 66-32 on January 29.

The legislation renews the program for four and a half years, expanding coverage to an estimated 4 million otherwise-uninsured children. In addition to benefiting at least 11 million SCHIP recipients overall, it affirms that mental health is integral to physical health and critical to improving health outcomes by requiring that mental health services must be offered at no more restrictive limitations than medical services for SCHIP recipients. It will remove higher co-pays and stricter limit on the number of treatment visits, creating parity between mental health services and medical and surgical benefits provided by the plans.

The new legislation also eliminates the five-year waiting period for legal immigrant children and pregnant women. Costs for the renewal and increase in recipients will be paid for by an increase in the federal cigarette tax, from 39 cents to $1.

SCHIP covers children in families with incomes too high to qualify for Medicaid but often too low to obtain other health insurance. The program grants matching federal funds to states in order to provide health insurance for these children.

The parity provision is particularly important because low-income children enrolled in Medicaid and SCHIP have the highest rates of mental health problems. Mental disorders affect about one in five American children. Mental health care is therefore a key component of the array of services needed for healthy childhood development. Without needed treatment, children with mental disorders are at increased risk for school failure, contact with the juvenile justice system and even suicide.

(Reprinted from the Bazelon Center website at http://www.bazelon.org).

TRICARE approval for hospital-based psychiatric partial hospitalization programs

The Federal Register of December 20, 2008 includes a proposed rule to provide that TRICARE approval of a hospital is sufficient for its psychiatric partial hospitalization program (PHP) to be an authorized TRICARE provider. Upon implementation of this provision, separate TRICARE certification of hospital-based psychiatric PHPs would no longer be required. This rule will establish uniform requirements for recognizing a hospital-based PHP as an authorized TRICARE provider.

TRICARE certification standards for psychiatric PHPs are defined in 32 CFR199.6(b)(4)(xii) and further elaborated upon in the TRICARE Policy Manual.

Currently, TRICARE authorized providers of psychiatric PHP services must have the Joint Commission accreditation and must comply with additional, detailed, unique TRICARE certification standards. Compliance with at least some of the unique TRICARE certification standards could require significant recurring staffing costs that psychiatric PHPs would not otherwise incur. Few facilities are willing or able to undergo this added TRICARE certification process, and it could adversely impact beneficiaries' access to psychiatric PHP care. Further, substance use disorder rehabilitation facilities are required to comply with unique TRICARE certification standards only if they are free-standing facilities (i.e., not part of a hospital). TRICARE does not require separate certification of hospital-based substance abuse PHPs. TRICARE approval of a hospital is sufficient for its substance abuse PHP to be an authorized TRICARE provider.

In late 2006, TRICARE established a working group to study the issues surrounding its behavioral health benefit. Recently, the working group completed its recommendations and developed several initiatives to improve TRICARE beneficiaries' access to behavioral health benefits. One of the recommendations was that TRICARE no longer impose its unique certification standards upon hospital-based psychiatric PHPs. Rather, TRICARE approval of a hospital be sufficient to establish the hospital as an authorized provider of its PHP services to TRICARE beneficiaries.

Through this proposed rule, TRICARE will adopt the above recommendation. It will establish uniform requirements for recognizing a hospital-based PHP as an authorized TRICARE provider. It will provide a better balance between quality of PHP care and access to it than now exists. It will significantly increase the number of TRICARE authorized psychiatric PHPs, thereby potentially improving TRICARE beneficiaries' access to PHP care.

In accordance with the recommendations of the working group, the above change will be audited for a period of time to ensure no untoward effects upon the elimination of any unique TRICARE certification standards.

For further information contact:

Mr. Tariq Shahid, Office of the Assistant Secretary of Defense (Health Affairs) TRICARE Management Activity, at (303) 676–3801.

Major League Baseball, McCormick Foundation raise nearly $6 million for veterans through "Welcome Back Veterans"

The McCormick Foundation's Board of Directors has approved more than $2.9 million in grants of nearly $6 million raised to nonprofit organizations serving veterans as part of Welcome Back Veterans, it was announced today.

Welcome Back Veterans, a national public awareness and fundraising initiative that addresses the mental health and employment needs of America's returning war veterans and their families, was created by New York Mets Chairman and CEO Fred Wilpon and private citizens, and is supported by Major League Baseball, Major League Baseball Advanced Media and the McCormick Foundation.

The first round of grants will be distributed to 12 nonprofit organizations that provide mental health services to veterans, job training and placement, and family care. Included in the grants are funds provided to the **University Hospitals of Weill Cornell** in New York City, **The University of Michigan** in Ann Arbor and **Stanford University** in Palo Alto, which will be opening clinics in each of their locations to treat veterans and their families.

Welcome Back Veterans has raised more than $3.9 million as of October 17, 2008. An additional $2 million in matching funds was provided by the McCormick Foundation (first $4 million raised matched at 50 cents on the dollar). With all administrative costs paid by Major League Baseball and the McCormick Foundation, approximately $5.9 million is available for distribution to nonprofit agencies targeting veterans' greatest needs. The distribution of the $3 million balance, and any additional funds that are expected to be raised, is targeted for early spring 2009. The program is ongoing and will continue to distribute and raise funds. In 2008, on July 4th weekend and September 11th weekend, Major League Baseball conducted pre-game events, sold special merchandise and conducted promotional activities for the U.S. veterans returning from Iraq and Afghanistan. All players wore special "Stars & Stripes" caps during both weekends and Tom Hanks starred in a Public Service Announcement which was widely distributed throughout the United States. The goal of Welcome Back Veterans is to raise millions of dollars to address the mental health and job needs of veterans and their families while providing thousands of job opportunities.

"We owe a debt to these veterans and their families which we can never fully repay," said Brig. Gen. (Ret.) David L. Grange, president and chief executive officer of the McCormick Foundation. "We are grateful for Major League Baseball and the caring citizens who have stepped up to help and give generously, even in these difficult times. The funds raised, along with the matching dollars, will go directly to high quality agencies enhancing the health, family and livelihood of those who have courageously served our country and protected our freedom."

"Everyone at Major League Baseball appreciates the enormous sacrifice made by the brave men and women in our armed forces and this effort is an attempt to demonstrate our appreciation," said Baseball Commissioner Allan H. (Bud) Selig. "With the ability to reach millions of patriotic Americans at ballparks, on television and through the Internet, we hope to showcase this very important issue and help our veterans in their transition from the battlefield back to their lives at

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home."

The mission of Welcome Back Veterans is driven by the profound need to provide returning veterans the quality medical treatment and long-term employment assistance they deserve to restart their lives and care for their families. The latest statistics indicate approximately 300,000 veterans who have returned from Iraq and Afghanistan are currently suffering from post traumatic stress disorder (PTSD) or major depression, and about 320,000 may have experienced traumatic brain injury (TBI) during deployment (Lisa H. Jaycox and Terri Tanielian, Invisible Wounds of War, Rand Corporation, 2008)

The Welcome Back Veterans initiative is complementary to and supportive of the ongoing government programs already in place.

Universities receiving funds

Cornell University (Ithaca, N.Y.)

For the Program for Anxiety and Traumatic Stress Studies, providing comprehensive psychiatric evaluation and treatment for Operation Iraqi Freedom (OIE) and Operation Enduring Freedom (OEF) veterans and their families, including family therapy, couples therapy and psychological services for children.

Stanford University (San Francisco)

For the Veterans Connect Center program, establishing the program as part of the Department of Psychiatry and Behavioral Sciences division of the University's School of Medicine; serving as a point of entry for veterans into mental health care; helping veterans transition into the Veterans Affairs (VA) system; providing free evaluation and time-limited treatment; educating veterans about VA services and enrolling eligible veterans in those programs as necessary.

The University of Michigan (Ann Arbor)

For Veterans Treatment Program Phase I, expanding partnerships and collaborations with local veteran service organizations; conducting peer-to-peer programs that will use volunteers to encourage veterans to seek treatment and to support them while they remain in treatment; providing mental health services to at-risk children and families of veterans; and developing national distribution of channels to disseminate learnings and best practices for treatment of these special populations.

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A French poodle and a collie were walking down the street. The poodle turned to the collie and complained, "My life is such a mess. My owner is mean, my girlfriend is having an affair with a German shepherd and I'm as nervous as a cat."

"Why don't you go see a psychiatrist?" asked the collie.

"I can't," replied the poodle. "I'm not allowed on the couch."

Editorial staff

Editor:
Janis Price
Associate Editors:
Radmila Bogdanich
David Peterson
Pat Sanders Romano
Hank Williams

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Janis Price
Section Administrator
Department of Psychiatry
University of Michigan Health System
UH9D 9822B
Ann Arbor, MI 48109-5118
(734) 936-4860
(734) 936-6880 Fax
janprice@umich.edu