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The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Radmila Bogdanich

First of all, I would like to thank the AAP Board and members for honoring me by selecting me to serve as President of this wonderful organization during the next year. If I had to pick just one thing that makes our organization so great, it has to be our members. In spite of our busy schedules and work and personal commitments, you, our members, always find time to do your part to help our organization and our fellow AAP's succeed at the task at hand. Thank you!

Our Baltimore conference was successful in every way. I would like to personally thank our members "on the ground" in Baltimore, **Tony Bibbo** (U Maryland) and **Beth Ambinder** (Johns Hopkins U) and **Narri Shahrokh** (U California, Davis), Immediate Past President, for planning such an outstanding and informative program. I need to make a special mention of thanks to Tony for going above and beyond the call of duty when he took Narri (who was also going above and beyond the call of duty, when she accidentally broke her foot in the hotel lobby) to the Emergency Department. Best wishes for a speedy recovery, Narri!

During the past year, a lot of hard work went on behind the scenes as we worked on the 2010 Benchmarking Survey. At this time, I must recognize the Benchmarking Committee members [**Toni Ansley** (Ohio State U), **Lindsey Dozanti** (Case Western U), **Narri Shahrokh** (U California, Davis); **Paul Summerfield, MD** (Tufts University), **Joe Thomas** (U Michigan) and **Hank Williams** (U Washington)] for all of their hard work during the past year in working with me to develop the survey instrument, and collect and analyze the data. Of course, we wouldn't have any data to share if you, our members, didn't take the time to complete the instrument so "Thank you" to all of you who took time out of your busy schedules to complete the survey.

We're in the midst of spring, and spring brings time for new growth. For those of you who were at the Baltimore conference, we talked about the continued growth of our organization and new opportunities. As a result of collaborating with the AACDP on the benchmarking project, we have forged a closer working relationship with the Chair's group. It is my hope that this relationship will

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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:

Bryan Downey
The Children's Hospital
U Colorado
(720) 777-3052
downey.bryan@tchden.org

Tim Kelly
Child Mind Institute
tim.kelly@childmind.org

Sherine Khalil
Child Mind Institute
sherine.khalil@childmind.org

Dawn Leadley
SUNY Upstate Medical Center
(315) 464-3180
leadleyd@upstate.edu

AAP bids farewell to these members and good friends:

Michael Cull
Vanderbilt U

Todd Gershon
Albert Einstein SOM

Leslie Hobbs
U Mississippi

Janice MacAdam
U Kansas

President's message (continued)

continue to move forward as we develop joint ventures to further the professional development of the members of both groups. There will be more to come on this development.

With the changes brought forth by dissolution of the MGMA APA spring conference and the loss of their financial support of our organization, we discussed the need to "brand" the AAP as a national organization. Two new names were brought forth: The National Association of Administrators in Academic Psychiatry (NAAAP), and the National Association of Academic Psychiatry Administrators (NAAPA). If you have other suggestions, please email them to me at rbogdanich@siumed.edu We recognize that this process will not be a simple one but is worthwhile as we continue to grow as a nationally recognized professional organization.

Finally, and I know you won't believe this, but we have begun to plan our Fall Educational Conference. It's going to be in Santa Fe, New Mexico, in the Hotel Santa Fe, beginning in the evening of October 19th and ending on October 21st . (Our conference will be held directly before the MGMA in Las Vegas). If you're interested in helping with the conference or have ideas for presentations, etc. please contact President-Elect **Lindsey Dozanti** (Case Western U) or **Sarah Thomas** (U New Mexico) our person "on the ground."

Have a fun and safe summer.

The Board of Directors and membership of Administrators in Academic Psychiatry send their sincerest sympathy to Janice MacAdam on the recent loss of her sister.

Benchmarking report

A panel consisting of **Radmila Bogdanich**, **Lindsey Dozanti, Joe Thomas** and **Hank Williams** presented initial data gathered from the 2010 Benchmarking Survey at the Spring AAP conference. The survey was a collaborative effort between the AAP and the AACDP. The survey committee consisted of Radmila Bogdanich (Chair) and members Lindsey Dozanti, **Narri Shahrokh**, **Paul Summergrad MD**, Joe Thomas, Hank Williams.

Surveys were sent electronically to all AAP and AACDP members at 125 medical schools; 39 Departments participated in the survey (24 Public and 15 Private). The committee hopes to have the survey report completed by the end of summer. All participants will receive a hard copy and an electronic copy which will allow them to write specialized reports pertinent to their department. Copies of the survey will be available for purchase for those that did not participate. The details are still being finalized.

The following individuals and schools participated in the AAP 2010 Benchmarking Survey :

Contact	Chair	University
Toni Ansley	John Campo, MD	Ohio State University
David Allen	James Meador-Woodruff, MD	Univ of Alabama
Anthony Bibbo	Anthony Lehamn, MD	U of Maryland SOM
Jane Biehler	Ondria Gleason, MD	U of Oklahoma COM
Radmila Bogdanich	Stephen Soltys, MD	SIU School of Medicine
Marika Brigham	Mark Gold, MD	U of Florida COM
Gregory Brownstein	Paul Summergrad, MD	Tufts Univ SOM
Paul Cavaretta	Steven Dubovsky, MD	University at Buffalo, NY
Brad Cherry	Alan Schatzberg, MD	Stanford Univ SOM
Dwayne Clayton	Rita Horton, MD	LSU HSC
Shiyoko Cothren	Alan Gellenberg, MD	Pennsylvania St U COM
Bill Davis	James M. Steenson, MD	W. Virginia SOM
Margart Dobson	Marijo Tamburrino, MD	Univ of Toledo
Lindsey Dozanti	Robert Ronis, MD	Case Western
Christine Fitts	Alan Green, MD	Dartmouth
Ellen M. Francis	Betty Pfefferbaum, MD	U of Oklahoma COM
Kary Green	Terry McMahon, MD	Texas Tech U HSC
Richard Erwin	John Lauriello, MD	U of Missouri, Columbia
Ruth Irwin	Peter Whybrow, MD	UCLA CA
Jim Landry	Daniel Winstead, MD	Tulane U. SOM LA
Christine Loveday	Merry N. Miller, MD	E. Tennessee State Univ
Janice McAdam	Russell Scheffer, MD	U of Kansas COM
Paul McArthur	Eric Caine, MD	Univ of Rochester, NY
Elaine MacIntosh	Steven P. Wengel, MD	Univ of Nebraska COM
Stuart Munro, MD	Stuart Munro, MD	U Missouri - KC
Janet Namini-Ferino	John Csernansky, MD	Northwestern U SOM

Social media and legal liability

By David Allen

Jeff Natterman, JD, MA, Risk Manager (The Johns Hopkins Hospital) and Counsel (The Johns Hopkins Health System), provided an excellent review of social media from the perspective of legal and personal risk. The presentation was an eye-opener for many that are unfamiliar with the various forms of social media and the associated risks.

Social Media has broadened the opportunity for better and increased communication, allowing organizations to get their brand exposed and out to more potential customers via electronic communication modalities, such a Facebook, YouTube, Twitter, My Space and others. The increased exposure has also created hazards for the unwary. Healthcare organizations are particularly vulnerable given the various regulatory agency standards and assorted laws and rules around patient information and confidentiality.

Liability can come in many forms. Civil liability is created via civil law, as opposed to criminal law, and is the branch of law dealing with disputes between individuals and/or organizations, in which compensation may be

awarded to the victim. For instance, if patient if harmed by the negligent actions of a physician or nurse and the patient claims damages against the physician or nurse, or organization, for loss or injury sustained from the negligent acts, this will be a civil law case. An example of negligence from the social media situation could occur via the handling of patient records or information and negligently allowing for this information to be disclosed without patient authorization. This example is one of many and often times when a patient sues an organization, a shotgun approach is used meaning that a variety of civil causes of action are claimed by the plaintiff in hope that one or more of them will stick. Examples are listed below:

- Defamation (pid)
- Breach of privacy (no consent to post)
- Interference with contractual relations
- Interference with economic relations
- Intentional infliction of emotional distress
- Trademark (confusing consumers about brand)
- Copyright (us copyright act 17 usc 101)
- Negligence (duty, breach, causation, damages)
- Loss of consortium (marital relations)
- Breach of contract (look out on agreements!)

In addition to civil liability, social media can become a vehicle for criminal prosecution. Social media is a great source of detectives, divorce lawyers and law enforcement. Since much of modern communication occurs within electronic or social media, the unwary and unsavory, and those involved in moral turpitude, can have their activities tracked easily if they post these things on social media sites or for that matter any form of electronic communication.

Lastly, administrative liability can arise when social media is used and information is exposed that either violates

administrative laws, such as professional licensure statutes or organizational policy. Examples for the presentation included a physician discussing his apparent diversion of drugs and his preference of drug, all not prescribed by his doctor it seemed. Other examples include embarrassing photos of excessive drinking, compromising photos and comments that would or could expose an employee to corrective action or firing if viewed by an employer. Current and future employers are watching and have created policy in some cases addressing social media.

(David Allen is the Executive Director of the University of Alabama Birmingham department of psychiatry).

Example tip sheet from an organization

The following tips are provided to help the members of our workforce correctly communicate using these new technologies:

- When participating on personal blogs or social networking sites like Facebook or MySpace where it is noted that you have an ORGANIZATION connection, do not relate your work experiences.
- Make it clear that you are speaking for yourself and not on behalf of ORGANIZATION. In your profile or "About Me" section, you should consider adding this language: "The views expressed here are my own and do not reflect the views of my employer."
- Do not share confidential or proprietary information about ORGANIZATION.
- Patient privacy must be maintained at all times. Hence, *never* post any information about patients or research participants, even when they are not named.
- Use good judgment and strive for accuracy in your communications. Realize that the comments posted on your site are permanent and could reveal personal things about you. Also, if ORGANIZATION is noted as your employer, errors could reflect poorly on the institution and may result in liability for you or ORGANIZATION.
- Use a personal email address when participating on social sites.
- Change your password frequently and do not use the same password that you use for email, online banking accounts, or other business purposes.
- Be respectful and professional to fellow employees, business partners, and competitors. Be sure that your blogging and social networking activities do not interfere with your work commitments.
- If you have questions about what is appropriate to include in your blog or social networking profile, contact the Marketing Office, the Privacy Officer, or the Security Officer.

Disaster preparedness from a mental health perspective - Three views

By Dan Hogge

Lisa Dixon, MD, Director of Health Services Research, University of Maryland, introduced a topic of increasing concern and a topic often discussed by many departments but seldom have in place firm decisions on how to control risk and minimize potential disasters in our work environments.

An important place to start is with a clear definition of psychosis and the many diagnoses that branch off from this basic illness. By far, the numbers show that violence increases or the risk of violence increases with substance abuse. Those respondents with a "significant mental illness" plus a problem with substance abuse clearly need additional monitoring and support. We don't need to stereotype patients but definite precautions are required and well-defined policies understood to keep the work environment safe both for the patient and for hospital employees.

Wanda Binns, MSW, Manager, University of Maryland, reviewed how an effective EAP provides a front line defense against violence in the workplace and is a key component to providing a healthy work environment for both patients and employees.

When policies are written and communicated they provide both strength and boundaries for professional staff and help to reduce the possibility of potential conflict. Without policies we are not setting the standard of professional behavior and invite opportunities for employees to set their own level of expected behavior. The use of EAPs is one of the best tools to transition employees thru difficult issues both in their personal lives and in the challenges of work.

George Economas BS, Director of Internal Security, Johns Hopkins Institution, reviewed how the security officers in their institution responded to a very unfortunate crisis with a patient who killed both his parents and himself one fateful afternoon. Mr. Economas was very clear that the major lesson they learned was the importance of immediate communication with the public, the government, and the hospital employees to ensure the safety of all concerned and to help reduce the high level of anxiety that will explode with such a terrible event.

Subsequent developments have included again the writing of safety policies and the proper training of staff to strengthen the bonds of trust between the professional staff and the community at large.

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

Psychiatry's clinical mission and challenges for the academic medical center

by Janet Namini

Dr. J. Raymond DePaulo, Jr., MD, Henry Phipps Professor and Director, Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, and Psychiatrist-in-Chief, The Johns Hopkins Hospital, discussed the beliefs of the first Dean of Johns Hopkins, Dr. Adolf Meyer, regarding the clinical setting in which to provide the best psychiatric care. He believed that the academic setting, with the tripartite mission of clinical, education and research, is best designed to move better care forward.

To that end, Dr. DePaulo pointed out some of the current challenges that face the academic psychiatric field. These include:

Clinical perspective:

- Current treatments for the severely mentally ill haven't changed markedly in the last 30 years;
- Molecular and brain science hasn't influenced the clinical setting as of yet;

Educational perspective:

- The educational process for residents is being further influenced by the ACGME (i.e. the "16 hour" rule disrupts the continuity of training) and financial constraints of an underfunded mission;

Financial perspective:

- Diagnosis-based (DRGs) payment systems for psychiatric care is not sustainable based on the current model;
- EMTALA (Emergency Medical Treatment and Active Labor Act of 1985) enacted by Congress in 1986 to prevent the practice of 'patient dumping' from emergency rooms. The law was amended to give ER physicians admitting privileges to every hospital in the U.S. so as to clear their overcrowded emergency departments without funding the mandate. It just moved the unfunded care from the state settings into the community.
- Lack of accessible chronic care settings for both chronically mentally ill patients (State psychiatry beds) as well as developmentally disabled adults. The total number of psychiatric beds throughout the United States has decreased rapidly over the last 20 years. Between 1990 and 2002 general and private psychiatric hospital beds have decreased by approximately 28%. Between 1960 and 2002 State psychiatric beds have decreased by almost 91%.
- Decline in number of psychiatrists working in the inpatient settings due to low payment rates, burden of regulations and increased liability due to more acutely ill patients with increasingly shorter lengths of stay.

The objective of an NIMH funded research study, Improving Psychiatric APR-DRGs, as presented by **Anthony Lehman, MD, MSPH**, Professor and Chair, Department of Psychiatry, University of Maryland School of Medicine, was the development and testing of improvements to the APR (All Payor Related)-DRG system. This was accomplished with existing billing data and then new data items abstracted from medical records from the State of Maryland.

The Medicare payment system was a cost based

system until DRG's were introduced in FY1984. The failure of psychiatric DRGs led to TEFRA (Tax Equity and Fiscal Responsibility Act**)** payments for inpatient psychiatry. Then in 2003 the Medicare Modernization Act led to a new inpatient psychiatric payment system - prospective per diem payment.

The construction of DRGs used for Medicare payment was developed by statistically clustering hospital discharges to make homogenous length of stay groups, which wasn't always clinically meaningful. The APR-DRGs were developed using clinical panels that identified clinically meaningful clusters and then were tested statistically. They used four levels of severity (or subclass) with each cluster. The four subclasses address patient differences related to severity of illness and risk of mortality. The problem with merging these two attributes is that one doesn't follow the other. A patient may be severely ill but have a low risk of mortality.

In the end the DRG system was not well correlated to the true costs in psychiatry. The ARP-DRG system works against psychiatric services in an academic setting because of the higher acuity of the patient population then in a community hospital.

How could the DRG and APR-DRG systems be improved? The first step in the research was to use existing billing data and abstract a sample of medical records to obtain admission and treatment characteristics expected to explain variations in length of stay and costs. Through much analysis, the research was unable to improve the predictive power of APR-DRGs for those two variables. The next step was to abstract data from the medical record to classify patients into clinical treatment models, severity of illness, complexity of management and type of treatment.

With this new chart data, Michael Kaminsky, MD at Johns Hopkins tested the predictive power of the data not taken into account with the DRG system. Those data elements were the following:

- Admission characteristics: legal status (voluntary vs. involuntary); suicidality;
- Treatment characteristics: medication compliance; acuity of care (restraints, seclusion);
- Signs-Symptoms-Response to Treatment: verbal or physical aggression toward staff; continued suicidality after first and second week.

These characteristics were much more predictive of consumption of resources then the DRG and/or APR-DRG systems. The explanatory power for LOS went from 14% to 28% for Hopkins' discharges.

Enhanced APR-DRGs were used for the study but the enhancements have not yet been put in place in Maryland. These were the largest predictors for LOS and cost and none were related to diagnosis. They are listed in order of explanatory power from highest to lowest:

- Aggressive behavior, day 10-30
- Seclusion
- Combination: seclusion and either involuntary admission/certification or use of restraints
- Constant observation: greater than 96 hours
- Physical restraints
- Involuntary certification at or after admission
- Benzodiazepine withdrawal with monitoring

Modifying APR-DRGs were also used for the study (but the enhancements have not yet been put into place in Maryland). The clinical characteristics are applied across all APR-DRG psychiatric categories.

A rule was developed for each characteristic that specifies how much its presence should increase case severity (one or two levels) and specifies the maximum level to which severity should increase overall (level 3 and 4).

Preliminary test show approximately 30% improvement in explaining variations of LOS and charges.

The next steps in the research project are the following:

- Finalize the improved APR-DRG categories for psychiatric discharges
- Simulate financial effects in Maryland by comparing current payment system to use of improved APR-DRGs and to Medicare payment methodology in FY07-08.
- Complete data set on quality indicators and examine implications of use in Pay for Performance in Maryland, (Target: October 2011)

(Janet Namini is the administrator for the Northwestern University, Feinberg School of Medicine, department of psychiatry).

New resident training rules

By Deb Tatchin

A panel discussion on the newly mandated resident training rules was conducted by **M. Philip Luber, MD**, Associate Professor, Director of Education, Department of Psychiatry, University of Maryland School of Medicine; Director of Residency Training, University of Maryland/Sheppard Pratt Program; **Karen L. Swartz, MD**, Associate Professor, Associate Director for Residency Education, The Johns Hopkins Hospital; **Keith Persinger, MBA**, Senior Vice President and Chief Financial Officer, University of Maryland Medical Center and University Specialty Hospital; **Sarah K. Tighe, MD**, Chief Resident, Johns Hopkins University School of Medicine Department of Psychiatry and Behavioral Sciences; **Vinay Parekh, MD**, Chief Resident, Johns Hopkins University School of Medicine, Department of Psychiatry and Behavioral Sciences; and **Ruby Lee, MD**, Chief Resident, Department of Psychiatry, University of Maryland School of Medicine.

The new training changes fall into two categories, duty hour limitations and rules on supervision and are effective on July 1, 2011. The purpose of residency training is to give residents optimal opportunity for training in a safe environment.

The new duty rules recognize the dangers associated with sleep deprivation on both the resident and on patient care. Intermediate level residents must have eight hours between their scheduled duty periods and can only work 16 hours straight. They must have 14 duty hours free following 24 hours of in-house duty. Because residents in the final years of their education have to be prepared to practice medicine and care for patients over irregular or extended periods of time, their rules are less strict. While it is still desirable to have eight hours of duty free time between scheduled duty periods, there may be circumstances when this is not possible. They can work 24 hours straight but can work an additional six hours wrapping up the work. Working six hours in an outpatient area after a 24 hour shift is not allowable. Residents may not be scheduled for more than six consecutive nights of night float.

The new supervision rules are intended to assure that adequate supervision is available to residents as their training progresses. At the beginning of training the entire interaction needs to be supervised directly. Once the trainee is able to recognize when help is needed, can ask for help, can demonstrate an ability to perform an intake, can complete a history and physical assessment, can deal with safety concerns and present cases clearly, the trainee can be advanced to the indirect level. Indirect supervision allows for the trainee to treat a patient as long as direct supervision is immediately available. The resident might treat the patient and report later about what was done. Residents must care for patients in an environment that gives them the opportunity to work as a member of a multidisciplinary team.

These changes present a challenge to all academic institutions. Who will backfill and provide the level of care? What will be the cost? In Maryland, attendings and nurse practitioners will perform the services that were done by residents in the past. Patients will be seen by two clinicians instead of one. Will these new rules allow for adequate training? Will they have enough experience? There is a significant financial consequence to the changes in resident training. It is an unfunded mandate that is estimated to cost the University of Maryland $3.5M per year. Some fear that further reductions in duty hours might follow.

The impact on staff is significant. The attendings are working longer hours (60-80 hours) without additional compensation, their workload has changed significantly. During this same period they have had to adapt to the electronic medical record. Currently each clinical faculty supervises one or more trainees. Community physicians train residents too. The University of Maryland is considering giving incentives for teaching.

The demand for nurse

practitioners continues to grow. Their skill set and salary makes them an attractive alternative to physicians. The time to train a nurse practitioner to work in Psychiatry is significant and they often transfer to another department.

Patients will have a greater number of caregivers as a result of the new rules. There was some discussion about the need for additional communication and increased hand-off of care. The panel participants agreed that there can be a lack of continuity and they have developed formal sign-outs to deal with this.

They estimate that it will take ten years to see the impact of this change.

(Deb Tatchin is Finance Manager of the U Michigan Department of Psychiatry).

Departmental development activities

by Shiyoko Cothrin

Jessica Preiss Lunken, the Director of Development in the Department of Psychiatry and Behavioral Sciences at Johns Hopkins provided an overview of the Hopkins Development philosophy. Ms. Preiss Lunken was originally hired to provide Development oversight for both the departments of Psychiatry and Neurology because the prevailing thought was that there would not be enough funding available from grateful patients in Psychiatry only. Ms. Priess Lunken has clearly proven that this is not the case as she has raised an astounding $13 million dollars in philanthropic donations to Psychiatry for the current year.

Ms Preiss Lunken outlined the "Rules of Engagement" to consider when developing a successful philanthropy program. Among the many critical factors described is the importance of the physician-patient relationship and understanding where the patient is in the course of their disease. Physicians need to be

aware of patients that may have means and an interest in giving. Learning to be aware of the questions that patients or their families ask is important to the development process. Grateful patients may be interested in giving if they have had a good experience or successful treatment but Ms. Preiss Lunken reminded us that some patients and families are motivated to give if they have not had the best outcome and are looking to use the opportunity to help others. In addition to being able to identify potential donors, it is just as important to understand what a department has to offer a potential donor in order to match programs needing funding to donors with an interest in those programs or diseases.

In an effort to continue to develop a philanthropically-minded culture, Hopkins has used videos and posters to remind both patients and staff of giving opportunities. Many times, staff may be the first to hear patients express interest in giving.

Ms. Priess Lunken also highlighted the importance of taking a long-term approach towards development and the stewardship of donations. Building trust and rapport with potential donors is paramount as is ongoing involvement of Department and University leadership. As more donations are being directed toward specific projects, the Hopkins development team provides donors with details on outcomes from the research or programs that their donations support. In addition to sending annual reports, the Hopkins Development team will often visit donors yearly and schedule periodic communication.

(Shiyoko Cothrin is the Operations Director of the Penn State U department of psychiatry).

The impact of health reform on psychiatry

by John Herzke

An expert panel consisting of **William Tucker, MBA, CPA**, Chief Corporate Officer, University Physicians, Inc. and Assistant Dean for Practice Plan Affairs, University of Maryland School of Medicine; **Howard H. Goldman, MD, PhD**, Professor, Division of Health Services Research, Department of Psychiatry, University of Maryland School of Medicine; and **Scott Berkowitz, MD, MBA**, Fellow in Cardiology and Geriatrics, Johns Hopkins University School of Medicine, presented information regarding the impacts of both federal and state healthcare reform efforts on mental health. Mr. Tucker began the discussion by addressing some of the main themes of healthcare reform efforts, namely the desire to create structures in the healthcare system that enhance accountability and affordability. He noted a common problem in the traditional fee-for-service model whereby healthcare providers are incentivized to provide unnecessary services, and there is often a failure to coordinate between providers for the same patient, leading to duplicative and/or conflicting treatments. Mr. Tucker also pointed out some common characteristics of traditional academic medical center culture:

- Hierarchical
- Autonomous
- Competitive
- Expert-centered
- Individualistic

One of the desired outcomes of healthcare reform is to encourage academic medical centers to transform their cultures from some of the preceding characteristics toward the adoption of the following attributes:

- Collaborative
- Team-based
- Service-based
- Patient-centered
- Mutual accountability

Mr. Tucker touched on some of the popular healthcare reform models and pilots that have been rolling out in recent years. He discussed medical homes, which are intended to coordinate care among primary care providers, reduce cost as well as conflicting treatments, and encourage patient-centered, team-based care. Bundled payments represent another initiative that has been piloted by CMS, particularly in orthopedics and cardiovascular services, whereby payments are provided for entire episodes of care and physicians and hospitals are incentivized to collaborate in a more cost-effective manner. Other significant initiatives include hospital 30-day readmission rate reduction efforts that seek to improve upon quality related to the transition of patients between settings of care, partial capitation (particularly physician services), pay for quality performance, EMR incentives, and healthcare innovation zones.

Mr. Tucker and Mr. Berkowitz focused particularly on the structure, intent, and implications of Accountable Care Organizations, which are included as a pilot initiative in the Patient Protection and Affordable Care Act (ACA) with a planned start date of January 1, 2012. Important aspects of ACOs include:

- Designed to be flexible and provider-based, rather than payor-based
- No requirement for patients to be formally enrolled (patients can receive care outside of ACO), and voluntary provider participation
- Minimum 3-year duration and at least 5,000 Medicare patients, determined retrospectively by where beneficiaries receive primary care services
- Traditional fee-for-service payments under Medicare would continue under current methodology

- Providers in ACO will share in cost savings if risk-adjusted, per-beneficiary spending falls below established benchmarks

Mr. Tucker outlined important risks to consider regarding ACOs, such as a lack of clearly-defined business details, implications of additional provider consolidation that may result from providers' attempts to effectively coordinate care, and potential risk of conflicting anti-trust, anti-fraud, and Stark laws which have not been updated to address ACOs.

Dr. Berkowitz noted some of the specific opportunities presented by ACO pilots for academic medical centers such as Johns Hopkins. Those providers who already have or are positioned to develop broad, coordinated services within their communities stand to benefit from the cost savings opportunities offered by an ACO framework. In addition to describing all of the in-depth requirements to form an ACO as well as the potential benefits, he provided specific information regarding the lack of clarity in the ACA surrounding the financial modeling and other business details of ACOs. Many of these specifics are in currently proposed regulations, regarding which CMS is in the process of gathering comments and will be deciding upon later this year.

Dr. Goldman focused primarily on the broader impacts of healthcare reform on behavioral health. Specifically, he noted that two acts of Congress created the greatest benefit of expanding access to behavioral health services: the Mental Health Parity Act of 2008, and the Affordable Care Act (ACA). The Mental Health Parity Act required insurance plans which offer mental health coverage to provide such with the same level of benefits (co-pays, deductibles, limits, etc.) as their medical coverage, but did not require insurance plans to offer mental health coverage. In spite of little mention of mental health in 2010's ACA, this law nevertheless mandated that all insurance plans provided through the creation of health insurance exchanges will provide mental health benefits. The combination of these two acts ensures that all insurance plans will offer mental health coverage and will be offered with comparable benefits to medical services.

The ACA's other implications for mental health providers depend greatly on the payor mix of those providers. Dr. Goldman postulated that providers with significant Medicaid and/or self-pay patient populations, both of which are disproportionately affected by mental health and substance abuse issues, should see a greater financial benefit from reform. More patients will meet Medicaid's expanded eligibility criteria, and self-pay populations will largely be covered. Providers with large Medicaid populations will be incentivized to maintain or develop case management services, which have demonstrated evidence of criticality to Medicaid mental health patients and are covered by Medicaid, as opposed to private payors which typically do not cover case management. Dr. Goldman noted that further efforts are underway toward improving Medicaid payment rates.

Dr. Goldman provided a specific example of a patient population which would benefit from ACA's new insurance requirements. In his Schizophrenia Bulletin editorial published July 21, 2010, he noted that ACA's mandate of expanded parental insurance coverage of children up to age 27 will create greater access and improved, targeted treatment options for mental health patient populations, particularly schizophrenic patients, whose onset of illness typically occurs in the age range of late teens to early twenties.

All of the speakers together presented a balanced view of the effects of healthcare reform on mental health, highlighting both opportunities such as increased access and the potential for improved reimbursement, as well as risks such as poorly defined structure and possible legal pitfalls associated with accountable care organizations (ACOs).

(John Herzke is an administrator in the Johns Hopkins Medicine department of psychiatry).

Managing your research portfolio – Part two

This is the second in a series of articles for *The GrAAPvine* that will discuss different issues and tools involved in managing your research portfolio. In this issue we will cover creating a research receivables pipeline. Future articles will discuss:

- Tracking indirect/RCR costs;
- Managing the salary funding balance with researchers, and others.

Creating a Research Receivables Pipeline

Get out your crystal ball…

Does your Chair ask you to do that from time to time? Not likely.

Yet the ability to predict the resource needs and available revenues for your department's research mission is critical to your success as an administrator.

We can create a research "pipeline", just like a private company will do, to help us plan and manage future "real" and "possible" revenues, expenses, and commitments.

First, let's take a look at your research portfolio. We'll define that as:

- Ongoing awards funded in previous years.
- New awards, funded in the current year.
- Proposals still pending from the previous fiscal year
- Proposals pending in the current fiscal year, or
- Proposals that are being submitted in the coming months of the current fiscal year.

This list should help you define the research you have, as well as what you might have in the future several years out.

The list also represents project dollars you need to manage, and potentially, the expense dollars you may need to commit as supplemental salary, matching dollars, research and office space costs, equipment, IT charges…the list goes on and on.

Your research portfolio may also represent revenue dollars as indirect costs that could return to your department in part or as a whole.

Now let's list:

- All current funding by year, based on proposal and award information.
- Next, all outstanding proposed funding by year.
- Finally, list those proposals you know will be submitted this year or next

Let's tag on real or proposed direct and indirect costs, and organize all in separate columns, by the year we feel the revenue or expense will occur.

Finally, prioritize by what you know as expectation of funding, using 1 as certain, line Non-competing renewal, 2 as less certain, such as Competing renewal, and so forth.

How does your funding stream look with just 1's, 1's and 2's, and the rest?

You will also want to account for any department commitments in conjunction with any proposals, such as benefit dollars needed on a training grant.

Use this tool on an ongoing basis—updating it regularly—to help manage your current and future resource needs.

It is also a terrific tool to help decide whether or not to take on certain projects.

CMS issues new rules for telemedicine credentialing and privileging

On July 5, 2011, The Centers for Medicare and Medicaid Services regulation revising the conditions of participation(CoPs) for both hospitals and critical access hospitals (CAHs) for the credentialing of telemedicine physicians becomes effective. Prior to this date, a hospital or CAH receiving telemedicine services had to go through a burdensome credentialing and privileging process for each physician and practitioner providing telemedicine services to its patients. The new law removes this undue hardship and financial burden.

The prior regulations required a hospital's governing body to appoint all practitioners to its hospital medical staff and to grant privileges using the recommendations of its medical staff. In turn, the hospital medical staff used a credentialing and privileging process, provided for in CMS regulations, to make its recommendations. CMS requirements do not take into account those practitioners providing only telemedicine services to patients. Consequently, hospitals applied the credentialing and privileging requirements as if all practitioners were onsite. This traditional and limited approach failed to embrace new methods and technologies for service delivery that might improve patient access to high quality care.

CMS came to the conclusion that this previous requirement was a duplicative and burdensome process for physicians, practitioners, and the hospitals involved in this process, particularly small hospitals and CAHs, which often lack adequate resources to fully carry out the traditional credentialing and privileging process for all of the physicians and practitioners that may be available to provide telemedicine services. In addition to the costs involved, small hospitals and CAHs often do not have in-house medical staff with the clinical expertise to adequately evaluate and privilege the wide range of specialty physicians that larger hospitals can provide through telemedicine services.

Essentially, the new provisions will allow for the governing body of the hospital (or the CAH's governing body or responsible individual) to rely upon the credentialing and privileging decisions made by the distant-site telemedicine entity when making its own decisions on privileges for the individual distant-site physicians and practitioners providing such services, if the hospital's governing body (or the CAH's governing body or responsible individual) ensures, through its written agreement with the distant-site telemedicine entity, that the distant-site telemedicine entity's medical staff credentialing and privileging processes and standards meet or exceed CMS standards.

The removal of unnecessary barriers to the use of telemedicine may enable patients to receive medically necessary interventions in a timelier manner. It may enhance patient follow-up in the management of chronic disease conditions. These revisions will provide more flexibility to small hospitals and CAHs in rural areas and regions with a limited supply of primary care and specialized providers. In certain instances, telemedicine may be a cost-effective alternative to traditional service delivery approaches and, most importantly, may improve patient outcomes and satisfaction.

Can telemedicine improve geriatric depression?

Studies have shown a high rate of depression among elderly homebound individuals, and few patients receive adequate treatment, if any. To address this issue, researchers at Rhode Island Hospital and other organizations have developed a telemedicine-based depression care protocol in home health care. The early findings from their pilot study will be presented at the 29th Annual Meeting and Exposition of the National Association for Home Care and Hospice on October 3.

Thomas Sheeran, PhD, ME, clinical psychologist in the department of psychiatry at Rhode Island Hospital, led the study. Sheeran explains, "Using telemedicine in home care to provide disease management for geriatric depression is timely for several reasons. The home care industry is already using telemedicine to provide chronic disease management for many medical illnesses, such as heart disease. However, guideline-based depression care often is not included in these monitoring programs. Also, research suggests that telemedicine can be successfully used to address mental health needs of the elderly in community settings." Sheeran adds, "Finally, work by the Cornell Homecare Research Partnership and others has shown that community health nurses – who typically are the telehealth disease managers in home care– can identify and successfully provide this service for their elderly home care patients."

Through the pilot study, Sheeran reports that overall, feasibility and patient satisfaction ratings were very high. He notes that a majority of the elderly participants reported they were satisfied or very satisfied with the protocol, that they quickly became comfortable using the telehealth equipment and there were few technical problems. More importantly, they felt it improved their care and that they would be willing to use it again. The researchers also found that telehealth nurses reported that with the majority of their patients, the Depression TeleCare Protocol was easy to implement, there were few technical problems, that it improved care and improved depression outcomes. Both patients and nurses believed that confidentiality was maintained.

Sheeran also comments, "At the start of the study, 19 of these patients met full diagnostic criteria for Major Depression, with a mean depression severity score in the 'Markedly Severe' range. We were very pleased to find that at follow-up, the average depression severity scores were in the 'Mild' range, indicating significant improvement in depression severity through the use of this protocol. While these findings need to be replicated in a more rigorously controlled randomized trial, we believe these results offer great encouragement for reaching this population who can experience a better quality of life from this program."

The project began at the Cornell Homecare Research Project at Weill Cornell Medical College and was completed at Rhode Island Hospital, in collaboration with the University of Vermont's Telemedicine Program. In addition to the three academic centers, the project partnered with three home health agencies in New York, Vermont and Florida to integrate and pilot evidence-based depression care into existing telehealth programs.

In his presentation, Sheeran, who is also an assistant professor at The Warren Alpert Medical School of Brown University, will provide a description of the clinical protocol, implementation challenges and more information on the preliminary findings of the pilot work.

The study was funded by a grant from the National Institute of Mental Health and by the Cornell Clinical and Translational Science Center. Other researchers involved in the study with Sheeran include Martha L. Bruce, Phd, MPH, professor of sociology in psychiatry at the Cornell Homecare Research Partnership, Weill Cornell Medical College, and Terry Rabinowitz, MD, DDS, professor of psychiatry and family medicine at Fletcher Allen Health Care, Telemedicine Program, University of Vermont College of Medicine.

(Reprinted from News@Rhode Island Hospital, 10/5/10)

Lists, by the numbers

by David Peterson, FACMPE

History buffs will recall that after World War I, President Woodrow Wilson proposed a series of 14 points to facilitate the rebuilding of relationships, healing of wounds, prevention of more conflict and ultimately a League of Nations. Georges Clemenceau, France's Prime Minister at the time, famously responded to President Wilson's 14 points by saying (paraphrased), "14 Points. 14 Points. God himself only needed 10."

This leads to the topic of lists. Lists are everywhere and can be a useful tool for executives in every walk of business, to include the business of healthcare. Keepers of lists are abundant. In his autobiography, former Secretary of State Colin Powell, referenced a short list of reminders he kept under his desk blotter. In his recent autobiography, reference is made to former Secretary of Defense Donald Rumsfeld's list of rules, a list labeled by some of Rumsfeld's associates as "Rummy's Rules." Wilson offered up the aforementioned "14 Points." And then, of course, there is the list - the 10 Commandments - Clemenceau referenced in his response.

Interestingly, 10 seems to be a magic – and manageable - number. Traditional management theory places a manager's "span of control" between 6 and 10. (Nowadays, some argue that the span can be enlarged depending upon the type of organization involved and the level of technology (email etc.) available.) According to the management theorists, a span larger than 10 becomes unmanageable. One can say the same for the number of items on lists – especially to-do lists.

To-do lists are intended as a way to organize and address work in a productive way. Some experts state that to-do lists that become too long, become unproductive themselves, ultimately discouraging the list maker because the list becomes unmanageable or unachievable in the amount of time allotted. There is something simply satisfying to "ticking an item off a list" or, even more satisfying, completing a to-do list. Consequently, building a reasonably achievable to-do list, with a reasonable length (less than 10 items long) and with a reasonable amount of time to complete it is optimal and most satisfying.

The American College of Medical Practice Executives (ACMPE) has composed a list of skill sets critical to a healthcare executive's success in its Body of Knowledge™. Coincidentally, the ACMPE lists 8 (notably less than 10) areas of expertise and these areas include :

- Business Operations
- Financial Management
- Organizational Management
- Human Resource Management
- Information Management
- Patient Care Systems
- Quality Management
- Risk Management

Healthcare executives who master this list become Certified Medical Practice Executives (CMPE).

The Administrators in Academic Psychiatry (AAP) maintains a list of members, one that has grown to over 100, and when this list is cross-referenced with the ACMPE membership list, 17 AAP members (also listed) are found to have dual membership in both the AAP and ACMPE. And, many of these have "mastered the list."

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AAP/ACMPE Dual Membership

Name	Organization	ACMPE status
DeCourcey, Carol	University of Massachusetts Medical School	Nominee
Dozanti, Lindsey	Case Western Reserve/University Hospital	Nominee
Erwin, Richard	University of Missouri – Columbia	CMPE
Gaupp, Bill	Baylor College of Medicine	CMPE
Green, Kary	Texas Tech University Health Sciences Center	Nominee
Hyer, Judith	Scott and White Hospital and Clinic	CMPE
Kersey, Patricia	Mayo Clinic College of Medicine	Nominee
Landry, James	Tulane University School of Medicine	CMPE
Mills, Crystal	Louisiana State University School of Medicine	Nominee
Mueller, Steve	University of Texas Medical Branch	Nominee
Munroe, Florie	Health Quest	CMPE
Peterson, David	Medical College of Wisconsin	FACMPE
Taylor, Marietta	Bassett Healthcare	FACMPE
Thomas, Carol	University of Louisville School of Medicine	CMPE
Thomas, Joseph	University of Michigan Health System	CMPE

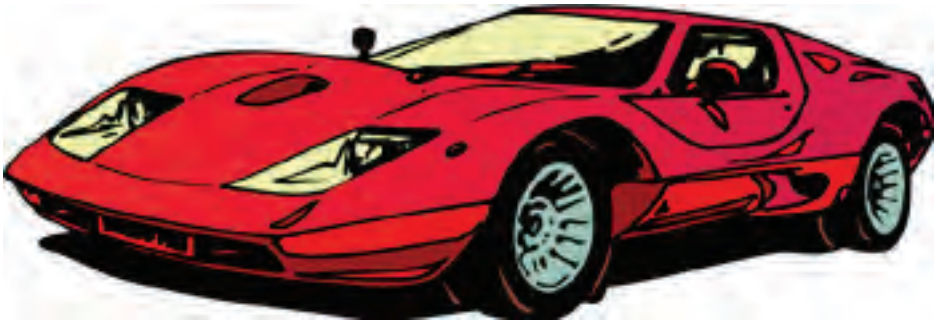
For information on joining the ACMPE or the board certification and fellowship process, contact the ACMPE directly at 877.275.6462 ext. 889 or contact David Peterson, FACMPE at 414.955.8990, email at peterson@mcw.edu or at the Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wisconsin 53226.

Administrators in Academic Psychiatry
Fall Educational Conference
Santa Fe, NM
October 19-21, 2011
www.adminpsych.org

Medical Group Management Association
Annual Meeting
Las Vegas, NV
October 23-26, 2011
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)!

A man went into his shrink's office and says, "Doc, you have got to help me! Every night I keep dreaming that I'm a sports car. The other night, I dreamed I was a Trans Am. Another night, I dreamed I was an Alfa Romeo. Last night I dreamed I was a Porsche. What does this mean?"



"Relax," says the shrink, "You're just having an auto body experience."

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

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