Vol. 18 No. 3
Summer 2006

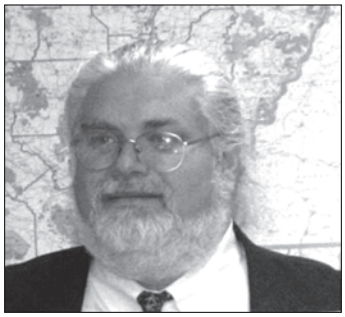
The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Jim Landry



WOW, Chicago was AAP's kind of town! The most valuable component of my membership in AAP is the ability to network in person with my colleague and friends – THE experts in psychiatry administration - at our educational conferences. This past year Membership Director, **Steve Blanchard** (U Iowa) and his committee were able to add fourteen new members to our AAP family. More impressive was that seven of our new members attended their first educational conference!

Our 2006 Fall Educational Conference will be held in Tucson, Arizona on November 3-4, 2006. I would encourage ALL members to attend this conference. **Brenda Paulsen** (U Arizona) is our colleague on the ground, and has been working very diligently for the past six months making arrangements with our conference site. Please mark your calendars and plan on attending. If you would like to present, or have ideas for presentations or presenters, please contact President-Elect/Education Chair **Elaine McIntosh** (U Nebraska) at the email address listed on the back page.

I want to express my appreciation to the members of this past year's Education Committee who helped plan the Indianapolis (relocated from New Orleans) and the Chicago conferences. The success of our conferences depends on the willingness of our members to volunteer their time to plan these events. Thank you to **Marti Sale** (U Kentucky), **Elaine McIntosh, Hank Williams** (U Washington), **Christine Johnston** IUPUI), **Doris Chimera** (U Texas - Galveston), **Radmila Bogdanich** (Southern Illinois U), **Cindy Smith** (Washington U), **Patricia Birkmeyer** (U Texas – Galveston), **Rich Erwin** (U Missouri), **Jim Puricelli** (Loyola U), **Pat Romano** (Albert Einstein COM), **Janice McAdam** (Kansas U) and **Steve Blanchard.**

On behalf of all the membership, I want to express a special thanks to **Pat Romano** and the Board of Directors for their leadership and support this past year. Relocating a conference was no small feat, supporting members in the Gulf Coast region was nothing short of amazing, all while moving the organization forward was nothing but inspiring.

Continued on page 5

Comings and goings

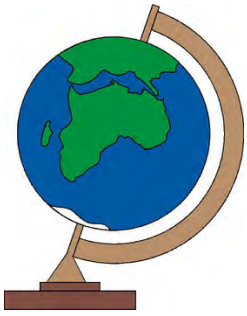
Please feel free to call new members and personally welcome them to our organization. One of the things that makes AAP special is its friendly members! The hospitality offered by a personal contact will surely be appreciated.

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

Laura Collins
University of Washington
laurac@u.washington.edu
(206) 731-8519

Rudd Kierstead
Cornell University
ruk2007@med.cornell.edu
(212) 746-3315

Andrea Rahlf (welcome back!)
U Illinois - Chicago
arahlf@psych.uic.edu
(312) 355-1709



Julie Smith
Southern Illinois University
jsmith2@siumed.edu
(217) 545-7673

Jill Toepfer, RN
Southern Illinois University
jtoepfer@siumed.edu
(217) 545-7675

AAP wishes the best of luck to the following member:

Doris Chimera has left the University of Texas Medical Branch at Galveston to accept a position with Harris County Health District (Houston). Happily, she will remain a member of AAP as her new responsibilities keep her involved with academic psychiatry.

Low fat and high profile

In 1993, **Joanne Menard** (U Washington) began participating in a longitudinal study of the benefits of eating a low fat diet. She and 49,000 other women had to reduce their intake of fat to 20 percent of their diets. Joanne gave up lots of high fat foods, and boasts in the February 27, 2006 issue of *People Magazine* that she hasn't eaten butter in 10 years!

That's right, Joanne is in

People! In the same magazine as Britney Spears, Halle Berry and Heather Locklear, Joanne appears on page 89, along the shore of Lake Washington, with her husband, Bob Boggs, and dog, Zooey.

While Joanne is pleased with the results she has experienced due to healthier eating, she is most proud that taking part in the study promotes continued research into women's health.

The Board of Directors of AAP wishes sincere condolences to . . .

Joanne Menard on the loss of her mother

Your 2006-2007 board of directors

The 2006-2007 AAP Board of Directors was approved at the Spring Conference business meeting in Chicago. The members of the Board welcome your comments and questions as well as your participation, so please feel free to contact any one of them. All email addresses and phone numbers are printed on the back page of The GrAAPvine.

President	Jim Landry	Tulane University
President-Elect	Elaine McIntosh	University of Nebraska
Immediate Past President	Pat Sanders Romano	Albert Einstein College of Medicine
Secretary	Debbie Pearlman	Yale University
Treasurer	Janice MacAdam	Kansas University
Membership Director	Steve Blanchard	University of Iowa
Member-at-Large *Strategic Planning/Governance*	Paul McArthur	University of Rochester
Member-at-Large *Membership*	Joanne Menard	University of Washington
Member-at-Large *Education*	Marti Sale	University of Kentucky
Member-at-Large *Benchmarking*	Hank Williams	University of Washington

Keeping up with old friends

Past President and honorary member, **Mary Jo Swartzberg** (Medical University of Ohio), has recently begun a new position as Autism Services Coordinator for the Northwest Ohio Regional Autism Advisory Council. She is responsible for assisting in the coordination of autism services for public schools, educational services centers, boards of MR/DD, charter schools, parent advocacy groups, private providers, medical programs and university programs in northwest Ohio.

She continues to work part time at MUO in the Department of Psychiatry as Program Director of Public and Community Psychiatry.

Are you receiving your listserv emails?

Most AAP members say that the most valuable networking tool available to them is the listserv. In recent months, members have been able to ask questions about RVUs, faculty evaluations, shadow charts, and med/psych inpatient units to illustrate the variety of topics.

If you have a question about any administrative topic, all you have to do is ask the experts - our members - and you'll get lots of information to help you work through your issues and solve your problems.

But, you can't benefit from the list if you aren't enrolled. When you joined AAP, you were sent an email asking you to verify your address and your interest in the listserv. If you deleted your message without responding, you aren't getting messages. If that's the case, and you'd like to get the benefit of your colleagues' expertise, send an email to our list moderator, Rich Erwin, at erwinrw@health.missouri.edu, and he'll get you enrolled.

Awards . . .

Accolades for his long term contributions to Administrators in Academic Psychiatry were given to **John DiGangi** (U Massachusetts) in the form of the *President's Award*. John has served on the Board of Directors as both the Membership Director and as a Member at Large. He provided significant planning support for the AAP Fall conference when it was held in Boston and has shared his expertise several times as a conference speaker. And, John recently led the effort to update the Strategic Plan and Goals, to a more workable document.

The *Rising Star Award* is presented to all new members (within the first three years of membership) who have participated in a significant way in AAP activities. This could include speaking at a conference, writing an article for The GrAAPvine, serving on a committee or any other activity recognized by the Board as contributing to AAP. Recipients this year were **Patricia Birkmeyer** (U Texas - Galveston), **Jane Biehler** (U Oklahoma), **Ronald Menaker, FACMPE** (Mayo Clinic), **Christina Nesbeda** (U Massachusetts), **James Puricelli** (Loyola U), and **Cynthia Smith** (Washington U, St. Louis)

John DiGangi and Pat Sanders Romano

Tina Nesbeda, Jim Puricelli and Ron Menaker (missing: Patricia Birkmeyer, Jane Biehler, Cindy Smith)

. . . and appreciation

It's time again to give special thanks to those members who have helped produce this newsletter. Without the assistance and good nature of everyone who volunteers, producing The GrAAPvine wouldn't be as easy or as much fun as it is. Each time I put out an issue I think how lucky I am to have such wonderful friends and colleagues who are willing to write an article, manage a quarterly column or send me a joke. So, thank you! You're terrific!

Tony Bibbo
Radmila Bogdanich
Lindsey Dozanti
Rich Erwin, CMPE
Lee Fleisher
Dan Hogge
Pat Sanders Romano
Janice McAdam
Ronald Menaker, FACMPE
Joanne Menard
Janet Moore
David Peterson, FACMPE
Karen Roe
Hank Williams

President's message

Continued from page 1

Pat, Queen of the AAPs, was the link to my AAP family during my Katrina experience. She was one of the pillars that helped support me personally (and professionally) get through this past year – Pat, I don't know how I will ever be able to repay you.

The expression of concern by my AAP family in the aftermath of Katrina was amazing, although not unexpected. I was very touched by the outpouring of love and support at the Indianapolis conference, where I received shirts (and other treasures) from many different universities. The "I'd give you the shirt off my back" sentiment was truly heartfelt. Many of our members offered me and my family housing, assistance of all kinds, adopted my stepdaughter and her kids when their home flooded, and some even came down to help make repairs on my farmhouse. I am truly grateful to AAP – my extended family.

Often we refer to AAP as a family, and I would like to let the above paragraph illustrate to our new members that you did not just join a professional organization. You joined an organization whose members truly care about each other. I would encourage all members, especially new members, to attend our fall and spring educational conferences – this is how we strengthen the bonds of our organization – plus we learn some pretty nifty stuff!!

It is truly an honor to have been elected president of this organization. I know I have large shoes to fill, but Pat has laid the foundation for AAP to move forward as an organization. Finally, I would like to recognize the Board of Directors for the current year, and look forward to working closely with each of one. Past President – **Pat Romano**, President Elect – **Elaine McIntosh**, Secretary – **Debbie Pearlman** (Yale U), Treasurer - **Janice McAdam**, Membership – **Steve Blanchard**, Member at Large/Strategic Collaboration – **Paul McArthur** (U Rochester), MAL/Membership – **JoAnne Menard** (U Washington), MAL/ Benchmarking – **Hank Williams**, and MAL/Education – **Marti Sale**, and *GrAAPvine* Editor - **Jan Price** (U Michigan).

Jim

Coming attractions

American Medical Group Association
September 17-20, 2006
Minneapolis, MN
www.amga.org

Medical Group Management Association
October 22-25, 2006
Las Vegas, NV
www.mgma.com

Administrators in Academic Psychiatry Fall Conference
November 4, 2006
Tucson, AZ
www.adminpsych.org

The GrAAPvine provides information about educational opportunities of interest to its members. It does not necessarily endorse these programs (except, of course, our own!)

Why you should be a member of MGMA

The Medical Group Management Association (MGMA) has several assemblies, including the Academic Practice Assembly (APA), which holds its conference each spring. Within the APA are several academic special interest groups (ASIG), including **Administrators in Academic Psychiatry**. As an ASIG, we benefit from assistance with funding our educational programs and networking sessions, as well as help with conference planning.

Currently only 30% of our AAP members are also members of MGMA, and of that number, only 78% are members of the Academic Practice Assembly of the MGMA.

While it isn't a prerequisite of AAP to be a member of either the MGMA or it's assembly, there are very good reasons to be:

- Access vital information, medical practice management tips, library research, legislative and regulatory developments, breaking news and industry trends
- Participate in any of 75 education events throughout the year
- Use MGMA benchmarking survey reports to address your practice challenges and improve performance
- Join any of 20+ MGMA Assemblies and Societies to build solid networks with peers in your practice specialty or business function area *(Ed. As part of your membership in MGMA you are entitled to membership in one assembly. Additional assembly memberships are available for a nominal fee)*.
- Use the online career resources
- Receive member discounts on products and services
- Become board certified in medical practice management through ACMPE and earn the highest distinction as a Fellow in ACMPE
- Network with some of the most knowledgeable and respected people in your profession.

For more information or a brochure on MGMA, email membership@mgma.com or call toll-free 877-ASK-MGMA (275-6462, ext 889.

MGMA Internship Program

Bring an aspiring medical practice manager to your team through the Medical Group Management Association (MGMA) and the American College of Medical Practice Executives (ACMPE) Internship-Residency Program. You'll give a qualified college or university student valuable experience in a practice environment while benefiting from their eagerness to learn and participate.

If your organization is interested in free advertising for an administrative internship and/or fellowship position, take a few minutes to complete our online posting form at http://www4.mgma.com/marcom/internship.htm.

Questions? Call Melissa Emdin toll-free at 877.275.6462, ext. 232, or e-mail interns@mgma.com.

Academic Practice Compensation Survey

Top-performing academic practices understand that developing a vision for the future — and pursuing it — begins with ongoing assessment. To help in your pursuit, MGMA delivers the most relevant benchmarking data in the industry.

The MGMA annual *Academic Practice Compensation and Production Survey Report for Faculty and Management* contains data on more than 12,000 faculty physicians and nonphysician providers in more than 350 medical departments. Use the report to evaluate the performance of individual faculty physicians and nonphysician providers, develop compensation and production targets for your providers and managers, and assess your compensation methods for compliance. Item 6526

MGMA member: $300; Affiliate: $350; Nonmember: $500

Order today. Go to the www.mgma.com or call toll-free 877-ASK-MGMA (275-6462).

The executive suite

Points of intersection: The AAP spring conference, professionalism and the Medical Practice Management Body of Knowledge Review

by David Peterson, FACMPE

After returning from the AAP Spring Conference in Chicago where a variety of timely topics were discussed, I had the privilege of participating with others from around the country in a conference call "conversation" about the topic of professionalism, a conversation that will be featured in an upcoming issue of the American College of Medical Practice Executives' *Executive View*. Throughout the conversation, continuing education arose as one of the themes that was repeated by many of the conference call participants.

About the same time this spring, a new learning tool published by the Medical Group Management Association (MGMA) was released. Titled the *Medical Practice Management Body of Knowledge Review*, this is a resource comprised of nine booklets designed "to build the core knowledge and skills required for career success." Before writing more about this, I need to disclose a conflict of interest. Because I am one of the authors for the series (Volume 8: Professional Responsibility), I have a distinct bias toward the series and the value it offers.

Edited by Lawrence F. Wolper, MBA, FACMPE, the *Body of Knowledge Review* series covers:

Volume 1: Overview
Volume 2: Business and Clinical Operations
Volume 3: Financial Management
Volume 4: Governance and Organizational Dynamics
Volume 5: Human Resource Management
Volume 6: Information Management
Volume 7: Planning and Marketing
Volume 8: Professional Responsibility
Volume 9: Risk Management.

This subject matter was designed to cover the eight management domains identified in the American College of Medical Practice Executive (ACMPE) *Body of Knowledge* and also complements the material tested in the ACMPE's Board Certification Exams. In fact, the series of booklets is structured for those "considering certification in the…ACMPE" or those "reviewing foundation concepts for the ACMPE exams."

As some of MGMA's promotional literature about the series states, the booklets "provide a review of each management domain by highlighting key concepts, tasks, terminology, regulations and key resources while addressing specific tasks related to medical practice."

Hopefully the points of intersection are obvious. The administrators in academic psychiatry who met in Chicago are a committed group of professionals who are working together to advance the group's own body of knowledge. To be sure, the AAP Spring Conference was a great indicator of the *professionalism* of the group and the topics covered contributed to the *overall body of knowledge for the administrator in academic psychiatry*. Finally, the new *Body of Knowledge Review* series published by MGMA is another new powerful tool to help the practice executive continue to develop the skill set needed to excel in his or her position.

For those interested, this series can be found at www.mgma.com, by clicking on "Store" and then searching under "Medical Practice Management Body of Knowledge Review." *For more information on joining the ACMPE or the board certification and fellowship process, contact the ACMPE directly at (303) 397-7869 or contact David Peterson, FACMPE at (414) 456-8990, email at peterson@mcw.edu or at the Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wisconsin 53226.*

William J. Newel Lecture

Volunteering for Katrina: A Psychiatrist as a General Practitioner in Louisiana

by Dan Hogge

Adaptability and resourcefulness are the two key words that come to my mind when I think about the presentation of **Dr. Kenneth Silk,** Professor of Psychiatry, University of Michigan, as this year's William J. Newel lecturer.

With an opening slide entitled "The Great USA" Dr. Silk's presentation clearly showed how hurricane Katrina destroyed the lives and property of thousands of U.S. citizens. We all have seen the news broadcasts of the wreckage and the loss of human life but Dr. Silk's personal slides showed the power and force of nature and how even after five months the destruction was still prevalent in many ways.

Dr. Silk volunteered through the federal government website and set out to provide assistance for a population that had been changed forever. St. Bernard Parish, a community which prior to the hurricane had a population of 70,000, was now down to 10,000 - 15,000 with over 90% of the residences having water damage. With only three physicians out of eighty returning to the local hospital the need for medical care was enormous and the tasks almost overwhelming.

Helping to establish a primary care clinic with other medical

professionals was daunting and overwhelming. Procedures, medical records, and processes were rudimentary and as each room was made functional they felt like it was a major accomplishment and a personal victory. As Dr. Silk said, "The gestures of humanity and concern were overwhelming." Obviously, these volunteers felt great happiness and satisfaction in making even a small difference in the lives of these victims.

As in any difficult setting supplies were in short supply and lasted only two to three days at a time. Basic medications were scarce and improvising with substitutes was common. Dr. Silk said even the treatment of colds and blisters was considered important to these individuals. Additionally, he utilized his professional skills in other ways, such as treating PTSD which was a very common illness given the magnitude of death and trauma these individuals had to face. He made a poignant comment about how sincere most people were and how often he heard the comment: "I feel lucky because I know someone else who has it worse than me."

Often we have heard how the human spirit is strong and resilient. Dr. Silk recognized that people have a strong sense of community and they know it is their responsibility to strengthen and revitalize each other and their neighborhoods. Certainly, it is not where they stand right now in their lives but where they see their future and how they will arrive there.

Dr. Silk concluded with what he personally had learned and what he had taken from this great opportunity to assist mankind. His response was threefold:

He learned and appreciated the true resilience and strength of mankind and his ability to adapt and not lose hope. Second, he appreciated the opportunity to experience some real "hands on" medicine. The ability to wrap a wound or help a young man from losing his toe was gratifying. Lastly, the twelve hour work days were arduous and difficult but he made friendships that will last forever and he was glad that he was able to be in a place where he had the chance to help make a difference.

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

Performance measures: National perspective and current work to identify hospital-based inpatient psychiatric (HBIPS) measures

by Radmila Bogdanich, MA

During her presentation, **Celeste Milton, RN, BSN**, Associate Project Director, Group on Performance Measurement-Core Measures, Division of Research, Joint Commission on Accreditation of Healthcare Organizations, discussed why the federal government is emphasizing tracking performance in healthcare, reviewed current national efforts in measurement including the Joint Commission's initiatives, gave an overview of the Hospital-Based Inpatient Psychiatric Services (HBIPS) Project, and identified current data available as part of the Quality Check initiative.

Accreditation, regulation, Pay for Performance, demand for data by purchases and/or payers, managed care and transparency are all driving the movement for health care entities to collect performance measurement data. In the beginning, the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the Centers for Medicare and Medicaid Services (CMS) and the National Quality Forum (NQF) were responsible for measuring performance. Now, many more organizations are involved at the state, federal and organization level, resulting in many fragmented efforts.

The Hospital Quality Alliance, a collaboration of the CMS, American Hospital Association (AHA), Federation of American Hospitals (FHA), and Association of American Medical Colleges (AAMC); and supported by the Agency for Healthcare Research and Quality (AHRQ), NQF, JCAHO, American Medical Association (AMA), American Nurses Association (ANA), AFL-CIO and American Association for Retired Persons (AARP) has developed twenty measures that hospitals are currently reporting on. (These measures can be found at www.hospitalcare.hhs.gov). The Deficit Reduction Act of 2005 made public reporting of Inpatient Hospital Quality Data mandatory and hospitals must participate to get full reimbursement from CMS.

Four founding organizations make up the Ambulatory Care Quality Alliance (AQA) and include the American Academy of Family Physicians, American College of Physicians, America's Healthy Insurance Plans, and AHRQ. Today they are a steering committee of 11 organizations and 26 different performance measures including depression management at the physician level. The Depression Measures include Antidepressant Medication Management: Effective Acute Phase Treatment and Antidepressant Medication Management: Effective Continuation Phase Treatment.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospital Survey is a consumer assessment of healthcare providers and systems for public reporting which increases hospital accountability and incentives for quality improvement and enhances public accountability. This survey looks at things like nurse communication, doctor communication, cleanliness and quiet of hospital environment, responsiveness of hospital staff, pain management, and communication about medicines, discharge information and whether or not you would recommend this hospital to a friend.

Pay for Performance is based on the premise that financial rewards can be used to stimulate better performance, there are

Continued on page 10

Continued from page 9

currently over one hundred Pay for Performance programs.

Ms. Milton reviewed the Core Measures of the Joint Commission Performance Measurement Initiatives and the Hospital Based Inpatient Psychiatric Services (HBIPS) project which started out as a collaboration of the National Association of Psychiatric Healthy Systems, National Association of State Mental Health Program Directors and the National Association of State Mental Health Program Directors (NASMHPD) Research Institute (NRI). There are 18 members on the panel of this diverse group that has established 150 measures in various stages of implementation in five key areas: assessment of risk, substance abuse, trauma and patient strengths completed; hours of restraint use; hours of seclusion use; patients discharged on multiple antipsychotic medications; and discharge assessment and aftercare recommendations sent to community healthy providers upon discharge.

The Quality Check project began in July 2004 and was updated in March, 2005. The report is free and available on the web at www.qualitycheck.org. This report documents compliance with National Patient Safety Goals and National Quality Improvement Goals.

(Radmila Bogdanich is the administrator of the Southern Illinois University department of psychiatry).

Effort reporting at Northwestern University after the NIH/DoJ settlement

By JoAnne Menard

"We thank you for this opportunity to air our institutional dirty laundry." With that tongue-in-cheek introduction to a discussion on faculty effort reporting, **Jeff Tapper**, administrator for the Department of Psychiatry at Northwestern University (NU) introduced his two colleagues, **Bruce Elliott**, Director of the Office of Sponsored Research, and **Jennifer Hubert**, Effort Reporting Project Manager.

Northwestern is a private research university with $381M in sponsored awards, of which 70% are federal, including 50% NIH funding. Thirty-five percent of medical school faculty have a separately owned faculty practice plan appointment. NU has a common paymaster, but if other

institutions don't, it can affect how they address their reporting.

The Department of Psychiatry has $7.68M in sponsored awards, $3.4M of which are federal funds. No physicians in the department receive federal funds. Jeff's perception is that the NU psychiatry department is small compared to other AAP institutions.

A whistleblower complaint was filed at NU in 2001 charging that medical researchers had reported spending more time on federally sponsored projects from 1995 to 2001 than they actually did.

Allegations were that the practice plan salary was included as part of total effort charges, but hadn't been included in proposals and that PIs didn't have the capacity to meet the sponsored project effort commitments. The two year investigation focused on faculty with both NU and practice plan salaries and on K awards, which require 75% effort commitment.

According to Bruce, in October 2002, NU "agreed to disagree" and paid a settlement of $5.5M, which was finalized and published in February 2003.

The 3-1/2 year improvement

Continued on page 11

Continued from page 10

project, begun during the investigation, focused on NU policies and systems. The university had two main objectives for this project.

First, refinement and increased communication/training to faculty and administrators regarding effort reporting policies. This included clear definition of 100% effort on both the proposal and the faculty effort report, expectation of some level of faculty support in proposals, and faculty certification of their own effort reports.

Jennifer described the challenge of refining policies and increased communications as faculty become more involved and ask more questions and more issues require resolution. Also, the federal guidelines are somewhat vague and don't address many nuances and complexities.

Second, purchase, design and implementation of a Web-based effort reporting system. In addition to a certification tool, the system should provide a database to help monitor effort commitment.

NU worked with a consultant to develop an effort commitment management database system, which, according to Jennifer, is very important. The university found that the needs were too much to be accomplished in house, and identified an external vendor to provide customized data for a commitment management component. The report provides a summary with recommended percent change to meet a PI's overall commitment and also reports cost-sharing.

Jeff reported that the Department of Psychiatry is in the first stages of implementation of the new reporting system. The new system makes everyone accountable and the report provides an 18-month projection of prospective funding commitments.

Jennifer stated that NU talked to several schools and all were struggling to interpret the federal regulations on effort reporting. Everyone is grappling with the same questions and issues. The complex academic medicine environment includes teaching, research and patient care, which the government recognizes as "inextricably intertwined," but doesn't give clarification as to how to separate the elements.

There's probably a balance between what the government expects and what is reasonable. Jennifer advises documentation of what makes sense to you as an institution.

In summary, some of the lessons learned from the NU experience were:

1) Promote and communicate policies. They become irrelevant if no one understands or is aware of them.
2) Provide external communication (to sponsors). Clearly outline expectations and situations in proposals and progress reports. "Disclosure, disclosure, disclosure!"
3) Improve processes (and system, if necessary). First try to improve processes before deciding to improve systems, because improving systems is expensive.

(Joanne Menard is the administrator of the Harbor Medical Center division of the University of Washington department of psychiatry).

Strategies for personal effectiveness

by Janice McAdam, MPA

As **Ron Menaker, FACMPE** (Mayo Clinic) prepared this lecture he asked himself the following questions. What do you value? What are your strengths? What are your weaknesses? How do you manage your time? Is there such a thing as managing time? Are you a leader? How do you deal with failure? Are you a good

listener? What are your goals? How do you handle stress? In answering these questions, Menaker has discovered five strategies for becoming successful.

The first strategy found in successful individuals is *vision*. Vision is the foundation for success. Successful leaders appreciate the past and live in the present but anticipate what is going to happen in the future. Leaders "throw out the javelin called vision" as far as they can and work

Continued on page 12

Continued from page 11

backward to understand what is needed to succeed. This is in keeping with Habit #1, "Begin with the end in mind" in Steven Covey's book *Seven Habits of Highly Successful Managers.* Vision needs to be personal because life is personal. The imaging technique of looking at your vision and moving backward in time helps to personalize it.

Vision will encompass change. The definition of leadership is "a process to influence a team to achieve a common goal or vision." Leadership is a change process. The formula for change management is Dissatisfaction x Vision x First Steps > Resistance. This formula suggests that when changes are not made it is because one or more of the elements are missing. Change management is more successful when resistance is not ignored. When struggling with personal effectiveness, often times one element of the change management formula is missing, and in response we revert to a "tell, sell, yell" approach to change management. Tell you about the change, try to sell you on the change, and then yell at you until you change. A more effective strategy is to look to the formula for change management to see what element or elements are missing from the change plan. Is there dissatisfaction with the current process? Is there a vision for how the change will look when the goal is reached? Are the first steps the correct ones?

The second strategy is *focus*. You become what you think about. Value is expressed in what you are doing - not what you are saying (espoused values vs values in action). Saying that you value something does not make it important; acting on your values does. We have as much time as we are going to get so we need to decide whether a problem is important or urgent. Each person should establish their own priority management strategies. Menaker has a priority management strategy to set aside time for thinking and planning, to reflect. He used this time while at the AAP meeting to come to the meeting room early to visualize his presentation in the room, to reflect that the presentation was on track.

Understanding is the third strategy and comes from Steven Covey's Habit #5: "Listen for understanding and then be understood." The Five Ds of communication are dialogue, discuss, debate, decide, and divisiveness. Have a dialogue to discuss and help decisions be made that are good for all parties. The process may include debate but not divisiveness. Empathic listening is the desire to fix the problem instead of listening to the problem. People want their voice to be heard. The quality of relationships can improve by listening empathically. Listen by being silent.

In strategy four, *building trust* is the key to successful relationships with others. Care, integrity, and results are all part of the strategy. We get results by caring with integrity about others. We can reach goals by building trust in each other and trust in the process.

Strategy five is *response ability*. Response ability is our ability to respond to the continuous need for improvement. The Japanese call this Kaizen and use the technique in continuous improvement. Is there a better way to get something done? Can we raise the bar? Can we improve the quality of the team? The quality of work is better when working in teams because of the richness of ideas the group brings to the process. Within the team we build new relationships to make changes where needed even when things are going well.

As we learn to serve in leadership roles we learn to move from what we want to what the needs are of others to help us all reach the goal or vision. In summary, 2nd century Rabbi Hillel said, "If I am not for myself who will be for me? But if I am only for myself who am I? And if not now, when?"

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

Take two minutes

Take two minutes is AAP's "in person listserv," where we have the opportunity to ask practice management questions and our colleagues - the experts - have an opportunity to share their knowledge and help everyone learn.

by Lindsey Dozanti

Are you using a clinical model for your outpatient clinic? (Resident see patient, faculty stops in for the key portion) internal medicine clinic model; attending rotates with resident/SW? How do you bill? How is the clinic structured?

Rich Erwin (U Missouri). – Our residents that have offices stagger appointments with one attending; the attending spends a few minutes and uses CPT 90801, CPT 90862 or CPT 90805.

John DiGangi (U Massachusetts) – Residents see medication management cases; there is one attending; these are training clinics and we bill CPT 90801 or CPT 90862

Roxanne Morganthaler (U Washington) - Our Gero psych clinic bill consult codes. All new patients are seen with a senior resident who is paired with a resident. Usually see four new patients (90 minutes); high level 99245; geropsych bills prolonged service in addition; 2 bills are generated (tech/pro fee)

Jill Toepfer (Southern Illinois U) - In this last year we had medical assistant taking patients in gero clinic for weights; CPT codes were listed on the charge ticket but it was a free service

Have any of you been involved in creating "spin-off" ventures for your department or university? We are beginning to explore the idea of spinning off one of our clinical programs in order to raise money and expand the program.

Dan Hogge (U Utah) - Has been involved with the development of corporation to study of pheromones. There are shares in a corporation; goal is to develop perfumes that increase your attraction for the opposite sex. The corporation is owned by the university.

What experience in terms of revenue trends are departments having with Medicare Reimbursement under the new PPS Reimbursement System - and what impact are revenue levels having on department operations?

John DiGangi – Has been getting reports from Finance that it's looking a lot better than originally thought; CEO of health system sent notice from CMS that Medicare rates are going to increase as of July 2006; 1st year has been better than expected

Steve Blanchard (U Iowa) – We are doing well under TEFRA system under $250; no impact

What planning has your clinical operation done to work with patients who are using Health Savings Accounts (vs. traditional insurance)? Are you experiencing additional price competition/price cutting by competitors? We think psych may be an optional thing.

Margaret Moran (Medical University of Ohio) – We are treating as private pay; we have a private pay policy and discount if they pay at time of service. Prompt pay fee is higher than insurance.

Jim Landry (Tulane U): We have a prompt pay discount of 40%; we allow any payor to discount on specific CPT; we do not discount initial evaluations.

Brenda Paulsen (U Arizona): We've always been price sensitive; we try to be in the middle of the road of competitors; the corporation has prompt pay but our practice doesn't use it because prices are already competitive.

Pat Romano (Albert Einstein COM): Substance abuse programs are captive population; prepay 11 months of treatment and receive a full year; saves administrative time and costs

Does anyone have CNS employees and if so are services provided inpatient and outpatient?

Steve Blanchard – We have CNS employees and they bill outpatient services. We do pretty well revenue wise.

Does anyone make money with PhDs billing and if so how do you do it?

Jim Landry – Our PhDs are used in training where they go to

Continued on page 14

Continued from page 13

other communities in the country and bill a huge rate. Gastric bypass patients are required to get evaluated from PhDs and self pay rates.

Marti Sale (U Kentucky) – Our PhDs provide forensic services and it does well

Janice McAdam (Kansas U) – We have one PhD that provides neuropsych testing; time spent on testing demonstrates that he is making money; also does forensic work; have people all over the country; 2 other PhDs that aren't making money clinically; one of them clinical director

Lindsey Dozanti (Case Western U) - We use our PhDs in IOPs/PHPs, they receive fixed support for providing group services and they do quite well.

Rich Erwin – PhDs also doing gastric bypass exams; they charge $390/hr for evaluations; booked for next 5 months

Mayo has such a huge employee and dependent population; 70K employees and dependents; division of department that has focused on this population. How are you staffing for employees and their dependents? Staffing patterns would be helpful. How many people do you need to take care of these?

Steve Blanchard - Our department was the only preferred provider; don't look at the clinic size; It is more and more acceptable for employees to come there.

How do you assign RVUs to teaching hours; research; how many publications? Does anyone have standards to measure productivity in this area?

Margaret Moran — Referred the questioner to Indiana, which had done work in this area.

Joanne Menard (U Washington) – Through process improvement trying to decide what kind of standards focused on clinical activity. Assessed 20% for teaching and used MGMA 50% median 2201 only against actual effort.

Dan Hogge — Would like to see more standardization in ways to measure education/ teaching/research

Nari Shahrokh (U California - Davis) - Assigned values to certain jobs, i.e., committee work; research; teaching hour per hour; medical student teaching = 200%; 100% for teaching. Research % of part of salary credited to them. Nari had a document published regarding this topic and would be willing to put on the listserv.

John O'Laughlen (U Washington) – Words of Wisdom were: Reflect back to effort certification; be careful when benchmarking the entire work your faculty do; could dig a grave; warn against what you want to do; medical school pushing back; the more you put out there the more you have a chance to be in a Catch-22.

For those of you that use productivity as a base of compensation how do you credit travel? If you're using RVUs based upon CPT how does that count?

John DiGangi — RVU = set the benchmark based on current average of clinic. 2400 = average clinic RVU

Ellen Francis (U Oklahoma) – Don't use the RVUs; if they're doing travel work; they charge the same rate of contract.

Brenda Paulsen - We bill travel time for rate = hourly of contract; sometimes reduced; or flat fee that charges for their time; same thing for forensic; $350/hr. We don't use RVUs

How are people using RVU's for education/research/ administrative time? How are you benchmarking?

Margaret Moran — Tries to use RVU based on service and CPT that has RVU and assign for contract work; manual calculation; it's painful.

Marti Sale – Special services; no RVUs assigned

Jim Landry – No RVUs; Price Waterhouse trying to convert to RVUs.

Steve Blanchard - if any service where there isn't an assigned RVU, we back into it to assign an RVU (Business Intelligent Unit)

We may be moving towards getting out of insurance work except inpatient for a few providers; thinks there is sufficient volume to absorb loss projected by moving towards this model. Is there anyone else considering such a change?

John DiGangi: U Mass has boutique, cash only clinic; works at community mental health clinic (sexual disorder clinic = highly motivated $3K) U Mass pays to provide this service.

Continued on page 15

Continued from page 14

What method was used for the last successful recruitment?

Terry Gevedon (U Kentucky) – Feed them and tell them why you want them there; Screen carefully and treat them royally!

Janet Moore (Michigan State U) – Has had good luck in recruiting residents

Jill Smith (Southern Illinois U) – Start with realtor who can show them what home they can buy with offered salary

Pat Romano– Urban medicine – someone who is interested; homegrown people; worked very nicely for them; look for folks that like MASH medicine

Brenda Paulsen – Posting in *Psychiatry News* has been good; 3-4 times for phone conference/ screening works well; really careful to do reality checking; use a relocation service

Warren Teeter (Wake Forest U) *wanted to go on record to predict that rTMS will be approved and then will have to make the decision to decide how much to charge.*

Steve Blanchard – Already has a machine and doesn't think it will be any time soon that insurance

Let's see whose prediction wins out!!!

(Lindsey Dozanti is the administrator of the Case Western University department of psychiatry).

New Institute of Medicine report on improving quality of mental health care

Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders

Millions of Americans today receive health care for mental or substance-use problems and illnesses. These conditions are the leading cause of combined disability and death of women and the second highest of men.

Effective treatments exist and continually improve. However, as with general health care, deficiencies in care delivery prevent many from receiving appropriate treatments. That situation has serious consequences—for people who have the conditions; for their loved ones; for the workplace; for the education, welfare, and justice systems; and for our nation as a whole.

A previous Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001), put forth a strategy for improving health care overall. However, health care for mental and substance-use conditions has a number of distinctive characteristics, such as the greater use of coercion into treatment, separate care delivery systems, a less developed quality measurement infrastructure, and a differently structured marketplace. These and other differences raised questions about whether the Quality Chasm approach is applicable to health care for mental and substance-use conditions and, if so, how it should be applied. This report, *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*, examines those differences, finds that the Quality Chasm framework is applicable to health care for mental and substance-use conditions, and describes a multifaceted and comprehensive strategy to do so.

The strategy addresses issues pertaining to health care for both mental and substance-use conditions and the essential role that health care for both plays in improving overall health and health care. In doing so it details the actions required to achieve those ends-actions required of clinicians; health care organizations; health plans; purchasers; state, local, and federal governments; and all parties involved in health care for mental and substance-use conditions.

The report can be ordered in either book or PDF format from the Institute of Medicine at http://www.nap.edu/catalog/11470.html. It is also available to read and search online at http://www.nap.edu/books/0309100445/html/.

(Reprinted from Institute of Medicine website).

NIH electronic grants submission

by Hank Williams

Academic researchers in Psychiatry and other fields are beginning to "wade into the waters" of submitting their grant applications electronically through a process called Grants.gov. Grants.gov is a new federal portal that allows users to electronically find, apply, and manage grant opportunities. A gradual move to electronic submission of National Institutes of Health (NIH) applications began in late 2005, with transitions expected to take about a year.

Grants.gov hopes to simplify the grants management process by creating a centralized, online process to find and apply for over 900 grant programs from the 26 federal grant-making agencies. Researchers are able to download applications, work on them offline, then upload and submit them to the appropriate funding agency.

To submit an application through Grants.gov, registration is required in both Grants.gov and eRA Commons. Grants.gov registration provides the ability to submit applications electronically. eRA Commons registration allows NIH to receive applications electronically from Grants.gov and validate them against agency-specific business rules. It also provides a way for NIH and registered users to communicate electronically after submission. Assignment, review outcome and summary statement information is available through the eRA Commons.

The applicant organization, Signing Official (SO), and the Principal Investigator (PI) must be registered in the NIH eRA Commons. The SO and the PI need separate accounts in Commons. Only an SO has the ability to "reject" an application in Commons to address warnings or if the assembled application does not reflect the submitted application package due to eRA Commons or NIH system issues.

If an SO is given a PI role, it overrides the SO's privileges such as the ability to reject the application, submit eSNAPs or Just-In-Time information and to request No Cost Extensions.

Psychiatry administrators should work closely with their university Offices of Sponsored Projects to understand new processes and internal timeline review requirements.

Applicants will need to download the PureEdge viewer free of charge from Grants.gov at http://grants.gov/Download Viewer. The viewer will allow applicants to download application packages and guides.

For NIH applicants, an application to create PDF files will be needed. On the Grants.gov Customer Support webpage (http://grants.gov/CustomerSupport) is information on tools and software that the applicant can use, including a link to "Convert Documents to PDF."

Target submission dates for several NIH grant categories have already passed, and some are yet to come, such as:

RO1 Research Project Grant Program is scheduled for February 1, 2007;

K Career Development Awards are planned for June 1, 2007;

R18/U18 Cooperative *Agreements, and R25 Education Projects* are scheduled for October 1, 2006.

Consult your Office of Sponsored Projects staff for additional dates, information, and requirements.

The GrAAPvine *is very pleased to introduce our newest Associate Editor,* ***Hank Williams*** *(U Washington), who will be keeping us up to date on the latest research information.* Research news *has been part of this newsletter almost since it's inception and Hank joins the ranks of very able associate editors.*

As Finance Administrator of the University of Washington Department of Psychiatry and Behavioral Sciences, Hank has (among other things) responsibility for research administration. His department is second ranked among School of Medicine departments in the amount of research grant income with an annual budget of approximately $30 million.

All this makes Hank well qualified to write this column and we look forward to his contributions. Welcome, Hank!

NIH electronic submission transition plan

Type of Grant		Target Submission Date for Non-AIDS Applications	Target Submission Date for AIDS Applications
Small Business Innovation Research/Small Business Technology Transfer (SBIR/STTR)	R41,R42 R43,R44	Dec. 1, 2005	Jan. 2, 2006
Support for Conferences & Scientific Meetings	R13/U13	Dec. 15, 2005	Jan. 2, 2006
Research Dissertation Grant Program	R36	Feb. 17, 2006	May 1, 2006
Academic Research Enhancement Award (AREA)	R15	Feb. 25, 2006	May 1, 2006
Biomedical Research Support Shared Instrumentation Grants	S10	March 22, 2006	May 1, 2006
Interdisciplinary Research Consortium (Roadmap)	X02	April 18, 2006	May 1, 2006
Small Grant Programs Exploratory/Developmental Research Grant Awards Exploratory/Developmental Research Grant Awards/Exploratory/Development Grants (Phase II) Clinical Trial Planning Grant Program	R03 R21 R21/R33 R34	June 1, 2006	Sept. 1, 2006
Research Demonstration and Dissemination Prjcts. (Cooperative Agreement) Education Projects Research Facilities Construction Grants	R18/U18 R25 C06/UC6	Oct. 1, 2006	Jan. 2, 2007
NIH Director's Pioneer Award Program	DP1	Jan. 22, 2007	
Research Project Grant Program	R01	Feb. 1, 2007	May 1, 2007
Resource Career Development Minority Biomedical Research Support Thematic Project Grant Research and Institutional Resources Health Disparities Endowment Grants – Capacity Building Research and Student Resources Health Disparities Endowment Grants – Educ. Programs	G K S11 S21 S22	June 1, 2007	Sept.1, 2007
Fellowship	F*	Aug. 5, 2007	Sept. 1, 2007
Training Hazardous Waste Worker Health and Safety Training Cooperative Agreement International Training Cooperative Agreement/ Phase 2 of FIC mechanism D71	T* &D U45 D71/U2R	Sept. 10, 2007	Jan. 2, 2008
Centers General Clinical Research Center Program Minority Biomedical Research Support Research Projects (Cooperative Agreements) Co-op. Clinical Research Grants/Co-op. Agreements Research Programs Cooperative Agreement Specialized Center Cooperative Agreement Exploratory Grant (Cooperative Agreements) Resource Related Research Projects	P M01 S06 U01 R10/U10 U19 U54 U56 R24/U24	Oct. 1, 2007	Jan. 2, 2008

Additional information is available at era.nih.gov

Medicare provides payment increase, policy changes for inpatient psychiatric facilities

Inpatient psychiatric facilities (IPFs) will receive an average 4% increase in Medicare payments, beginning in July.

The higher payments, for discharges occurring July 1 or later, will be under a final rule announced by the Centers for Medicare & Medicaid Services (CMS). This increase includes the effects of market basket updates resulting in a 4.5% increase in total payments for Rate Year 2007, July 1, 2006 to June 30, 2007. The market basket shows how much the costs of goods and services used by a particular industry have changed over time.

Within this average, government-operated psychiatric hospitals receive the largest share of the total increase. The final rule also includes several changes in payment policies for these facilities.

The payment increase will go to approximately 1,800 inpatient psychiatric facilities, including hospitals limited to psychiatric treatment, distinct part psychiatric units of acute care hospitals, and critical access hospitals that are paid under a prospective payment system (PPS). This system, which was mandated by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and made effective Jan. 1, 2005, is intended to foster higher quality and more efficient care for Medicare beneficiaries with severe mental illnesses.

"Many beneficiaries, after receiving appropriate psychiatric care in an inpatient facility, can return home or move to an alternative setting," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "The changes in this final rule support our continuing efforts to improve the quality of mental health care for Medicare beneficiaries. The IPF prospective payment system is helping to support effective care in the appropriate setting for patients with mental illnesses."

Payments under the IPF PPS are based on a single federal per diem rate that includes both inpatient operating costs and capital-related costs, including routine and ancillary services. The per diem rate for Rate Year 2007 is $595.09, up from $575.95 in Rate Year 2006.

This base rate is adjusted for four patient characteristics: age, diagnostic-related group assignment, the presence of certain other diseases or conditions (comorbidities), and the patient's length of stay.

Adjustments also are made to the base rate to reflect these facility characteristics: the presence of a qualifying emergency department, teaching status, rural location, and each facility's wage index. Facilities in Alaska and Hawaii also receive a cost-of-living adjustment. In addition, the IPF PPS provides additional payment for each electroconvulsive therapy treatment furnished during a stay.

Medicare also continues to pay separately for certain costs, including physician and nonphysician practitioner services paid under the Medicare physician fee schedule, bad debt and direct graduate medical education costs.

In this first update to the PPS for inpatient psychiatric facilities, CMS is adopting a number of refinements to the payment policies affecting these facilities, including:

- Adoption of a new market basket to estimate inflation in the costs of goods and services provided in inpatient psychiatric facilities. The new market basket is based on data from three types of hospitals excluded from the inpatient PPS for acute care hospitals – inpatient rehabilitation facilities, inpatient psychiatric facilities and long-term care hospitals.
- Implementation of the Office of Management and Budget's geographic areas definitions based on the new Core Based Statistical Areas for use in determining the wage index adjustment.
- An increase in the fixed dollar loss threshold amount for outlier payments from $5,700 to $6,200 to keep overall estimated outlier payments at 2% of total payments as per diem rates increase. This threshold is the amount by which the hospital's costs for treating a case must exceed the Medicare payment amount for that case before Medicare will make an additional payment to the facility.
- A payment increase for electroconvulsive therapy using the new market basket from $247.96 to $256.20.
- Changes to other policies, including recreational therapy and physician recertification.

This rule also incorporates changes in coding and Diagnosis Related Group classifications that were adopted in the inpatient PPS final rule for fiscal year 2006.

The IPF PPS rule went on display May 1st at the Federal Register. It can be viewed at: http://www.cms.hhs.gov/InpatientPsychFacilPPS/Downloads/CMS-1306-F_5-01-06.pdf .

More information is available at http://www.cms.hhs.gov/InpatientPsychFacilPPS/.

Consultation billing checklist and FAQ

In December 2005, CMS changed the Medicare consulting billing guidelines in Transmittal 788 (change Request 42115) to clarify that the ordering physician must document the request for consult before the consulting physician can bill for such consult. On April 12, 2006, CMS released a statement stating that they *do not expect the consulting physician to verify that the ordering physician has documented the consultation request in the patient chart*. The Medical Group Management Association (MGMA) has compiled a checklist and a list of Frequently Asked Questions.

Checklist

A visit is a consult if:

· Services are provided by physician or qualified nonphysician practitioner.

· Requesting physician is seeking advice, an opinion, a recommendation, a suggestion, direction or counsel on evaluating or treating a patient.

· The request is made to a physician or qualified nonphysician practitioner who has expertise in a specific medical area beyond the requesting professional's knowledge.

· The intent of the consultation is for the consulting professional to evaluate the patient and have the patient return to the requesting professional for care.

Frequently Asked Questions

1. If a service is a consult, will Medicare reimburse the provider for their services?

Medicare will reimburse for consults if: (1) a physician request the consult, (2) the request and need for the consult are documented in the patient's record, and (3) the consultant must provide a written report to the referring physician.

2. What services during a consultation will Medicare reimburse a professional for during a consultation?

Medicare will reimburse a consulting professional for taking a patient's history, providing an examination, ordering test needed in the evaluation, and writing a report that includes a diagnosis.

3. If this is a consult that Medicare will allow reimbursement for, what type of consult should be listed on the claims form?

There are two types of consults: office or other outpatient and initial inpatient. An office or other outpatient consult is simply a consult provided within a consultant's office or other ambulatory facility while an initial inpatient consult is one that takes place at an inpatient hospital, a skilled nursing facility, or a partial hospital setting.

4. If this is a consult that Medicare will allow reimbursement for, what level of consult should be listed on the claims form?

Within each type there are different levels of complexity ranging from level three to level five. The classification of level is dependent upon the extent of the patient's history taken, the thoroughness of the physical examination, and the complexity of the consultant's medical decision making. . .

5. Can a professional in a group practice refer a patient to another professional within the same practice for a consultation?

Carriers may pay for a consultation in this situation as long as all requirements are met for the appropriate CPT consultation code usage.

6. What services can a professional provide during a consultation?

During a consultation, the consulting physician may initiate diagnostic and/or therapeutic services. If the consulting professional continues these services in subsequent visits, they cannot bill these visits as consultations.

7. What documents must a professional requesting a consultation provide in a patient's file?

The requesting physician must document in the patient's file that he/she is seeking further diagnostic information from another professional with knowledge beyond their own in a specific area.

8. What documents must a professional providing consultation services provide in a patient's file?

The consulting professional must provide a written report of his/her findings to the requesting professional, which they will use in the treatment of the patient. The report must include a history and examination of the patient. If the requesting and consulting professionals are within the same group practice, the patient's record must include a document request for consultation, consultant's patient history notes, consultant's patient examination notes, and consultant's report of findings to the requesting professional.

9. How must the claims form be completed in order to be reimbursed for a consultation?

The claims form must contain a diagnosis as well as the requesting and consulting professionals National Provider Identifier or Legacy number.

Reprinted and adapted with permission from the Medical Group Management Association, 104 Inverness Terrace East, Englewood, Colorado 80112 5306; 303.799.1111. www.mgma.com

Doctor, doctor . . .

. . . I keep thinking I'm a set of curtains!
Pull yourself together, man!

. . . I keep thinking I'm a bell.
Well, just go home and if the feeling persists, give me a ring.

. . . People tell me I'm a wheelbarrow.
Don't let people push you around.

. . . I keep thinking I'm invisible.
Who said that?!

. . . Nobody understands me.
What do you mean by that?

. . . People keep ignoring me!
Next!

. . . I feel like a pack of cards.
I'll deal with you later.

. . . I've only got 59 seconds to live.
Wait a minute please.

Editorial staff
Editor:
Janis Price
Associate Editors:
Radmila Bogdanich
David Peterson

The GrAAPvine is published quarterly and distributed to the members of Administrators in Academic Psychiatry as part of the membership in AAP.

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

Janis Price
Section Administrator
Department of Psychiatry
University of Michigan Health System
UH9C 9151
Ann Arbor, MI 48109-0120
(734) 936-4860
(734) 936-9983 Fax
janprice@umich.edu