Vol. 18 No. 4
Fall 2006

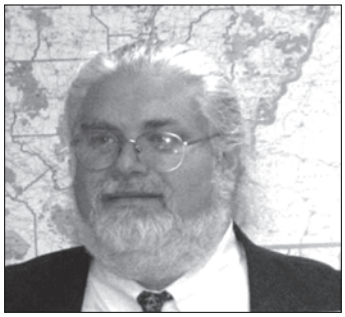
The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Jim Landry



I hope that everyone has had the opportunity to take some time off from work this summer to spend time with their families and friends. A break from our hectic schedules is essential for each of us to rejuvenate ourselves and prepare for the upcoming year. It is always nice to welcome the new medical students – isn't it amazing how young they are getting!

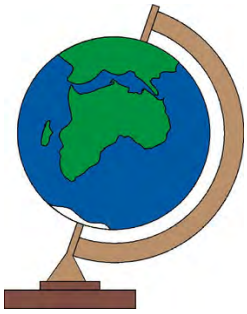
Many of us have experienced above average temperatures in the last month or two. I believe that this was **Brenda Paulsen's** (U Arizona) ploy to entice our northern members to go to Tucson for the fall education conference November 3-4. **Elaine McIntosh** (U Nebraska) and the education committee have been working very hard to present an outstanding program, and I would like to express my appreciation for their time and hard work. Please see Elaine's article (page 3) with the details. I look forward to seeing everyone in Tucson.

Several of our colleagues have left their positions in the last few months to pursue other opportunities (see *Comings and goings*, page 2). We wish them well and thank them for their contributions to AAP. I would like to note that as our friends and colleagues leave, many of their replacements have joined AAP. I am very encouraged by this – this means that AAP has evolved as an organization to a level where membership is recognized as a critical component of professional growth and successful psychiatric department management. I would like to express my appreciation to Membership chair, **Steve Blanchard** (U Iowa) and Member-at-large for Membership, **Joanne Menard** (U Washington), who have worked so hard to help AAP achieve this new status.

It takes someone special to be an administrator in psychiatry. Our specialty, although often treated as a stepchild by our affiliated hospitals, universities and third party payers, affects patient in every other medical specialty. We tend to be more creative in problem solving and resolution as we understand the broader spectrum of medical practice; and of course we tend to be experts in identifying sources of funding to sustain our practices in a world of reimbursement that does not believe in mental health parity. Ultimately, we try to ensure that our faculty can provide the highest level of patient care, and train the next generation of mental health providers.

Continued on page 6

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 member:

David Chafetz
University of Vermont (Fletcher Allen Health Care)
(802) 847-6292
david.chafetz@vtmednet.org

Gloria Dunne
University of Chicago
(773) 834-0848
gdunne@yoda.bsd.uchicago.edu

John Flanagan
Weill Medical College - Cornell University
(212) 746-3961
jof9043@nyp.org

Jeanette Pach
University of Chicago
(773) 834-3678
jpach@yoda.bsd.uchicago.edu

Larry Peters
New York University
(212) 263-8984
larry.peters@nyumc.org

Lauren Gabelman Urban
SUNY Downstate Medical Center (Brooklyn)
(718) 270-2728
lauren.gabelman@downstate.edu

AAP wishes the best of luck to the following members:

Patricia Birkmeyer, who has moved to the University of Texas Medical Branch at Galveston Department of Pediatrics.

Howie Gwon (Johns Hopkins University), who has accepted a position in Emergency Management Hopkins.

Fidel Lakew (SUNY Downstate Medical Center), who is on sabbatical to work in Africa overseeing the opening of HIV clinics through a grant with Columbia University.

Marilyn Powell, who has left the University of Chicago.

Philip Wolfe, who has left the Cornell University Department of Psychiatry.

Cactus facts

The saguaro cactus blossom is the official state flower of Arizona. The white, funnel shaped, night blooming flowers, grow on the trunk and branches of the saguaro cactus during May and June. The red fruits of this largest American cactus are edible.

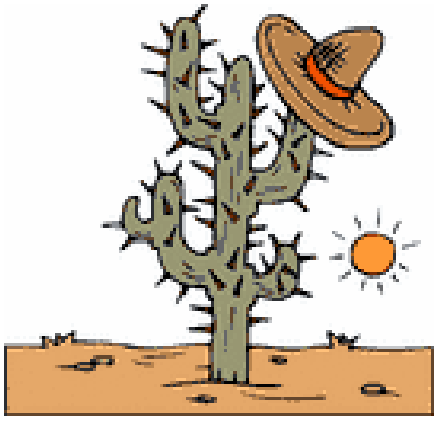
Saguaro is an Indian word. The correct pronunciation is "sah-**wah**-ro."

Although the saguaro can grow to 50 feet, it only grows an inch or so a year. The average saguaro lives to 200 years.

A saguaro cactus will take between 50 and 100 years to grow an arm. Its arms usually begin to grow only after it is about 15 feet tall and around 75 years old.

The outside skin of the saguaro is smooth. Inside the full grown saguaro there are 2 inch spines that absorb water. The saguaro then expands like an accordion. It can hold about a ton of water in its spines.

The saguaro cactus only grows in the Sonoran desert.



Arizona law mandates an automatic year in jail for anyone caught removing, stealing or intentionally destroying a saguaro.

Fall education conference: Blazing new trails in psychiatry

by Elaine McIntosh

One thing I have learned in my ten plus years of association with an academic psychiatry practice is that change is always on the horizon. Change challenges our management skills, motivates professional growth and development, and requires vigilance in identifying new trends. The theme for this year's Fall Education Conference in Tucson, Arizona, November 3-4 is "Blazing New Trails in Psychiatry." It is the goal of the Education Committee to put together a conference that will give AAP members insight into the latest philosophies of psychiatric care, management trends, and issues that will challenge the missions of our departments. **Brenda Paulsen** (U Arizona) has done an extraordinary job of reserving the Westward Look Resort, planning our dinners for Friday and Saturday nights, and is enlisting faculty at the University of Arizona as guest speakers on a wide variety of topics. Popular favorites such as a member-led panel discussion on state-of-the-art staff development practices and Take Two Minutes, where members have an opportunity to ask specific questions of their AAP colleagues regarding management issues, will also be on the program. The department head of the University of Arizona department of psychiatry, **Alan Gelenberg. MD** will deliver the MacLeod Lecture on faculty governance. Other speakers presenting a variety of topics in the field of psychiatry will also be on the program.

The conference will kick off on Friday evening with a complimentary Margarita reception at the resort and then a southwestern themed networking dinner at El Charro. This is a great time to catch up on what has been happening with your AAP friends. The Saturday networking dinner will be held at Terra Cotta, which I am told is "awesome." Friday night's dinner attire is casual and Saturday night's attire is business casual.

Hotel reservations can be booked by calling the Westward Look reservations department at (800) 722-2500 or emailing for reservations at reservations@westwardlook.com. To receive the group rate of $145 per night, single or double occupancy, please identify yourself a part of the U of A Department of Psychiatry group. October 1, 2006 has been established as the cutoff date for making reservations at the special rate. The resort will honor the $145 per night rate from Tuesday, October 31 through Monday, November 6 on a limited block of rooms, so book early to insure your accommodations at the special rate. Individuals may cancel or change their reservations up to 14 days prior to their arrival without penalty. Please email Elaine McIntosh at emcintos@unmc.edu or Brenda Paulsen at bpaulsen@email.arizona.edu if you have any questions or need assistance in making reservations.

Tucson offers a variety of fun activities in addition to the conference. The world famous Kartcher Caverns are within a short drive from the resort. Additionally, visitors can enjoy golf, horseback riding, hiking, the Arizona Sonora Desert Museum, or just relaxing by the pool with a refreshing beverage.

Congratulations to **Sandy Richards** (U Michigan) for being selected Medical School Staff Member of the Year. Sandy was recognized for her many innovations and process improvements, including a clinical process redesign in Psychiatry and taking the lead in space-planning and activation for the new Rachel Upjohn Building.

Congratulations to . . .

Jim Puricelli and partner, Adam Lazar, on the adoption of their beautiful new daughter, Grace Lazar Puricelli. Grace was born July 28, 2006 and weighed in at 8 lb 11 oz and 19 inches.

Multiple principal investigators coming

by Hank Williams, MPA

All federal research agencies are currently preparing for the implementation of policies and procedures to formally allow more than one Principal Investigator (PI) on individual research awards. The current timetable aims for a fall 2006 implementation.

The multiple PI option is targeted specifically to those projects that do not fit the single PI model, supplementing but not replacing the single PI model.

Features of the multiple PI option include:

· Grant application forms are expected to include sections for more than one PI;

· Each of the listed PIs will be designated by the grantee institution and will be expected to share responsibility for directing the project or activity;

· The institution will be asked to select a contact PI at the time of application;

· Information on each PI will be stored in NIH databases and appear in official reports;

· The NIH will ask for a "Leadership Plan" to describe the roles and areas of responsibility of the named PIs, the process for making decisions on scientific direction, allocating resources, and resolving disputes that may arise. The quality of the "Leadership Plan" will be considered by peer reviewers as part of the assessment of scientific and technical merit.

Department issues under the Multiple PI option

Department and institutional recognition of faculty and staff for the purpose of promotion, tenure, and space allocation frequently includes an assessment of the ability to attract externally sponsored research awards, and the financial impact of those awards.

Multiple PIs on research awards will require our departments and schools to consider and develop policies around issues such as:

· Credit – Academic institutions will need to develop internal criteria, guidelines and procedures that would enable all PIs on a project to receive credit from their institution;

· Fluidity of funds for the project under a single award – Two possible strategies for managing funds in multiple-PI awards will be considered: A single, shared budget with joint oversight by the PIs throughout the project period. This would provide maximum flexibility to move funds between PIs and various aspects of the project as required; or individual working budgets for each PI. This would be based on a joint decision by the PIs at the time of application about how the funds should be divided. During the project period, funds could be reallocated via a joint decision of the PIs.

· Linked awards – Under this option, the NIH would issue two or more awards for a collaborative project, and each PI would have financial authority over his/her part of the project. However, it might create leadership and financial boundaries within a collaborative project.

Awards to more than one institution

The NIH frequently makes awards that involve more than one institution. In almost all cases there is a single awardee institution and a secondary institution that receives an allocation of funds from the primary award in the form of a subcontract or some other type of consortia arrangement.

Two possible approaches for multiple-PI awards to more than one institution are:

· Continue to use the subcontract approach. Making a single award would appear to preserve the concept that the research is being conducted as a single, integrated project. However a single award could appear to confer unequal authority across the PIs;

· Linked awards – Under this option, the NIH would issue two or more awards for a project that involves collaboration across two or more institutions. This would have the advantage that each PI/institution would receive "credit" for the project and each PI would have financial authority over his/her part of the project. However, it might create leadership and financial boundaries within a collaborative project.

(Hank Williams is the finance administrator of the University of Washington department of psychiatry and behavioral sciences).

NIH policy on late submission of grant applications

Number: NOT-OD-06-086
Release Date: August 11, 2006
National Institutes of Health

This notice provides an update and further clarification of the policy published on January 27, 2005 (Notice OD-05-030). The new dates for AREA applications are included as is information about the New Investigator Pilot. Further details about the process of accepting late submissions are provided.

NIH expects that grant applications will be submitted on time. Standing dates are listed at: http://grants.nih.gov/grants/funding/submissionschedule.htm.

· For applications that are required to use paper format these are submission or postmark dates; applications are on time if they are sent on these dates.

· For applications that are required to use electronic submission this requires successful submission to Grants.gov by 5 p.m. local time on the date indicated.

· For **both paper and electronic submissions,** when these dates fall on a weekend or holiday, they are extended to the next business day. However, Requests for Applications (RFAs) and Program Announcements with Special Referral Considerations (PARs) with special receipt dates **always** must be **received (by Grants.gov for electronic applications and the Center for Scientific Review for paper applications)** on the dates designated in the announcement to be on time. This is clearly noted in the website above and in the text of each RFA/PAR.

The long standing NIH policy on late applications is stated in the application instructions. Late applications are generally not accepted. Permission for a late submission is not granted in advance. In rare cases, late applications will be accepted but only when accompanied by a cover letter that details compelling reasons for the delay. While the reasons are sometimes personal in nature, an objective evaluation of their merit requires that some details be provided. It is not sufficient, for example, to state simply that there has been an unforeseen circumstance that delayed submission. Specific information about the timing and nature of the cause of the delay is necessary so that a decision can be made. Only the explanatory letter is needed; no other documentation is expected.

NIH will consider accepting late applications based on the acceptability of the explanation and the processing time required for two different kinds of submission dates:

· **Regular Standing Submission Dates**: January 10, February 1, February 25, March 1, May 10, June 1, June 25, July 1, September 10, October 1, October 25, November 1. Applications must be **received** at the NIH within two weeks of the standing submission date.

· **Expedited Standing Submission Dates**: April 1, April 5, April 15, May 1, August 1, August 5, August 15, September 1, December 1, December 5, December 15, and January 2. Applications must be **received** at the NIH within one week of the standing submission date.

The windows of time for consideration of late applications have been carefully chosen so that the late applications can be processed with the cohort of on-time applications. In all cases, when the regular standing submission date or expedited submission date falls on a weekend or federal holiday and is extended to the next business day, the window of consideration for late applications will be calculated from that business day. **Note that the late window always ends in a receipt (not submission) date for both paper and electronic applications.**

NIH will not consider accepting late applications for the **Special Receipt Dates for RFAs and PARs. This includes the special receipt dates (March 20, July 20, and November 20) for resubmission/amended applications that are part of the New Investigator Pilot (http://grants.nih.gov/grants/guide/notice-files/NOT-OD-06-060.html).**

NIH will consider all late applications received within the window of time specified above but will not automatically accept all of them. The reasons for the delay will be carefully considered by the Division of Receipt and Referral at the Center for Scientific Review and a decision made. In unusual cases the reasons provided will be considered by senior staff of CSR; Institutes/Centers will be consulted for applications that are their review responsibility. Applications submitted within the window with reasons that are not found to be

Continued on page 6

NIH late submission policy

Continued from page 5

acceptable will be returned without review. NIH does not expect to accept any applications received beyond the window of consideration.

In the past, late applications have been accepted for reasons such as: death of an immediate family member of the Principal Investigator, sudden acute severe illness of the Principal Investigator or immediate family member, or large scale natural disasters. Recent service by the Principal Investigator **only** (this does **not** include other participants in the application) on an NIH extramural review group that could reasonably be expected to require a time commitment that could have been used to prepare an application is also an allowable reason. Note this applies only to NIH extramural review activities, not those of other Federal agencies or private organizations. Examples of reasons that have not led to the acceptance of a late application are: heavy teaching or administrative responsibilities, relocation of laboratory, health problems, personal events, or review service for participants other than the principal investigator, attendance at scientific meetings, or having a very busy schedule.

It is important to emphasize that these various examples are just that, examples. No NIH staff member whether in the Center for Scientific Review or any of the other Institutes/Centers has the authority to give permission in advance for a late application. Contacting the Division of Receipt and Referral or any other component of the NIH will not lead to either permission to submit late or an evaluation of the acceptability of the reasons for a delay.

President's message

Continued from page 1

Trying to provide access to mental health care is a challenge in post-Katrina New Orleans. August 29th will be the one year anniversary of Katrina, and there are still no psychiatric inpatient beds in the city. Outpatient access is not much better, as it is estimated that 80-90% of mental health professionals left New Orleans. The result is that so many folks have been traumatized for so long, but have no place to go for inpatient treatment, and only limited access for outpatient treatment. The national media has begun to report on this travesty; hopefully, the national spot light on New Orleans' lack of mental health access will help communities across the country get increased funding and provide additional access for those in need.

In closing I would like to solicit your help. In the near future, you will be receiving two surveys – one regarding educational conferences and one regarding benchmarking. The educational conference survey will ask for input on the structure, location, timing, and what we can do as an organization to increase member participation at our conferences. The second survey is an initiative that is being lead by Benchmarking Chair, **Hank Williams** (U Washington), to develop a tool that we can use to benchmark data as it relates to psychiatry. I ask that everyone complete these surveys to ensure that the board is meeting the needs of the AAP membership.

Enjoy the rest of your summer – hope to see EVERYONE in Tucson!

Jim

Mark your calendars now!

AAP Fall Conference

November 3-4, 2006

Tucson, Arizona

Enhancing Financial Reporting to Key Stakeholders

Registration open for online education course

Learn to assess important financial information, how to analyze data, develop printed reports and enhance your presentation skills when you take this six-week, facilitator-led, online course.

You'll be able to create an effective financial picture of the group's performance and effectively deliver financial summaries and build trust among your physicians. The limited enrollment allows for maximum interaction and sharing of information between course participants.

Register today for this upcoming course:
Oct. 16 - Nov. 26, 2006

MGMA member: $595 Nonmember: $659

http://www.mgma.com/education/calendar/Enhancing-Financial-Reporting-to-Key-Stakeholders.cfm or call toll-free 877.275.6462.

This program is part of the Core Learning Series.

MGMA® medical practice simulation

Gain powerful insights and enhance critical-thinking skills during this five-week, facilitator-led, online simulation, where you take on the role of administrator at a 12-physician, primary care practice. Understand the immediate and long-term effects that your decisions and actions have on financial, staffing and organizational results. You'll find this simulation a useful test of your competencies, no matter what size or specialty of group practice you currently work in.

During this simulated three-year time span, you'll face the same types of underlying issues, deal with similar topics and complete the same kinds of tasks required of any successful practice administrator. The results you'll see played out in your virtual group practice are based on MGMA survey data, the gold standard in group practice management. You'll gain a hands-on experience that can't be learned or tested by conventional means.

Simulation highlights

- Receive weekly updated financial reports and a group practice dashboard that graphically show how the organization has been affected by your decisions.
- Experience three years of management compressed into five weeks, and grasp the long-term effects and interrelationships among organizational processes.
- Face real-life issues such as the effects of employee moral on productivity, leasing space, expanding services and implementing an electronic health records (EHR) system.
- A practice management expert facilitates the simulation and provides additional resources and support.

Simulation Objectives

During this five-week simulation, you will:

- Develop organizational and analytical skills in medical practice management.
- Apply competencies in the eight technical domains of the Body of Knowledge for Medical Group Management.
- Use a systematic approach to problem-solving and decision-making to address operational issues, growth strategies and the long-term improvement needs of the practice.
- Analyze how the components of health care delivery work together on a strategic level.

Simulation fees

$595 per individual MGMA member

$659 per individual nonmember

Group discounts are available. Call toll-free 877.275.6462, ext. 888 and speak with a customer service representative.

Fee includes online reading materials, structured exercises, weekly performance results, access to an instructor and American College of Medical Practice Executives (ACMPE) credit. No travel is necessary for this simulation.

Simulation dates

Oct. 9 — Nov. 12, 2006
registration deadline is Oct. 7
Nov. 6 — Dec. 10, 2006
registration deadline is Oct. 30
Jan. 15 — Feb. 18, 2007
registration deadline is Jan. 8
May 14 — June 17, 2007
registration deadline is May 7

Suggested reading

by Radmila Bogdanich, MA

"Leadership and Chairmanship in Psychiatry" Literature Review, *Academic Psychiatry*, Vol. 30(4), July/August 2006, pp 269-318

I couldn't pass up the chance to do a different type of review for this edition of The GrAAPvine. The July-August 2006 Issue of *Academic Psychiatry* had a special feature section entitled "Leadership and Chairmanship in Psychiatry" composed of twelve different articles. I would encourage all of you to read the entire series in this edition of the journal. As psychiatry administrators, it behooves us to understand the myriad leadership issues related to our academic departments. Working for a complex organization that has the tripartite mission of providing educational, clinical and research services is indeed a challenge in many ways. Not only is our mission composed of three diverse legs of core services, we also have to manage the delivery of those services within huge bureaucracies and deal with issues involving academic freedom, tenure, a competitive health care market, ever increasing complexity in research ventures, decreasing state revenues, etc. By understanding the leadership challenges our chairs and our other academic division/ program heads face, we can respond to emerging issues in a proactive and global way, rather than a narrow and limiting fashion.

When I first applied for my current job, I was so excited about the possibility of working with individuals who were experts in human behavior, motivation, group dynamics, etc. As time went on, I was surprised that even these people can, at times, have difficulty leading or managing a department, a division or a program. The series of articles in this special report does an excellent job of explaining why, even with all of the behavioral knowledge our faculty leaders have, leadership can still be difficult and is always challenging. The organizations we work in are a living, breathing, everchanging entities, with their own cultures, some of which are unspoken. What works at one given time, with a given set of individuals may be totally unworkable under different circumstances. Following is a synopsis of four articles I hope you will be encouraged to read the entire issue. I think you will find, as I did, that we are really not as isolated as we think we are in our profession, our problems are not unique to our department or school, and what we experience day in and day out is simply the nature of managing an organization.

Dr. Carl Greiner, in his article "Leadership for Psychiatrists" poses 10 questions that a potential leader should ask when determining whether or not he/she will be a good fit for the position. He states that it is critical to have a mentor, and that one must gain knowledge in the areas of "quality management, leadership effectiveness, basic accounting and legal issues, organizational accountability, delegation of authority, negotiating, knowing the strengths and weaknesses of your leadership style, and how to conduct effective meetings." Dr. Greiner touches on how "psychiatric training in individual and group psychotherapy is helpful when used to understand the factions that develop over controversial issues" but that psychiatrists get into trouble when they use this knowledge for "interpretation rather than for guiding the next steps of the group." Dr. Greiner presents sound insight into the essential traits a leader must have and also thoughtfully points out that it is good for a leader to align himself with someone who is strong in the areas where he/she is weak. In addition to the insights this article provides, from a recruitment point of view I found Dr. Greiner's article helpful in terms of what kinds of information to provide to faculty who are interviewing for leadership positions and what kinds of questions to ask of them as well.

Dr. Karen Broquet's article, "Leadership: From a Psychiatric to an Institutional Perspective" was a refreshing examination of how at every leadership level leaders face common challenges and oftentimes have very little authority over circumstances impacting their work Dr. Broquet relays obstacles she has overcome in her transition from Residency Program Director to Associate Dean for Residency

Continued on page 9

Continued from page 8

affairs, the importance of understanding, motivating and enjoying people, maintaining balance in life and staying focused on the mission.

Roger Meyer, M.D., does an outstanding job of identifying the unique challenges to academic psychiatry departments as they fulfill their trifold mission of education, clinical service and research in his article entitled "The Tripartite Mission of an Academic Psychiatry Department and the Roles of the Chair." He also provides excellent recommendations for how to overcome these challenges. This article is a "must read" for anyone on your management team. The insights offered will help your staff in brainstorming solutions to current problems your department is experiencing, and it will also help them understand how our "uniqueness" makes it so difficult for us to compete with other departments. Dr. Meyer states that department chairs function much like middle managers in corporate America. They "need the support of the leadership of the medical school and the teaching hospitals" (who oftentimes have competing agendas), while having to maintain the confidence of the faculty and advocate for their interests. Hospitals aren't concerned with undergraduate medical education or NIH research. The chair must be able to meet the school's teaching goals while also maintaining the clinical service role. As an example, he discusses the fact that schools give little financial support to psychiatry departments in proportion to the large amount of responsibility they have in medical student educational. Medical student education must be a high priority for the department, but few resources and/or incentives are available to the faculty or department.

Research poses it own set of problems with the difficulty in getting NIH funded projects if your department or medical school doesn't have the foundation to support a well developed research program. Historically, the NIH generally funds departments who have PhDs as principal investigators rather than only medical doctors**.** Dr. Meyer suggests that departments that are trying to establish a research program should apply for NIH K30 grants that senior residents can apply for under the tutelage of a faculty member. For those schools that do get large NIH research grants, there is a great deal of pressure for departments to provide increasing resources to maintain and expand the research endeavor.

Finally, Dr. Meyer addresses clinical practice issues and discusses how decreasing funding for education has put increased pressure on departments to increase clinical activity to support the educational mission. As we all know, psychiatry departments have difficulty in sustaining themselves on their clinical revenues, without some sort of subsidy. The author discusses the disparities among clinical departments in relationship to clinical income, the political effects within an organization, and strategies to overcome some of these barriers.

AAP members will be pleased to find that Dr. Stuart Munro, in his excellent article "A Tool Kit for New Chairs" discusses the manual that the AACDP developed to assist new Chairs as they assume psychiatry leadership positions within their organization. He also references the AAP Benchmarking survey and discusses some of the survey results.

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

The Board of Directors of AAP extends its sincerest condolences to

Joe Thomas

on the recent loss of his mother.

CPT changes and additions

Psychiatry Section

90871 - ECT multiple seizure. This code was deleted. All visits for ECT should now be coded using 90870.

0018T - Delivery of high power, focal magnetic pulses for direct stimulation to cortical neurons. A parenthetical note was added regarding coding for repetitive transcranial magnetic stimulation (rTMS) for treatment of clinical depression, directing clinicians to use Category III code 0018T.

95970, 95974, and 95975 - Neurostimulators, Analysis-Programming. The CPT Editorial Panel approved coding for vagus nerve stimulation (VNS) therapy for treatment-resistant depression. Clinicians performing VNS therapy should use codes 95970, 95974, and 95975 found in the neurology subsection of the CPT manual.

Consultations

New descriptive language has also been added to CPT in an effort to better define the use of the consultation codes.

- Consultations that are **requested by a physician** or other appropriate source should be noted in the patient's written record; the consulting physician should also provide a written report of findings back to the requesting entity. In this instance the appropriate consultation CPT code should be used.
- A consultation initiated at the **request of patient or family** should *not* be reported using the consultation codes but rather the appropriate office visit codes.
- **Mandated consultations** (e.g., third-party payers) should be reported using the consultation codes along with modifier 32.

Inpatient psychiatry PPS comorbidity changes

Listed below are ICD-9-CM coding changes that affect the comorbidity adjustment under the Inpatient Psychiatry Facility Prospective Payment System. These changes are published in the IPPS Final Rule and are effective October 1, 2006.

Invalid Code:

238.7 Other lymphatic and hematopoietic tissues (Oncology Treatment)

New Codes:

052.2 Postvaricella myelitis (Infectious Diseases)

053.14 Herpes zoster myelitis (Infectious Diseases)

238.71 Essential thrombocythemia (Oncology Treatment)

238.72 Low grade myelodysplastic syndrome lesions (Oncology Treatment)

238.74 Myelodysplastic syndrome with 5q deletion (Oncology Treatment)

238.75 Myelodysplastic syndrome, unpsecified (Oncology Treatment)

238.76 Myelofibrosis with myeloid metaplasia (Oncology Treatment)

238.79 Other lymphatic and hematopoietic tissues (Oncology Treatment)

Revised Codes (title changes):

403.01 Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease

403.11 Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease

403.91 Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease

404.02 Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease

404.03 Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease

404.12 Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease

404.13 Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease

404.92 Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease

404.93 Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease

The executive suite

The "Expertness" characteristic of a professional

by David Peterson, FACMPE

In the coming months, one of the focuses of the American College of Medical Practice Executives (ACMPE) will be on the topic of professionalism so it seems only fitting to headline this issue's column with a definition of "professionalism" from Princeton University's WordNet.[1] Princeton's definition is an interesting combination of words, combining "expert" and "characteristic." Both words hint that there are even more descriptors of professionalism.

Ron Menaker, FACMPE (Mayo Clinic), Chair of the ACMPE Board of Directors offered some additional descriptors in his talk on "Strategies for Personal Effectiveness" at the AAP Spring Conference. He used words such as "trust," "values," "continuous improvement" and "understanding."[2] These words can also be found in the term "professionalism" and when they are combined with "expert" and "characteristic," they begin to paint a picture of a committed individual who strives for excellence in her/his position.

Related to all of this, a coauthor and I spent 60 pages or so trying to define these and other words in the volume titled "Professional Responsibility" for the Medical Group Management Association's *Medical Practice Management Body of Knowledge Review* series. In this volume, we offered definitions of professional responsibility - definitions that include professionalism - and described ways for the practice executive to comply with the tasks related to professional responsibility that are described in *The ACMPE Guide to the Body of Knowledge for Medical Practice Management ("The Guide")*:[3]

1. Advance professional knowledge and leadership skills;
2. Balance professional and personal pursuits;
3. Promote ethical standards for individual and organizational behavior and decision-making;
4. Conduct self-assessments;
5. Engage in professional networking;
6. Advance the profession by contributing to the body of knowledge; and
7. Develop effective interpersonal skills.

The Guide identifies "Professional Responsibility" as one of the eight skill sets under its Technical/Professional Knowledge and Skills competency required of the medical practice executive. (*The Guide* can be found online and viewed or downloaded at no charge at http://www.mgma.com/acmpe/bokguide.cfm.)[4]

Of the eight skill sets identified by *The Guide*, "Professional Responsibility" (also known as "Professionalism") might be the most difficult to describe, but as we say in our book, "professional responsibility might just be the invisible hand that touches upon and guides the medical practice executive through the other seven domains of medical practice leadership."[5]

To see professionalism in action, one need only attend an AAP Spring or Fall conference and witness the interactions between the attendees, or see responses to member queries on the AAP's listserv. Because of this, for those AAP members seeking Board Certification, the Professional Responsibility component will likely be the easiest portion of the exams.

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.

Endnotes

1 WordNet 2.0 Copyright 2003 by Princeton University.

2 McAdam, Janice. Strategies for Personal Effectiveness. The GrAAPvine, Vol. 18, No.3, p. 12.

3 The ACMPE Guide to the Body of Knowledge for Medical Practice Management. October 2003. p.1.

4 Ibid. p. 122.

5 Peterson, David J. & Mace, Ken. (2006) Professional Responsibility. In Lawrence F. Wolper (Managing Ed.), *Medical Practice Management Body of Knowledge Review*. Englewood, CO: MGMA, 2006.

How successful people stay successful

How DO successful people stay successful? The authors of *Success Built to Last*, the sequel to *Built to Last – Successful Habits of Visionary Companies*, Mark Thompson, Stewart Emery and Jerry Porras focus on the characteristics of successful individuals and help to answer that question.

The authors found that successful people did not set out to be "classically" successful – chasing power, wealth and praise – but rather strove to make contributions to benefit others, often extending beyond their own lifetimes. These people started out to be good at what matters to them and when timing and circumstances united, they ended up with success.

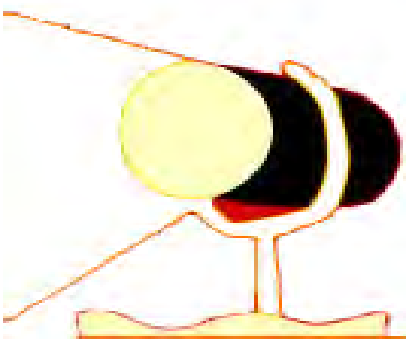
There are three fundamentals which drive lasting success – meaning, thought and action – which are all interlinked. According to author Mark Thompson, "If you take any one of those principles away – for example, if you take meaning away from thought and action – you might be successful in the short term. This is because you have a plan in your head and execute against it. But if your plan is disassociated from meaning, it might not matter. And it wouldn't have the meaning which sustains you through the inevitable challenges and difficulties if trying to create a career. That fundamental step of finding meaning, finding the passion that matters to you and that drives your behavior, is often skipped."

Passion – loving what you do – is key to being successful. If you aren't passionate, those who are will overtake you. Thompson continues, "Loving what you do is a competitive imperative, not simply a nice thing to have." Leaders interviewed for the book stated that they "started out with a focus area that [they] cared about and became expert at, and then [when] the opportunities started to present themselves" they were ready to seize the moment. Loving what you do makes it easier to stick with the journey and prevail at the end even when circumstances aren't now working in your favor.

Even with passion and strong principles, all leaders make mistakes. However, Thompson and Emery found that true leaders "harvest their failures" and turn them into wisdom. Successful individuals view failure as input on what does not work for them. In being disciplined about assessing results—both good and bad—and using these lessons as opportunities for improvement, leaders continually transform themselves, adapt to meet the changing needs of their environment, and have lasting impact.

Abstracted from Knowledge@Wharton, "How Successful People Remain Successful," April 19, 2006.

SPOTLIGHT



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 3-4, 2006
Tucson, AZ
www.adminpsych.org

Administrators in Academic Psychiatry Spring Conference
April 21, 2007 (Medical Group Management Association/Academic Practice Assembly conference to follow April 22 - 24, 2007)
Boston, MA
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!)

U-M Med School software keeps track of business

By Tracey Birkenhauer

The University of Michigan Medical School built a strategic reporting system that has been so successful it soon could be commercialized and sold to medical schools across the country. Michigan State University could be the first pilot site.

With this homegrown system, UMMS administrators can track everything from real-time operating margins by department to the number of research dollars required to support a given number of square feet.

It also can track every grant received and every course taught by each faculty member for the past five years.

The Web-based system is comprised of three tools built by Medical School Information Services: M-STAT, M-DASH and M-ALERT.

With guaranteed funding a thing of the past, chief financial officer William Elger in 2002 decided it was time to run the medical school like a business - a novel concept for a clinical institution.

With buy-in from the dean, Elger formed what he called "the breakout group" to create a new financial management approach.

"At each meeting, they had to report progress," he said. "If they hadn't made progress, they were off the team."

No one endured that shame.

The breakout group defined key performance indicators, the foundation upon which the system was built.

"We were trying to change the culture with tools to help us think more institutionally, not departmentally," he said. "If someone wants research space, we look at how they're using the space they have now."

The system tracks 2.5 million gross square feet, 1,800 faculty, 1,000 staff, 680 medical students and 350 graduate students.

"The University of Michigan now has the most advanced financial reporting system of any medical school in the country," Elger said.

That's why medical school administrators have come calling - 20 of them already have visited UMMS to examine its reporting system.

U-M's Office of Technology Transfer currently is trying to license the system. The team that built it must make some changes to its back end before it can be commercially viable.

"We're trying to make it more independent of the current infrastructure," said Karen Dannemiller, associate director of Medical School Information Services.

"We're in national talks. People have asked if they can buy it, but it's not like we're a software vendor and we'll shrink wrap something and send it to them."

She said they could send other schools the code, but without the same infrastructure, they couldn't use it. Once the system is ready, they may create a spin-off company to sell it.

The next-generation dashboard system allows users to manipulate variables to highlight financial trends, calculate break-even costs for research space usage and model various "what if" scenarios, in addition to many other functions. Most elements of the system were launched over the past several years, but some functionality is still under construction. Thus, UMMS hasn't measured the system's efficacy in quantifiable terms, such as dollars saved.

Having real-time business intelligence at administrators' fingertips has helped the almost $1 billion operation align resources with needs.

Before launching these applications, staff members could spend several weeks gathering data from various sources to compile reports and charts. Budget meetings between the dean and department chairs were largely consumed with reconciling each person's set of numbers. Further confusing the matter, metrics were defined differently by department.

"We're no longer debating on numbers," Elger said. "It allows us to say, 'What do you expect to generate in a certain amount of space?'"

The system could spread university-wide in the next few years.

(Reprinted with permission from Ann Arbor Business Review, Thursday, August 3, 2006).

Amazing anagrams

Phrase	Rearranged to
DORMITORY	DIRTY ROOM
PRESBYTERIAN	BEST IN PRAYER
ASTRONOMER	MOON STARER
DESPERATION	A ROPE ENDS IT
THE EYES	THEY SEE
GEORGE BUSH	HE BUGS GORE
THE MORSE CODE	HERE COME DOTS
SLOT MACHINES	CASH LOST IN ME
ANIMOSITY	IS NO AMITY
ELECTION RESULTS	LIES - LET'S RECOUNT
SNOOZE ALARMS	ALAS! NO MORE Z 'S
A DECIMAL POINT	I'M A DOT IN PLACE
ELEVEN PLUS TWO	TWELVE PLUS ONE

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