Vol. 20 No. 1
Fall 2007

The GrAAPvine

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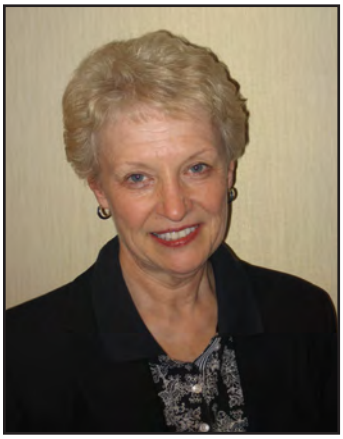
Administrators in Academic Psychiatry

From the president's desk

by Elaine McIntosh



First I want to recognize that this issue marks the 20th anniversary of The GrAAPvine. Congratulations are in order for all those who have contributed to this AAP publication over the years. The GrAAPvine is a very effective tool in informing and educating our membership on the organization's events and functions, and on the latest issues facing academic psychiatry, and has provided a forum for our membership to communicate innovative ideas to fellow administrators. No recognition of The GrAAPvine would be complete without acknowledging the hard work and dedication of it's editor, **Jan Price** (U Michigan) in association with associate editors, **Radmila Bogdanich** (Southern Illinois U), **David Peterson** (Medical College of Wisconsin) and **Hank Williams** (U Washington). HAPPY BIRTHDAY, GrAAPvine!

On October 4th and 5th, the AAP fall conference was held in beautiful Deer Valley, Utah near Park City, the site of the 2000 Winter Olympics. **Dan Hogge** (U Utah) did a great job as our site member coordinating lodging and meeting accommodations at the Chateaux at Silver Lake and arranging for delicious meals at the Chateaux and in Park City. President-Elect and Education Chair **Steve Blanchard** (U Iowa) and the Education Committee put together a great program that included the MacLeod Lecture by Dr. William McMahon on his administrative challenges as the new chair of the University of Utah Department of Psychiatry. This topic was further enhanced with a panel discussion on "Searching for My New Boss" with participants, **John DiGangi** (U Massachusetts), **Debbie Pearlman** (Yale U), **Dan Hogge**, and **Janice McAdam** (Kansas U). Kelly Lundberg, PhD presented on the topic of issues and challenges associated with becoming a contracted provider. The first day wrapped up with information sharing in the Take Two Minutes session, facilitated by **Narri Shahrokh** (U California, Davis) and **Margaret Moran**

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Comings and goings

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

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

Trina Dillon
U Pittsburgh
dillontd@upmc.edu
(412) 246-6801

Maura Monteforte, MPA
New York University
maura.monteforte@med.nyu.edu
(212) 263-2374

Glory Novak
U Arizona
novakg@email.arizona.edu
(520) 626-2184

AAP wishes the best of luck to the following member:

Lori Batkay (U Pittsburgh) who, because of a departmental reorganization, will no longer be involved in AAP.

Susan Cambria (Dartmouth Medical School) has left the Department of Psychiatry for a job in the private sector.

Awards presented to deserving members

Although both awards were announced at the Spring educational conference in Boston, the recipients of the President's Award and the Board of Directors Awards were not present to receive their deserved accolades.

Rich Erwin (U Missouri), AAP's webmaster and moderator of the listserv, finally received the President's Award, given for long-term commitment and contributions to the organization.

Brenda Paulsen (until recently the department administrator at U Arizona) was presented the Board of Directors Award for leading the planning of the 2006 Fall conference in Tucson, Arizona. This award is given in recognition of a significant current contribution to AAP.

Rich Erwin receiving President's Award from Past President Jim Landry.

Jim Landry presents Board of Directors Award to Brenda Paulsen.

AAP benchmarking: Working through the challenges

AAP continues to wrestle with the issues and challenges of identifying benchmarking data relevant to individual AAP member needs. This was never more evident than in the discussions at our recent AAP Fall Education Conference in Park City, Utah.

We continue to make progress, but as we "peel back the onion" of what our members need and want in benchmarking data, we struggle with reducing these needs to the lowest common denominators.

Here's a recap of our progress so far:

- The delivery of Benchmarking information for members is a major item in the AAP Strategic Plan
- An AAP board member position is dedicated to this mission,
- We have begun building a "roadmap" for this effort to provide financial, clinical, and performance benchmarks for its membership over the next several years. The goal is to target data sources for Psychiatry administrators of existing studies and literature on best practices for our field.
- We've done a review of current benchmarking efforts by other relevant organizations, such as Medical Group Management Association (MGMA), University Health System Consortium (UHC), and Association of American of Medical Colleges (AAMC); and
- Established priorities among the membership to develop a "roadmap" of issues for study during the next 2-3 years.

In the Spring of 2007 AAP did an initial mail survey of members, and received 37 responses. Members were asked to identify general topics of interest where best practiced data would be important.

"Clinical Financial" ranked highest as a common topic.

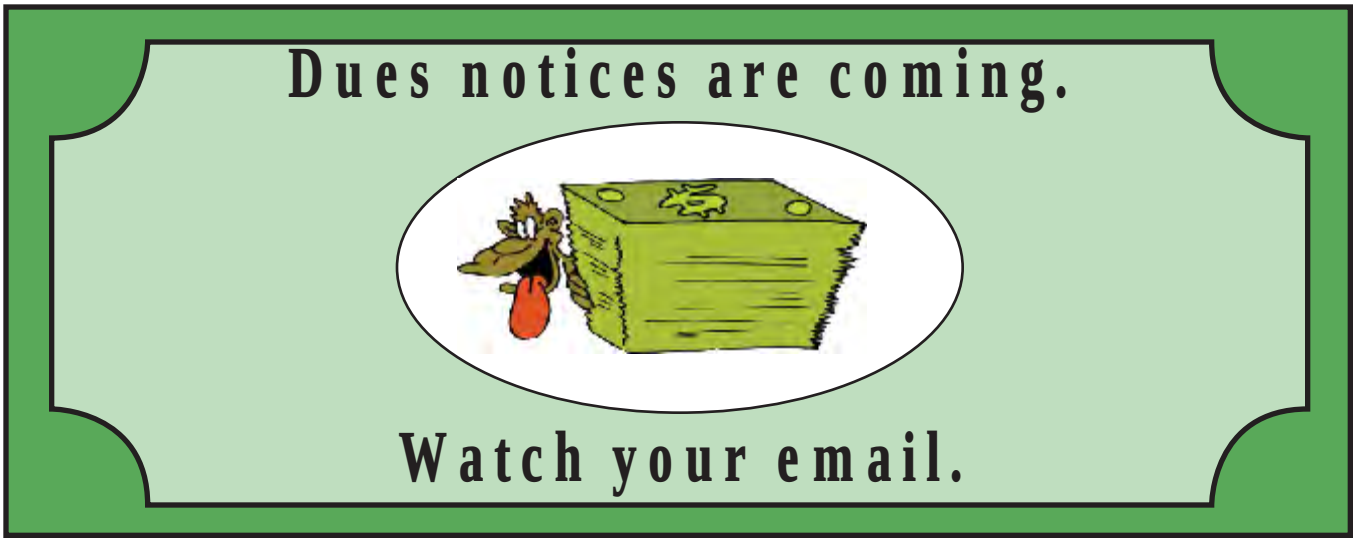
Prior to Park City we did a second survey via email, with 47 responses. The goal of this survey was to narrow down, or better identify, common definitions for "Clinical Financial".

"Faculty Productivity" ranked highest, and gives us guidance, but still is not perfectly defined. In Park City, participants discussed the many different meanings of "Faculty Productivity", even within a context of "Clinical Financial".

Next steps were identified during Park City's Friday work session on benchmarking:

- Board members will continue discussions with MGMA and UHC/AAMC over use of their respective survey data, and its availability to AAP members.
- The board will also seek other sources of relevant data that may already exist.
- The benchmarking sections of the AAP work plan will continue to be refined, and
- Further member discussions and presentations will be planned for the AAP Spring Education Conference in Orlando, Florida.

Also, all members are encouraged to participate in this year's MGMA survey of clinical practices and academic departments.



President's message

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Dobson (U Toledo). The morning of the second day was devoted to discussions on benchmarking. **Hank Williams** and **Toni Ansley** (Ohio State U) led this very informative presentation and discussion. In all, the conference accomplished the goal of sending attendees home with new and pertinent information. The new two-day program was successful in fostering a more relaxed format with adequate time for question and answer sessions and discussions with speakers.

In conjunction with the fall conference, the Board of Directors conducted a day-long meeting on October 3. In addition to the usual business items and reports from each Board member, the Board focused on updating and revising AAP's strategic plan. AAP has been operating with a three-year strategic plan that was implemented in 2004. This very comprehensive plan gave the Board a great foundation on which to build the new strategic plan. The Board considered all of the objectives of the prior plan and discussed whether or not the objectives had been met, and if not met, whether they should be retained, and what new objectives should be added. Member-at-Large for Strategic Planing **Margaret Moran Dobson**, with assistance from **Pat Sanders Romano** (Albert Einstein College of Medicine), spent a great deal of time summarizing input from various members on the status of the prior objectives. This work provided the basis for the Board's discussion. The Board welcomes input from our membership on the direction of AAP over the next several years. Work will continue on the strategic plan over the next several months and a proposed document with be presented to the general membership in the spring. Please feel free to contact any Board member with your thoughts and ideas for the strategic plan.

Preparation now begins for the spring 2008 conference in association with the Academic Practice Assemble conference to be held at the Disney Contemporary Resort in Orlando, Florida. The AAP conference will be held on March 29, 2008. The APA conference will be held March 30 through April 1. I hope that all of you will consider attending this conference and take some time to enjoy Disney World.

The AAP strategic plan

One of the keys to the success of AAP is the existence of a strategic plan. This plan describes our organization's background, core values, mission and vision and provides an outline of five strategic activities that AAP is engaged in to further our mission. The current AAP Strategic Plan covers the time period from 2004 through 2007, and is available on our website.

As 2007 draws to a close, we are in the process of examining our strategic plan. As a first step, during the summer months several members closely scrutinized the strategic plan's objectives to determine if these objectives had been completed and/or remained central to our mission. During the fall board meeting, each board member reported on those parts of the strategic plan that were relevant and also made recommendations for future initiatives and objectives.

Currently, a task force is in the process of taking those comments and recommendations and drafting a revised document for dissemination and discussion. Anyone requesting additional information about the strategic plan, the strategic planning process or with any suggestions may contact Elaine McIntosh at emcintos@unmc.edu, Margaret Moran Dobson at Margaret.Moran@utoledo.edu, or Pat Sanders Romano at promano@aecom.yu.edu.

Coming attractions

Administrators in Academic Psychiatry Spring Conference
March 29, 2008
Orlando, FL
www.adminpsych.org

Academic Practice Assembly Educational Conference
March 30 - April 1, 2008
Orlando, FL
www.mgma.com

National Association of Psychiatric Health Systems Conference
April 6 - 8, 2008
Washington, DC
www.naphs.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!)

MGMA Connexion

MGMA™ Medical Group Management Association

Your defining source for excellence in medical practice management

MGMA Connexion goes virtual!

Now you can read the MGMA Connexion magazine online - and it's searchable.

Remember - you must be an MGMA member to access the journal.

The GrAAPvine

This article is an adaptation of one written in 1997, when the (then named) Grapevine turned ten years old. It's been updated to include its growth over these last ten years. Enjoy the look back!

The AAP newsletter was established in 1987 under the able and dedicated editorship of **Norm MacLeod**. President **Alice Johnson** expressed the hope in the first issue that "The Grapevine will provide a forum for sharing current information on 'hot' topics and for increasing our knowledge about our members and their departments. We have an opportunity to make some important contributions to the professional development of those involved in the management of academic psychiatry and I am enthusiastic about this new venture. With your help, it will succeed."

In Spring 1992, after almost four years at the helm, Norm MacLeod passed the "red pencil" to **Mary Jo Swartzberg**. In that issue President **Sandy Wigley** wrote, "We want to express our appreciation for the time and effort [Norm] has given to make this publication successful. He has done an excellent job of bringing together the multifaceted talents of our members through development of a superb publication."

During Mary Jo's tenure, The Grapevine continued to grow. Most issues were ten or twelve pages long. Not able to stay away, Norm MacLeod began writing a quarterly column, "Suggested Reading," intended to "apprise AAP members of informative publications in health care administration, mental health and other related fields." This feature joined other regular features such as the Profile, President's Desk, Billing and Research News.

Then in the summer of 1994, **Jan Price** took over editorship of the newsletter. Jan had been involved with The Grapevine since its inception and worked under the able leadership of both editors so understood the commitment to excellence that was the history of the newsletter.

Features, a fresh look and a new format

The Spring 1995 issue was dedicated to the 10th birthday of AAP and featured a profile of the association, a photo collage of our first ten years and special birthday wishes from past AAP presidents. The 20th birthday celebration of AAP was commemorated similarly, with comments and photos of past presidents.

Soon after the 10th anniversary issue, we became more than hard copy. In the Fall of 1995, AAP announced the introduction of its website, which included excerpts from each issue of the newsletter. In Spring 2002 AAP began posting the entire newsletter to the website. Spring 2000 saw a

The GrAAPvine - 20 years old this year! My initial reaction when Jan Price reminded me of this was to wonder where the years went and how did I get so old so fast! After recovering from that thought, I reflected on how much progress AAP has made since it was just a small group of administrators who used to meet in the conference hotel lobby during the annual meeting of the Academic Practice Assembly.

The GrAAPvine seemed to be a natural extension of what was happening then. As I recall, membership had doubled over the previous year, AAP had just held its first stand-alone, day-long educational conference in New Orleans, and some members were talking about establishing a Midwest AAP conference as well. It was clear that the organization needed a way to communicate in order to continue to provide educational information between annual meetings and, further, to create an ongoing sense of connection among AAP members. I had the privilege to serve as the first editor and to help get the newsletter off the ground. Subsequent editors and all of the many contributors over the years have grown The GrAAPvine into a vibrant, informative and fun communications tool of which AAP can be justly proud. Thanks for the opportunity to have been part of this effort.

celebrates 20 years!

big change – our name changed (by editorial fiat!) from The Grapevine to *The GrAAPvine*. In the Summer of 2003, a new masthead was designed and in 2006, the monkey eating grapes (grAAPs?) was added to the masthead and the Monkey Business pages.

In Fall 1997, the Back Page was introduced, where members will find a joke, funny story or other attempt at humor, often at the expense of psychiatrists or the mental health profession!

Our Associate Editors

From almost its inception, *The GrAAPvine* has run columns on specific topics: Research, Technology, Billing, and later The College Corner and Suggested Reading. Each has been headed by associate editors responsible for its content. Our Research column has been led by **Richard Hearndon**, **Doris Haley** and, since Summer 2006, by **Hank Williams**.

The Fall 1997 issue of the Grapevine saw the first of a long running series of articles entitled "The College Corner" (since Spring 2006 called "The Executive Suite") written by **David Peterson, FACMPE,** AAP's Forum Representative for the American College of Medical Practice Executives. The purpose of these articles has been to encourage our members' professional growth through membership in the College and the challenge of certification and fellowship status. In April 2005, at the Spring Educational Conference in New York, David was awarded AAP's first Board of Directors Award for his continued contribution to the newsletter.

In the very next issue, Winter 1997, **Radmila Bogdanich** became an associate editor, writing the Suggested Reading column after Norm MacLeod's departure. Over the years, Radmila has summarized numerous books and articles of interest to our members.

Alice Johnson was right – the newsletter has been successful from the beginning because of the efforts of so many people, in addition to the editorial board. While there have been an outstanding group of associate editors throughout the years, a large number of members have contributed to *The GrAAPvine* in a variety of ways. Beginning with the very first issue, our newsletter has boasted articles from the rank and file of AAP. Without those earliest efforts, *The GrAAPvine* might not have taken on the professional flavor it has had throughout its life. Over these 20 years, AAP members have continued to contribute their time and their expertise to add to everyone's professional development, just as Alice predicted. While our look and size and even our name may have changed, one thing remains constant. The editorial staff continues to promise professional high standards for every issue of *The GrAAPvine* into the future.

It was 1985 when the chairman of our (then called Medical College of Ohio) University of Toledo Department of Psychiatry received a letter from Bill Newel, psychiatry administrator at the University of Wisconsin, indicating that plans were underway to establish a professional association for administrators who worked in academic psychiatry. He requested feedback from the chairs of departments of psychiatry on this idea. The purpose of initiating this group was to provide educational and networking opportunities for the administrators. During the 1980's many changes were occurring in the health care industry, especially in the field of psychiatric medicine. So the timing was perfect. Soon a growing number of chairs from departments of academic medicine saw the value in the creation of this organization. In early 1987 several members of AAP sat, sipped coffee and discussed the idea of having a publication that would offer a consistent manner by which AAP members could receive timely and topical educational information. This led to the development of the AAP Grapevine (now called The GrAAPvine). A quarterly publication written and published by members of AAP, The GrAAPvine has proven to be a valuable tool for academic psychiatry administrators. Indeed, The GrAAPvine has received accolades from both chairs and administrators of other academic medicine disciplines around the country. Congratulations GrAAPvine on setting the bar for academic excellence for the members of AAP!

NIH changes to eRA Commons

by Hank Williams

NIH has updated the eRA Commons Status software with a new look and functionality. This new version of Status incorporates user-requested features that will provide additional tracking capabilities and better application organization for improved system performance:

- New search feature: Ability to search for and track electronically submitted applications from the Status screen using the Grants.gov tracking number. The Grants.gov tracking number will continue to be searchable throughout the lifecycle of the application/grant - even after the NIH assigns its own application ID (i.e., accession number or grant number).
- Reorganization of the application/grant data into two separate sections:

1. Recent and pending electronic application submissions that require action to complete the submission process (e.g., checking errors/warnings, viewing assembled application), have been refused by a Signing Official or are within the two day assembled application viewing window.

2. List of applications/grants (both paper and electronic) that have been submitted successfully and are available for post-submission status (e.g., review assignments, review results, summary statements, Notice of Award). Also includes list of awarded grants for accessing other Commons features (e.g., Just in Time, eSNAP, Financial Status Report, Closeout)

- Grouping of multiple submission attempts for a single application. Provides a cleaner screen view and consolidated submission history. This new strategy will change the look and feel of the Status screens; however, the underlying process remains the same. The eRA Commons Help Desk is available to assist with any questions.

Additional Details for Signing Officials

- The ability to search by Grants.gov tracking number has been added to all the basic Status searches. The Grants.gov tracking number for an application is provided in the emails sent by eRA Commons during the submission process.
- Use any of the basic Status searches (except "Recent/Pending eSubmissions") for post-submission status and to access other Commons features. You will no longer need to use a separate "eApplications" search to find applications/grants submitted electronically.
- Use the new "Recent/Pending eSubmissions" search option when tracking recent and pending electronic applications.

Additional Detail for Principal Investigators

- A new screen will appear when selecting the Status tab, rather than listing all applications/grants associated with your account. Use the options provided to select the specific application/grant or appropriate list based on your task.
- If multiple attempts are needed to complete the electronic submission process without errors, only the most recently processed submission will be listed. A new hyperlink, "Show All Prior Errors", will be added to the application status line that will provide a listing of the current and all previous submission attempts and the associated Grants.gov tracking number, date of submission and errors/warnings.
- The Grants.gov tracking number for an application is provided in the emails sent by eRA Commons during the electronic submission process.

THE BOARD OF DIRECTORS OF AAP WISHES ALL OF OUR MEMBERS A JOYOUS HOLIDAY SEASON AND A HAPPY AND HEALTHY NEW YEAR.

The executive suite

Bach in psychiatry

David Peterson, FACMPE

In Itamar Moses' play, *Bach at Leipzig*, one of the main characters named Johann or Georg (all of the main characters are named Johann or Georg), describes how a fugue is composed in a soliloquy in the second act. It seems that great fugues are based on a series of notes that repeat, build and expand upon themselves throughout the piece. One of the effects of this compositional style is a consistent theme that resonates throughout the musical production.

This repetitive and consistent technique is often seen in the communication styles of effective leaders or message campaigns. In the early 1990's the message, "It's the economy, stupid!," was posted in certain campaign headquarters throughout the country to keep the candidate and his supporters focused on the important theme of the political campaign. Advertisers sure get it and use the technique when they bombard the public with repetitive, simple messages about the virtues of the product or service they are peddling. And for leaders, whether it's successful crisis management, change management or growth management, the phrase "staying on message" is a familiar one.

A drumbeat of repetition can serve the medical practice executive equally well. A few simple themes reinforced over and over (and over) again can move a group practice – and a department of psychiatry – in a direction that is desired. Practiced behavior, consistently reinforced, is a foundation for excellence and this is true in music, sports and most other things including organizational management.

Identifying a handful of key targets, values or goals and consistently and continually referencing those same goals in different venues provides a common touchstone for faculty providers and staff alike. Pick and prioritize from a group of clinical measures such as quality of care, patient access, time-to-next-appointment, and patient satisfaction or financial measures such as accounts receivable management, charges, collections and relative value units, or scholarly work measures such as publications, teaching and research, consistently reference and reinforce these same priorities and like notes in a fugue, they will begin to resonate throughout the organization.

The **American College of Medical Practice Executives** has identified in its **Body of Knowledge** a series of skill sets – also a kind of series of notes - for the successful medical practice executive. Regardless of the medical specialty (psychiatry, medicine, surgery to name three) or type of practice (academic, single specialty or multispecialty group), the ACMPE has found that competence in the same eight but different management domains is a marker of success for the medical practice executive. These eight domains, in no particular order, are:

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

Honing skills and achieving a measure of competence in each of these areas helps the medical practice executive identify the notes necessary to successfully lead and manage.

For more information on joining the ACMPE or the board certification and fellowship process, contact the ACMPE directly at 877.275.6462 ext. 889 or contact David Peterson, FACMPE at 414.456.8990, e-mail at peterson@mcw.edu or at the Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wisconsin 53226.

Norman MacLeod Lecture

Perspectives of a new chair

by Radmila Bogdanich

William McMahon, MD; Professor and Chair, University of Utah, Department of Psychiatry, provided a realistic and insightful presentation of the trials and tribulations of becoming a new chairman in a department of psychiatry. He gave the audience a very frank overview of the tasks and challenges of a new chair, and the role of the executive administrator in enabling a successful transition in leadership. He used his personal experiences at the University of Utah as the basis for his examples and insights.

The recruitment of a new chair of Psychiatry at the University of Utah was a very lengthy process and thus, frustrating at times for Dr. McMahon, the incumbent candidate. How many years should he wait for a decision and put his career on hold, not to mention how long he would keep his family in limbo while waiting for a decision? As an internal candidate he had unique challenges but also inside knowledge and a proven track record that set him apart from other candidates.

Once hired, Dr. McMahon envisioned the future by mission in the areas of research, education and clinical care. He also recognized that he must reach out to the community to be effective. Public speaking and the development of one-to-one relationships were critical to establishing alliances and his ultimate success. Also, he had to make decisions of when to follow the mission at all costs or adapt the mission to fit the environment. Further, he had to plan and manage the

strategic growth of the department, recruit new faculty, and retain and develop current faculty.

To obtain a broad overview of the state of the Department and gain buy-in from faculty, Dr. McMahon interviewed thirty faculty and staff. He revised the organizational structure to begin building a management matrix and presented a "State of the Department" Grand Rounds to get everyone on the same page.

Dr. McMahon was given the mandate to increase research funding. It was difficult to compete nationally for grant dollars when the institutions historical ranking was 48 out of 50 and the university's indirect costs were very high. National competition for research was very strong and Utah couldn't compete unless the university had a bigger infrastructure. They had three to four staff to assist in research development but really needed fifteen to be competitive. This was a major area of concern and a roadblock to success in building research.

Assuming new responsibilities was, at times, very stressful. Expectations can be unrealistic. It was important to remember that effective change takes time, to honor the history but not be imprisoned by it, and that ultimately the decisions are yours to make. Setting and enforcing standards was critical.

Inspiring change was difficult. Everyone wanted change but only wanted the good things that change brought about. Retaining key faculty was essential; there were people that the department couldn't afford to lose. Dr. McMahon found that when speaking with faculty and staff, it was important to titrate the bad news with the good. It was also good to match faculty strengths with their performance expectations (a faculty member may know how to be a good clinician but not a good researcher). Going outside of the department for mentorships was also a good way to improve faculty development when there weren't enough mentors within the department.

New chairs are often given start-up funds to develop the department. Dr. McMahon found that it was important to use his start-up funds very wisely—and to avoid bankruptcy. His executive administrator played a critical

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role in assisting him to recognize and manage critical risks as well as opportunities. He found that you can not allow faculty to negotiate their own deals with outside contracts because it could be a money losing venture for the department, and that you must make sure that your support costs are covered.

Change did not happen overnight. A twelve month timeline was developed for strategic change which included defining and implementing a new faculty incentive program and goal setting.

To be successful, you should employ a mission-based management philosophy and distribute resources according to mission. This works best when it is transparent, consistent, flexible, realistic, and inclusive. Your initial goals should be to 1) strengthen working relationships; 2) discuss challenges and opportunities; and 3) develop faculty incentives and be consistent with base salary allocations

The department is now valued for its collegiality, regional excellence, leadership and entrepreneurial spirit. The challenge is how to maintain traditional strengths (strong clinical services) while building a research infrastructure.

Dr. McMahon's philosophy of administration is:

- Be supportive
- Assure department growth and survival
- Change the historical perception to be in line with new vision
- Raise money. New sources of income should be identified and funding should be increased by 20% every 5 years.
- A faculty development program is essential. You are developing a career, not just a job. Make it grand but not grandiose.
- Be realistic in your expectations for growth and prioritize goals

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

Searching for my new boss

by Tina Nesbeda

Janice McAdam (Kansas U), **Debbie Pearlman** (Yale U), **John DiGangi** (U Massachusetts), **Dan Hogge** (U Utah), presented their experiences as administrators during chair recruitment. Each panel member discussed a different stage in the recruitment and orientation process for a new chair in their respective departments.

Across all universities, the search committee chair was appointed by the dean. The search committees had varying amounts of representation from the department of psychiatry, ranging from minimal to significant. In no case did an administrator serve on the search committee. However, some administrators were involved by providing information to the dean and/or search committee chair regarding department needs. This process varied with some administrators involved in meetings and others preparing and/or editing "briefing packets." The information provided was similar and included departmental information such as structure, finances, space, faculty information, and in some cases, the skills and qualities of a new chair deemed important by the department.

All administrators did meet with final candidates, typically during the second or third visit. In all cases, these meetings included an in depth review of the department's "portfolio" including clinical, research, teaching and faculty activities; resources; critical issues; and finances. In some cases the administrator was involved in identifying key areas for negotiation of new chair packages, involving funds, resources, and space. These activities were conducted with varying degrees of senior university involvement and support. Balancing the needs of the department, institution, and

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the candidate were the focus of internal discussions and external conversations with applicants.

Three of the four panel participants had long term working relationships with their previous chairs prior to engaging in the process of searching for their new chair. Three administrators are currently working with new chairs. The transition to working with a new chair also has some similarities across institutions. Administrators were involved in the new hire process and setting up offices and equipment along with initial orientation activities. Administrators focused on short term goals of "getting up and running" and alerting and orienting new chairs to significant issues.

New chairs appear to be focused primarily on the financial responsibilities of the administrator's role and to not necessarily recognize that the scope of the job includes high volume, day to day, operational issues for which administrators are usually responsible. The longer term focus for the administrators working with new chairs involved clarifying the operational and financial scope of work, and in that process to help the chair better understand how his or her expectations and goals fit or cause changes to the administrator's role. The administrator-chair relationship is critical to the smooth functioning of a department and could change with new leadership.

The panel consensus was that open communication and collaboration were the key ingredients in establishing the interpersonal relationship between the new chair and the administrator. All panel members felt the change in leadership was good for them and their departments as it created opportunities to refocus and renew the energy of the department faculty and staff. *(Tina Nesbeda is the academic administrator of the University of Massachusetts department of psychiatry).*

Becoming a contracted provider: Issues and challenges

By Jackie Rux

Kelly J. Lundberg, Ph.D., Director of Assessment and Referral Services and a Clinical Consultant at the Utah Addiction Center, gave an overview of the challenges faced during implementation of a plan to address delays in accessing publicly funded substance abuse treatment in Salt Lake County. The delay, which took from three to six months, caused individuals waiting for treatment to become discouraged and put them at risk for continued use, overdose, criminal behaviors and increased medical expenses. In 2001, Dr. Lundberg approached the Director of the Utah Division of Substance Abuse with the concept of free Interim Group Services (IGS). She was motivated to provide a safe environment for individuals awaiting addiction treatment. Her goals were to provide training and exposure for a variety of disciplines so that understanding and awareness of those who struggle with addiction can be increased and stigma decreased, to generate research regarding the effectiveness of the Interim Group, to serve as a subject pool for studies investigating aspects of substance abuse, and, at the same time, save the county money. Interim Group Services was implemented in three phases from December 2001 to the present. It began with an annual budget of $70,000 to cover rent, bus tokens, healthy snacks and drinks, payment for facilitators and administrative costs including management, data collection and supervision. The budget has grown to over $1 million today.

In Phase 1 Dr. Lundberg established a group schedule, sublet a room from an agency, developed fliers describing the services and met frequently with Salt Lake County funded substance abuse treatment agencies on making referrals. Students were hired as group facilitators and the doors opened for treatment. Individuals who had sought treatment at a specific agency were placed on a wait list and referred to IGS. Those not on a wait list were encouraged by IGS facilitators to contact an agency to initiate the process. It took several months before attendance became regular and for outside providers to feel less threatened by IGS. Eventually, with the feedback of satisfaction from clients who had attended IGS and the fact that the clients were more treatment ready

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at admission, attendance increased.

In September of 2003 Dr. Lundberg was awarded a fee for service contract from Salt Lake County Division of Substance Abuse to provide assessments for DUI offenders. This clinic was named Assessment & Referral Services (ARS), and Interim Group Services became a program within ARS. Frustration grew in watching individuals who were participating in IGS await treatment for an unnecessary and more expensive level of care and in watching individuals wait months for admission at one agency, when there was another agency that had immediate opens. But IGS could only control treatment placement for those individuals they were seeing who were DUI offenders in need of county funded treatment. They were assessed, referred to an agency for the appropriate level of treatment and could attend IGS while waiting admission.

From July of 2005 to July 2007, IGS entered Phase 2. There were concerns that many individuals were being admitted into residential treatment who clearly were not in need of residential treatment. Individuals were still waiting months for admission to one agency when there was another agency that had immediate openings. At the same time, Salt Lake County Substance Abuse was given County Offender Reform Act (CORA) dollars. These dollars needed to be spent in a unique and effective way on jail diversion. An addendum was thus added to the contracts for Salt Lake County substance abuse providers stating if treatment agencies are unable to admit a client into treatment within two weeks, the client would be referred to IGS, the client would not be placed on that agency's wait list, ARS would assess these clients and refer them to the appropriate agency and ARS would assess individuals for the appropriateness of CORA funding during this process. The IGS contract budget was increased, a

fee for service contract with ARS was established for the assessments and the jail diversion program was implemented. Groups began to get larger and additional facilitators were hired. There were concerns regarding the appropriateness of court ordered referrals as they related to agency placement or level of care which prompted more coordination. A website was developed by IGS that listed the various funding options, address and contact information by agency and allowed each agency to update the length of time estimated for admission.

The criminal justice referrals increased dramatically in 2006. The increase was accommodated by IGS but raised the question of who should be funding IGS. It was clear to IGS that this should be jointly funded by the criminal justice system, substance abuse system and the Division of Child and Family Services.

Phase 3, Interim Group as a front door to treatment, began in July 2007. There were concerns that agencies were admitting many clients on their own, despite having wait lists for other clients, creating inequities in admissions. Additionally, it was difficult for Salt Lake County to ascertain the real treatment needs if agencies were admitting clients on their own who did not necessarily need the identified level of care. Furthermore, in 2006, $50,000 of County treatment monies were spent on individuals admitted by treatment agencies who were not Salt Lake County residents. Concerns prompted several changes. Agencies could not directly admit an individual in need of Salt Lake County funding into their substance abuse treatment program. Clients must be referred to IGS where arrangements for an assessment would be made, after which they are referred to the appropriate treatment. Due to a new electronic billing system, agencies would not be able to bill for client services unless authorized by ARS/IGS or Salt Lake County.

While hurdles remain, ARS/IGS data shows continued improvement and that the process is working. Dr. Lundberg's project has come a long way since it's inception with much thought and compassion toward the clients.

(Jackie Rux is the financial manager for the Medical College of Wisconsin department of psychiatry).

Take two minutes

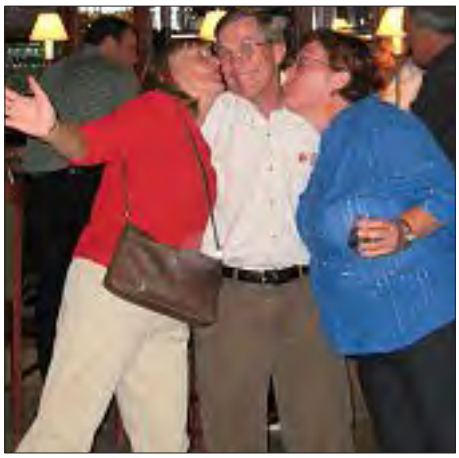
During this session, AAP members pose questions to the entire group and, like an in-person listserv, obtain responses from members. The following is a listing of topics discussed. A complete transcript was sent to those in attendance. If others would like a transcript, please e-mail your request to Margaret.Moran@Utoledo.edu.

- Psychologists in the psychiatry department
- Epic or any other electronic medical record (EMR)
- Honoraria paid to outside speakers
- Grand Rounds attendance
- Grand Rounds frequency
- Billing for charges associated with research
- Departmental taxes on clinical trails
- Post-trial record retention financial responsibility
- Clinical trial financial negotiations
- Staffing post-EMR implementation

Photo gallery

Partying in Park City

JoAnne Menard and Elaine McIntosh smiling for the camera



Margaret Moran Dobson and Tina Nesbeda smooching with Dan Hogge

Good friends Jackie Rux and Brenda Paulsen

Institute of Medicine Report:

Eradicating tumors is not enough; Cancer care providers need to proactively address patients' psychological and social needs as well

WASHINGTON -- Cancer therapies save and prolong many lives, but they and the tumors they target also can exact a debilitating toll on patients' mental and emotional and cause health problems that typically are not dealt with during oncology treatment. Cancer care that focuses solely on eradicating tumors without addressing the patient's general well-being can increase patients' suffering, may compromise their ability to follow through on treatment, and falls short of achieving quality care, says a new report from the Institute of Medicine.

The report proposes a new standard of care under which all oncology care providers would systematically screen patients for distress and other problems; connect patients with health care or service providers who have resources to tackle these issues and coordinate care with these professionals; and periodically re-evaluate patients to determine if any changes in care are needed.

To achieve this standard, the report recommends an evidence-based model for ensuring that psychosocial health services are an integral part of cancer care and provides strategies for implementing this model in settings with varying levels of resources. The vision laid out in the report could apply to the care of other serious chronic illnesses as well, noted the authoring committee.

"Killing cancer cells is important, but it's not enough to ensure that the adverse effects of patients' therapies don't undermine their gains," said committee chair Nancy E. Adler, vice chair, department of psychiatry, and director, Center for Health and Community, University of California, San Francisco. "This report provides an action plan for overcoming the barriers to psychosocial health services that patients need to be as healthy and whole as possible during and after cancer treatment."

Many of the services and resources already exist, often at no cost to patients, but oncology providers are not proactively identifying patients' needs and helping them find and use these resources, the committee noted. Because many of these services are free or are reimbursable through health insurance providers and programs, the creation of new benefits or payment mechanisms would not be necessary for the most part, the report says.

Cancer patients' psychosocial needs range from information about their therapies and the potential physical side effects, to treatment for depression, stress, or other mental and emotional conditions; assistance with daily activities that they can no longer perform independently; and assistance with transportation, prosthetics, medications, and other supplies they cannot afford or to which they do not have ready access. The report lists multiple resources of free services and information available to cancer patients and their families.

The committee acknowledged that currently there are not enough psychosocial services and resources to meet the needs of all patients and that cancer care providers can only partially resolve some problems, such as lack of health insurance or poverty. However, this should not preclude attempts to remedy as many psychosocial problems as possible.

Because individual clinical practices vary by their setting and patient population as well as by available resources, they will also vary in how they implement the proposed standard of care. The report offers examples of how some large and small practices deliver this care successfully and suggests ways that even providers with limited resources could do so.

"Many cancer care providers may be surprised at the array of psychosocial health services

Continued on 16

U Michigan PsychOncology Program

The PsychOncology Program at the University of Michigan Cancer Center is devoted to relieving the numerous negative social and psychological effects of the disease. The program is led by faculty from the Department of Psychiatry and specializes in helping people face the emotional issues unique to cancer.

Through the PsychOncology clinic, Cancer Center staff provide services including education, support and counseling assistance to address the social, emotional and spiritual needs associated with cancer. Specialists include social workers, psychiatrists, psychologists, child and family life therapists, nurses, art therapists and complementary therapy professionals.

Services include:

- Facilitating support and education groups on both cancer-specific and general coping topics
- Providing both individual and group counseling sessions for patients and family members
- Facilitating crisis management counseling

Education is offered regarding the emotional side of cancer. Print and audiovisual materials are available through the Patient Education Resource Center (PERC) and on line. Instructional programs are also hosted at the Cancer Center on a variety of topics including parenting with cancer, grief and loss issues and handling the holidays.

All of these services are coordinated through the PsychOncology clinic, where clinical social workers, psychiatrists and nurse practitioners are available for consultation.

Continued from 15

available nationwide at no cost to patients," said committee member Patricia Ganz, director, cancer prevention and control research, Jonsson Comprehensive Cancer Center, University of California, Los Angeles. "Our report also provides practical guidance to providers about how they can design their practices to better address their patients' needs."

The policies and practices of many health insurance purchasers and payers support the delivery of psychosocial health care, but they are not delivering this care uniformly, the committee concluded. Not all insurance plans fully use available mechanisms to compensate providers for assessments and interventions to develop tailored care plans, help patients manage their illnesses, and coordinate their care with other providers.

Group purchasers -- Medicare, Medicaid, and employers -- and health insurance plans should assess how psychosocial care is addressed in their agreements with each other and with health care providers and determine the adequacy of payment rates, the report says. They may find, for example, that interventions are currently covered in their payment and reimbursement mechanisms. However, mechanisms may need to be developed for reimbursing higher-than-average levels of care coordination.

Multiple organizations could significantly influence cancer care providers' adherence to the proposed standard of care. The National Cancer Institute, as the nation's leader in developing better approaches to cancer care, could include requirements for addressing psychosocial health needs in its protocols, standards, and programs. Standard-setting organizations such as the National Comprehensive Cancer Network -- an alliance of 20 leading cancer centers in the United States -- and the American College of Surgeons' Commission on Cancer could incorporate the report's recommended standard and its components into their own standards.

The study was sponsored by the National Institutes of Health. Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policy makers, health professionals, the private sector, and the public. The National Academy of Sciences, National Academy of Engineering, Institute of Medicine, and National Research Council make up the National Academies. A committee roster follows.

Copies of Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs are available from the National Academies Press; telephone. 202-334-3313 or 1-800-624-6242 or on the Internet at http://www.nap.edu.

This news release and report are available at http://national-academies.org

New AHA report offers strategies on improving behavioral health services

By Matthew Malamud

The AHA recently released a report aimed at helping hospitals improve behavioral health care services for patients.

"Behavioral Health Challenges in the General Hospital: Practical Help for Hospital Leaders," is the culmination of two years of work by the AHA's behavioral health task force, and centers on six themes that address strategies hospitals can undertake within their own organizations and in their communities to improve services for patients with behavioral health disorders. They include:

- Ensuring that assessments of the health needs and resources in their community include attention to behavioral illness
- Developing a behavioral health plan that takes into account the behavioral health needs of their patients and the available community resources
- Fostering community collaboration by providing the leadership and initiative that develops a community-wide plan of services, and to make sure staff are aware of the behavioral resources in the community
- Making the case for adequate funding of behavioral health services
- Following, as an employer, the National Business Group on Health's guidelines for improving employer-sponsored behavioral health services, and
- Working with their regional, state and national associations to be strong advocates for behavioral health.

"As the 24/7 access point for health services in their communities, the general hospital is both the front door to services and too often the backstop to other agencies and organizations," said AHA President and CEO Rich Umbdenstock. "We believe our report offers the broad recommendations that can accelerate the improvement of behavioral health services in community hospitals."

The behavioral health task force was an initiative of the AHA Board's long-range policy planning committee. "The subject of behavioral health and its status as a poor step-child in the American health care system was something that concerned the board," said Thomas Kennedy, III, the former AHA board member who chaired the task force. He said the board believed "it was time for the AHA to take a hard look at [the issue] and put forth some recommendations for the field."

Among the top challenges confronting hospitals was inadequate financing, which has forced many public and private organizations to curtail appropriate services, as well as a shortage of behavioral health care specialists. "Many behavioral health patients have been uninsured, underinsured, and their care reimbursed less than cost," the report noted. "Others have had health insurance that excluded or restricted behavioral health benefits," the task force said in its report.

If those trends continue, "our capacity as a country to take care of folks with behavioral illnesses is going to erode," noted Kennedy.

He said the AHA report seeks to highlight the fact that behavioral health issues are part and parcel to the entire health care service landscape. "It is no longer proper to talk about physical illness and mental illness as if they were totally unrelated to one another," Kennedy said.

In fact, almost a quarter of all adult stays in community hospitals involve behavioral health disorders, according to a government study.

(This article first appeared in the September 17, 2007 issue of AHA News).

OIG announces 2008 workplan

Reviews in the works for psychiatry provider areas

Congress created Offices of the Inspector General (OIGs) to be independent and objective units within Federal departments and agencies for the purposes of: (1) conducting audits and investigations of programs and operations; (2) coordinating and recommending policies to promote economy, efficiency, and effectiveness in the administration of programs; (3) preventing and detecting fraud and abuse; and (4) keeping the Department Secretary or agency administrator and Congress informed about the necessity for corrective action.

On an annual basis, OIG conducts a comprehensive work-planning process to identify the areas most worthy of attention in the coming year. The various factors taken into account include:

- requirements for OIG reviews, as set forth in laws, regulations, or other directives;
- requests made or concerns raised by Congress and the Department's management;
- significant management and performance challenges facing the Department, which are identified as part of the Department's annual performance assessment review;
- work performed by the Department and other organizations, such as the Government Accountability Office and the Office of Management and Budget (OMB); and
- management's actions to implement OIG recommendations from previous reviews.

In September, the Office of the Inspector General of the Department of Health and Human Services announced its work plan for fiscal 2008.

The 111-page guide reveals that the OIG intends to scrutinize claims for mental health and psychotherapy services provided to Medicare patients in nursing homes. According to the work plan, "A previous OIG review found that approximately 31 percent of outpatient claims for Part B mental health services allowed by Medicare did not meet coverage guidelines, resulting in $185 million in inappropriate payments."

Other areas of review relevant to psychiatry providers include:

- whether children enrolled in Medicaid managed care received required services, including mental health services and screenings;
- whether appropriate adjustments were made for facilities that operate emergency departments. As stipulated in the Medicare Prospective Payment System for inpatient psychiatry, some of these facilities receive an adjusted rate if they maintain a qualifying emergency department;
- Medicare payments for psychiatric services. Medicare will pay for items or services only if they are reasonable and medically necessary. The OIG will determine whether claims submitted for psychiatric services were supported and billed in accordance with Medicare requirements;
- Medicare claims for services furnished "incident to" the professional services of selected physicians. Medicare Part B generally pays for services "incident to" a physician's professional service; such services are typically performed by a nonphysician staff member in the physician's office. The OIG will examine the Medicare services that selected physicians bill "incident to" their professional services and the qualifications and appropriateness of the staff who perform them. This study will review medical necessity, documentation, and quality of care for "incident to" services;
- outpatient alcoholism and substance abuse services to determine whether providers claimed reimbursement in accordance with Federal and State rules. Medicaid reimbursement may be available for outpatient alcoholism and substance abuse services provided in hospital-based or freestanding clinics. Prior OIG work identified significant noncompliance with these rules related to outpatient alcoholism and substance abuse services. In several states, reviews will be conducted of providers that receive the largest amounts of Medicaid reimbursement for these services.

It is expected that reports on these and all other reviewed areas will be completed in FY2008 and FY2009. An online version of this document is located at http://oig.hhs.gov/publications.html. Questions about this publication can be directed to OIG's Office of External Affairs at 202-619-1343.

Consultation documentation

The Office of the Inspector General of Health and Human Services has said that consultation billing is on their radar screen. A minimum standard for documentation of a request for consultation should be met in order to better assure reimbursement

The four R's of consultation documentation

- *Request* – There must be a paper request (email, document of phone call, consult request form, letter) from the referral source which is placed in the patient's record.
- *Reason for the request*
- *Render the service*
- *Report to the requestor*

Example introduction: Dear Dr. X; Thank you for referring Mr. Smith for consultation about the management of his diagnosis of bipolar II. This report is a record of and my recommendations for further treatment.

Review of Systems

In order to bill for the higher levels of consultations, the documentation must include a review of systems which covers ten organ systems. The patient may complete a questionnaire, a staff member or medical student may document the review, but the consultant must review and confirm or amend the data collected and sign and date the checklist. Links to a checklist and an American Academy of Child and Adolescent Psychiatry coding training module are given below.

http://medinfo.ufl.edu/other/itt/ros/ros_list.pdf

http://www.aacap.org/galleries/PracticeInformation/CPT_Module_October_2006.pdf

(See Pages 14 and 15 for Review of Systems info.)

(Adapted from an email from Susan Cook, reimbursement specialist, U Michigan department of psychiatry).

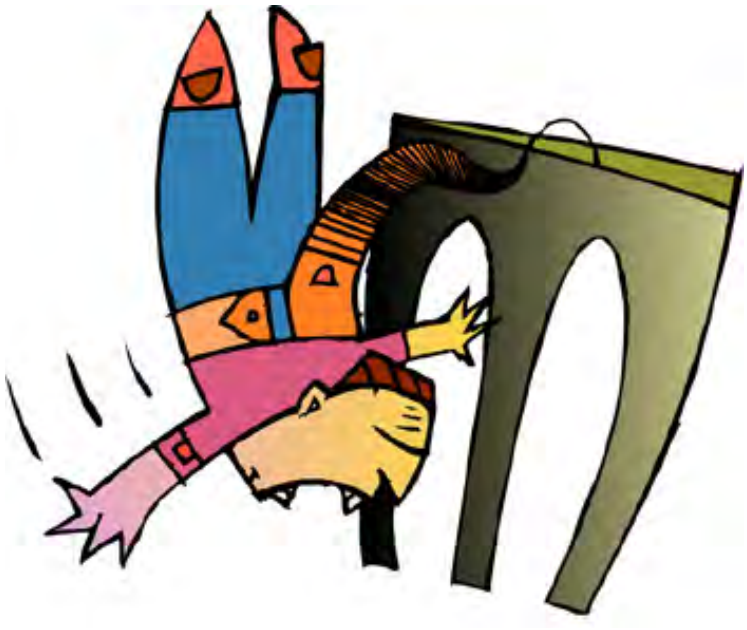
UPDATE

Tamper-resistant prescriptions

CMS' guidance on the tamper-resistant law, set forth in an August 17, 2007 State Medicaid Director letter, contains two phases. For the first, a prescription must contain at least one of the three tamper-resistant characteristics in order to be considered "tamper resistant."

1) one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
2) one or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;
3) one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

For the second phase, prescriptions must contain all three characteristics. At least one of the three tamper-resistant characteristics is required on April 1, 2008. All three characteristics are required on October 1, 2008.



If you jump off a Paris bridge, you are in Seine.

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