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Summer 2008

The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Steve Blanchard

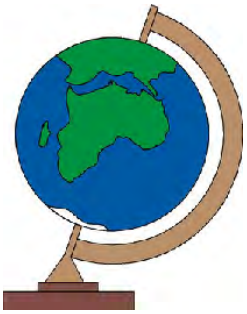
I have just finished mowing the lawn for what must be the 25th time since I last prepared this column. That hour or so represents some of the best thinking time in the week.

I must tell you that I learned some new skills this summer—I learned how to sandbag and the proper way to build sandbag levees. I also became aware of the importance of the incident command process during a major natural disaster. On June 11-12 it became apparent that the Iowa River would flood the University of Iowa campus and the local community. Thousands of volunteer hours were consumed in filling and stacking seven million sandbags in an effort to control the flooding. The flooding surpassed the 100 year flood plain to be classified as the 500 year flood. The hospital implemented its emergency command system on Friday, June 13. Clearly the drills that preceded the real deal paid off as problems were solved and the hospital continued to function despite the fact the steam plant was no longer operable, interstate roadways were closed and communication systems were threatened. The official detour for what is normally a 30 minute commute was now a 4-5 hour drive. Everyone worked together to solve the problems that arose while also addressing the needs of staff members personally affected by the floods.

The results of the flood are significant to our University community. Damages to University properties and equipment are estimated at $231 million. 350 classes need different locations this fall. Enrollment is up; will the dormitories be ready for fall occupancy? Where will the art studios be located? When will the steam plant be back in operation? I continue to see large dehumidifiers running as they seek to dry out buildings, thereby eliminating concerns about mold. I did not expect to be learning how to work through a disaster of this type this summer. I certainly will look at the intrusion of another emergency drill differently the next time I get that page.

Continued on page 4

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:

Michael Cull
Vanderbilt University
(615) 322-8704
michael.cull@vanderbilt.edu

Ann Giauque
Indiana University
(317) 274-1222
agiauque@iupui.edu

Patricia Kersey
Mayo Clinic College of Medicine
(507) 255-8481
kersey.patricia@mayo.edu

Steve Mueller
University of Texas Medical Branch (Galveston)
(409) 747-8307
smueller@utmb.edu

The California Gold Rush

The "Rush for the Gold" began in Coloma, a town not far from Sacramento. Test your knowledge of the California Gold Rush.

1. The California Gold Rush began with the discovery of gold in:
   A) 1849 C) 1847
   B) 1848 D) 1850

2. Gold was first discovered at:
   A) Sutter's Mill C) Sully's Mill
   B) Sumpter's Mill D) Miller's Mine

3. Approximately ___ people came overland in a 6-9 month trek to California in 1849 to find their fortunes.
   A) 51,000 C) 13,000
   B) 45,000 D) 32,000

4. At its height, the Gold Rush saw approximately ___ immigrant Chinese working the mines.
   A) 25,000 C) 10,000
   B) 5,000 D) 12,000

5. The invention of water cannons used to pulverize the rock in which the gold was found resulted in:
   A) run off C) pay dirt
   B) pay off D) payola
   i

6. In the first year of the Gold Rush, profits amounted to:
   A) $10 M ($236 M in 2005 dollars) C) $5 M ($118 M in 2005 dollars)
   B) $20 M ($472 M in 2005 dollars) D) $18 M ($427 M in 2005 dollars)

1) B 1848 2) A Sutter's Mill 3) D 32,000 4) A 25,000 5) C pay dirt 6) A. $10 million

Save the date!!

AAP fall meeting October 16-17

The Administrators in Academic Psychiatry Fall Meeting will be held October 16-17, 2008, at the Embassy Suites Sacramento-Riverfront Promenade, in Sacramento California.

The meeting will be two days packed with learning and networking opportunities for our members and guests.

There will be a networking dinner the evening of October 15 which is a great opportunity to catch up with old friends, meet new ones, and learn about issues and answers that can apply to you and your department.

Thursday, October 16 will begin with breakfast and President's welcome, followed by the McLeod Lecture, and additional presentations.

Thursday afternoon will include presentations and working sessions on benchmarking, and the favorite "Take Two Minutes." Dinner in Old Sacramento will follow.

Friday, October 16 will again include breakfast, and

a morning full of working presentations. The conference will adjourn by noon.

Watch your email and the AAP website, www.adminpsych.org, for further details and registration forms.

Conference Site and Hotel Accommodations

Embassy Suites Hotel
Sacramento – Riverfront Promenade
100 Capitol Mall
Sacramento, CA 95814-3244
916-326-5000

There are a limited block of rooms until September 23, 2008. After this date, reservations at the group rate ($179) will be accepted on a space-available basis only. Please note, if the block fills prior to the cut-off date, rooms may or may not be provided at the group rate.

Call the hotel directly at 916-326-5000 and ask for Reservations. Identify yourself as an attendee of the AAP conference to receive the special group rate. Upon availability, rates are honored one day prior to and one day after the conference if you wish to extend your stay. This can be extended longer based on availability.

New GrAAPvine sections introduced

This issue of *The GrAAPvine* introduces two new sections: *Residency World* by Associate Editor **Pat Sanders Romano** (Albert Einstein School of Medicine) which will highlight issues relevant to residency education, and *In the Pipeline*, which will inform on recent legislation passed or in committee. If you have a particular topic you'd like to have highlighted in either of these sections, please drop a line to Jan Price at janprice@umich.edu.

53 years is long enough!

One of AAP's founding fathers, and one of it's most admired members, **Norm MacLeod**, is retiring. He served as secretary of the association from 1986-1988, in the presidential rotation from 1989 to 1992, and as the first editor of The GrAAPvine also from 1989 to 1992. Soon after, Norm became active in the Academic Practice Assembly of the Medical Group Management Association, serving on several committees and finally as president from 1997-1998.

After graduating from college, Norm served as a Peace Corps volunteer in a health project in northeast Brazil. His first professional job after receiving his MSPH in 1968 was as the administrator of the Department of Psychiatry and Neurology at Walter Reed Army Medical Hospital in Washington DC.

Norm served in Vietnam for two years as executive

officer, Medical Company, 23rd Infantry Division. Upon his return stateside, he worked as administrator of the Institute of Psychiatry and Human Behavior of the University of Maryland Hospital in Baltimore before moving to the University of Michigan. His next move, in 1992, was to serve as the administrator of the Harvard Consolidated Department of Psychiatry, a consortium of eight independent Harvard-affiliated psychiatry programs into one department under one chairman.

In 1994, Norm left the department of psychiatry to take on another huge challenge when he became the Vice President and Chief Administrative Officer of Harvard Medical International, a corporation of Harvard University who's mission it is to assist other countries in the training of medical professionals and scientists and in the development and construction of health care systems, facilities and services.

His last day of work was May 30, 2008 but he will be staying on in a consulting capacity for 1-2 days weekly at least through December.

Norm says, "53 years of working is long enough! It has been a privilege to be associated with such talented and nice people and I wish everyone the very best in their professional and personal lives. I will always have fond memories of AAP." And we who know Norm will always have fond memories of him.

President's desk *(continued from page 1)*

On a different note, I have often thought that the U.S. could not have designed a more complex payment system for healthcare services if it tried. An article in the Spring 2008 *Proto* published by Massachusetts General Hospital discusses the cost implications of the current reimbursement system. The data indicate that 30 percent of expenditures for health care services are consumed by the payment system itself. Is it possible to re-engineer this system?

The Fall Conference in Sacramento is fast approaching. The dates are October 16 (Thursday) and 17 (Friday). The program promises to be among one of the best educational events sponsored by AAP. **Hank Williams** (U Washington) and **Narri Shahrokh** (U California – Davis) have put together an exciting agenda for this conference. Please mark your calendars and plan to attend the Fall Conference.

I want to thank each member for volunteering in all the ways you do. Keep those questions and responses on the listserv coming!

Residency world
Annual chief resident meeting

By Pat Sanders Romano

You may have noticed that your 2008-09 Chiefs returned to you on June 2, 2008 tired, self-assured, and five pounds heavier. That is, if they were among the 100 Chiefs who attended the 36th Annual Chief Residents' Meeting over the weekend. I had the opportunity to meet and get to know this very dynamic group. Having been affiliated with this meeting for the past ten years, this cohort was definitely the brightest, most articulate and most challenging group of participants.

Our weekend started on Thursday evening with dinner and an opportunity for a varied and regionally scattered group of peers to meet and catch a few minutes of down time. Over the years we have 'tweaked' the schedule and we have found that starting on Thursday evening allows for both more intensive learning time and more networking time, both of which are important components of the experience. All day Friday and Saturday and the morning of Sunday were packed with small and large group meetings. The work day starts early and lasts until dinner.

What is the experience?

Through the use of small and large groups, facilitated by senior faculty of the Department of Psychiatry of Albert Einstein College of Medicine, the participants have the opportunity to experience their leadership style and hone their leadership skills. The experiential nature of the program can be initially uncomfortable for the Chiefs who are accustomed to didactics; however the design of the program ties the experience together and brings closure on the final day of the meeting. The small group, made up of 10-12 participants, mixed by gender, school and region, is facilitated by two faculty members and is very demanding. The large groups strive for participation of all of the participants and provide the "grist" for the small group work. Meals, breaks, receptions, and evenings allow the Chiefs to develop a network of peers throughout the country and Canada. All of the Chiefs are given participant contact information.

What is the outcome?

Aside from the 5 pounds (the food is really excellent!), the opportunity to sing karaoke to the faculty, and the lifelong bonds developed; there was a great deal of learning going on. There are a number of Chairs and Training Directors who are alumni; our past participants are the core of academic psychiatrists. Each year we do a comprehensive evaluation; this is some feedback we received on this year's evaluations: "Thank you for this challenging experience which helped me grow personally and professionally." "It was an incredible learning experience." "After five years of therapy, I learned more about myself in these three days." … [The small group] "was really what we made of it, but the structure of the conference and the sparse direction helped to make it most worthwhile." … [The large group] "was interesting - more understandable after the fact." "We really appreciated our [small group] facilitators and felt they were very insightful, constructive and compassionate. I will miss our group." "Both [facilitators] were great. Let us figure things out on our own. Really appreciated their comments at the end."

Thank you - for sharing your incredible Chiefs with me for a weekend, and for the support you gave to enable them to attend.

(Pat Sanders Romano is the administrator of the Albert Einstein School of Medicine department of psychiatry.

Ms. Romano has disclosed a financial relationship with this organization. This disclosure is merely intended that any potential conflict should be identified openly so that the readers may form their own judgments about the article with the full disclosure of the facts).

The executive suite
Macro thinking in a micro world

by David Peterson, FACMPE

In a 24/7 world with perpetual and universal connectivity, most would agree that the pace of a professional's life has quickened. The world doesn't sleep and information abounds from various sources and time zones. Want to know how the markets opened in Asia? CNBC will tell you at 3 am or so (depending upon your time zone). Want to know the weather in Europe? The Weather Channel, for one, will accommodate. Need to know, well, anything? The internet will get you "there" anytime you choose. Technology makes the world a smaller place, putting data, information, or even a conversation a click away. This is arguably a good thing, but sometimes overwhelming for some.

Closer to home, uninterrupted connectivity to the office allows for easy access to email systems, data warehouses, documents and spreadsheets, to name a few. Data can be sliced, diced, analyzed and packaged to a micro degree. Doorstop-worthy reports cross desks that cover any number of areas to include space utilization, grants management, compliance, physician bump rates and patient no show rates, not to mention the billing and collection reports that provide a host of detailed information.

In short, there's a cascade of data and information - often conflicting - that pours out of systems and often results in a lot noise out there.

Listening to, sorting through, and prioritizing the right noise is the challenge of every successful medical practice executive. The ability to recognize what can be ignored and what can't separates a manager paralyzed by information overload and an effective executive who can identify and listen to the right noise at the right time.

Advice that is offered to work through this information overload includes clichés and metaphors that become tiresome and endless: keep your eye on the ball, keep your eye on the prize, look at the big picture, skate to the spot where the hockey puck will be are a few. These phrases are overused because they are also true.

One way to "stay on course" (there's another one) is to consider the deceptively simple strategic question, "What business are we in?" Remembering to continually ask and answer this macro question can help filter the noise and keep the practice executive focused on the right priorities at the right time. In his presentation to the AAP membership at the Spring 2007 meeting, Mr. Joseph Naughton-Travers touched upon this topic and suggested some tools that could be used to help an organization's leadership regain focus.

Other actionable techniques that can help practice executives stay focused are:

- Listen to organizational leadership. What priorities can be heard and identified?
- Align effort and resources toward these priorities.
- Find key indicators and benchmarks for these priorities and develop reports – "dashboards" is the trendy word nowadays – that track these priorities.
- Avoid distractions (noise).
- Maximize effort and organizational impact by managing by exception.

Membership in the American College of Medical Practice Executives is an excellent way to stay current and test and hone the skill set necessary to filter the noise, focus on the big picture and think in a macro way about a micro world. Through its website, Body of Knowledge™, active listserv, electronic and print publications, the ACMPE provides its membership a professional port in the middle of a noisy storm.

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

Engaging physicians for change

By James L Reinertsen

How the team can incorporate quality and safety. Public transparency of hospital quality data, pay for performance, campaigns such as the Institute for Healthcare Improvement's (IHI) 100,000 Lives and 5 Million Lives campaigns and, most recently, non-pay for non-performance all require rapid and sustained improvement in difficult care delivery problems such as hospital-acquired infections, surgical mishaps and failure to provide reliable evidence-based medicine. Many executive teams struggle with this task, and when they are asked why, a frequent answer is, "We cannot get the doctors engaged in the hospitals quality agenda."

Very little happens in a hospital or other care system that is not the direct result of a doctor's order or the indirect result of a policy approved by a body of physicians such as the organized medical staff. If executives wish to change what is being done, then the doctors' orders or the policies that doctors adopt must change. Physicians cannot make the changes happen by themselves, but they are in a powerful position to prohibit change, and therefore their engagement is critical.

Executives might ask, "How do we engage physicians?" And many also would add to this question: "... especially given our history of a failed joint venture three years ago that still has half the medical staff angry with us" or some other description of contextual and relationship difficulties that go well beyond quality and safety. IHI's answer to this question is found in the white paper Engaging Physicians in a Shared Quality Agenda. Published in 2007, the paper can be found at www.ihi.org.

Physicians cannot make the changes happen by themselves, but they are in a powerful position to prohibit change, and therefore their engagement is critical.

Each element of the framework has many nuances, but a summary includes:

1. Discover Common Purpose

Executives should reverse the engagement question and ask "How can we get engaged in the doctors quality agenda?" They quickly will learn that "physicians' quality agenda" is not an oxymoron. Doctors care deeply about their patients' outcomes and about wasted time (especially their own). In contrast, doctors are less excited about improving the hospital's publicly reported quality scores, reducing length of stay or removing waste in the supply chain - all of which they tend to think of as "the hospital's problem, not mine."

Effective leaders address this problem by framing their aims and measuring results differently. Instead of aiming to be in the top 10th percentile of CMS Core Measures, some hospitals now aim to reduce the risk of needless deaths in their hospitals. One strategy might be to improve the reliability of CMS Core Measures for acute myocardial infarction and pneumonia. Physicians, however, want to know that they are working for something they believe in.

2. Reframe Values and Beliefs

Healthcare executives and doctors need to re-examine and reframe their core values about each other, and what it means to be part of a system of care, if true engagement in quality and safety is to occur. Executives must begin to think of doctors as partners rather than as customers - a very difficult shift in power. And to be effective partners, doctors must accept responsibility for the system's quality results, not just for their own personal quality performance.

This type of cultural shift does not happen overnight and requires change in our conversations and agendas.

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For example, consider the traditional Morbidity and Mortality Conference. Instead of a review in which doctors ask, "Did someone make an error of judgment or of technique in this case?" a redesigned M and M Conference has doctors and administrators asking a very different question: "What were the system factors - culture, structure, processes - that contributed to this death, and what can we do together to change these factors?" Over time, as this question repeatedly is asked and addressed with real action, physicians will feel more like valued partners in the operation of the hospital and will begin to work on the system of care, not just in the system of care.

3. Segment the Physician Engagement Plan

Not all physicians need to be engaged in each quality initiative, and those who must be do not need to be engaged in exactly the same way. Effective leaders develop a segmented plan for engaging physicians. For example, there could be plans for a few physician champions, another plan for physicians who are members of the improvement team, a plan for the structural leaders of the medical staff who might adopt a new hospital policy based on the work of the team, and so forth.

It is important when designing each of these segmented plans to include one for those physicians who are likely to be naysayers or blockers of recommendations that emerge from the project team or of policies that are recommended by the structural leaders.

4. Use Engaging Improvement Methods

Doctors are often cynical about quality improvement (QI) because many QI methods - ways of meeting, data reporting, etc.appear to have been perfectly designed to turn them off.

For example, when we ask busy doctors to join an improvement team that meets every two weeks in a conference room during the time they would otherwise be making rounds, and then we use the vast majority of meeting time for activities that do not require any physician input, and we go on month after month in these meetings gathering data without testing any changes, and we eventually send out some flawed data to each individual doctor showing them how they have performed on quality measures, and then we ask them to shape up, these are improvement methods that are guaranteed to disengage, not engage, doctors.

IHI's white paper lays out a number of approaches, including some guidance on how to use individual physician performance reporting and how to standardize clinical processes.

5. Show Courage

Change is never easy, especially when powerful voices speak out against it. In healthcare organizations, physicians are among the most powerful voices of all, and the collegial nature of physicians makes them reluctant to challenge other doctors' powerful, negative voices. This leads to a common problem in health systems: nine doctors want to go forward with a change, but one loud negative voice stops the process in its tracks - a phenomenon I call monovoxoplegia. Versions of this phenomenon occur in doctors' meetings, improvement teams, executive team meetings and even in board rooms. Lay board members often sit silent when one doctor speaks up against a proposed change. There is no simple answer to the problem of monovoxoplegia. The overarching theme of an approach is to build an organizational culture of courage - the courage to ask questions, challenge the status quo and support the doctors and nurses who do wish to make improvements.

6. Adopt an Engaging Style

Doctors tend to focus on an individual patient, take deep individual responsibility for patient outcomes, overestimate the risks associated with changes in practice and value their own experience over data and formal studies. Some style suggestions for working with these and other cultural quirks of doctors might be:

- Involve doctors from the beginning. Do not hand them a final or near-final version of proposed changes.
- Work with the real leaders. These doctors might or might not be the tided, structural or official leaders. But they

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need to be on board if the change is to go forward.

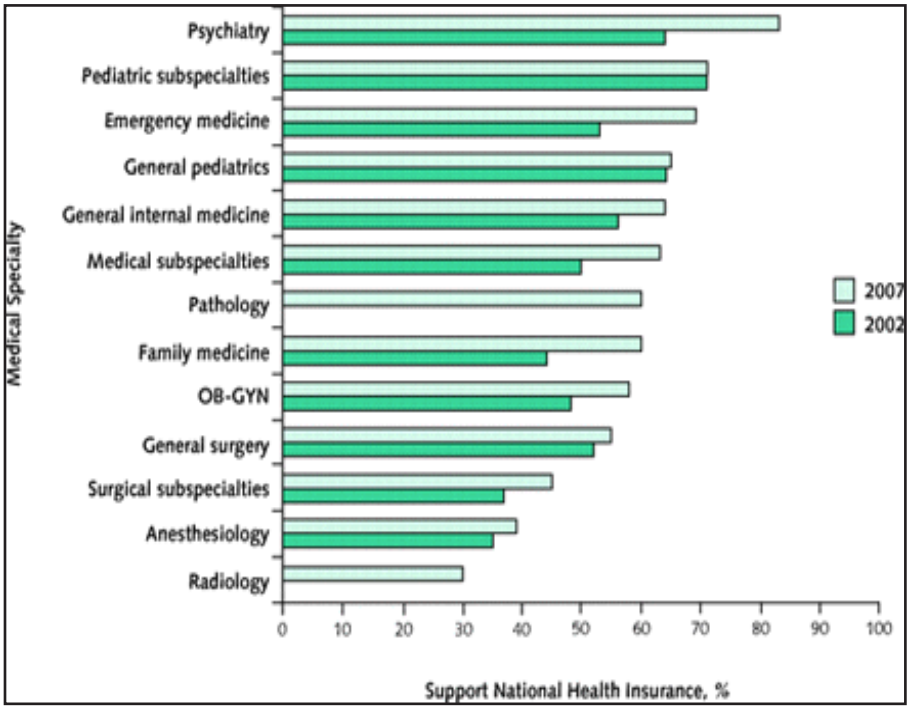
- Choose messengers and messages carefully. Doctors will listen to a proposed change differently depending on what type of doctor (specialist, general practitioner, etc.) is speaking.
- Be transparent, especially with data. Doctors do not trust interpreted data. Give them access to the raw materials.
- Value their time with your time. If an executive leader asks doctors to take time to engage in a critical strategic initiative but cannot attend the meetings himself, doctors feel manipulated and undervalued. Engagement will suffer accordingly.

And as for the larger contextual issues - physicians as competitors, the history of the failed joint venture, and other historical barriers to engagement - many executives are finding that an excellent way to rebuild trust and repair relationships is to discover a shared hospital/physician quality and safety agenda to begin to get real results for the real reason we all are here - our patients.

James L. Reinertsen, MD, is senior fellow with the Institute far Healthcare Improvement. He can be reached at jreinertsen@thi.org.
(Reprinted with permission from the Healthcare Executive, *May/June issue, American College of Healthcare Executives).*

Psychiatry by the numbers

Support for government legislation to establish National Health Insurance in 2007 and 2002, by specialty



Reprinted with permission from *Annals of Internal Medicine*, April 1, 2008

What's new?

UNC psychiatry launches forensic psychiatry program and clinic

The Department of Psychiatry of the University of North Carolina at Chapel Hill School of Medicine has expanded its psychiatric services in the forensic area with the opening of a new Forensic Psychiatry Program and Clinic.

The new program, which provides a wide range of criminal and civil services, such as determining the capacity of defendants in criminal cases to stand trial as well as the capacity of individuals in civil cases to manage their own finances or refuse treatment, is the only program of similar scope in North Carolina that is based on the campus of a major research university.

"This enables us to draw upon all of the other resources available through UNC - Chapel Hill and the UNC Health Care System," said Dr. Sally C. Johnson, one of three clinicians who comprise the program's evaluation and research team. "That is a tremendously helpful feature of our program, because completing comprehensive evaluations on individuals who need forensic psychiatry services often includes utilizing other medical and laboratory services. These services, as well as consultation with a variety of experts in other fields, are readily available at UNC. We hope that the research we are doing will ultimately prove helpful to the medical and legal professionals who are involved in the handling of cases where forensic psychiatry plays a role."

Dr. Johnson brings to the program extensive experience from her career service as a public health physician and as an evaluator and administrator in the Federal Bureau of Prisons. She has conducted forensic psychiatry evaluations of defendants in many high-profile criminal cases, including former TV evangelist Jim Bakker, would-be presidential assassin John Hinckley and Theodore "Ted" Kaczynski (i.e., the "Unabomber"), which she conducted while employed as Chief Psychiatrist and Associate Warden of Health Services for the Federal Correctional Institution in Butner, N.C.

In addition to Dr. Johnson, team members include Dr. Alyson Kuroski-Mazzei, who also serves as Associate Training Director of the Forensic Psychiatry Fellowship Program for psychiatry residents who plan a career in this subspecialty area, and Dr. Eric Elbogen, a scientist-practitioner with specialized clinical and research expertise in forensic and neuropsychological assessments.

Research projects currently under way include a study of factors associated with increased risk of suicide and violence among Iraq and Afghanistan veterans and analyzing statutory language in juvenile sex offender laws in all 50 states. The goal of the latter project is to describe how juvenile sex offender laws define juvenile sex offenses and in what ways jurisdictions are similar or different, evaluating the key challenges and difficulties in applying such laws in the context of recent criminal cases.

This program allows attorneys, clinicians and clients to obtain focused or comprehensive assessments unique to their legal questions and needs. The program operates a clinic, housed in the North Carolina Neurosciences Hospital at UNC Hospitals, which will provide consultation and evaluations on an outpatient basis.

More information about the Forensic Psychiatry Program and Clinic and updates about clinic activities and training opportunities can be found at http://www.psychiatry.unc.edu/forensic/ or by calling (919) 966-5540.

New hospital-based inpatient psychiatric services measure set available to meet Joint Commission's ORYX requirements

by Ken Powers, Media Relations Manager, The Joint Commission

Effective with October 1, 2008 discharges, accredited hospitals that provide acute inpatient psychiatric services will be able to use The Joint Commission's Hospital-Based Inpatient Psychiatric Services (HBIPS) measure set to meet current Joint Commission ORYX performance measurement requirements.

In conjunction with the HBIPS measures, The Joint Commission also will implement an important modification to existing ORYX performance measurement requirements by offering free-standing psychiatric hospitals the option of collecting and submitting data on either the seven measures included in the final HBIPS measure set or nine non-core measures, in order to meet ORYX requirements. Additionally, general medical/surgical hospitals that provide acute inpatient psychiatric services will be able to select the Hospital-Based Inpatient Psychiatric Services measure set as one of their four sets of core measures needed to meet ORYX requirements for 2008. Detailed specifications for the seven HBIPS measures are available on The Joint Commission's website.

"We were pleased to receive such strong field support for the HBIPS measure set," says Jerod M. Loeb, Ph.D., executive vice president, Quality Measurement and Research, The Joint Commission. "The measure set is the result of strong collaborative work and addresses important components of care in the psychiatric setting."

The development of the final measure set follows extensive field review and public comment, and pilot testing of the candidate measure set. The final measure set includes:

- Admission screening for violence risk, substance use, psychological trauma history and patient strengths completed;
- Hours of physical restraint use;
- Hours of seclusion use;
- Patients discharged on multiple antipsychotic medications;
- Patients discharged on multiple antipsychotic medications with appropriate justification;
- Post discharge continuing care plan created; and
- Post discharge continuing care plan transmitted to next level of care provider upon discharge.

The Joint Commission will publicly report hospital performance on the measure set through Quality Check once the measure set has received National Quality Forum (NQF) endorsement and Hospital Quality Alliance (HQA) approval. The data will not be included in The Joint Commission's Priority Focus Process or its Strategic Surveillance System until that time.

For information on the measure set or to take advantage of this opportunity to use HBIPS to meet ORYX requirements, please contact Frank Zibrat, associate director, ORYX Implementation, Division of Accreditation Operations, at 630-792-5992 or fzibrat@jointcommission.org.

OOPS!

Toni Ansley's email address was incorrectly printed in the Board of Directors listing on the Back Page of the Spring 2008 issue of *The GrAAPvine*. You'll find the correct address in this issue.

Research news

by Hank Williams

NIH paper submissions going electronic

NIH has announced plans to transition the remaining paper processes for submitting research proposals to electronic processes in the coming months.

Those programs affected are: Research Career Development, or K awards; National Research Service Awards (NRSA fellowships), F awards; and Other Training Grants, or T and D awards.

The electronic submission process will be through Grants.gov using the SF424 application.

Plans for submission dates and programs are as follows:

February 12, 2009 - Research Career Development (all K's except K12)

April 8, 2009 – Individual National Research Service Awards (F)

September 23, 2009 – Institutional National Research Service Awards and Other Training Grants (T, D), D43, D71/U2R, and K12

NIH electronic submission changing from Pure Edge to Adobe

NIH has announced that it will move from PureEdge to Adobe software versions of the SF424 grant application forms for all electronic submissions.

The new Grants.gov 2007 system supports the use of application forms that can be downloaded and completed using free Adobe Reader software, rather than the PureEdge software that is currently required for the SF424.

Grants.gov is switching the underlying product used to create their grant application forms from PureEdge to Adobe.

The basic look and feel of the forms remains the same. The overall process of finding opportunities, downloading application packages, preparing forms and submitting applications remains the same.

Users will notice some small differences in form layout, but the main differences are in form navigation.

Unfortunately, there is no automated way to extract information from a PureEdge form to populate the Adobe form beyond cutting and pasting.

NIH will pilot the Adobe forms in the fall of 2008 with a few select funding opportunity announcements.

Assuming the pilot goes smoothly, and the forms approval and development process go as planned, the first standing submission deadlines using Adobe forms will be in January 2009.

Suggested reading

by Radmila Bogdanich

The Stigma of Families with Mental Illness. Academic Psychiatry, Vol. 32, No. 2, March-April 2008, pps. 87-91

Administrators in academic psychiatry are very familiar with the issue of "stigma" in our profession. Our departments deal with it in relationship to medical student education and medical student perception of psychiatry as a field to choose to practice in. Residents deal with issues of stigma as well. Residency training affords our residents the opportunity to recognize the issue of stigma and its impact on not only patient care and family support systems but access and equity issues as well. Even among our own colleagues in various clinical departments and practice plan CEO's, psychiatry is sometimes deemed the poor stepchild.

This issue of Academic Psychiatry, entitled "Special Collection: Reaching Out to Families and Overcoming Stigma" has a wealth of knowledge related to stigma and what we can do to address it. The article in the collection that I found most interesting describes the stigma that families experience when one of their members has a mental illness and offers a number of solutions that we can use to address stigma in our training programs and patient care.

The authors describe various categories where stigma is used including ethnicity, gender, body size, poverty, clothing, prejudice, stereotypes, and discrimination. When people are discriminated against, they lose the opportunity to participate in things such as work, home ownership or rental, insurance, relationships, etc.

The authors point out that when one talks about the stigma of mental illness, we must recognize the difference between "public stigma," such as refusing to rent an apartment to someone who has a mental illness and "self-stigma," when the individual with a mental illness believes the public stigma and therefore also believes that they are unworthy of decent housing (as an example) and will not be able to rent a nice apartment. Therefore, they start discriminating against themselves. This then causes a spiraling effect in which their self esteem suffers and they don't try to find decent housing and continue living in the family home.

The authors have formulated a definition of "family stigma" which includes "blame, shame, and contamination." They cite research that found family members believe they should hide their relationship with their family member who has a mental illness, that relatives with a mental illness cause strained relationships among family members and friends, and that family self-esteem is affected. Public perception of mental illness often blames parents for the start of mental illness and then the public doesn't feel the need to support those families. All of this, of course, further negatively impacts the person with a mental illness.

The authors provide some solutions to eliminate family stigma through our training programs. They suggest that treatment plans should be formulated that address stigma and also provide families with examples of how to deal with this issue. Strategies include "increasing the awareness of stigma, identifying coping techniques, finding safe and supportive environments to explore experiences with stigma, participating in anti-stigma programs, developing an awareness of the impact of stigma, and providing opportunities to practice coping skills."

As far as changing public stigma, the authors state the approaches of protest, education (challenging myths) and contact (interaction between the public and patients) are helpful. Specific power groups in the community, such as "landlords, employers, police officers and health care providers" should also be targeted.

Self-stigma can be addressed through "promoting personal empowerment and

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participating in activities that promote a person's sense of self worth." It is always helpful to have persons with mental illness who have become successful professionally speak out on the subject. A recent example is Brooke Shields and her disclosure of postpartum depression. Participating in NAMI and other such groups is also helpful.

By beginning to address stigma through our training programs, and also through the care that we provide patients and their families, we begin to develop a grass roots effort that will further educate others about the realities of mental illness. Remember, we are all connected by only six degrees of separation.

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

Coming attractions

Administrators in Academic Psychiatry Fall Conference
October 16-17, 2008
Sacramento, CA
www.adminpsych.org

Medical Group Management Association Annual Conference
October 19-22, 2008
San Diego, CA
www.mgma.com

Association of American Medical Colleges Annual Conference
October 31 - November 5, 2008
San Diego, CA
www.aamc.org

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

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

MGMA Academic Practice Assembly Annual Conference
April 19-21, 2009
Los Angeles, CA
www.mgma.com

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

In the pipeline

Medicare mental health parity approved

Just a few days after reconvening from the July recess, the Senate joined the House in passing the Medicare Improvements for Patients and Providers Act of 2008 (H.R. 6331) by a veto-proof 69-30. Less-publicized than the provision that would halt a payment cut for physicians providing treatment to Medicare patients is new equity between mental health and medical coverage.

When enacted, the bill will end a longstanding requirement that affects Medicare beneficiaries who need outpatient mental health services. Currently, they face a discriminatory 50% coinsurance for outpatient psychotherapy and services furnished by non-physician mental health professionals (20% for prescription and monitoring of medications to treat mental illness). In contrast, other outpatient health services require only a 20% copayment.

The present outdated and unfair higher copayment for mental health services has served as an incentive to use inpatient or institutional care instead of outpatient services. It has also led seniors and people with disabilities who rely on Medicare to forgo needed mental health treatment.

The bill would establish mental health parity within the Medicare program, phasing in a reduction of the higher co-payment over six years, to 20% in 2014.

The House passed H.R. 6331 by a vote of 355-59 on June 24th. The overwhelming majority in both chambers made a veto override likely, should the Administration carry out its earlier threat. The passage of H.R. 6331 is a significant accomplishment and makes great strides in modernizing Medicare.

UPDATE: On July 15, Congress voted quickly and overwhelmingly to override the President's veto, by 383-41 in the House and 70-26 in the Senate. The Medicare Improvements Act, with equal coverage of mental health services, becomes law.

(Reprinted from the Judge David L. Bazelon Center for Mental Health Law, Newsroom, July 10 and July 15, 2008).

H.R. 6331
THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT

MAKING OVERDUE IMPROVEMENTS TO MEDICARE

Forty-four million American seniors and people with disabilities depend on Medicare for their health care. H.R. 6331 seeks to make Medicare work better for every senior citizen and every person with a disability. It pays particular attention to the needs of those living in underserved areas, and beneficiaries with low incomes and less access to health care. The bill provides approximately $4.5 billion in beneficiary improvements over 5 years. The improvement to mental health coverage is as follows:

Seniors and people with disabilities can be particularly prone to depression and other mental health problems, but Medicare currently requires a much higher co-payment for mental health services – 50 percent – than the 20 percent required for physical health care services. H.R. 6331 provides parity in coverage for mental health services by lowering co-payments over six years until they match other co-pays – making sure that seniors can afford the screening and treatment they need. The bill also expands the drug benefit's coverage to include benzodiazepines and barbiturates used for mental health treatment.

Prepared by the Committee on Ways and Means and Committee on Energy and Commerce

Jim and Bill were in a psych hospital. The doctors had devised a surefire test to determine if a patient was ready for discharge. They were asked two questions and if they answered correctly, they were deemed cured and free to go.

Jim was called into the doctor's office first and asked if he understood that he'd be discharged if he answered the questions correctly. The doctor said, "Jim, what would happen if I poked out one of your eyes?" Jim said, "I'd be half blind." "That's correct. What would happen if I poked out both your eyes?" "I'd be completely blind." The doctor stood up, shook his hand, and told him he could leave the hospital.

On Jim's way out, as the doctor filled out the paperwork, Jim mentioned the questions to Bill. He told him what questions would be asked and the answers. Bill was called in. The doctor went through the formalities and asked, "What would happen if I cut off one of your ears?" Bill, remembering what Jim had told him, said, "I'd be half blind." The doctor looked a little puzzled, but went on. "What would happen if I cut off both your ears?" "I'd be completely blind." "Bill, how can you explain that you'd be blind?" asked the doctor. "Well," replied Bill, "my hat would fall over my eyes."

Editorial staff
Editor:
Janis Price
Associate Editors:
Radmila Bogdanich
David Peterson, FACMPE
Pat Sanders Romano
Hank Williams

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