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The GrAAPvine

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Administrators in Academic Psychiatry

From the president's desk

by Steve Blanchard

The lawn mowing chores are almost finished for this season. It is now time to tune up the snow blower and make sure it is ready to run on those cold mornings featuring twelve inches of new white stuff.

The fall meeting in Sacramento is now complete. Thanks again to President-Elect **Hank Williams** (U Washington) and Member-at-Large **Narri Shahrokh** (U California-Davis) for their efforts in putting together one of our best educational conferences ever. A special thanks to the faculty of UC Davis who provided interesting presentations and challenged us with new thoughts about our business and services. It was great to see so many (twelve) first time attendees among the 40 members gathered at the Embassy Suites. I certainly hope that you will come back for other meetings. The network fostered by AAP continues to grow and flourish. Once again thanks to Hank and Narri for a terrific conference in every way.

This fall has seen the passage of a Federal mental health parity law. Mental health parity has been under consideration by Congress for many years. The primary authors of this legislation were the late Senator Paul Wellstone (D-MN) and Senator Peter Domenici (R-NM). The legislation was attached to the Emergency Economic Stabilization Act of 2008. The law became effective on October 3, 2009. It will most likely be reflected in health plans with renewals occurring in January 2010. The goal is to publish regulations by the second or third quarter of FY 2009 in order to allow companies to adjust their health plans. We will all want to review the rules and regulations for this legislation as they are published.

During the Fall Board of Directors meeting for AAP, **Tom Tantillo** (Children's Hospital of Philadelphia), Treasurer, reported that AAP is now incorporated. The Board further instructed Tom

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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:

Nirmala Beharry
Albert Einstein School of
Medicine of Yeshiva University
(718) 904-4491
nbeharry@aecom.yu.edu

Christine Fitts
Dartmouth College
(603) 650-6404
christine.a.fitts@dartmouth.edu

Kathy Lelevier
University of California - Davis
(916) 703-0250
kmlelevier@ucdavis.edu

Elizabeth Madson
University of Minnesota
(612) 273-9820
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Jim Myers
University of Washington
Seattle Children's Hospital
(206) 987-3393
jim.myers@seattlechildrens.org

Brenda Rongkawit
University of Kansas
(316) 293-2638
brongkawit@kumc.edu

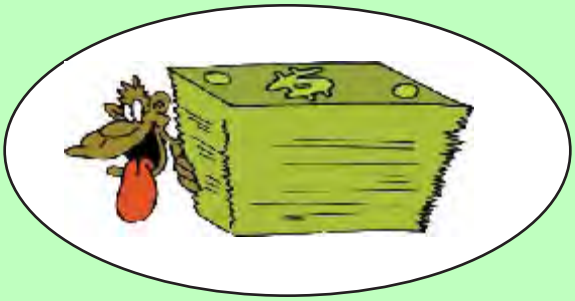
Phillip Thompson
University of Colorado - Denver
(720) 777-3050
thompson.phillip@tchden.org

Jennifer Walsh
Weill Cornell Medical College
(212) 746-3315
jaw2015@med.cornell.edu

AAP wishes the best of luck to the following former members:

Susan Cambria (Dartmouth College)
Diane Carugati (Temple U)
Carley Holland (Vanderbilt U)
Roxanne Morganthaler (U Washington)
Jim Puricelli (Loyola U Chicago)

Dues notices are coming.

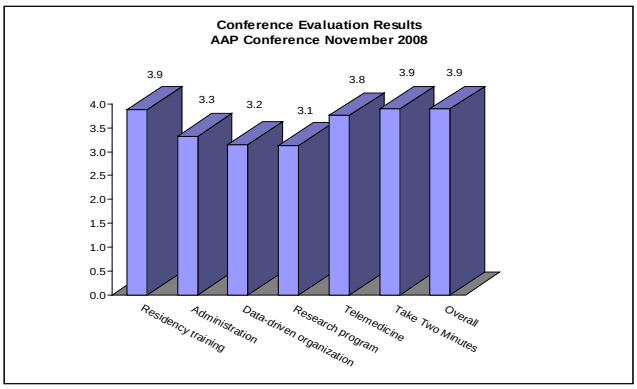


Watch your email.

First timers comment on the conference

This November saw our biggest contingent of new members and first time attendees at an AAP conference (see photo page 4). The members of the Education Committee work hard during the year to prepare two programs worthy of the valuable time of our members, and feel a special responsibility to make first timers feel welcome and valued and to feel that their time was well spent. We asked these members to write a few comments on their evaluations or send them later. Here are what a few of them said:

- As a first time attendee, I found the conference to be very educational. I enjoyed learning about everyone's different issues and perspectives. The group is very friendly and made me feel welcome.
- As a first time attendee, I was impressed with all the AAP members and the content of the conference. I think the conference presentations were very relevant and the overall planning was great! Contacts I have made will be very beneficial to me in my position. DON'T CHANGE ANYTHING!
- First time participating and thought it is a great group to belong to. Planning on future attendance.
- As a first time attendee, I look forward to the spring conference. Great venue for sharing ideas with colleagues who are dealing with similar issues.
- I thought the conference was the most useful conference that I have ever attended. I came away with several ideas to explore and many valuable contacts. I have been to other conferences that, even with networking events, I left feeling like I didn't know anyone. At this conference people went out of their way to welcome new people.



- Being new to Psychiatry and the School of Medicine I had hoped to join an organization that would be a good resource and provide information relative to my position and the department. AAP has proven to be an incredible resource for relevant information. I had not previously attended an AAP conference prior to Sacramento and wasn't sure what to expect, but I was impressed with the thoughtful planning that made the entire conference a success. The conference "buddy" program provides a great introduction to the conference and my "buddy" made me feel welcome right from the start. I found the presentations at the Fall conference to be very beneficial and the AAP members to be a welcoming, fun and knowledgeable group. I know there is much more I can learn from AAP members and I don't plan to miss another conference in the future!
- As a first-time attendee of an AAP conference, I must say that I enjoyed meeting everyone (putting faces to e-mails). The welcoming dinner was really nice and provided a great environment to chat with other attendees (did I mention that I crashed the dinner as I forgot to register ahead of time!). The presentations were well done and organized, especially enjoyed the Telemedicine and Telepsychiatry and Data Driven Organization presentations. I appreciate the hospitality and collegiality of peers and realize that we have many common psych administrative and operational issues (even though I am based at a public safety-net hospital). Look forward to hosting you next Fall in the Mile High City (that would be Denver)!

Awards presented to deserving members

Each year, Administrators in Academic Psychiatry recognizes outstanding service to the organization by presenting several awards. Although generally presented at the Spring meeting, this year two members were awarded certificates at the fall meeting in Sacramento, California.

The Rising Star Award, given to a member who has made a contribution by serving on a committee, writing an article for the newsletter, or in some other way participating in the operation of AAP, was presented to **Dwayne Clayton** (Louisiana State U) for his support to new members.

Dan Hogge (U Utah), whose award was announced in the spring but was not present to accept it, received the Board of Directors Award. This award is given to acknowledge a significant current contribution to the organization made by a member. Dan led the planning of last year's fall conference in Deer Valley, Utah, from finding a beautiful location, arranging speakers, selecting menus and restaurants, and even keeping the weather beautiful!

Congratulations to both deserving recipients!

A bumper crop of new members and first time attendees

Front row: Nirmala Biharry, Annemarie Lucas, Brenda Ronkawit, Andrea LeClaire, Kathy Lelevier, Bronson Troyer, Mario Harding
Back row: Jim Myers, Edie Bamberger, Ruth Irwin, Randolph Siwabessy, Michael Cull

Norman MacLeod Lecture

Secrets to running a successful residency training program

by Pat Sanders Romano

This year the attendees at the AAP Fall Conference were treated to a dynamic MacLeod Lecture by Mark Servis, MD, Professor and Vice Chair for Education and the Roy T. Brophy Endowed Chair at the UC Davis Department of Psychiatry and Behavioral Sciences. His impressive credentials include nineteen years as the training director for the department's general psychiatry residency training program. His research interests include psychiatric aspects of bariatric surgery and neurological disorders, personality disorders, medicine and spirituality, administrative psychiatry, psychiatric consultation to primary care, faculty development, and undergraduate and graduate medical education. Dr. Servis has been honored with numerous teaching and mentoring awards both locally and nationally, and he has served as President of the American Association of Directors of Psychiatric Residency Training.

When Dr. Servis began his career at UCD, the training program was on probation. Having been "through the wars" (and won) he graciously shared with us his seven secrets to building and running a successful residency program.

Secret # 1: *Recruitment* is the single most important activity in residency education. A residency program will only be as good as the quality of its residents. If the recruits are good, everything else naturally follows. To assist with internal recruitment, the departmental development of a medical student interest

group, PsychSIG, allows the institution to nurture and facilitate recruitment of their "own". Audition Electives attract 4th year students from other schools, departments do well to offer these electives to attract and screen good students. ERAS provides a streamlined way to get the information you need about applicants. The challenge is in filtering, since a typical medical student applies to 15 to 20 programs. UC Davis is cautious when screening IMGs as they feel they do not have the same assurance of quality from the pool, they will only interview IMGs that they know. The Interview Day is the crux of recruitment, both to attract the best applicants and to determine their suitability. Dr. Servis recommends putting a great deal of effort and faculty involvement in the day, and also notes that applicants take a hard look at the current residents. To ensure that the residents selected are going to be happy and thrive, the selection process should include a selection committee consisting of half faculty and half current residents, all with an equal vote, because residents have important insight. The final step, the National Resident Match Program, prevents institutions from "working out a deal" with applicants.

Secret # 2: *Problem residents* consume time, energy, emotion and destroy department morale. Departments do well to prepare for difficulty by having very explicit competencies and objectives and need to pay careful attention when requirements are not met. Early identification, based upon explicit requirements is key - waiting until the 2 or 3rd year is not advisable. Following the institutional due process policy completely should lessen the chances of court challenges, as most challenges succeed when due process is ignored.

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The program faculty must play multiple roles: head coach, trainer, referee and cheerleader to the problem resident. The Program Director should never be the cheerleader, but should be the head coach. Finally, the department should have the courage to act. There is a correlation between problem residents and problem physicians in the community. It is better, according to Dr. Servis, to have an empty slot than a problem resident.

Secret # 3: The *Training Office* is the engine behind the enterprise. A good program coordinator, one who is in charge of all of the office activities, makes the program look good. Web-based and high technology tools should be used whenever possible. The Training Office staff should be able to develop appropriate relationships with faculty, residents and students. The staff needs to be flexible, adaptive, and tolerant; they should almost assume a parental role with residents. Boundary issues need to be adhered to, as it is not advisable for the staff to want to be "like one of them." Coordinators should be encouraged to join and participate in the organization Training Administrators for Continuing Medical Education and to strive to become certified.

Secret #4: To build a stable and secure organization, *funding and affiliation* are key. GME funding is a major and current political issue that will require attention and political activism. The development of partners for the program on the county, state, VA and community level is vital. And once the partnerships are formed, building and maintaining affiliations should be a priority. Regular communication facilitated through an identifiable liaison person, who is funded by the program and the affiliation will lead to continued success.

Secret # 5: The *external accountability process* should never be neglected. The Accreditation Council for Graduate Medical Education (ACGME) and Residency Review Committee (RRC) evaluate and accredit programs. They are focused on core competencies; the results of online resident surveys (ACGME expects 90% return rate, less than that will trigger a site visit); duty hours (medicine rotations are often the cause); the Program Information Form (PIF) which all faculty and residents should be familiar with; and a site visit. American Board of Psychiatry and Neurology certification of program graduates is a criterion for RRC/ACGME accreditation. Residents will have to pass three live Clinical Skills Verification (CSV) exams in order to be Board Eligible. It is suggested that residents take the CSVs at the end of their PGY 1 year, the end of the PGY 2 year and the beginning of the PGY 3 year. (For more information on this new requirement see http://www.aadprt.org/training/clinical_skills_assessment.aspx). The PRITE is a written exam given each year of residency which proves to be the single best experience for Part I. There will no longer be a Part II Board exam, the oral has been dropped and the exam is not entirely computer based, with online simulations.

Secret # 6: *Special events* celebrate the work that is being done and gives meaning. Orientation serves to bring the new resident into the larger program community and to welcome them. It is symbolically important. Graduation is a saying of "goodbye" and recognition of transformation. During the residency retreats, lunch meetings, mock boards, social events serve to provide peer support, to reduce stress and to foster independence.

Secret # 7: *Continuous Quality Improvement* is a work in progress. Residents have the best data, programs do well to learn from them what is working and what is not and what their ideas are for solutions. It is important to understand that there is no such thing as a perfect residency program. The CQI process should allow for formal and informal mechanisms for feedback. And, programs need to foster a culture of responsiveness and change. Residency training programs will be successful if the residents feel that they are stakeholders.

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

Psychiatry administration: What your college professors didn't tell you

By Glory Novak

An engaging session began with a show of hands – it was obvious that most of us didn't dream of becoming an administrator when pursuing our Bachelor's degree; many were not even business majors. So, how did we all end up as administrators in academic psychiatry?

AAP members **Radmila Bogdanich** (Southern Illinois U) and **Liz Smith** (Thomas Jefferson U) shared their thoughts on what it takes to be a good administrative leader, and with all due respect to our faculty – surprise! – leadership skills don't come from a college textbook.

Does technical expertise alone make one successful? Hardly. The highest attribute required of a good business leader is integrity (31%), according to Robert Hall Management Resources. Even without some of the technical college-course material, we can be successful by embracing environmental learning – mastering skills while "out there" in the real world. Along with some domain knowledge, essential characteristics of a strong administrator include the ability to form alliances; leadership and interpersonal skills; and relationship building with other departments, your practice plan, GME, and of course, the finance and human resource folks.

The importance of building strategic relationships can't be overstated. Radmila explained that a strong administrator needs stable alliances with the chair, faculty, staff and peers

across campus. Up flashes a slide of The Lone Ranger … most certainly not our desired leadership role model. "Even The Lone Ranger knew he

needed Tonto," Radmila added. The message? Make connections; don't try to go it alone.

What else did our college professors not tell us? The importance of establishing a good reputation, for one. This includes being consistent with principles and values, and maintaining that positive image over time. These positive actions in turn bring you credibility and respect as a leader.

Liz presented the concept of knowledge management. As administrative leaders, we need to be able to communicate effectively, offer and accept feedback, filter information, draw on pooled expertise, and be visionary in order to generate enthusiasm and buy-in. (Pssst: Gossip permeates our departments … why didn't they tell us about that in college?)

The session became even more interactive as we broke into small groups to discuss cases from our home institutions, identifying problems, key players, what interventions and skills were used, and outcomes. Throughout the group report-outs, we saw that the essential characteristics for success were not lessons we learned from a college professor, but by working to hone skills in a "real world" setting.

In a session sprinkled with first hand expertise from Liz and Radmila, we were able to reflect on those skills and attributes that allow each of us to be successful at our institutions. Thanks to our AAP colleagues – who are not professors, but are excellent teachers – for a fun and interesting session.

(Glory Novak is the administrator of the University of Arizona department of Psychiatry).

Helping to build the patient-focused, data-driven organization

by Elaine McIntosh

Shaifali Ray, Senior Manager at Faculty Practice Solutions Center (FPSC) presented an overview of the organization. It's purpose is to provide an application of comparative data to inform performance improvement and revenue enhancement in academic departments of psychiatry. FPSC is supported by the University HealthSystem Consortium (UHC) and the Association of American Medical Colleges (AAMC). Eighty-four academic institutions participate nationwide by supplying practice data.

Since its creation in 2001, FPSC has been accumulating and refining data into meaningful information for member institutions. Information is provided by subspecialty and can be sliced and diced to meet the end users needs. The benefits and value that FPSC hopes to provide with its online service is statistically rigorous benchmark data on academic clinical practices, comprehensive analyses on critical areas of focus, practical tools to help achieve performance goals, best practice case studies and opportunity alerts, networking opportunities with over five thousand FPSC users, and access to additional resources for custom analyses and consultation to meet your specific needs. Shaifali has offered to assist individual administrators with crunching data for their specific needs and can be contacted via her email address, ray@uhc.edu.

Participating institutions electronically extract and send physician-level billing data to FPSC. Data types that are submitted from institutions are total billings for each procedure, site of service for each procedure, CPT code for the procedure, payer class for each procedure, CPT code modifiers, ICD-9 codes utilized,

frequency of billed procedure, and patient demographic information. RVU data is applied after the data submission is collected from members to insure consistency in RVU application. FPSC applies a multi-stage validation process to all data to ensure data integrity. The conference attendees participated in a discussion of the validity of the information produced by FPSC and the group was in general agreement that flaws in the end product were more frequently created by the type of data that member institutions were providing rather than FPSC processes.

The question was raised as to what benchmarking measures FPSC provides. There are multiple benchmarking measures provided by FPSC: Work RVUs, total RVUs, billed units per clinical FTE, evaluation and management (E&M) coding distribution, scope and mix of services, charge lag analysis, charges by CPT code, denial rates, collection rates, and other revenue cycle indicators, and custom peer cohort benchmarking. The benefit of the FPSC benchmarking data over other benchmarking sources is that the data set is comprised of faculty physicians, it covers the broad scope of specialties, there is a consistent methodology in RVU calculation, the use of individual MD detail allows for the exclusion of outliers and analysis of coding behaviors, and feedback and refinement through direct communication with members.

The information that FPSC provides can be used in setting appropriate expectations for and measuring faculty clinical activity. The information can also play a role in managing compliance activities to ensure that coding is consistent with the services provided. The management of revenue cycle activities can be aided with the FPSC data by identifying and correcting areas of undercoding, minimizing charge lag, understanding charge profile, measuring timeliness of collections, monitoring denials by type and reason, and identifying underpaid items. As a resource FPSC also provides information on external forces and their impact on our academic practices.

For additional information, you can access the FPSC website at http://www.facultypractice.org. *(Elaine McIntosh is the administrator of the University of Nebraska department of psychiatry).*

Build it and they will come:

Developing a community-based clinical and translational research program at UC Davis

by Dan Hogge

Dr. Cameron Carter, Professor and Director of the UC Davis Imaging Research Center, provided a great overview of the achievements that have been made in translational neuroscience. The map for building a comprehensive research program in translational neuroscience can be defined as a path taking a comprehensive research program from the proverbial "bench to the beside."

1. "The Bench" - Basic molecular, cellular and systems of neuroscience and neuropharmacology.
2. Behavioral, noninvasive and invasive studies of normal and disordered cognitive and emotional processing in animal models.
3. Behavioral and neuroimaging studies of normal and disordered cognitive and emotional processing in humans.
4. "The Bedside" - Clinical Trials targeting symptoms and deficits.

As the program has grown, key relationships are needed to enhance and maintain the momentum of the research program in a dedicated 6,000 square foot research center. Collaboration occurs between the MIND Institute, the Center for Neuroscience, the Alzheimer Center, and the Clinical and Translational Science Center.

Research space is shared as they move their research forward.

One of the key clinics that has evolved from this translational research program is the EDAPT (Early Diagnosis and Preventative Treatment) Clinic of Psychotic Illness. The rationale for this clinic is based on the claim that an untreated psychosis is associated with poor outcomes and that an early intervention leads to a robust treatment response with an improved functional outcome. The highly skilled professional team strives to target two types of populations:

- Early psychosis or "first episode" patients (regardless of the ability to pay)
- Ultra High risk patients.

A key relationship needed to maintain the strength of the program has been between the Department of Psychiatry and the Sacramento County Mental Health System. The department provides qualified and skilled faculty and a sense of good will to the community in this collaborative effort.

As a conclusion to his presentation Dr. Carter discussed the unique qualities each of the faculty bring to the clinic and how they work with the patients in specific areas of attention, language, memory, and the patient's emotional processing.

A natural sequence to building a program includes a good business plan, constructing an excellent team, and the desire to work hard, have fun, and to make a difference in the lives of the good citizens in your community.

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

Telemedicine and telepsychiatry: An overview of the clinical, administrative and sustainability issues

by Jeff Charlson

The AAPs in attendance in Sacramento were treated to a wonderful talk on telepsychiatry from Dr. Donald Hilty and Jana Katz-Bell, both of University of California - Davis. They discussed experiences gained from UC Davis' telemedicine network, which has grown to over 100 sites since its pilot program in 2002. Today, over thirty specialties use the network to distribute their consultation to primary care sites throughout the state. Psychiatry currently makes up 18% of their telemedicine mix.

Videoconferencing's technological barriers have diminished over the past several years due to the build out of high speed internet utilities. It is a useful tool for clinical care, education, meetings, and research. However, many challenges beyond the technological remain in choosing how and which services to provide. UC Davis mostly provides interactions for primary care consultation, and feels that the benefits of this model are to provide not only patient care,

but also to build confidence and skills in psychiatric management for the primary care provider. Patients seem to readily accept telemedicine treatment. Although it is not necessary for the first visit to be face-to-face, it may be helpful if

your future service will be more management than consultation.

Ms. Katz-Bell amplified many of Dr. Hilty's concepts and moved the presentation toward how to organize these concepts and elements into a program. She felt that a telemedicine program would have the greatest chance of success in organizations that have a strong culture of outreach and closely parallel the organization's goals. Most successful clinical leaders are those who have a passion for clinical outreach and who can later learn the technical side, and are not necessarily the best 'techies' of the medical group. Among the many other tips Ms. Katz-Bell shared with the group, she frequently stressed the importance of hiring a dedicated program coordinator, and deemed them the "Hero" of the program.

She shared a few video vignettes used for training providers and for lobbying legislators. A host of legal, regulatory, and financial issues were discussed. Many of the relevant laws and regulations vary across state lines, so it is important to clarify your institution's specific situation. The American Telemedicine Association and the Center for e-Health Law were suggested as good follow-up resources.

(Jeff Charlson is the administrator of the University of Wisconsin department of psychiatry).

Take Two Minutes

Following are excerpted questions from this popular session.

How are you managing revenue from pharmaceutical companies for speaking /consulting engagements? Are you running through the department and/or institution versus direct payment to the faculty member?

Marti Sale (U Kentucky) – It depends on whether they did it on their own time. If they have taken vacation, then faculty retain the funds. If not on their own time the revenue goes to the dept.

Jim Landry (Tulane U) – Faculty retain the first $20,000; after that they turn it into institution.

Sara Thomas (U New Mexico) – Some faculty have made special arrangements with the Dean whereby they send the money to the SOM and funds are used to build retirement.

Steve Blanchard (UIowa) - A draft policy is under review which will allow faculty to retain $10,000 and the rest goes to the institution.

Radmila Bogdanich (Southern Illinois U) – Faculty can take vacation time and keep revenue. If not on vacation time they can donate to the department's foundation. Special arrangements exist to use professional time. Under those circumstances, a contract is initiated that allows faculty to retain 20% of revenue.

Narri Shahrokh (U California -Davis) - Their compensation plan allows two options. Faculty can keep a maximum of $20,000 and turn in the rest or retain 100% of the honorarium if done on their own time. If the service is more of a consulting role, the income is run thru the department and revenue can be paid as salary or paid out as a bonus at the end of the year.

Deb Pearlman (Yale U) - Faculty are allowed to consult one day of seven and they keep they money. COI forms are completed annually. No monitoring or tracking is done centrally. She anticipates this process will change due to increased scrutiny.

Elaine McIntosh (U Nebraska) - Faculty are allowed 2 day per month to do consulting. They complete a from to disclose COI and compensation has to be approved by the Chair and approved by the Dean

Does anyone have an incentive plan for staff?

Ellen Francis (U Oklahoma) - They have an incentive plan that is based on Press Ganey result benchmarks, telephone monitoring, abandoned call rates and registration accuracy. Departments are measured and if exceed the bar staff get a percentage of payroll. Incentives are paid every 6 months.

Jan Price (U Michigan) - Have an up to $500 lump sum payment for performance over and above which can be paid at any time to recognize the employee. They don't require but encourage staff to take an educational program every year (Ex: power point, advanced excel)

Sara Thomas (U New Mexico) - They permit one conference a year if productivity is good for professional staff; for administrative staff an appropriate meeting is permitted.

Marika Brigham (U Florida) - Universities aren't allowing payment to staff; in previous years they could pay extra for bonus, etc.. but last 2 years not allowed to do anything outside of promotion or annual merit review.

Kathy Levelier (U California - Davis) - Managers participate with bonus plan based on how well the system

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does; can give $250 on the spot awards and above with different justification, promote development in training; can give gifts of $10-$50 any time.

Steve Blanchard - Only $75 per person; not more than 3 gift cards which must be tracked; Can hold back 1% of annual review $ and give throughout

Marti Sale - In January, going to gift cards;

Pat Sanders Romano (Albert Einstein COM) - Due to being a union facility, there is very little they can do regarding incentive; They do promote educational opportunities

For those of you who use residents and fellows, how do you set and manage productivity of residents?

Toni Ansley (Ohio State U) - There were major issues with PGY3's because their rotation is all clinic experience; they generate revenue and complained that they were money generators vs there for education. In the early part of Spring started to block schedule education sessions and have a different supervisor; They start out with a 200 patient case load (28 hours/week made available) and may end up with 250 but only seeing patients about 60% with no shows, etc…

Sara Thomas - They went thru huge curriculum changes to resolve problems/complaints; trying to convey message to leadership and anyone that interacts with them.

Narri Shahrokh - UC Davis doesn't use caseload as a measure; 3rd year residents are 100% clinic but have didactics on Monday afternoon and Wednesday morning. The residents do groups at another facility so half day for travel, etc. Some of them teach so if they do, they are out of clinic; on average, they are scheduled for 24 hours but out of that they have 3 hours of weekly supervision and 30 minutes of administrative time for every 4 hours in the clinic.

***P**arity law that just passed; how will that impact us?*

Steve Blanchard - The program will begin January 2009; anticipates it will hit most plans in January 2010. Like a lot of changes; if the policy states it is going to cover 365 days it doesn't mean 365 will be covered; it will still requires authorization and will still have carve outs

Pat Sanders Romano - States her understanding is that it is only for plans that currently cover mental health; and suspects that plans will opt out of providing mental health services.

Narri Shahrokh - In 2000 California went to parity so all plans carved out to others and providers didn't see difference in volume or change in the process

Thomas Tantillo thinks it needs to be clear that just because they carve it out, the benefit is set by the insurer who sets the plan limits

If you have physicians who are dedicated to inpatient services., are you paying more for them than outpatient faculty?

Marti Sale - Hospitalist go to outpatient after a few years and then the department is stuck with higher salary

Andrea LeClaire (The Children's Hospital University of Denver) - Don't pay differently but they do inpatient and day treatment and over time some want to go to outpatient. Have struggled with recruitment

Jan Price -Pay hospitalists more money and child even more; they are required to do inpatient, consultation-liaison, and cover the psych emergency service

Thomas Tantillo -They pay 40K more for child docs an average salary of 175K

Sarah Thomas- Are paying base salary plus supplement

Gloria Dunne (U Chicago) - Inpatient faculty receive $75,000 minimum additional salary; recently approved new salary structure; and are paying more for board certification.

Glitz and complexity

by David Peterson, FACMPE

Wandering through the exhibit hall at any annual MGMA conference is like wandering through a free-air market, with vendors, exhibitors and displays flashing at every passerby, hawking the benefits of their wares. The experience offers a glitzy potpourri of sights and sounds. MGMA's meeting in San Diego was no different, except there seemed to be several hundred exhibitors representing their products with a heightened degree of enthusiasm, perhaps the result of a turbulent economy.

The majority of the exhibitors focused on selling some type of tool to manage the revenue cycle, electronic medical records, meet financial challenges, track money and risk, and, there's always a head hunter or two.

These management tools for sale are not easy systems to understand, adopt, buy or lease, and the benefits (hopefully) from the product(s) usually occur after a significant amount of time and money and human resources are invested. Evaluating these systems and products, understanding the level of connectivity required, making informed decisions and balancing the risk/reward of each against the backdrop of a competitive marketplace, regulation, compliance, tight funding and the needs of multiple stakeholders requires a complex skill set. Beneath the exhibitor glitz is an increasingly complex world of medical practice management.

"Complexity in leadership models" was the topic of one of the breakout sessions at this year's annual conference and was delivered by Mr. Alan Winkler, MHSA, FACMPE (Vice President, Clinic Operations, St. Vincent Hospital, Little Rock, AR). It seems that "complexity theory" has been used by a number of large businesses, organizations and governments to "lead complex systems involving large numbers of interacting … interactions that are nonlinear, sometimes illogical and can produce major consequences." Complex systems are affected "by external conditions and systems that constantly change."[1]

Sound familiar?

There are four different levels of situational complexity: simple, complicated, complex and chaotic. Each situation has its own identifiable characteristics and each situation responds to different styles of leadership ranging from delegated styles to rigid command and control. On one end of the continuum, a "Simple" environment responds to leadership styles of delegation and management by exception where at the other end of the continuum, a "Chaotic" environment responds best to an authoritative command and control style of management. "Complicated" and "Complex" environments fall in between, responding best to leadership styles that combine elements of both delegation and command combined with the time to study, analyze and incorporate stakeholder buy-in.

Academic departments of psychiatry (as do other academic departments) present leadership challenges ranging form the simple to the chaotic. Administrators who can recognize these different types of challenges and respond with the most effective leadership style have the highest probability of success. To be sure, leadership situations are rarely black and white and this fact alone lends another degree of complexity to any leadership challenge. The **American College of Medical Practice Executives** offers a variety of continuing education and networking opportunities, including a board certification process, that help administrators build the skill sets necessary to succeed in complex environments.

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.

Endnotes

1 "Complexity in Leadership Models," Alan D. Winkler, MHSA, FACMPE, MGMA presentation, October 20, 2008.

Not much new with funding at National Institutes of Mental Health

by Hank Williams

What is currently happening with NIMH funding of new and competing grants in FY09? Not so much.

Although the agency has no final FY09 budget, NIMH plans to continue the FY08 funding policy of supporting grants below the 20th percentile, with priority based on 1) Institute and division priorities, 2) balance in the existing research portfolio and 3) new investigator status.

In FY08 NIMH was able to support 581 new and competing grants and 95 new R01 investigators.

Projections for FY09 show support for far fewer new and competing grants, perhaps as few as 450 new research project grants (R series grants) and less than 90 new R01 investigators.

NIMH remains hopeful that these numbers may improve with careful management of the appropriated funds, but expect a year when several outstanding grants under the 20th percentile will not be funded.

NIMH Continues Its Strategic Plan

NIMH priorities used to make funding decisions are heavily influenced by its new Strategic Plan, which will serve as a guide to the Institute for advancing mental health science over the next five years. The plan describes four main strategic objectives:

- Promoting discovery in the brain and behavioral sciences to fuel research on the causes of mental disorders
- Charting mental illness trajectories to determine when, where, and how to intervene
- Developing new and better interventions for mental disorders that incorporate the diverse needs and circumstances of people with mental illness
- Strengthening the public health impact of NIMH-supported research.

The Plan identifies a number of areas, from fundamental discovery to translational research to implementation science, which will be the goals for future investments. In December, NIMH will begin planning initiatives for FY10 that are closely aligned with the Strategic Plan.

Update on Electronic Submission of Grant Applications

NIH has updated its transition schedule to Adobe-based grant application forms for electronic submissions of SF424 Research and Related (R&R) applications

Most electronic submissions to NIH must use Adobe application forms starting with the January 25, 2009 receipt date, with a few exceptions. As NIH waits to incorporate the latest updates to the Adobe forms by December 2008, there are two critical points applicants need be aware of:

- New funding announcements (FOAs) that were released after September 1, 2008, will not have Adobe application forms for downloading until December 2008.
- Existing FOAs that were released prior to September 1, 2008, will have PureEdge application forms that will remain active and available until they are replaced by Adobe forms in the December time frame (with the exception of small business and conference grants which will have new Adobe forms in February 2009). However, do not wait for the Adobe forms to become available to work on your application — you can

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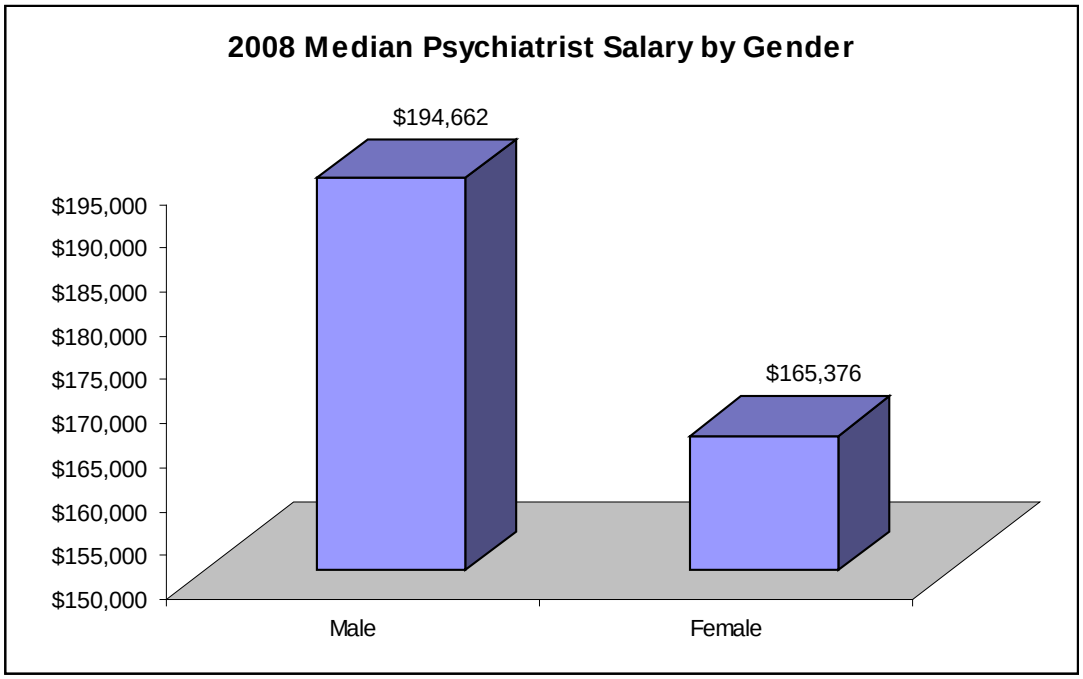
develop your research plan components and required application attachments now, then add them to the new Adobe forms in December when they are available.

There are only two versions of Adobe Reader that Grants.gov currently recommends for use with the new application forms — version 8.1.2 and version 9.0 (the versions may change, stay tuned to Grants.gov's Download Software page for details). Both are available for free download at Grants.gov. Earlier versions of Adobe Reader will not be accepted by the system.

If you share your application forms with other individuals or get subcontract forms from other institutions and they open the forms or send in forms in an older version of Adobe, this will likely create problems for a successful submission, so make sure that any individual accessing the forms opens them in the workable versions of Adobe.

PSYCHIATRY BY THE NUMBERS

2008 median psychiatrist salary by gender



Source: *LocumTenens.com 2008 Compensation and Employment Survey — Psychiatry*

CMS issues ICD-10 fact sheet

The international classification of Diseases, 10th edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) could enhance accurate payment for services rendered and facilitate evaluation of medical processes and outcomes. A number of other countries have already moved to ICD-10, including: United Kingdom (1995); France (1997); Australia (1998) Germany (2000) and Canada (2001). The new classification system provides significant improvements through greater detailed information and the ability to expand in order to capture additional advancements in clinical medicine.

ICD-10-CM/PCS consists of two parts: ICD-10-CM – diagnosis classification system developed by the Centers for Disease Control and Prevention for use in all U S. health care treatment settings. Diagnosis coding under this system uses a different number of digits and some other changes, but the format is very much the same as ICD-9-CM; and ICD-10-PCS – The procedure classification system developed by the Centers for Medicare & Medicaid Services (CMS) for use in the U S. or inpatient hospital settings ONLY. The new procedure coding system uses 7 alpha or numeric digits while the ICD-9-CM coding system uses 3 or 4 numeric digits.

The current system, International Classification of Diseases, 9th Edition, Clinical Modification (ICD 9-CM), does not provide the necessary detail on either patients' medical conditions or on procedures performed on hospitalized patients. ICD-9-CM is 30 years old, has outdated and obsolete terminology, uses outdated codes that produce inaccurate and limited data and is inconsistent with current medical practice. It cannot accurately describe the diagnoses and inpatient procedures of care delivered in the 21st century.

ICD-10 CM/PCS incorporates much greater specificity and clinical information, which results in: Improved ability to measure health care services;

- Increased sensitivity when refining grouping and reimbursement methodologies;
- Enhanced ability to conduct public health surveillance; and
- Decreased need to include supporting documentation with claims;

ICD-10-CM/PCS includes updated medical terminology and classification of diseases; provides codes to allow comparison of mortality and morbidity data; and provides better data for:

- Measuring care furnished to patients;
- Designing payment systems;
- Processing claims;
- Making clinical decisions; Tracking public health;
- Identifying use and abuse; and
- Conducting research

ICD-10-CM/PCS would not affect physician , outpatient facilities, and hospital outpatient departments' usage of Current Procedural Terminology (CPT codes) on Medicare fee-for-service claims as CPT would continue.

	ICD-9-CM	***ICD-10-CM***	***ICD-10-PCS***
Diagnosis codes	• 3-5 digits • First digit is alpha (E or V) • Digits 2-5 are numeric	• 3-7 digits • Digit 1 is alpha • Digits 2 and 3 are numeric • Digits 4-7 are alpha or numeric (alpha digits are not case sensitive)	
Procedure codes	• 3-4 digits • All digits are numeric		• 7 digits • Each digit either alpha or numeric (alpha digits are not case sensitive and letters O and I are not used to avoid confusion with numbers 0 and 1).

CMS to require authentication information for contacts with Medicare program

Beginning March 1, 2009, the Centers for Medicare & Medicaid Services will require that you authenticate provider information to complete calls using the Interactive Voice Response (IVR) system or with a customer service representative. Providers must supply three data elements:

- A National Provider Identifier (NPI);
- The Provider Transaction Access Number (PTAN); and
- The last five digits of the provider's your tax identification number (TIN).

Providers will be limited to three attempts to provide these three pieces of information correctly.

Historic improvements in mental health coverage

Recent congressional action blocked the impending 10.6% cut in the Medicare payment update for the rest of 2008 and for 2009, and made other changes in the payment formula. For the rest of 2008 and for 2009, psychiatrists will see a temporary 5% increase in payment for psychotherapy services provided in an inpatient, outpatient, office, partial hospital, or residential care setting, provided that the services are "insight oriented, behavior modifying, . . . supportive . . . or interactive psychotherapy."

More importantly, this bill provides that the most significant changes in Medicare coverage of treatment of mental illness since the program was founded more than 40 years ago are now the law of the land.

First, starting in 2010, the 50% coinsurance for outpatient mental health services will be reduced by 5% per year through 2013. In 2014 and thereafter, Medicare patients will pay the same 20% coinsurance for outpatient mental health services that they pay for all other care under Part B.

Second, effective January 1, 2013, Medicare Part D will pay for benzodiazepine and barbiturate prescriptions.

Third, effective with the date of enactment, Medicare law will include special protections to ensure that medically vulnerable patients will be assured access to "all or substantially all" of the medications they require, specifically including antidepressants and antipsychotics among other medications.

TMS approved by FDA for major depression

In the Health Journal column of the Wall Street Journal's (10/21/08), Melinda Beck writes that in transcranial magnetic stimulation (TMS), a treatment in which "a psychiatrist places a metal coil against your head . . . rapid magnetic pulses penetrate your scalp and skull and produce a mild electrical current in the left prefrontal cortex of your brain." A TMS treatment "lasts about 40 minutes, and is done daily for four to six weeks." Patients who are "suffering from major depression . . . could start feeling better within a few weeks." According to psychiatrist Sarah Lisanby, M.D., of Columbia University, patients with depression have exhibited "improvement in mood, sleep, appetite, energy level, and a restoration of hopefulness and self-esteem."

The Associated Press (10/21/08) reports that the Food and Drug Administration "approved Neuronetics Inc.'s NeuroStar [TMS] therapy specifically for patients who had no relief from their first antidepressant." The agency "cleared the prescription-only NeuroStar based on data that found patients did modestly better when treated with TMS than when they unknowingly received a sham treatment that mimicked the magnet." According to "Dr. Philip Janicak, of Rush University Medical Center in Chicago, who helped lead the NeuroStar study, [TMS] is expected to cost $6,000 to $10,000, depending on how many treatments a patient needs."

(From memo by John Greden, MD, Executive Director, University of Michigan Depression Center, October 21, 2008).

CMS issues Medicare enrollment changes

The final 2009 Medicare physician fee schedule includes a number of changes that will have a detrimental effect on medical practices and practitioners' ability to enroll in the Medicare program. Most significantly, beginning on January 1, the Centers for Medicare & Medicaid Services (CMS) will limit the ability of practices to retroactively bill for services provided to Medicare patients by defining the effective date for billing privileges for practitioners and medical practices as the later of:

- The filing date of a Medicare enrollment application that was subsequently approved by a Medicare contractor; or
- The date an enrolled physician or nonphysician practitioner began furnishing services at a new practice location.

CMS has provided for limited circumstances in which medical practices and practitioners will be able to retroactively bill for services provided prior to the effective date.

To further complicate the enrollment situation, the agency will now instruct contractors to deny applications that are not completed correctly instead of rejecting them. Denied applications can only be reopened if they are appealed. Practices and practitioners have a limited time in which they can file an appeal. Denial notices from Medicare contractors should clearly indicate this time limitation and appeal requirements.

Coming attractions

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

Durbin introduces bill to improve mental health services on college campuses

Competitive grant program would fund college counseling center outreach and student treatment

[WASHINGTON, D.C.] – U.S. Senator Dick Durbin introduced legislation on July 23, 2008 to improve mental health services on college campuses. The Mental Health on Campus Improvement Act creates a competitive grant program that would provide funding to colleges to focus on both outreach to identify students with mental health needs and treatment of students coming to counseling centers for help.

"The shootings at Northern Illinois University and Virginia Tech focused national attention on college campuses and the challenges of identifying students who need mental health services," said Durbin. "Colleges are encountering students who 10 to 20 years ago would not have been able to attend school because of mental illness, but who can do so today because of advances in treatment. Unfortunately today, there is very little federal help available for colleges to expand their mental health services and outreach programs. My legislation seeks to change that."

The International Association of Counseling Services recommends counselor to student ratios of 1 to 1,000 – 1,500. The average ratio on campuses in the United States is growing, with an average of only one counselor for every 2,000 students. In fact, several Illinois colleges and universities report dramatically high ratios of full-time employees to students. At the same time, incidents of mental illness among students are reaching new heights with ten percent of college students having contemplated suicide and forty-five percent having felt so depressed they found it difficult to function.

Durbin's legislation would ensure that colleges and universities have the resources and support they need to add personnel and aid students at a vulnerable time in their development by:

- Establishing a grant program within the Department of Education to assist colleges and universities in providing direct mental health services and outreach to students, families, and staff to increase awareness of mental health issues. The funds may also be used to hire staff and expand mental health training opportunities.
- Calling on the Centers for Disease Control and Prevention to create a public health awareness campaign around mental health and to reduce the stigma associated with mental illness for students. CDC would be required to seek input from national mental and behavioral health organizations and colleges and universities.
- Providing federal leadership by establishing an interagency working group on college mental health to discuss mental and behavioral health concerns and promote federal agency collaboration to support innovations in mental health services and supports for students on college and university campuses.

The Mental Health on Campus Improvement Act has the support of the following national organizations: the National Association of State Universities and Land Grant Colleges, the National Council for Community Behavioral Healthcare, the National Association of Independent Colleges and Universities, the American Association of Community Colleges, the American Psychological Association, the Bazelon Center for Mental Health Law, Mental Health America, the American Council on Education, the Depression and Bipolar Support Alliance and the American Counseling Association. It has been referred to the Committee on Health, Education, Labor, and Pensions.

Contact: Christina Mulka Christina_mulka@durbin.senate.gov 202-228-5643

President's desk (continued)

Continued from page 1

proceed with application to the Internal Revenue Service to designate AAP as a 501C(6) tax exempt organization. I want to thank Tom for his work in clarifying the organizational and legal structure of AAP during the past several months.

The status of the redesigned AAP web site was discussed. The Board agreed that an RFP should be issued to vendors to provide web design and hosting for our website. Several vendors have been identified for inclusion in the RFP process. There was also discussion of the dues structure for AAP. The dues have not increased for several years. In order to continue the activities of AAP, it was agreed by resolution that the membership dues for calendar year 2009 would increase to $125 per year. Waiver of membership dues in the first year will continue for new members.

The Spring Conference will take place in Los Angeles, California in April 2009. The conference will be held in conjunction with the Academic Practice Assembly Conference sponsored by the Medical Group Management Association. The AAP educational event will be held on Saturday, April 18, 2009. The Board of Directors will meet on Friday, April 17, 2009. Please mark your calendars and plan to attend the Spring Conference.

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

May your holidays be filled with the joy of the season and the love of family. . .

. . . and may your new year bring happiness and fulfillment.

What's new?

UNC School of Medicine establishes Carolina Institute for Developmental Disabilities

The University of North Carolina at Chapel Hill School of Medicine has established a new institute to advance research, training and treatment efforts aimed at aiding children and adults with developmental disabilities.

The new Carolina Institute for Developmental Disabilities (CIDD) brings together four existing programs on the UNC campus – the TEACCH Program (Treatment and Education for Autistic and Related Communication Handicapped Children); the Clinical Center for Development and Learning; the Family Support Network of North Carolina; and the Neurodevelopmental Disorders Research Center.

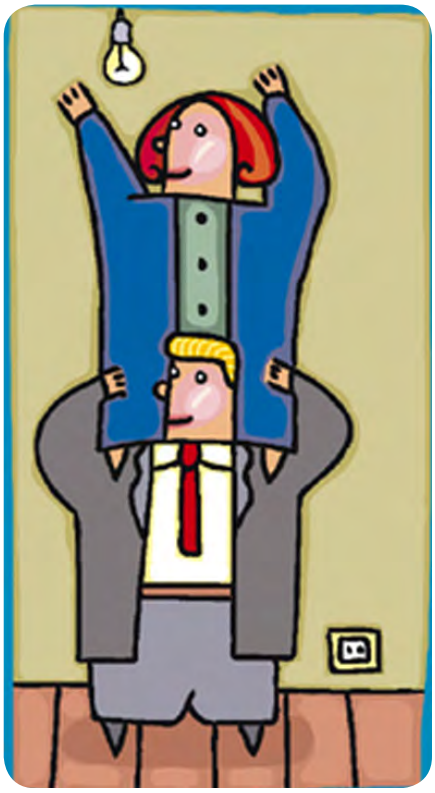
"I believe the formation of the Carolina Institute will substantially raise our ability to provide state-of-the-art treatment to individuals with developmental disabilities, conduct cutting-edge clinical and research training, and position UNC as one of the premier research programs in the country in the area of developmental disabilities," said the institute's founding director, Dr. Joseph Piven, Sarah Graham Kenan Professor of Psychiatry and Pediatrics in the School of Medicine and in the College of Arts and Sciences' psychology department.

The new institute will be one of the largest programs for developmental disabilities in the country and UNC's primary source for treatment, education and research in this field. Partnerships with organizations across the state to promote and develop education and treatment programs will be an integral part of the institute's mission. The institute will also provide important, state-of-the-art resources aimed at supporting North Carolinians with developmental disabilities and their families, and will promote research on the causes, development, effects and treatment of these conditions.

Other leaders of the institute include Jim Bodfish, Ph.D., professor of psychiatry and pediatrics, who has been named the new director of the Clinical Center for Development and Learning. Jeffry Low, a project director at the Clinical Center for Development and Learning, has been selected as the institute's deputy director, overseeing administrative aspects of the organization. Gary Mesibov, Ph.D., a professor in the medical school's psychiatry department and a psychology professor in the College of Arts and Sciences, and Irene Zipper, Ph.D., clinical professor in the School of Social Work and a fellow with the Frank Porter Graham Child Development Institute, will continue as directors of TEACCH and the Family Support Network, respectively. Plans for the new institute include relocation of the Clinical Center for Development and Learning to an 18,000 square foot building on a 5 acre campus 1.5 miles south of the UNC campus, which currently houses the TEACCH program. This is pending approval of building plans by the Town of Carrboro

Visit the institute's new Web site, http://www.cidd.unc.edu/ to learn more.

How many psychiatrists does it take to change a light bulb?



Just one, but it takes nine visits.

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

Publication deadlines

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

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