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The GrAAPvine

Inside this issue

Administrators in Academic Psychiatry

From the president's desk

by Narri Shahrokh

Soon it will be the beginning of a new year. I don't know about you, but this time of year always makes me more pensive. It's a time when I think about the past, the good things (and the bad) that have transpired through the year. It is also the time I start thinking of my new year's resolutions – and hope this is the year I manage to stick with them!

This year has seemed more hectic than any of the previous ones, but at the same time, it has been fulfilling. As the President of AAP, I feel blessed to have had the support of so many extraordinary people on the Board. They have worked hard to lead us into a benchmarking effort that, I believe, will be very useful to all of us, administrators and chairs alike. We could not have done this without the leadership and intense efforts of **Radmila Bogdanich** (Southern Illinois U), who kept us going through numerous weeks of teleconferencing and discussions.

Our President Elect, **Toni Ansley** (Ohio State U), and Member-at-Large for Education, **Mario Harding** (Denver Health MC), worked very hard, with incredible help from Vanderbilt's own **Pam Wesley,** to deliver what was, once again, a very stimulating and useful meeting.

Tony Bibbo (U Maryland) and **Beth Ambinder** (Johns Hopkins U) are now in the process of thoughtfully planning our Spring Conference, which will take place in Baltimore on April 28-29, 2011.

Registration information will be forthcoming in January, and I hope you will join us for what will certainly be another exciting opportunity to gather together, network (one of the best perks of our organization) and listen to exciting speakers. Always a member favorite, don't forget the "Take 2 Minutes" part of our meeting.

I would like to take this opportunity to wish you all a wonderful holiday season and a Happy New Year!

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:

Jared Abramson
U Miami
(305) 243-6400
jabramson@med.miami.edu

Bradley Cherry
Stanford U
(650) 723-5466
bcherry1@stanford.edu

Kary Green
Texas Tech U
(806) 743-2820
kary.green@ttuhsc.edu

Virginia Lewis
Northwestern U
vlewis1@nmff.org

Margaret Nelson
Loyola U Stritch SOM
(708) 216-2271
mnelson@lumc.edu

Brenda Paulsen
Duke U
(919) 684-5489
brenda.paulsen@duke.edu

Angela Wharton
East Carolina U
(252) 744-2038
moyea@ecu.edu

In sympathy

The Board of Directors and members of Administrators in Academic Psychiatry express our sincere sympathy to

Rich Erwin (U Missouri) on the loss of his mother,

Narri Shahrokh (UC Davis) on the recent loss of her father

and

David (Medical College of Wisconsin) and Ingrid Peterson on the recent death of her father

AAP named lectures

William J Newel Spring conference lecture

William J. Newel, first president of Administrators in Academic Psychiatry and the driving force behind the formation of AAP in 1985, was honored by the creation of an annual lectureship in his name in 1993. During his tenure as administrator of the Department of Psychiatry at the University of Wisconsin, Bill felt the need to exchange ideas with fellow administrators and to learn from others in the field who had information to share. Over a period of two years, from 1984 to 1985, he led a small group of colleagues in a discussion about the possibility of forming an organization of psychiatry administrators. He took it upon himself to organize the effort to contact people in administrative roles in psychiatry departments across the country to encourage them to attend an organizing meeting in Dallas in May 1985. That meeting resulted in the creation of a steering committee that met later in the year in Chicago to form what is now Administrators in Academic Psychiatry. At the inaugural meeting of AAP in West Palm Beach, Florida in 1986, Bill was elected its first president.

While there were several people who contributed significantly to AAP's formation, Bill's vision, leadership and enthusiasm led ultimately to the development of AAP into the active, successful organization it is today.

Anthony Reading, MD, Chair, Department of Psychiatry, University of South Florida

Mary Jane England, MD, President-Elect, American Psychiatric Association

Bennett Leventhal, MD, Chair, Department of Psychiatry, University of Chicago

James Randolph Hillard, MD, Chair, Department of Psychiatry, University of Cinncinati

Naleen Andrade, MD, Chair, Department of Psychiatry, University of Hawaii

Jerald Kay, MD, Chair, Department of Psychiatry, Wright State University

John Greden, MD, Chair, Department of Psychiatry, University of Michigan

Alan Gelenberg, MD, Chair, Department of Psychiatry, University of Arizona

Paul McHugh, MD, Chair, Department of Psychiatry, Johns Hopkins University

Russell Armistead, Former Vice President for Health Affairs, Wake Forest University

Karen Milner, MD, Medical Director, Washtenaw County Community Support and Treatment Services

Richard Vieth, MD, Chair, Department of Psychiatry, University of Washington

Scott Wetzler, PhD, Vice Chair for Managed Behavioral Care, Department of Psychiatry, Albert Einstein College of Medicine and Chief Operations Officer of University Behavioral Associates

Kenneth Silk, MD, Professor, Department of Psychiatry, University of Michigan

Douglas Ziedonis, MD, Chair, Department of Psychiatry, University of Massachusetts

Vaughn McCall, MD, Chair, Department of Psychiatry, Wake Forest University

David Feinberg, MD, CEO and Vice Chancellor, University of California, Los Angeles Health System

Octavio Martinez Jr, MD, Executive Director, Hogg Foundation for Mental Health

Lynda Frost, JD, PhD, Director of Planning and Programming, Hogg Foundation for Mental Health

Norman MacLeod Fall conference lecture

Norman MacLeod was honored in 2003 with the establishment of the Norman MacLeod Fall Conference Lecture, presented each Fall as the keynote address. One of the founders and a charter member of Administrators in Academic Psychiatry, Norm was instrumental through the early years in creating the framework for the growth of our organization.

In the Fall of 1985, Bill Newel, then administrator of the University of Wisconsin psychiatry department, convened a steering committee to create a new organization of psychiatry administrators under the umbrella of the MGMA Academic Practice Assembly (APA). One of the participants at that original meeting was Norm MacLeod. During that initial session, Norm helped draft the bylaws under which we still operate. He served as AAP's first secretary from 1986-1988, in the presidential rotation from 1989-1992 and was the first editor of *The GrAAPvine*, also from 1989-1992. Even after stepping down as editor, Norm continued his involvement with the newsletter as Associate Editor, writing both the Suggested Readings column and, while on the APA's Special Interest Group Council, a column about the APA. Additionally, Norm was coauthor of the first AAP Faculty Incentive Survey Report, produced in 1993.

2003 Martin Lazoritz, MD, Associate Chair, Clinical Operations, Department of Psychiatry, University of Florida

2004 Paul Summergrad, MD, Chair, Department of Psychiatry, Tufts University

2005 Dennis Jones, MSW, MBA, Administrator, Indiana University Psychiatric Associates and President and CEO, Indiana University Psychiatric Management and Health/Behavioral Health Consulting

2006 Alan Gelenberg, MD, Chair, Department of Psychiatry, University of Arizona

2007 William McMahon, MD, Chair, Department of Psychiatry, University of Utah

2008 Mark Servis, MD, Vice Chair, Department of Psychiatry, University of California, Davis

2009 Jennifer Kopke, MA, LAC, Assistant Secretary, Louisiana Office of Mental Health
Richard Dalton, MD, Medical Director, Louisiana Office of Mental Health

2010 Michael Cull, PhD, Assistant Professor, Department of Psychiatry, Vanderbilt University

May the new year bring peace, joy, health and whatever you wish for yourself

Norman MacLeod Lecture

Public/academic partnership: The development of a data-driven practice model in Tennessee's child welfare system

by Janice MacAdam, MPA

Michael Cull, PhD, MSN, Assistant Professor of Psychiatry and Administrative Director of Outpatient Psychiatry of Vanderbilt University Medical Center presented the process of reformation of the child welfare system in Tennessee. Through the courts and the development of Centers of Excellence (COE), Tennessee leveraged its strengths to improve the system by identifying and implementing evidence based practice. Dr. Cull discussed the outcomes for the State and the psychiatry department.

There were two court cases that effected the changes in the welfare system. The first was a class action lawsuit in 1998, John B v. Meade. The case was brought because the state of Tennessee failed to assure children get Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) as required by law while running Medicaid programs. The complaint centered around inadequacy in both outreach and care. The consent decree came in 2001 and called for improvement in outreach efforts, update and implementation of statewide periodic screening, improved access, enhance measurement of performance, and better integration of health care and custodial services.

The COE was developed to answer the consent decree and improve children's health, both mental and physical, and provide for their safety, especially those in foster care. Five were funded – Vanderbilt, Memphis, Eastern Tennessee State University, Knoxville, and Chattanooga. The COE makes recommendations and referrals to target a child's specific needs by promotion of data-driven decisions. Weaknesses in meeting the needs of the child are identified early and result in multi-provider case consultations and limited direct services. The provider team, which now includes MDs, LPNs and PAs, receives continuous education and training through workshops, telehealth, and regular conferences. The early success of the COE led to an expanded role which came from the other court case.

The second case, Brian A. v. Bredesen was in 1998 and specifically targeted child welfare. Tennessee had one of the highest rates of congregate care in the nation due to lack of foster homes. Case workers were overburdened and children were placed based on homes available and not on needs of the children. Because of the large amount of children placed and in the system, they were often separated from other family members and lost in the system. The consent decree came in 2001 calling for a cap on caseloads and requiring standardized assessments to help in the placement of children by needs and in the least restrictive setting.

The result of the COE using a standardized case manager's assessment was the Total Clinical Outcomes Management (TCOM). TCOM was developed as a system based on data by testing and determining every need of the child. Using assessment data to support decision making, there is standardization and personal opinions are removed. All trainers are trained in a standardized manner in an interactive training environment with the Child and Adolescent Needs and Strengths (CANS) assessment. It is used in support by COE in training and consultation as a third party review. The data is used to monitor child outcomes. In April 2009, 100% of the raters

are trained and there are about 1600 assessments per month.

The system benefited through standardized assessment that met the child and adolescent needs and strengths. The assessment is based in communication theory and is reliable, valid and non-parochial. The assessments were designed to facilitate the conversation between child and provider. The CANS Algorithm provides decision support. Driving training efforts are the risk behaviors by age and behavior and emotional needs by age. There has been a decline in number of children in custody from 11,000 in 2004 to 7,500, in 2008 with the leveling out now to those most in need. The number of reports has increased because citizens now know who to report to and know that something will get done. There is an increase in the number of children entering the program but not in intensity or amount of services needed. There is also secondary data utilization in the review of high-risk children and data use in support of special projects such as grant writing.

The department of psychiatry at Vanderbilt has benefited through increased funding resulting in higher gross revenue and more staff and faculty. Academic productivity now includes conference talks on trauma treatment, juvenile justice, and assessment and service planning. A number of publications, book chapters and peer reviewed articles have resulted through this initiative. On the horizon is expansion of intensive in-home services and crisis services. Contracts are being developed for training, data analysis, and consultations. And with all the data there is an increase in research activity.
(Janice McAdam, MPA is the administrator of the University of Kansas Medical School-Wichita department of psychiatry).

The Use of Informatics Tools for the Management of Psychiatric Patients

by Beth Ambinder

William M Gregg, MD, Assistant Professor of Biomedical Information, Vanderbilt University, discussed how regulatory and quality of care issues demand that medicine be practiced as a team sport and that to meet these standards, a method of organizing data is required. The challenge faced is to use data to improve care. While early applications in psychiatry have been identified, as the need to progress toward advanced care coordination or "medical home" increases, more applications will become required.

Challenges of informatics tools include their cost where spending has more than doubled over the past 40 years and duplication of effort with respect to the entering of data.

The impact for psychiatry is evidenced by the disease prevalence estimated at 26% of the adult population and

co morbid conditions such as diabetes (22%) and asthma (27%). The gap in quality is shown by the statistic that more than 50% of those with diagnosed chronic disease are inadequately managed. In addition, although best practices for the management of patients with pneumonia for example are well documented, (blood cultures followed by the right antibiotic at the right time) only 30% of patients actually receive all of the recommended interventions.

The clinical system or micro system is the basic building block of an individual patient's record from an individual clinic, inpatient unit, etc. Although a patient sees only their caregivers, many underlying layers exist around the clinical system including, labs, pharmacies and other ancillary services related to that encounter.

As clinicians are data driven, data can be used to improve care. There is no shortage of data to support a patient's care; however the data is poorly organized. To be truly useful it must be

available at the point in time when a decision is to be made or "just in time." Culture and process change are necessary components to allow informatics to drive clinical engagement.

Factors that are currently driving change are the availability of the next generation of electronic medical records having capabilities beyond being electronic paper records and the awareness that the data exist, thereby creating tension to access it.

Primary areas that are contributing to the demand for enhancements in informatics include:

- Regulatory requirements
- Drug/treatment and safety monitoring
- Population level reporting
- Just in time information needs
- Coordination with usual work flow

To be genuinely useful and minimize opportunities for introduction of error, manual data entry must be minimized by pulling data from existing databases. The Vanderbilt system flags noncompliance by reviewing when a patient has last received a necessary follow up exam. In the pediatric clinic, if an appointment is requested for an acute illness and the child has not had the appropriate well child exam in the interim, the acute visit is automatically converted to a comprehensive exam. This has increased compliance for children with their recommended well child visits by more than 60%. The advice Dr. Greg gives is to start with the earliest opportunities first, such as drug safety, which can be fostered by following patients prescribed high risk medications.

Population level reporting is designed at Vanderbilt with clinicians, administrators and patients in conjunction with the IT programmers. The system encompasses 40,000 patients and is accessed by 500 providers. The development is less than 4 weeks in general and change throughout the process is constant. The pediatric clinic completed more than 70% of the process outlined above in 6 weeks. Of note, one should never be afraid to discard failed processes. Other words of advice included;

- Aim for improvement, not perfection
- Involve everyone in the clinic. (This is critical)
- Start early and make sure changes are quick

Advanced care coordination is the next logical step in chronic disease care coordination with the aim of engaging patients in their own care. Informatics tools can be used to augment dashboards and to risk-stratify patients with the goal of directing resources to them appropriately. Care coordination is driven by a central cross-clinic plan of care. At its best risk stratification is;

- Personalized
- Evidence based
- Iteratively improved
- Used to effectively allocate resources
- Algorithmic

A demonstration of the model used by Vanderbilt followed beginning with documentation of a medical event. A prompt then follows for a laboratory value or symptom change. Resource organization and monitoring plans which may include specialist referral, patient education and/or information are then developed. The system allows providers to see how many times they are "touching" the patient. Care coordination leads to an uncovering of the "layers of the onion" so to speak. Using this process, 75% to 80% of hypertensive patients are adequately controlled, which greatly exceeds the national norm of approximately 30%. When asked about funding for the professionals who staff the care coordination office, the response was that currently insurers are providing $600,000 annually to support this kind of work for their insured patients. The expectation is that savings will flow to them through avoidance of the consequences of noncompliance.

Another question from the audience was raised as to whether the EPIC system would allow this kind of care coordination since many conference participants are either using it currently or are in various phases of evaluation and implementation. The response was that it does incorporate some modules that work in this way and it was advised that participants stress the need for the vendor to make changes that will contribute to meaningful use.

The next question related to how to engage the patient up front. Dr. Gregg stressed the importance of providing

opportunities for face to face contact with care coordinators, especially for patients with the highest risk potential and thus the greatest benefit derived from their engagement. The current medical system does have capacity but resources are just not used effectively. Elimination of the "just in case" visit that monopolizes provider's time allows them to access that capacity effectively. Key advice is to automate, evaluate and progress. The core data set is critical to patient management and comprises about 25% of the total data. Most documentation is ponderous and time consuming and thus not useful to a decision making tool such as a dashboard.

The last question related to whether "push back" had been raised by risk management attorneys if data accessed by patients went to the wrong patient or if data was missing. The response from Dr. Gregg was that you look at the data and you fix it. There is significant effort focused on medical malpractice due to errors of commission and not nearly enough on the impact of errors of omission.

(Beth Ambinder is the administrator of the Johns Hopkins University department of psychiatry).

Identifying and intervening on high risk physicians: The PARS® Project

by David Allen, RN, MSHA, JD, FACHE

The presentation by James W. Pichert, PhD, Co-Director, Center for Patient and Professional Advocacy, Professor Medical Education, opened with a review of common experiences regarding "outlier," disruptive, difficult, special colleagues, present in almost all of our work environments. These issues and individuals can lead to both monetary loss or business loss for an institution and professional career disruption that in many cases can be avoided with the proper interventions.

In response to a need to appropriately and adequately address these experiences and individuals, The Center for Patient and Professional Advocacy was founded. The purpose of the center is to promote patient satisfaction, professionalism, and restrain escalating costs associated with patient dissatisfaction. Initially in the center's development, founders examined research into the causes of increased risk and understanding why patients sue. A pillar of the center is

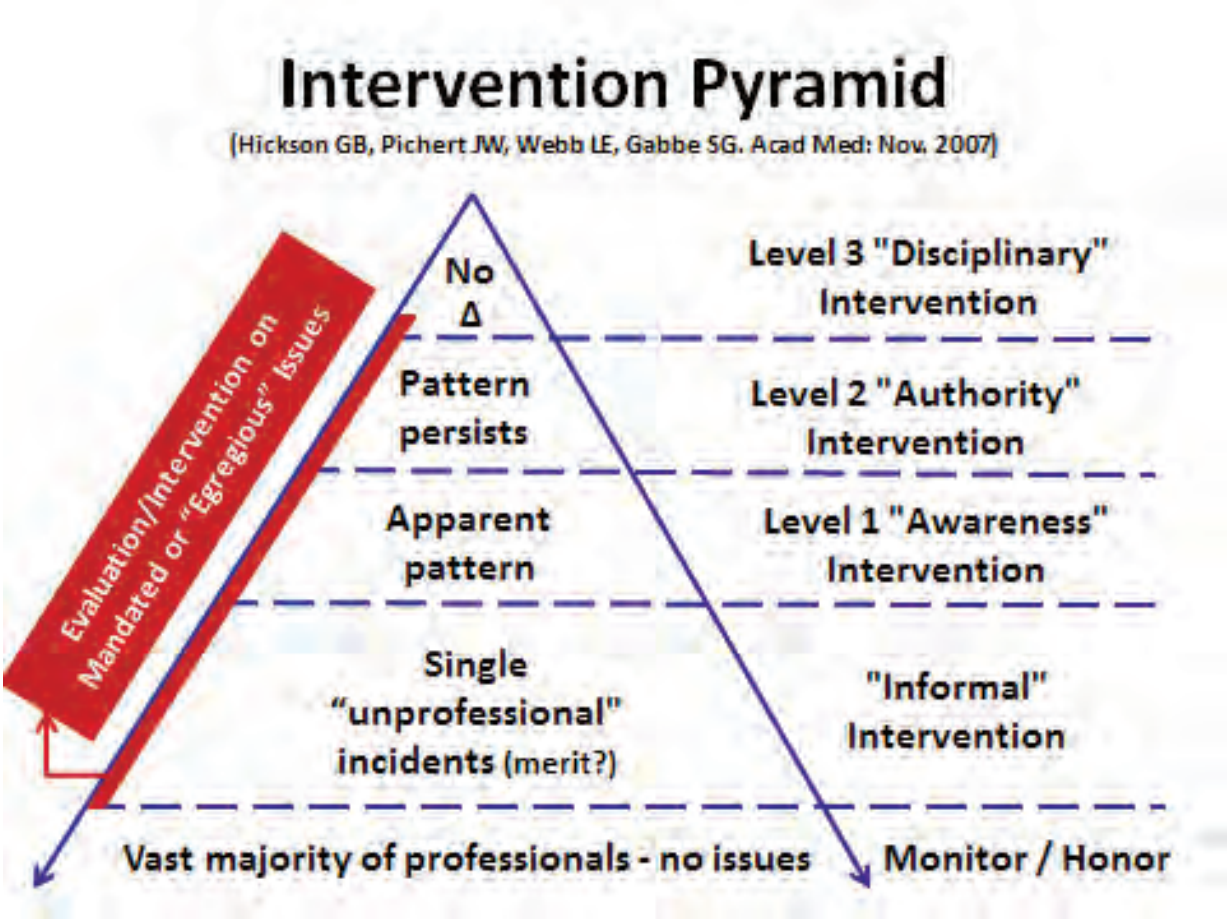
the PARS program along with proactive risk management.

The data in the area of risk indicated that 1-6% of patients are injured due to negligence but only 2% sue. Additionally, it was noted that non-monetary factors attract more suits and some physicians attract more suits. The top 6 reasons for the suit were as follows:

- Advised to sue by influential other, such as another professional
- Needed money
- Believed there was a cover up
- Child would have no future
- Needed information
- Wanted revenge, license

Overall, surgeons have the highest percentage of malpractice activity in terms of awards and settlement costs, followed by OB, pediatricians and internists. Patient perceptions are noted to play a key role in the frequency of these suits with communication issues with the physician being primary.

About half of the concerns about physicians are confined to 9-14 % of the total physicians in the organization, with the top 8% accounting for 50% of the risk management expenditures. These data are



useful in developing objective measurements of risk enabling organizations in identifying intervention strategies focused on the right people and areas. By collecting data on physicians, the organization can produce a profile that can be used to intervene with the right approach at the right time as noted in the chart above.

The PARS system requires commitment by leadership of the organization, policy support, models to guide interventions and training and resources to help disruptive colleagues. The system is data driven which requires that the organization maintain accurate monitoring and measuring systems in order to insure integrity of the system. Additionally, peer physicians used as "messengers," can play a part in the early intervention stage which often can reverse the course of high risk physicians or at least prompt them to know that there is concern. This promotes adaption from line physicians and can be less threatening to the individual early on in the process.

The PARS program at Vanderbilt has been successful. Return on investment was measured at a ratio of 5:1 and risk reduction scores improved among those physicians receiving interventions. Additionally this system models progressive discipline procedures common to most organizations. *(David Allen is the executive administrator of the University of Alabama Birmingham department of psychiatry).*

Burnout: Pitfalls & prevention

by Jackie Rux

The focus of this session was wellness and how we can create an individual action plan to help reduce stress, prevent burnout, and improve our overall health. Charlene M. Dewey, M.D., M.Ed., FACP, Associate Professor of Medicine and Co-Director, Center for Professional Health from the Vanderbilt University School of Medicine was the presenter.

Dr. Dewey suggested that we begin by doing a "self-assessment" of what stresses each of us out. Stress and burnout occurs for different reasons in different individuals, this isn't an area where we can generalize. This is where self awareness can be beneficial. (Dr. Dewey gave us a self awareness handout to use as a tool for our individual action plan. If you would like a copy of this 2 page handout, email me at jrux@mcw.edu). Self awareness is defined as a deep understanding of one's emotions, strengths, weaknesses, needs and drives. People with strong self awareness are neither overly critical nor unrealistically hopeful. Rather, they are honest – with themselves and with others. True thriving is….."Embracing the truth of who you are so that you can freely receive, give and hope, regardless of your circumstances." ~Debbie Smith, M.A., Center for Women in Medicine.

Stress can be a result of our professional environment where we are faced with work deadlines, meetings galore, financial issues, numerous changes, etc. We tend to experience more burnout in

midcareer when we are wearing multiple hats. Examples in our personal environment might include relationships, financial issues, or health concerns to name a few. Stress at high levels are bad; it affects our memory, kills neurons and can create a significant physiological response. Our brains are going at such a fast pace at times that it is not allowed to rest. (Multitasking is one example of this).

Stress can be defined as a state resulting from a stress; especially one of bodily or mental tension resulting from factors that tend to alter an existent equilibrium. When things alter our equilibrium, we need to finds ways to bring it back into balance. Dr. Dewey suggested reducing workplace stress by:

- Managing your energy
- Reducing distractions (e-mails, telephone calls, interactions)
- Planning appropriately
- Managing failures and successes (we can't do it all; that's when we suffer)

When productive stress moves to prolonged stress we experience a decline in function, reduced cognition and burnout. *Burnout* can be defined as exhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration.

Following are six sources of burnout: (frpm Maslach & Leiter, 1997. "*The Truth about Burnout: How Organizations cause Personal Stress and What to Do about it.*")

- Work overload
- Lack of control
- Insufficient rewards (not necessarily you; it could be the system or the organization)
- Unfairness
- Breakdown of community (no sense of togetherness and/or that you are not there for the same purpose)
- Value conflict (is the job right for you, why are you there?)

Some examples of the risk factors for burnout might be fatigue and sleep deprivation, previous mental health issues (depression), family problems, alcohol and drugs or a general dissatisfaction. Symptoms of burnout are chronic exhaustion, being cynical and detached and increasingly ineffective at work. Such symptoms can lead to isolation, avoidance, interpersonal conflicts and high turnover by

others and/or by yourself.

There are seven key areas to help manage stress:

- Sleep
- Balanced meals
- Physical activity
- Socialization
- Vacation/down times
- Spiritual engagement
- Have a physician

There are several "personal" protective factors that you should consider. Tend to self care issues first, address Maslach's six sources of burnout, and influence your happiness through personal values and choices. Adapt a health philosophy/outlook, spending time with family and friends are key. Similarly this applies with "work" protective factors. Again, address Maslach's six sources of burnout, gain control over your environment and your workload. Find meaning in your work, learn to set limits and maintain a balance. Look to a mentor and/or obtain adequate support systems.

It's important to learn to manage energy at work by listening to your body and identifying your own needs. Define limits, sometimes you just need to say NO! Create your own work environment with things that you find comfort in by personalizing it (within reason) with plants, music, etc. Try to eliminate distractions, be sure to take breaks and learn to plan ahead.

Keep in mind your resources and use them, whether that be your institutional employee assistance program, your primary care provider, a mentor, wellness programs, gym, substance services or even something as simple, yet relaxing and beneficial as a massage.

The truth is: The greatest strength of any institution is it's people!

Remember:

- You are valuable! Self-care is the foundation to your vitality at home and work.
- Look for and anticipate stress. Take action immediately to manage stress and energy.
- Recall the 6 sources of burnout and seek ways to prevent burnout in the workplace.
- Take advantage of resources when needed, especially mental health!

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

Integration of moderator models into electronic health records to optimize treatment of depression

by Mario Harding

On Friday morning, Dr. Richard Shelton, James G. Blakemore Research Professor, Professor of Pharmacology and Vice Chair of Clinical Research, Department of Psychiatry, Vanderbilt University,offered a lively presentation on the use of algorithms to optimize treatment of depression. As Dr. Shelton shared with us, the opportunity to move beyond human capacity to deliver and implement algorithms can lead to enhanced evidenced-based treatment. Moreover, pushing this knowledge into the community has immense

opportunity to advance care in the field of psychiatry.

Algorithms have been used by other specialties such as medicine and surgery for years to define structure and processes for the delivery of care. You may know these as key clinical pathways. The ability to replicate similar activities in the field of psychiatry represents a step forward in treatment regimens, especially depression.

Dr. Shelton shared his experience working with the Texas Medication Algorithm Project (TMAP). TMAP has been able to demonstrate that patients get better quicker when an algorithm is used in the delivery of care. As this happens, the more likely a patient is to adhere to their

treatment regiment. More info about TMAP can be found at http://www.dshs.state.tx.us/mhprograms/TMAP.shtm.

One exciting tool that Dr. Shelton would like to see developed at Vanderbilt and other sites across the country is a kiosk-based assessment tool. The tool would be patient friendly in gathering data from a patient related to their mental health status and subsequently entered into an electronic medical record (EMR).

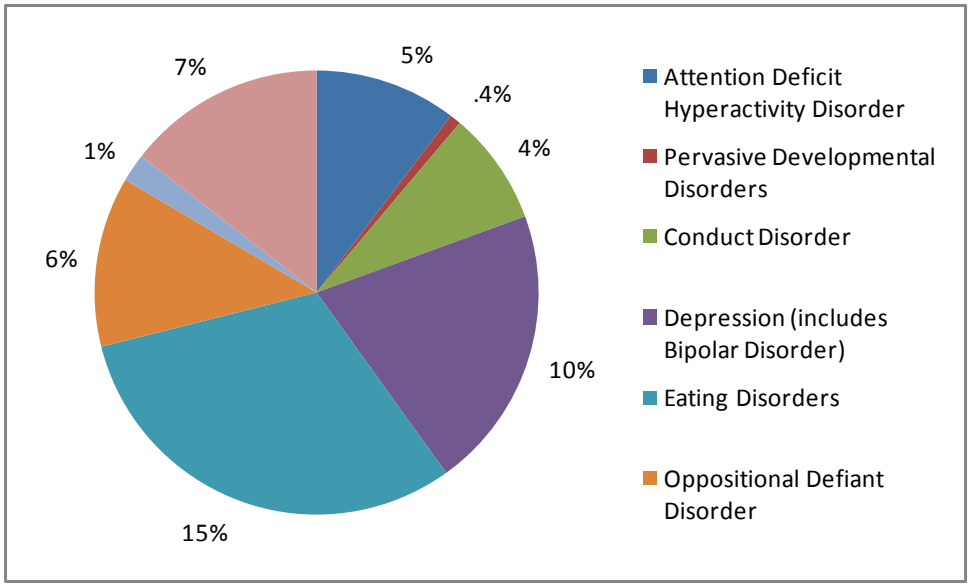
Dr. Shelton shared with the group the NIMH Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study. This is the largest study of its kind to evaluate depression treatment. It involves 4,041 patients recruited who are being treated with Citalopram. The results of the study showed that 72% of patients get well. Followup after 1 year showed that there was a 50% relapse rate and subsequent 36% sustained recovery. For more details on this clinical trial, go to http://www.nimh.nih.gov/trials/practical/stard/index.shtml.

As Dr. Shelton stated, algorithms encourage action but need to go further. This would entail the use of a moderator, a baseline variable that predicts response to a given intervention. The use of moderators in the treatment of depression can better match the treatment to the patient as opposed to matching patient to treatment. In the end, patients can get the best care available, particularly for those suffering from major depression.

(Mario Harding is the service line administrator, beharvioral health services at Denver Health Medical Center).

PSYCHIATRY BY THE NUMBERS

Child and Adolescent Mental Illness Statistics



Source: NIMH, www.nimh.nih.gov

Beyond ARRA, or more ARRA?

by Hank Williams

Over the last two years, most of our research programs in academic psychiatry have been enhanced by the American Recovery and Reinvestment Act of 2009, or ARRA.

Now that the well has run dry, are we looking at another round of stimulus funding that will pump some fresh research dollars into our programs? That's for the politicians to decide.

How well did you do with your ARRA proposals and spending the funds? Many of us successfully managed a number of projects that helped our research mission, and allowed us to hire a number of new people.

The most recent National Science Foundation data shows that in FY09 4,599 competitive awards were made, exceeding the target of 4,000. 6,762 investigators are being supported by these awards, exceeding the target number of 6,400.

Federal dollars will continue to get more competitive, as the state dollars for research do the same or worse. This continues to squeeze our programs in ways we never thought of.

Pressures on our state budgets are requiring our psychiatry programs to seek relief through our financial reserves, and to use research recovery dollars to plug holes traditionally funded through other means.

Looking at traditional NIH funding, here's an excerpt from the latest "Inside NIMH":

The FY 2011 President's Budget Request is $1.540 billion for NIMH (National Institute of Mental Health).

Over the summer, both houses of Congress reviewed the President's Budget Request; however, the House and Senate proposals have not yet been reconciled.

Until the budget proposals are reconciled and finalized through signature of the President, NIMH will operate at FY 2010 levels by means of a Continuing Resolution.

During the Continuing Resolution, NIMH will issue non-competing research grant awards at a level below that indicated on the most recent Notice of Grant Award (generally up to 90 percent of the previously committed level). Previous Continuing Resolutions, had upward adjustments after the final appropriation is enacted later in the year.

What should we expect for FY 2011? Two variables will determine success rates (success rate = number of grants funded/ number of applications). First, it is not known what the final budget will be. Congress could use the reconciliation process to lower NIH funding levels below the President's Budget Request. NIMH is assuming a 3.2 percent increase, which would allow NIMH to fund approximately 1,540 new applications, but this may prove to be overly optimistic -- FY10 amounts have been adjusted to reflect budgetary transfers between NIMH and NIH/the Department of Health and Human Services.

Second, NIMH does not know how many new applications will be submitted.

NIMH has not seen the expected flood of applications following funding of the American Reinvestment and Recovery Act of 2009 (ARRA). They expect this wave to hit late in FY11 with a consequent drop from the FY10 success rates.

Storytelling

by David Peterson, FACMPE

Aesop got it right. He figured out that powerful points could be made through fables, stories that dictionary.com defines as "a short story to teach us a moral lesson."

Fast forward a couple thousand years and witness bestselling author Malcolm Gladwell (Blink et. al.) borrow a page from Aesop's book. In his keynote address at the Medical Group Management Association's annual meeting in New Orleans this year, Mr. Gladwell artfully wove several stories together to make one powerful point; namely, more information does not necessarily help leaders make better decisions, but more information does lead to more confidence in the decisions, even if those decisions are wrong. Consequently, says Mr. Gladwell, leaders need to be wary of making assumptions and decisions based on misinformation or seemingly "perfect" information. Instead, says Mr. Gladwell, leaders should continually test assumptions, remain open to new information and avoid "locking in" on a decision based on the certainty of the information supporting it and despite new or other information to the contrary.

Mr. Gladwell made these points through his stories that ranged from the fall of Bear Stearns in March 2008, the denouement of the second Iraq war in 2003 and the pivotal loss for the North in the Battle of Chancellorsville on the Rappahannock River in 1863. According to Mr. Gladwell, these three events, almost 150 years apart, had one thing in common. All were failures caused by leaders (Jimmy Cayne at Bear Stearns, George W. Bush on post-Iraq planning, and General Joseph Hooker at Chancellorsville) making decisions with a certitude that was based on "perfect" information that was really imperfect and led to imperfect decisions.

There is research to support the idea that more information provides leaders with more confidence in their decisions, even when they are wrong. According to Mr. Gladwell, research in the 1960's originated by a psychiatrist (no less) found that a group of psychiatrists, when blindly polled, could not improve upon the accuracy of their initial diagnosis of a patient, even when they were provided with increasingly more information about that patient. Apparently though, their confidence in their diagnosis did improve as they got more information, even though their accuracy did not improve. There has been subsequent research that supports this notion that more information does not necessarily lead to better, more accurate decisions, merely more confident ones.

Medical practice executives rely on a constant stream of information. RVU production, charges, collections, accounts receivable, and expenses are just a few benchmarks that are closely tracked. Academic medical practice executives rely on even more information given the multitude of missions most often defined as teaching, research, patient care and community service. Each has its own set of data - data that becomes information and helps the leaders arrive at a set of decisions, set priorities and develop strategic plans. Ensuring that the information is good, reliable, auditable and salient is essential to good practice management and leadership.

Mr. Gladwell's message is clear. Good and effective leaders will do well by continually checking the data, challenging assumptions and remaining open to new information that can arise from a dynamic environment. Given the political and economic upheaval that began in 2007 (some would argue that the seeds for such upheaval were planted long before), Mr. Gladwell offered the audience a timely reminder that humble, thoughtful leadership will trump arrogant, "expert" leadership every time.

Finally, Mr Gladwell's speech was a lesson in communication itself. Like Aesop, he showed that a story can be an effective leadership device to communicate a point.

For 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 414.955.8990, 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.

USC professor underwrites new institute on law and mental health

Elyn Saks, recipient of a 2009 MacArthur Foundation "genius grant" and author of a memoir chronicling her battle with schizophrenia, has launched a center on mental health policy at USC Gould School of Law.

The Saks Institute for Mental Health Law, Policy, and Ethics is funded with a portion of the $500,000, no-strings-attached award Saks received from the MacArthur Foundation.

The institute will spotlight one important mental health issue per academic year, and each fall experts on the topic will give a Distinguished Lecture. In the spring, the Institute will host a symposium at which Saks hopes policy recommendations and model laws can be developed. Cambridge University Press has expressed interest in publishing each year's proceedings.

This year, the focus will be on the use of mechanical restraints in psychiatric hospitals. A Nov. 11 symposium will feature guest speakers Paul Appelbaum, MD, a nationally respected professor of Psychiatry, Medicine and Law at Columbia University; Susan Stefan, JD, a leading authority on mental health law and the Americans with Disabilities Act; and Kathi Stringer, an advocate for people with mental illness and someone who has experienced mechanical restraints herself.

"I wanted the subject of mechanical restraints to be the first area we highlighted because it is important—many people die in restraints each year and many more are degraded and traumatized—and there is momentum to try to reduce their use. I myself was mechanically restrained while hospitalized for mental illness—many times and for long periods of time—and I had nightmares about it for years after," said Saks, the Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences at USC.

After decades of hiding her illness, Saks published a memoir in 2007 about her battle with schizophrenia in "The Center Cannot Hold: My Journey Through Madness" (Hyperion, 2007). The memoir received rave reviews and worldwide acclaim.

The Saks Institute, headquartered at USC Law, is a collaborative effort that includes faculty members across seven USC departments: law, psychiatry, psychology, social work, gerontology, philosophy and engineering. Future topics may include coercion in psychiatric research, mental illness and veterans, and the criminalization of mental illness, among others.

"I'm very, very interested in these issues," said Saks. "The idea of having a whole group of people study and work together on an important project is great for me and I think it will be good for the field."

Saks has already assembled a Who's Who among mental health experts to consult or serve on the Institute's external board, including Oliver Sacks, Kitty Dukakis and Nobel Laureate Eric Kandel.

"It's a great external board and I'm very excited about that," Saks said.

Five or six USC Law students each year also will play an active role with the Institute, along with students from other participating disciplines at USC. These students will conduct the background research necessary to frame the study of each year's topic.

Research may include everything from reviewing literature to case-studying specific organizations to analyzing relevant laws and statutes, along with doing comparative study of other countries. Students affiliated with the Institute will receive the title of "USC Law and Mental Health Scholar." They also will receive a stipend and there is the potential for their work to be published.

"I hope the Saks Institute will become the 'go-to' organization for certain mental health law and ethical issues for other people around the country," she said.

(Press release, 9/16/2010).

Certain freestanding psychiatric hospitals required to submit HBIPS core measure data

The Joint Commission has secured endorsement from the National Quality Forum (NQF) for six of the seven Hospital-Based Inpatient Psychiatric Services (HBIPS) core measures. While data submission on the HBIPS measure set was previously optional, freestanding psychiatric hospitals with an average daily census greater than 10 inpatients and that are surveyed under the Comprehensive Accreditation Manual for Hospitals (CAMH) now will be required to submit data on the HBIPS core measure set. The requirement is effective beginning with January 1, 2011 discharges or episodes of care. After January 1, 2011, The Joint Commission will not accept data on non-core measures from these freestanding psychiatric hospitals. Freestanding psychiatric hospitals that submit data on the HBIPS measure set will be deemed to have met ORYX core measure reporting requirements through this data reporting alone. This change is in response to a growing desire for full implementation of the HBIPS measures from the field and other stakeholders, including the National Association of Psychiatric Health Systems, the National Association of State Mental Health Program Directors (NASMHPD), and the NASMHPD Research Institute, Inc.

This new requirement does not apply to general medical/surgical hospitals with inpatient psychiatric units or those that maintain a psychiatric hospital that is accredited as a site under the accreditation of the general medical/surgical hospital. However, these organizations may choose to submit data on the HBIPS measure set to meet current overall ORYX core measure set reporting requirements. Through the use of a set of standard performance measures, hospitals using the HBIPS measures are provided with the opportunity to compare their performance against a Joint Commission established target range of performance based on the each hospital's individual data and data from the entire set of reporting hospitals. Through this "target analysis," hospitals will be able to compare their performance against a comparative norm for purpose of identifying performance improvement opportunities.

These data, with the exception of the HBIPS-1 measure, will be publicly reported on Quality Check starting with January 1, 2011, discharges or episodes of care and used in the Priority Focus Process (PFP) and the Strategic Surveillance System (S3). Data received for HBIPS-1 will be displayed on each hospital's ORYX Performance Measure Report as a "test" measure, but they will not be publicly reported on Quality Check nor used in the PFP or S3 until the measure either receives NQF endorsement or The Joint Commission's Board of Commissioners determines that HBIPS-1 data should be made publicly available. Data submitted for the HBIPS measure set before January 1, 2011 will not be publicly reported on Quality Check nor used in the PFP or S3, however, aggregate HBIPS core measure data received in 2009 and 2010 will be included in The Joint Commission's Improving America's Hospitals 2010 Annual Report and the 2011 Annual Report.

Detailed information on the HBIPS core measures can be found in the Specifications Manual for Joint Commission National Quality Core Measures and in Update 2 of the 2010 CAMH. The measure set may be selected by accessing the ORYX Measure Selection (OMS) application under "Performance Measurement (ORYX)" on their secure Joint Commission Connect™ extranet or by completing the Hospital-Based Inpatient Psychiatric Services Core Measure Set Selection Form available on The Joint Commission's Web site. Questions about the HBIPS core measure set can be directed to the ORYX Help Line at HCOOryx@jointcommission.org or (630) 792-5085. (Contact: Frank Zibrat, fzibrat@jointcommission.org)

New Core Measure Set for Psychiatric Hospitals

Applicable to Freestanding Psychiatric Hospitals
Effective with January 1, 2011 Discharge Data

HBIPS 1	Admission screening for violence risk, substance use, psychological trauma history, and patient strengths completed
HBIPS 2	Hours of physical restraint use
HBIPS 3	Hours of seclusion use
HBIPS 4	Patients discharged on multiple antipsychotic medications
HBIPS 5	Patients discharged on multiple antipsychotic medications with appropriate justification
HBIPS 6	Post discharge continuing care plan created
HBIPS 7	Post discharge continuing care plan transmitted to next level of care provider upon discharge

National Association of Psychiatric Health Systems
Annual Meeting
Washington, DC
March 7-9, 2011
www.naphs.org

Administrators in Academic Psychiatry
Spring Educational Conference
Baltimore, MD
April 28-29, 2011
www.adminpsych.org

American Psychiatric Association
Annual Meeting
Honolulu, HI
May 14-18, 2011
www.psych.org

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

A distraught man went to a psychiatrist and exclaimed,"Doctor, I believe that I am possessed by an evil spirit."

After talking to the patient at some length, the psychiatrist said, "You do appear to have a problem. I'd like to see you again next Wednesday."

After a second session of psychotherapy, the pyschiatrist pronounced his patient completely cured.

For the next nine months, the psychiatrist sent the man a monthly statement for his professional services, but the man wouldn't pay and refused to acknowledge the debt.

Finally, the psychiatrist took the man to court and had him repossessed.

Editorial staff
Editor:
Janis Price
Associate Editors:
David Peterson, FACMPE
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
janprice@umich.edu