I hope that everyone had a Happy Thanksgiving and that you enjoy the upcoming holidays with family and friends.

The board has been busier than ever this year! I’d like to take this time to let you know what we’ve doing to keep the mission of NAAPA on track.

In between the educational conferences, teleconferences have occurred on a regular basis. The most recent board teleconference took place on November 15th. Our focus included finalization of the next benchmarking survey, reviewing web traffic and revisions needed as a result of feedback at the fall meeting, ongoing efforts to increase membership, and spring conference planning. We also spent some time discussing next steps with regard to a new logo.

At the fall conference, members were advised that the board had approved a line item in the budget to pay for an administrative coordinator to assist with a whole host of duties. The statement of work was sent out on Google groups and it is also posted to our website. I have received inquiries from 2 parties who expressed an interest in the position. Our goal is to conduct interviews over the next 4-6 weeks and to have someone on board by the end of January. If you know of anyone who is interested, please ask them to contact me.

The board has also created a finance committee which is new to the organization. The chair of the committee is Jim Myers. He successfully recruited Deb Pearlman and Steve Blanchard to the committee. You can expect an update from the committee at the spring conference.

It’s been just over a month since the fall educational conference occurred. Highlights on topics presented are included in this edition. I’d like to extend a special thank you to Beth Ambinder, President Elect and Chair of the Education committee. She wrote all of the conference highlight articles and she did an outstanding job of capturing the essence of the presentations!

I’d also like to thank Steve Blanchard for taking the photos of our presenters and member activities, including our special tribute to Jan Price, longstanding, member and newsletter editor who has resigned her post as editor and is now an honorary member.

The results of the completed evaluations from the fall conference rated the Quality of the conference as 3.81 and the Value as 3.63. The rating scale used for the evaluation tool is based on a scale of 1 (Poor) to 4 (Excellent). Based on completed evaluations from the spring 2012 conference the session referred to as “Take 2 Minutes” was added back to the program. The content rating for the “Take 2 Minutes” was a 4!! This really underscores its value! We also intend to include break out sessions to allow time for more in depth discussions on topics of importance. If there is a particular topic you would like to be considered as a break out session, please contact Beth Ambinder at (410-955-5129) or Marika Brigham at 352-265-7981.

Continued on Page 2
Three new members attended their first conference, Deb Gumbardo (Seattle Children’s Hospital), Brian Spector (Duke University) and Suzanne Morris (Univ of Virginia). I’m thrilled to share the overall comments from at least one of the new members (who identified as such on the evaluation) was that it was an “Excellent Experience”.

This year we’ve had terrific participation on the benchmarking committee and in fact just recently sent a draft of the next “mini” survey to Drs. Heckers, Summergrad and Ziedonis (who are either current or past Chairs of the AACDP) for their review. We are in the process of scheduling a conference call to discuss in more detail. This survey will focus on the clinical arena. Our goal with shortening the survey is to increase the response rate. In the future, we intend to have two other surveys that will focus on the research and academic missions. You will be hearing from Janet Namini, Chair of the committee announcing when you should expect to receive the survey.

Thanks to the Google groups list serv there has been an abundance of information sharing on the major changes in CPT codes. Following the presentation that Sarah Thomas gave at the fall education conference templates for documentation of E&M codes have been collected and will be posted on our web site http://www.adminpsych.org/ for you to download.

Thanks to Narri Shahrokh members are able to participate on a teleconference scheduled for December 3rd, which is sponsored by the National Association of Psychiatric Health System (NAPHS). Jeremy S. Musher, M.D. and President of Musher Group, LLC will provide up to date information on the CPT changes to occur on January 1, 2013. A summary of the discussion will also be posted on the web site for members who weren’t able to participate on the call.

In addition, a conference call has been organized with EPIC for any current or “to be” users. The call is scheduled to occur on December 5th. I’d like to thank Brenda Paulson for taking the lead in organizing the call. I’m sure it will prove to be very beneficial. The Education Committee is also considering a break out session devoted to the EPIC at the spring meeting and a summary of the call will be prepared for members.

The date and location of the fall meeting and has been posted on web site. The hotel was just secured last week and the program planning is well underway. Thanks to Jim Myers the on line registration process has been modified to enhance the member’s experience. Registration for the meeting will be $300.00. Regular updates will be posted.

Our annual business meeting will be held at the spring meeting. There will be several open positions on the board. Those include President Elect, Treasurer, Secretary, Member Director, Member at Large for Benchmarking and Member at Large for Technology Development.

For the benefit of our members new and old, I’d like to explain the nominating process. The chair of the nominating committee is the role of the Past President. This year it is Radmila Bogdanich and it is her job to secure two members to the committee. The committee identifies candidates and the slate of officers is then presented at the annual spring business meeting for a vote. The two members who have agreed to serve on this years nominating committee are Narri Shahrokh and Steve Blanchard.

During the fall meeting there was a suggestion to provide a brief description of the duties of the officers to better inform members who may have an interest in serving on the board. Those have now been posted on the web site. If you are interested in any of the positions, please reach out to a committee member.

As administrative professionals we all grapple from time to time with keeping up with the changes in the Healthcare industry. This year has been filled with a whirlwind of changes. Between the ACA’s, ACO’s, Meaningful Use, transitioning to new CPT’s and transitioning to ICD-10 the next year promises to bring more of the same and then some. Given that things seem to change minute by minute our network and access to the list serv and website makes our national organization priceless.

The role of what we do as Academic Administrators is changing as well. As leaders we are in a position to help staff members and faculty. We all have something to learn and something to share. Working together will help us to navigate the changes and hopefully avoid reinventing the wheel in certain instances.

I look forward to seeing you in San Francisco!

Best regards,

Lindsey
Comings and goings

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

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

Kevin Burnett
Assistant to the Chair
Department of Psychiatry
Southern Illinois University School of Medicine

Debra Gumbardo
Director
Psychiatry and Behavioral Health
Seattle Children’s Hospital
University of Washington School of Medicine

Suzanne Morris
Business Manager
University of Virginia School of Medicine

Brian Spector
Vice Chair
Administration
Duke University Medical Center

Liz Stevenson
Administrator
Department of Psychiatry
Oregon Health and Science University

Find practice management resources at MGMA-ACMPE’s website, http://mgma.com/
Highlights:
Spring Conference
Jackson, Wyoming
October 10-12, 2012

Antler Arches of Jackson
Conference Highlights

Special Tribute to Jan Price
Retired after serving as editor for over 25 years
and now an honorary member of NAAPA.

The GrAAPvine Vol. 24 No. 1
Dr. Hilt began his presentation with a discussion about child mental health and issues that all of us have faced including access and quality of care. Use of psychiatric medications in children is controversial by finding that the use of medications is two to three times more prevalent in children who are in foster care than those who are not. Between 2001 and 2010 the use of medications increased by 20% for US children although the increase for children in foster care increased by 68%. For children in the states of Washington and Wyoming the percentage has increased to 45%. Regional variation in care is also a concern and raises questions about best practices. These issues led to the development of a child psychiatry consultation program based at the University of Washington to better understand and address issues:

- Rising medication use
- Care standards
- Poly-pharmacy
- Increasing costs
- Inconsistent treatment planning
- Poor child psychiatrist access
- Community need for more assistance

This was possible due to the unique relationship the University of Washington has with the Medical Assistance program as some universities have declined to participate in such initiatives. At the outset, medication reviews were implemented with “flags” identified that would trigger the need for more detailed understanding of the prescribed medication and dosage. Since the program began in 2006, 1,900 such reviews have been completed. Generally, responses that contained insufficient information or illegible were factors that lead to a review. Due to providers being at remote locations and facing prescription reviews, a telephone discussion was held. The number of actual recommendations to not allow the pharmacy to fill the prescription occurred only 10% of the time. One of the lessons learned was that when a “hard stop” was necessary, this had to be accomplished in a timely manner. The expectation for all interactions was that it be viewed as a collaborative process. An interesting finding was the mere existence of the review program which contributed to the following practice changes:

- A change in the ADHD prescription 50% of the time prior to the scheduled review
- Denial in 28% of the prescriptions due to lack of a response from the provider
- 20% altered due to the opinion reviewer’s recommendation to deny the prescription
- Remaining 2% altered later

Other problems within the mental health system are the limited numbers of psychiatrists available to children in the region, particularly in Wyoming. For example, there are 8.7 child psychiatrists per 100,000 children nationally but only 6.6 and 3.9 per 100,000 respectively for children in Washington and Wyoming. Of particular concern is the access to a child psychiatrist for children in rural areas with only 0.3 per 100,000 in such areas. To offset these serious shortages, primary care providers are currently on the “front line”. The needs of primary care providers include:

- Mental health care education
- Tools and rating scales
- Assistance with resource connections
- Rapid consultation for difficult cases
- Specialists available to provide ongoing care collaboration

Dr. Hilt ended his talk with a discussion about the use of telemedicine equipment. He addressed the needs of providers both in primary care and in rural areas where access to specialty information is most difficult to obtain.
Leadership Development for Psychiatry Administrators

Daniel K. Winstead, MD
Chairman and Professor
Tulane University School of Medicine
Department of Psychiatry and Behavioral Sciences

By Beth Ambinder

Dr. Winstead has been the Department Chairman for more than 20 years and will be leaving this position in the near future to pursue his academic interest in the area of leadership. He was therefore uniquely qualified to share with the group the experiences he has had and how they had contributed to achieving his career goals. He began the session with two questions: 1.) “How is leadership defined?” and 2.) “Do you know it when you see it?” He provided several quotes from leaders who offered definitions one of which was authored by Dwight D. Eisenhower, “Leadership is the art of getting someone to do something you want done because he wants to do it”.

The next questions posed were “Are leaders autocratic?”, “Are leaders democratic?” The general consensus among participants was that it depends and that a different style can be appropriate depending upon the circumstances. Dr. Winstead then discussed participatory management vs. crisis management and under what circumstances each could be called upon by the leader. The discussion followed with how a leader is developed and that there really are very few “natural born” leaders. For most of us it is a matter of learning and developing a set of skills. Mentorship is critical but it is not necessary to have a mentor in the immediate work area. A mentor can be at another site altogether with communication via phone, scheduled meetings, etc. It is generally recommended that the mentorship include a combination of activities.

It is essential that leaders actively network through listservs and professional organizations. Networking should not overtake the individual’s primary job and always remember that no one is irreplaceable. Dr. Winstead described the key components of leadership as:

- Filling a vacuum, take on things that need a leader
- Pursuing noble cause (most of good leaders success is attributable to this)
- Recruiting a good team
- Inspiring the team and the masses
- Being bold, step up to the plate and take on a big problem
- Taking risks
- Aiming high and pushing the envelope, using “carrots”
- Challenging the odds
- Rolling up their sleeves, stay in touch with the real people in the Department by doing the work
- Don’t ask somebody to do something you wouldn’t do yourself
- Leading the way in times of crisis, you need to be there. Dr. Winstead talked about the manner in which he was consistently available to his faculty during hurricane Katrina even when that necessitated using a remote office location.

In terms of one’s own professional development, it is important to work for a boss that fosters your career development. In addition leaders should take advantage of courses that are available at your university as well as options for courses at other universities in your community. Lastly, Dr. Winstead urged the audience to keep your options open including options at other universities, academic medical centers, HMO’s and in private practices.

Website Interactive Session

Jim Myers
Seattle Children’s Hospital

Lacinda Riesland (by phone)
University of Alabama

By Beth Ambinder

Jim Myers (Seattle Children’s) and Lacinda Riesland (University of Alabama) talked through the website and what is available to members as a tool to stay connected with the organization. Attendees logged onto their laptops and navigated around the system and provided feedback regarding any aspects that might be ideas for future website development.

If anyone is continuing to have difficulty and would like to provide additional feedback, our webmaster is David Allen Barton (University of Alabama) and his email address is barton@uab.edu.
Conference Highlights

Engaging Faculty in Continuous Performance Improvement

Debra Gumbardo, R.N., MS, NE-BC
Director, Psychiatry and Behavioral Medicine
Seattle Children's Hospital

By Beth Ambinder

Ms. Gumbardo presented the program she coordinates at Seattle Children’s Hospital that serves the four state region of Washington, Idaho, Alaska and Montana. The facility has 250 beds, 20 of which are dedicated to Psychiatry, 330,000 total outpatient visits, including 40,000 Psychiatry visits and 6,000 employees. To engage faculty staff in continuous performance improvement they must first become familiar with theories of change management. This begins with discussing how to choose the problem to address and having all the tools in the room that people will need to do the job you want them to do. This needs to be followed by weekly updates and a plan for celebrating wins. If the leader isn’t the best person to do this, find someone on the team who is. Faculty leadership should be partnered with an operational manager. The philosophy of improvement at Seattle Children’s has the following components:

- Patients and families first, and faculty align around this principle
- Support staff in their work, plan a two hour meeting where managers are out in the work place
- Use data to drive change
- Long term approach

Waste in a process includes both underserving and over serving and according to the tents of the Toyota model, 95% of what we do is waste. People will do work a rounds to have the things they need to do their work. Both Ms. Gumbardo and Jim Myers, our board member, have attended extensive training in Japan studying their continuous performance improvement model. The first steps include:

- Organizational mandate – to focus on safety and improvement
- Education/training – initial and ongoing
- Acknowledge the Myth of Psychiatry
- Focus on process vs. clinical intervention

In developing a vision, it is important to align needs with the goal. For example, included in sustaining a nationally ranked child and adolescent psychiatry training program should be aligning resident program size with community needs.

Goals for continuous performance improvement need to be aligned with the institutional goals such as limiting cost increases to below inflation and improving access to in and outpatient care.

Following the trip to Japan, a daily management system for ambulatory care was posted in the faculty and staff break room. From employee engagement surveys the need for more work life balance and involvement in decision making was identified. The need for “huddles” and addressing safety concerns were also identified. An outcome was improved regarding resident workloads and the ability of residents to alert scheduling staff to the kinds of cases they needed for a better training experience.

Ms. Gumbardo closed with the observations of her faculty about the process as follows:

- Get everyone on the same page, speaking the same language
- Acknowledge clinical expertise – build competencies in change management
- Engage CPI experts to partner with faculty to lead the process
- Make CPI events fun, focused and well – planned
- Make sure the right people are on the team
- Reduce productivity expectations to allow participation
- Pay for performance

CPT Code Changes/Implementation

Sarah Thomas
Clinical Department Administrator
University of New Mexico

By Sarah Thomas

Effective January 1, 2013 many behavioral health CPT codes will be eliminated or changed and several new codes will be added. Sarah provided an overview of the information currently available for the 2013 changes.

CPT changes

Initial Eval codes 90801 and 90802 will be eliminated and replaced by a code for diagnostic eval with medical services and one for diagnostic eval without medical services.

Pharmacologic Management (90862) will be eliminated. Physicians will use E&M codes (99xxx series) instead.

Psychotherapy codes for outpatient, inpatient and interactive therapy (90804-90829) will be combined under 6 new codes (90832-90838) with an add-on code for interactive complexity and use of the appropriate E&M code for med management.

(Continued on page 7)
SAYING THANKS! Through Staff Recognition

Glory Novak, MBA
Department Administrator
University of Arizona

By Beth Ambinder

As a former Human Resources Manager, Glory has a great deal of experience with what it takes to not just retain staff but to encourage them to maximum productivity. The traditional reward system, which is largely one of compensation, is not providing the competitive edge that employers need for the following reasons:

- Pay checks alone do not motivate
- Staff increases are a scarce reality in university environments
- Intrinsic motivational power of non-cash rewards
- Ask your employees what they want!

Performance based programs are increasingly popular but these can be difficult to manage with many diverse roles and unclear expectations that may lead to feelings of favoritism.

Things that cost little if any money include bringing and sharing food, liberal dress for a special day (jeans), and asking employees “how are you?” and listening to the response.

The psychology of recognition is described in Maslow’s hierarchy of needs and includes the need to be appreciated and the need to “belong”.

Programs should be:
- More spontaneous than planned
- Unique or different
- Robustly applied by managers
- Sincere
- Consistent with a highly held value for example if patient centric, celebrate something that represents great care of patients
- Developed with employee involvement
- Evaluated periodically by employees
- Exciting
- Widespread; everyone has a chance to win
- Changed periodically

Glory then offered some do’s and don’ts with examples of do’s in making the event public, fun, and acknowledging the entirety of the employee. Among the don’ts were focus solely on longevity, the cost, and acknowledging staff only during scheduled events.

Glory then shared some events that she has coordinated for her staff. One was a themed “stars of Psych” weeklong celebration with shining star sharing accolades and accomplishments. Along with star shaped cookies, an ice cream social with the “stars” served by the faculty and trainees. Star bags with candy, themed pencils and notepads (note the food emphasis throughout!). Another event was a de-stressing event with a comfort food lunch in a quiet lunch room with raffles for baskets containing calming items, chocolate and gift cards for coffee breaks. The real surprise came at the end with free table or chair massages for all staff. Another occasion tied school spirit for the University of Arizona with items containing the UA logo as giveaway items. The last one was a themed “Good as Gold” event with lunch from the Golden Dragon, lemon muffins and golden delicious apples and bags of gold candy.

Glory’s closing quote from an unknown author was “People may not remember exactly what you did or said, but they will always remember how you made them feel.”
Identification and Integration of Academic Resources into a Frontier State – The Wyoming Experience

James Bush, M.D., FACP
State Medicaid Medical Officer
Wyoming Department of Health

By Beth Ambinder

Dr. Bush began with some of the demographic information that spoke to the challenges he faces as a psychiatrist in a frontier state. He explained that there are only two remaining frontier states, Wyoming and Alaska, designated by large land masses with small populations. The states of Maine, Massachusetts, New Jersey, Vermont, New Hampshire, Connecticut and Delaware combined have fewer square miles than Wyoming. In addition to the size of the state, mountainous terrain and significant amounts of snowfall that make roads impassable contribute to the challenges of getting care to patients. In terms of providers, compared to Washington’s 859 primary care physicians and 0.15 psychiatrists per 1,000 populations, Wyoming has only 536 and 0.09 respectively. Suicide rates are high and people are often afraid to ask for help.

In terms of mental health for children, there are only six child psychiatrists in the state and more children are entering the foster care/mental health system at significantly higher costs. It is often difficult to arrange evaluations for these children with a trained professional prior to placement. As in other states, children in foster care are on more psychiatric medications at higher dosages at younger ages.

Due to the shortage of psychiatrists, care is often provided by primary care physicians who expressed their concerns in a survey which portrayed the following results;

- 62% felt they could not meet the mental health needs of their patients
- 69% felt they could NOT consult with a mental health specialist in a reasonable length of time
- 66% felt their patients got good mental health care less than half of the time
- 78% felt less than half the time they could accurately diagnose behavioral health problems

An intervention was undertaken to address concerns identified in the survey with the following objectives;

- To provide appropriate screening for all children who were referred to the legal system
- To provide chart reviews on those children who have been prescribed psychotropic medications
- Beyond the standards set up by the Office of Pharmacy Services P & T Committee
- To provide elective consultation and collaboration care services for primary care providers providing services to Medicaid eligible children.

The PAL Program was established as a primary care support system offering toll free calls to an academic medical center with affiliated child psychiatrists.

Many physicians expressed thanks to the PAL team for providing them with the support they need to provide quality care to their patients. One outcome was an increased level of confidence titrating medication dosages down following a hospitalization.

As a result of the assessments there was less frequently found need for inpatient placements and more care within the child’s community and financial savings. Since the state of Wyoming has only three psychiatric residential treatment facilities, children were being sent out of state to places as far away as Chicago and Alabama making contact with family difficult.

Dr. Bush’s final point was that the work done by the University of Washington is a potential source of revenue for Academic Psychiatry Departments across the country. Working with Medical Assistance, the ability exists to identify prescribers whose prescribing practices fall outside standard practices and to perform case reviews on these patient charts. There are benefits to both the patients whose care is not within best practice standards and for Medical Assistance who is providing funding for medications that are not being prescribed to the maximal benefit of the patient.
Outpatient Best Practices

Lindsey Dozanti
Department Administrator
Case Western Reserve University/University Hospital

Jeff Charlson
Department Administrator
University of Wisconsin

By Beth Ambinder

Jeff had previously spoken at the spring meeting on the steps he has taken at the University of Wisconsin and was asked to return as this had been one of the most highly rated presentations of the spring meeting. Jeff referred to his concept of access to care for outpatients as ‘treatmentage’ meaning that we should strive to reduce the preparation we expect of patients and let them get in front of us. A biweekly clinical care group meets and covers a lot of cases in a short time. Patients who have been coming in weekly for many years need to be assessed on a regular basis to determine if there is a realistic expectation that further progress is anticipated or if the program is really the right fit for their needs.

Lindsey’s interest led to her undertaking a “Lean Six Sigma” following an intensive training course she attended. She focused on the Child and Adolescent Division which despite some interventions was unable to reduce its no show rate over a two year period. The project is ongoing but the questions being asked include:

· What are the top three reasons for no show
· Are particular days and times most vulnerable to experiencing no shows
· Does the incidence of no shows increase as the time out to the scheduled appointment increases
· Does the compliance rate for charging for no shows reduce the incidence

The plan is to collect data and implement processes to reduce the incidence. Also to report the data to providers with the expectation a no show process will be established.

Benchmarking

Janet Namini-Ferino
Administrator
Northwestern University

By Beth Ambinder

Since the original benchmarking survey was done a few years ago, Janet has been working with Pamela Wellesley (Vanderbilt) and John Herzke (Johns Hopkins Hospital) with the goal of reducing the amount of work respondents would experience when completing the survey. The resulting shorter version would be anticipated to increase participation. We discussed some of the items that the group felt were critical to retain and developed the following items:

· Revenue for faculty and clinical staff
· Which services run a profit
· Where is gap funding coming from
· Length of visits
· Appointment process
· How do you deal with non-compliant patients

This list would be vetted through the Chairs Committee and the actual survey would be available through Survey Monkey.

One consideration is how we can manage and cull the data as this is a time consuming process learned from the previous survey.

Additional information that was thought to be important was related to the research enterprise and includes:

· Submissions and outcomes
· Vetting process
· Awards
· Expenditures
· Productivity measures
· $/square foot
· Staffing methodology for pre and post award management
· How do we fund our research world

The research enterprise may be a topic for a future meeting as many of our members work in environments where this is a large focus of the department and not an area that has been covered extensively in meetings over the last few years.
Johns Hopkins Psychiatry Named #1 by US NEWS & World Report

Interview with Beth Ambinder, Administrator, John Hopkins Medicine—conducted by Pat Kersey, Mayo Clinic

Congratulations to Beth Ambinder and Dr. DePaulo Jr. for being selected #1 Psychiatry program in the country again. This recognition speaks to your Department Chair’s as well as your, and Johns Hopkins Hospital’s commitment to excellence in patient care, research and education.

Thank you, Pat. It is a great honor to receive this recognition among the excellent academic programs included in the survey. As you know Johns Hopkins Hospital was ranked as a whole at #2 behind the Massachusetts General Hospital, so being one of the five departments who retained this ranking was really important to us. Although there are always questions raised about the real meaning of the survey results, we believe that this ranking is beneficial in a number of ways. In terms of recruitment, interest by medical students in Psychiatry in general and it pursuing this specialty as residents at Johns Hopkins is increased leading to excellent residency candidates. Since many of our faculty is alumni of our residency, this will offer the opportunity to recruit faculty in the future that will continue the traditions that lead to this achievement. We are also reaching more patients, especially those with highly complex diagnoses as the patients and families from great distances contact our physicians because of the rankings. I would also like to mention that Johns Hopkins Hospital is also designated a Magnet Hospital which recognizes excellence and professionalism in nursing care. I mention this as we take great pride in our multidisciplinary care of patients and feel that it is the care patients receive from physicians, nurses and social workers that contributes to our national reputation. Lastly, the groundbreaking research done by our physicians and scientists is also recognized by our peers and is reflected in this recognition. Honestly though, we are very humbled by the world class departments of Psychiatry across the country that we are fortunate to have as collaborators and colleagues who join us in being recognized by the US News and World Report for their expertise and excellence.

Our members are interested in these rankings and the selection process. Can you tell us about the selection process US NEWS & World Report uses for Psychiatry?

Psychiatry is one of four programs/Departments that US NEWS ranks based on national reputation. The four ‘reputation only’ Departments are Psychiatry, Preventive Medicine & Rehabilitation, Ophthalmology, Rheumatology. Other Departments have multiple data driven criteria that are used in their selection plus reputation survey responses. These data are provided by the medical centers that are invited to respond to the US NEWS survey forms. The reputation scores are based on national survey results.

US NEWS surveys psychiatrists across the country asking where they would refer a patient. The reputation survey responses are used to rank order Psychiatry Departments based on frequently of being named. The top 10 are listed following this interview.

I would just like to add that I think being an active participant in the National Association of Academic Psychiatry Administrators has given me unique opportunities to reach out to colleagues on many topics through our very active email exchanges. In addition, I always return from our biannual meetings with new information and ideas on innovative approaches to our common challenges. I know there is real benefit to my Department from my membership as I am frequently asked by physician leaders in my Department to survey my NAAPA colleagues on how they address issues. Even when you are #1, you still have to strive to do things more efficiently and effectively and I would encourage my colleagues to get involved with the organization and the benefits it offers for their institutions.
US News and World Report 2012
National Rankings: Psychiatry

1. John Hopkins Hospital—Baltimore, MD
2. McLean Hospital—Belmont, MA
3. Massachusetts General Hospital—Boston, MA
4. Menninger Clinic—Houston, TX
5. New York-Presbyterian University Hospital of Columbia and Cornell—New York, NY
6. Sheppard and Enoch Pratt Hospital—Baltimore, MD
7. Mayo Clinic—Rochester, MN
8. Resnick Neuropsychiatric Hospital at UCLA—Los Angeles, CA
9. UPMC-University of Pittsburg Medical Center-Pittsburgh, PA
10. Austen Riggs Center-Stockbridge, MA
11. Yale-New Haven Hospital—New Haven, CT
12. Stanford Hospital and Clinics—Palo Alto, CA
13. Barnes-Jewish Hospital/Washington University—Saint Louis, MO
14. Hospital of the University of Pennsylvania—Philadelphia, PA
15. Emory University Hospital-Atlanta, GA
The Language of Mental Health
A Glossary of Psychiatric Terms

Interview with Author Narri Shahrokh, Chief Administrative Officer, University of California Davis - conducted by Pat Kersey, Mayo Clinic

Congratulations on the publication of your book, The Language of Mental Health. There was a great deal of interest and enthusiasm at our recent conference in Jackson, WY. I am sure all our members would like to learn about your book.

What prompted you to write the book *The Language of Mental Health: A Glossary of Psychiatry Terms*?

I was given the opportunity to edit this book by my Chairman Dr. Robert E. Hales who serves as Editor-in-Chief for the American Psychiatric Press. I have over 14 years' experience as the Psychiatry Chief Administrative Officer so it is a field that is familiar to me. In addition, I viewed this as a great opportunity to expand my knowledge and help those who work in the complex field of psychiatry.

Who is the targeted audience?

The audience is really anyone interested in psychiatry and particularly those who are new to this field. This includes mental health professionals, as well as patients and their families, and mental health advocates. In addition, attorneys who deal with the consequences of psychiatric illness will find it helpful to have concise descriptions of the various terms that we use and they need to understand.

Tells about your co-authors.

My co-authors were Robert E. Hales, M.D., M.B.A., Chairman of the Department of Psychiatry at University of California Davis, Katharine A. Phillips, M.D. of Brown University, and Stuart C. Yudofski, M.D., Chairman of the Department of Psychiatry at Baylor College of Medicine in Houston, Texas. All are recognized experts in this field. Each has tremendous breadth and depth of knowledge and experience and they helped me refine the definitions. This work was based on previous editions plus new terminology that has developed to reflect the more recent developments in the mental health care field.

This was very rewarding and a tremendous personal growth experience for me. I thoroughly enjoyed working with my co-authors and drawing on their expertise. The process took about nine months of weekends and evenings to write and revise all of the definitions.

How did you go about publishing it?

I was fortunate to be commissioned in 2003 by American Psychiatric Publishing, Inc. (APPI) to edit the American Psychiatric Glossary, 8th Edition, which was then translated into Spanish and Polish. In 2011, I was asked to update that to incorporate new terminology, drug information, mental health resources, and legal terms.
A Decade of Perspective

By Thomas R. Insel, M.D.—National Institution for Mental Health (NIMH), posted on his NIMH blog November 5, 2012.

Forwarded By Hank Williams, MPA

[Thomas R. Insel, M.D., director of the National Institute for Mental Health, posted the following in his NIMH blog on November 5. It is an insightful and thoughtful look at where we have been, and where we are going, in science and research, on his tenth anniversary as director. I am happy to have the opportunity to use my space to share his words. These are excerpts, and not the full text, of the posting. Dr. Insel’s blog appears regularly on the NIMH website, www.nimh.nih.gov.]

A Decade of Perspective

By Thomas Insel on November 05, 2012

In another week or so, I will have been director of NIMH for ten years.

A decade is long enough to witness two cycles of five-year grants, several generations of post-doctoral fellows, and turnover in most of the leadership of NIH and NIMH.

The perspective that comes with longevity is really about understanding how to balance the urgent public health need of patients and families with the slow and serendipitous path of science.

Science sometimes seems to produce more questions than answers. In a world of mental anguish where “time matters,” it may be hard to accept that science is a marathon not a sprint. But a decade of leading NIMH only confirms my belief that rigorous, unbiased science is the best answer—really the only hope—for delivering the preventions and cures needed so urgently for people with mental disorders.

It takes more than a decade, but there are no shortcuts for our science, there is truly not a moment (or a dollar) to waste. Plant it now.

Much of the history of psychiatry is tragically about blaming parents or sometimes blaming the person unlucky enough to become ill. Science can falsify these presumptions about cause—setting a limit to infinite error. And it helps us to set a higher bar for treatment, recognizing that current treatments are, at best, stepping stones to preventions and cures.

But there is a more fundamental role for science, which is nothing less than the quest for understanding our world. The homeless man with schizophrenia, the non-verbal child with autism, and the soldier with PTSD need services and treatment, but also understanding—because the quest for understanding spawns compassion, intimacy, and even wonder. The past decade at NIMH has been all about this quest, recognizing that after six decades, we are still at the very beginning of understanding the world of mental illness. There really are no short-cuts.

But I believe we are on the right path, trying to solve mysteries from neurons to neighborhoods and the vast landscape in between, with tools that get better every year. Medicine recently has had spectacular successes: brilliant science has transformed how we can prevent or cure heart disease, AIDS, and now several forms of cancer.

We are not there yet for any of the serious mental disorders that NIMH has pledged to prevent and cure. But make no mistake, these are mysteries with a solution. Genomics and neuroscience are revolutionizing the search with powerful new tools that will yield biomarkers, new diagnostics, and better treatments.

It is when we hit a new level of understanding measured by patients, not papers, that there is truly a breakthrough. I know that “time matters.” I also know that science is not a sprint. But the marathon is not endless. At this ten-year mark, when I am breathless, it is not from the distance traveled or seeing the distance ahead, but from the challenge of keeping up with the progress around me.

There is an old story, no doubt apocryphal, that President Kennedy asked a White House gardener to plant a great oak tree outside the rose garden. The gardener hesitated, explaining it would take decades for the oak to grow into a great tree. Kennedy responded, “Then there is not a moment to waste. Plant it now.”

Because “time matters” for people with mental illness and because there are no shortcuts for our science, there is truly not a moment (or a dollar) to waste.
The Executive Suite

Hurricanes and Psychiatry

By David Peterson, MBA, FACMPE

It’s the tail end of hurricane season but no one told that to Hurricane Sandy (now labeled a “Superstorm” it seems) and as some of the most recent listserv traffic has noted, many of us from around the country are thinking of our colleagues in the eastern part of the United States that were struck by the latest storm. It’s likely no stretch to note that our group’s past President, Jim Landry, CMPE (Tulane) is probably thinking about Hurricane Katrina as he reads about Sandy.

With the fullest of respect to those struck by a real hurricane, the business of psychiatry (not to mention the business of medicine in general) is being struck by what seems to be hurricane-like changes, so it seems timely to comment on a handful of changes that come immediately to mind, changes that are affecting each of us.

CPT Code Changes Effective January 1, 2013

The changes in coding for mental health services have been a hot topic in the ether. The changes occur in psychiatry’s bread-and-butter codes that we all know by heart. The changes notably hit the diagnostic evaluation code (90801), therapy codes (90804-90808) and medication evaluations (90862) to name a few. Clearly the changes will affect how services are documented and as some have noted, even affect how provider schedules might be built. Clarifications on how and what to document seem to be daily breaking news and each of us is working through the changes and thinking about the impact on our departments.

Sequestration Effective January 1, 2013

The popular press likes to refer to it as “the fiscal cliff,” but “sequestration” is the action in Congress that was adopted as part of the debt ceiling negotiation in the summer of 2011. Essentially, a $1.2 trillion budget cut was enacted to allow for the debt ceiling to be raised, an act that will result in automatic cuts to the federal budget if an agreement between leaders in the Executive and Legislative branches of government isn’t reached before January 1 to stop it.

Although the entire federal budget would be affected by sequestration, cuts affecting departments of psychiatry would be scheduled to occur in NIH, Medicare and Medicaid, to name three programs. Because of the uncertainties and variables attached to the elections and political process in general, planning for this type of fiscal storm is almost impossible.

Affordable Care Act (ACA) - Ongoing

New components of the ACA continue to take effect, adding impetus to healthcare consolidation and the development of Accountable Care Organizations (ACO’s). While the ACA has caused changes in the marketplace, some argue that systems and business in general remain frozen, holding back, while awaiting the outcome of the elections in November. Regardless of the outcome, change is afoot and retaining an ability to respond nimbly to the marketplace is prudent.

Local Issues

To borrow from former Speaker of the House Tip O’Neill who said “all politics is local,” healthcare is also quite “local” and each of us is addressing local, stormy weather either organizationally or in the marketplace itself.

The bottom line? Preparedness for stormy weather should be the rule of the day.

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@mcm.edu or at the Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, Wisconsin 53226.
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