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FUTURE OF PSYCHIATRIC SERVICES, LITERATURE SCAN, AND INTERNET2: Is There an Association? Sy Atezaz Saeed, M.D.

And the answer is Yes....this issue!

I am quite excited about the contents of this issue of the *Psychiatrist Administrator*. We have no other than John Talbott, M.D. contributing the lead article for the issue in which he very eloquently paints a vivid picture of the field while identifying major trends in recent history. Dr. Coffey, the recipient of this year's Administrative Psychiatry Award, a joint APA–AAPA venture, offers a commentary on Dr. Talbott's lead article. And, Dr. Lazarus offers a thought piece on the significance of "Soft Skills" for psychiatrist administrators.

Literature Scan

A brand new column starting with this issue is "Literature Scan". Last year Paul Rodenhauer, M.D. suggested that *Psychiatrist Administrator* offer a regular column that provides the reader an overview of what is appearing in literature on the subject of psychiatric administration and management. With this issue we start a new column to do exactly that. I am very pleased to welcome Jo Dorsch as the Column Editor for literature Scan. She is the Health Sciences Librarian at the Library of the Health Sciences-Peoria, University of Illinois at Chicago, where she is an associate professor with an adjunct appointment in the College of Medicine. She is a Distinguished Member of the Academy of Health Information Professionals and a National Library of Medicine/Association of Academic Health Sciences Libraries Leadership Fellow. Ms. Dorsch's research interests include evidence-based medicine, curriculum-integrated knowledge management instruction, and information outreach. She is the recipient of multiple grants including ones from the National Library of Medicine. She publishes widely in the library literature including contributions to the *Journal of the Medical Library Association*, *College & Research Libraries*, and *Medical Reference Services Quarterly*. She also contributes journal reviews, with physician co-authors, to the *Journal of the American Medical Association*.

Internet2

Having had an opportunity recently to learn something

about Internet2, I thought that it might be of interest to our readership to see what Internet2 may bring to the field of mental health. I invited Dr. Yost to write an article on the subject of Internet2 and its relevance to our field.

Internet2 is a consortium being led by 206 universities working in partnership with industry and government to develop and deploy advanced network applications and technologies, accelerating the creation of tomorrow's Internet. Internet2 is recreating the partnership among academia, industry and government that fostered today's Internet in its infancy. The primary goals of Internet2 are to¹:

- Create a leading edge network capability for the national research community
- Enable revolutionary Internet applications
- Ensure the rapid transfer of new network services and applications to the broader Internet community.

Internet2 is not a separate physical network and will not replace the Internet. Internet2 brings together institutions and resources from academia, industry and government to develop new technologies and capabilities that can then be deployed in the global Internet. Close collaboration with Internet2 corporate members will ensure that new applications and technologies are rapidly deployed throughout the Internet. Just as email and the World Wide Web are legacies of earlier investments in academic and federal research networks, the legacy of Internet2 will be to expand the possibilities of the broader Internet. As Dr. Yost points out in his article, more than a faster Web or email, these new technologies will enable completely new applications such as digital libraries, virtual laboratories, distance-independent learning and tele-immersion. A primary goal of Internet2 is to ensure the transfer of new network technology and applications to the broader education and networking communities.

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1. <http://www.internet2.edu/about/faq.html>.
ACCESSED March 12, 2004

THOMAS W. HESTER, M.D.



Aloha, fellow members and friends of the American Association of Psychiatric Administrators (AAPA). In my last column I briefly discussed three initiatives that were being taken to help revitalize our organization. These initiatives were:

to conduct conference calls of the executive committee throughout the year; to increase financial support for our NewsJournal; and to send targeted membership solicitation letters. In this column I would like to update you on the progress of these initiatives.

First, conference calls were conducted on August 8, 2003, October 31, 2003, January 22, 2004, and March 11, 2004. I was very pleased by the quality and level of participation. In conjunction with our annual face-to-face meeting in May, these teleconferences provide the continuity and time needed to effectively support our organizational work. Minutes of these meetings are posted on our website, www.psychiatricadministrator.org.

Second, as a result of Dr. Hatti's efforts, a grant was secured from GlaxoSmithKline to support our NewsJournal. The Executive Committee agreed that once ongoing financial support allows, the publication of our NewsJournal would increase from its current level of twice a year to three or even four times annually. Dr. Saeed's excellent editorial stewardship and the high quality of the articles warrant more frequent distribution. Dr. Saeed is receiving much needed help with the appointment of Dr. Lazarus as associate editor of the NewsJournal.

Third, largely as a result of Frances Roton's efforts, our paid membership has increased. Letters soliciting membership to our association were sent to psychiatrists who took the 2004 AAPA CME Course,

and to the members of the National Association of State Mental Health Program Directors' Medical Directors Council, and the American College of Physician Executives.

In addition to facilitating work on these three initiatives, the teleconferences provided opportunities to conduct a thorough review of our financial situation. Dr. Hatti analyzed the budgets and expenditure reports of the past several years in order to understand the roots of our financial problems. He concluded that the deficits over the last two years were primarily caused by a decrease in outside financial support. However, I am very happy to report that as we enter 2004, we are no longer in a budget deficit.

Several important changes have occurred in our Executive Council. I regret that Dr. Sowers had to resign as our Treasurer, because of his responsibilities as President of the American Association of Community Psychiatrists. We wish him well and appreciate his continued support and involvement with AAPA. I am very pleased that Dr. Lazarus has agreed to serve as our Interim Treasurer and that Dr. Herman and Dr. Vergare have joined us as councilors. We will be looking for someone to serve as our Secretary at our meeting in May.

Finally, I would like to update you on our annual meetings in May. Dr. Reid will be speaking at our Membership Luncheon. His topic will be "Organization Liability for Clinical Staff Negligence: *Beyond Respondeat Superior*." The annual membership luncheon will be held in the Julliard Room of the Grand Hyatt on Tuesday, May 4, 2004 from 12:00 noon to 2:00 p.m. The Executive Council meeting will follow from 2:00 p.m. – 6:00 p.m. in the Morosco Room, Conference Level of the Grand Hyatt. This extended Executive Council meeting will be dedicated to strategic planning. All members are welcomed to participate. I look forward to seeing you in New York.

THE FUTURE OF PSYCHIATRIC SERVICES: Is There Any?

John A. Talbott, M.D.

Textbooks of Administrative Psychiatry tend to chronicle the issues, problems and opportunities facing the field at the points in time of their publication despite their unstated wish to provide information that is not time-bound. For example, the first such text, Walter Barton's estimable "Administration in Psychiatry," published in 1962, dwelt largely with administrative issues encountered in the state hospital, which was at that time the primary site of treatment of the mentally ill; while his second text, "Mental Health Administration," published in 1983, dealt more with community psychiatric issues. Likewise, Saul Feldman's two editions of "The Administration of Mental Health Services," published in 1973 and 1980, reflected administrative issues at the height of the era of community mental health and community mental health centers.

In addition to this current edition, I have been the editor of two earlier textbooks of administrative psychiatry (Talbott and Kaplan 1983, Talbott, Hales and Keill 1992). Published in 1983 and 1992 respectively, each also reflected the times we lived in. In 1983, the era of community care, what some have called the post-deinstitutionalization era, was in full swing and efforts to patch-up the failures of that movement were reflected in that edition. Likewise, in 1992, issues of cost-containment and managed care began to be discussed.

Therefore, it is no surprise that the most recent edition of the APPI Textbook of Administrative Psychiatry reflects the changing times we now live in. I will try to summarize and synthesize some of the trends, themes and issues that have surfaced repeatedly in this text, without repeating the details so ably provided by the chapter authors. In addition, I will discuss some of the implications of these trends for psychiatric administrators. I will discuss them under six headings: Patient Trends, Treatments, Systems Issues, Reimbursement and Revenues, Technology and Language.

Patient Trends

Patient trends were and are powerful predictors of services and systems efforts. The trends that have most affected psychiatric services in the past include demographic, diagnostic and economic ones as well as the location where patients were treated and their changing roles, from passive recipient through collaborator to advocate and provider.

Demographic Trends: We continue to experience a further "graying" of America, with the life-extension of the American population leading to more senior citizens, more frail elderly and more of the elderly with medical and psychiatric problems, as well as a higher incidence of co-morbid chronic conditions. (In addition, the population described by Bachrach (1983) as the "young adult chronic patient" is now no longer young, and the insufficient care and treatment they received is further complicating their movement into the older age group.) The implication of this trend of the "graying of America" for psychiatric administrators is that our services need to become even more heavily involved with primary care specialists and gerontologists and in settings where the elderly are housed, e.g., nursing homes, retirement communities, assisted living settings, etc. (Talbott 1998). While continuing to train geropsychiatrists, we must also train general psychiatrists to better treat the elderly who have both psychiatric and medical problems.

Diagnostic Trends: Co-morbidity of medical and psychiatric conditions is very common among the elderly and co-morbidity of psychiatric and addictive disorders is very common in the younger age groups. Across the age spectrum, we are seeing many more patients with co-occurring psychiatric, medical and developmental disability problems. Surely the most vexing example is that posed by co-occurring mental illnesses and addictions, which as we have learned from the National Comorbidity Study, are extra-ordinarily common. The implication of this trend for psychiatric administrators is that services must be broader, more inventive and increasingly more modeled after those dual-diagnosis programs that combine addictions and psychiatric philosophies of treatment (e.g., lay-directed self-help as well as professionally-prescribed medication) and practices (e.g., 12-step programs as well as cognitive therapy). (Ridgely, Goldman and Talbott 1989).

The Severity Issue: Overlapping the two trends detailed above is that of the increased severity of the illnesses we are seeing, combined with the fact that patients are now seen for shorter lengths of time with different goals for treatment episodes than just a few years ago. Whether in the hospital, outpatient clinics or "private" offices, the rule regarding patients and their hospital stays is certainly - "sicker and quicker." The implication of this trend toward

increased severity, for psychiatric administrators, is that our services must be better equipped to diagnose, treat and follow-up severely mentally ill persons in less time and with fewer resources, while maintaining our effectiveness.

Economics: The two economic trends that have had and will continue to have the most impact on patients, are the burden of caring for the uninsured and cost-control/cost-cutting, carried out at this moment through the aegis of managed care. The implication of the move to managed care for psychiatric administrators is probably the most discussed issue in this text. It includes almost every topic to which we have devoted a chapter; from leadership to staffing; from cultural issues to ethical ones; and from the “private” sector to the “public” one. The implications for psychiatric administrators of our society’s continuing unwillingness to provide all Americans with health insurance is that we must advocate for a political solution to the problem while struggling with the ethical and clinical dilemmas of providing what we often think is substandard care or suffer economic consequences in a highly competitive market.

Issues relating to where patients are seen: Especially for psychiatric administrators working in the “public” sector, the vast shifts in where patients are located presents challenges for the present and future. For example, whereas 40 years ago, the preponderance of the severely mentally ill were in hospitals, now they are in a host of “community” settings, including “homes” that vary in quality and accessibility as well as some places that are even more difficult to reach, e.g., the correctional system and shelters for the homeless. The implication of this trend for psychiatric administrators is that if we are both ethically and/or contractually mandated or required to provide care for all the mentally ill wherever they are, the way we provide services and our ability to track patients must be improved.

Participation: One of the trends that has become more significant during the past few years is the increasing incidence of citizen/patient/consumer participation in decision-making. Whereas in the 1960’s, citizen participation was part of the community psychiatry ideology, now it is a necessary ingredient of “public” managed care initiatives and a potentially very decisive force if consumers of “private” managed care exert their influence rather than let insurance executives and benefit managers continue theirs unmodified. It must be mentioned, however, that one disturbing development is the increasing tension between primary consumers and secondary ones, e.g. family members, making some

decisions hard to reach when “consumer input” is sought. The implication of this trend for psychiatric administrators is that these citizens/patients/consumers hold tremendous power and can have a profound impact on the way services are shaped, cut and/or provided. For whatever reasons, however, most effective citizen power has been exerted primarily through legislation ensuring access to non-psychiatric care, e.g., mastectomies, deliveries, etc. The burden of the stigma of mental illness in the private corporate world and lack of a critical mass in the public world seem to be the rate-limiting factors to their exercise of this potential power.

Treatments

Since the publication of the last edition of the text, we have seen the institution of or expansion of or modification of services due to scientific, demographic/epidemiologic, organizational and economic/administrative factors.

New services in response to scientific developments: Certainly, those services that are derived from research have more scientific credibility than those advocated for because of other factors, including economic, political or administrative reasons. Thus, cognitive-behavioral therapy and other short-term therapies for a variety of illnesses, combined with drugs and psychosocial treatment for depression and schizophrenia, group interventions and psycho educational approaches for the chronically ill, and the new antipsychotics and SSRI’s, are clearly shaping the clinics and service lines set up to deliver them. The implication of this trend for psychiatric administrators is that treatments that have recently been proven effective will continue to dictate the way services develop unless formulary restrictions prevent such or payment is denied.

New services in response to demographic/epidemiologic developments: There are also many services that have developed or thrived because of the demographic or epidemiologic trends detailed in the section on Patient Trends. Thus, the provision of services for some groups of patients has been driven by their prevalence in the population, e.g., services for the dually-diagnosed, elderly with both medical and mental illnesses, mentally-ill offenders, homeless mentally ill, nursing home residents and those chronically mentally ill in need of resocialization-rehabilitation. The implication of this trend for psychiatric administrators is that we must not only be prepared to serve existing groups of patients but those created by future unpredictable events.

New services in response to organizational developments: As a result of the trend toward the development of service and product lines that are

marketable in the current competitive environment, services are often shaped by organizational pressures rather than scientific or demographic/epidemiologic ones. Thus, we have seen behavioral health programs incorporate psychiatry and the addictions, geriatric and children's health services incorporate gero-psychiatry and child psychiatric services, and woman's health services incorporate psychiatric and psychological services. The implication of this trend for psychiatric administrators is that in the future, as now, market niches, popular and competitive services and packaging opportunities will have to be closely followed.

New services in response to economic/administrative developments: Economic and administrative pressures can also bring about the development of new services. For example, managed care has been singularly important in helping to stimulate the initiation or expansion of services such as triage and rapid treatment, short-term hospitalization, Employee Assistance Programs (EAP's), Culturally Competent Services and Women's Health Services. However, as Hollingsworth and Sweeney recently pointed out, some pressures to reduce services may actually be "penny wise, pound foolish," [my quotes] such as the decision to trim services for the chronic mentally ill under public managed care, notably rehabilitation, community support and non-medical counseling. The implication of this trend for psychiatric administrators is that economic and administrative pressures will continue to shape service provision and psychiatric administrators must be sensitive to market forces and demands. Undoubtedly, the next great wave of services will come as a result of technological advances (as Michael Freeman argued in the Introduction and I shall discuss further below.) Telemedicine represents one area of enormous need and opportunity; chat rooms and information for patients and families currently available on the Internet is another.

Systems Issues

There are several trends that are related to the systems of health and mental health care as a whole. They include integrated systems, the relationship between primary care and psychiatry, the behavioral health carve-out, networks of providers and the privatization of the "public" system. ***The development of integrated delivery systems:*** Integrated delivery systems mean different things to different people but in all cases bring about a greater necessity on the part of psychiatric administrators to interact with others and other systems. For instance, if a delivery system offers primary, secondary, tertiary and

quaternary care, its practitioners and administrators must interact with an active expanded cast of medical, nonmedical professional and administrative staff. Likewise, if a system encompasses hospital intensive care, step-down, alternatives and ambulatory care, interaction with team managers, patient coordinators and case or care managers becomes essential. And in a carve-in situation, psychiatrists and other mental health providers have increased commerce with all primary and specialty care providers.

Increasing ties between primary care and psychiatry: As mentioned above, one of the major trends in recent years is the increased interaction with those working in primary care. As primary care-givers do more and more of the gate-keeping and provide what were once tertiary care services, we will find increased opportunities to do formal "Outpatient Consultation-Liaison," elbow-to-elbow consultation in primary care satellites and teaching "how-to and when-to" (refer or treat). The implication of this trend for psychiatric administrators is that we have to find staff members who are willing and able to perform these new roles, comfortable at teaching others, able to keep their hands-off service provision and skilled at interacting effectively with primary care-givers.

The behavioral health carve-out: While there has been a defacto behavioral health carve-out since the creation of mental hospitals in America separate from general hospitals, the carve-out of mental health and addictions services and patients needing those services to BHCO's is a relatively recent phenomenon. For psychiatric administrators who have functioned in private hospitals and public systems, life goes on, but under different rules. However, for those in general hospitals, integrated delivery systems and those dealing with primary and tertiary care initiatives, "life" now means maintaining or developing the capacity to perform both carved-in and carved-out work. The implication of the trend of the behavioral carve-out for psychiatric administrators is that we must develop the entire spectrum of services, including EAP and sports' team products, as well as administrative, outcomes measurement, sophisticated information management and quality assurance and quality improvement ones.

The trend towards networks of providers: The ability to be able to deliver services on a larger than local level, often on a regional or statewide basis, requires a network of providers or partnerships. For psychiatric administrators who are accustomed to closed-staffs, small, elite, academic faculties or providers employed by the public sector, this represents a challenge. The implication of this trend for psychiatric administrators is that they need to develop

systems, staffs and monitoring capacities, either internally, through contracts, or through partnerships.

The privatization of the “public” system: As the public system “privatizes,” whether through “managed care” of traditional public entitlement programs, such as Medicaid and Medicare, or sales to or partnerships with private entities of hospitals, clinics and other community services, psychiatric administrators involved in such initiatives will see marked changes. Such changes include the adoption of standards, methods to improve efficiency and management techniques pioneered in the private sector, as well as the adoption of market-driven behavior, a greater spirit of entrepreneurship and competitiveness and thinking that is “out of the box” the “public” entity has been in. The implication of this trend for psychiatric administrators is that it requires skills and training and knowledge about a host of activities that may seem “foreign,” e.g., those acquired first by persons working in the Managed Care industry and later by those in large private provider groups.

From Reimbursement to Revenues

In the last 7 years, we have gone from depending upon and talking about reimbursement to depending upon and talking about revenues. This involves a number of areas. **Assumption of Risk in “Private” Managed Care:** From the beginning, of course, managed care companies have operated in a fixed income, prospective, essentially capitated economic system. But providers, whether individual practitioners, provider groups or larger systems of care currently continue to receive much of their income retrospectively. Only as we move more steadily towards providers taking risk, will we see them turn toward prospective revenue and away from retrospective reimbursement. The implication of this trend for psychiatric administrators is that if costs can be controlled, outcomes maintained and satisfaction ensured, budgets will be more predictable, but assuming risk means that one must have the ability to act rapidly, contract rapidly, and hire and fire rapidly as well as control costs, manage care of populations oneself and have the information systems, etc. to handle the job.

Contracts: A relatively new way large entities or provider groups have survived and/or thrived is by becoming contractors of services; for instance, contracting to provide addictions or emergency services for other hospitals, delivering crisis intervention services for geographic areas and providing care in long-term care facilities (e.g., nursing homes), etc. Such contracts, like capitation, lead to the creation of more predictable budgets, without the risk of capitation or the uncertainty of maintaining volumes of fee-

for-service activities. The implication of this trend for psychiatric administrators is that they must have the skills to negotiate fair contracts, to ensure fulfillment of each contract, to monitor all its own activities and to manage pressures at the margins (e.g., to serve patients not strictly covered by the contract).

Medicaid: The rapid acquisition by state governments of 1115 waivers granted by HCFA for Medicaid expenditures has been dramatic. Certain consequences of such new systems are now commonplace despite their differences in method and whether behavioral healthcare is carved-in or carved-out or in some instances both (e.g., in Maryland, substance abuse is in the carve-in; services for the mentally ill, not usually performed by a primary care physician, are carved-out). For instance, in most cases the monies allocated are less than was the case historically, start-up problems and indeed, massive “screw-ups,” are frequent, and psychiatric administrators on the state or MBHO side see things much “rosier” than those on the provider side (which is the case with “private” managed care as well, the difference here being that we expect government to be less efficient than industry but to “care” more about the populations for which they have historically cared for.) The implication of this trend for psychiatric administrators is that those working in systems that traditionally serve such populations are at risk of losing both their populations as well as their care systems; that a whole new set of skills and tools is necessary (as mentioned above); and that like the Postal Service, converting to a private model requires vast shifts in cultural contexts, operating modalities and staff attitudes and behaviors.

One or Two Systems: Elsewhere (Talbot 1998), I have discussed whether managed care or managing care would lead to a single system of care or perpetuate the two current systems, although not necessarily with its two-class difference. Looking at it one way, we could hope that the historical split (at least since the establishment of state vs. private mental hospitals) between the public and private populations would finally disappear under a single system of management, e.g. managed care. On the other hand, you could also argue that there is such a vast difference between the “private” acutely-ill population and the “public” chronically ill one, in illnesses, symptoms, disabilities, services need, monitoring and outcomes - e.g., the employed, generally adequately functioning citizen living in a family with shelter, benefits and “health insurance” vs. the unemployed or underemployed, lower functioning citizen from an often dysfunctional family with shaky shelter and uncertain or only government safety-net benefits and insurance - that the two populations will always

require different systems. The implication of this difference in these two “futures” for psychiatric administrators is vast; under a “single system” we could be training, working and managing in a very consistent manner, but the downside would be that we would try to fit all patients into rigid molds or we could continue to operate ambidextrously - e.g., training, working and managing in very different ways for very different patients and services.

Technology

There is no area with such explosive growth and vast potential to change the way we function as technological change. Michael Freeman has ably pointed out the “disruptive” implications of this revolution. I will try not to repeat what he said but point to some areas that will complement the points he made in the Introduction and I have been making in this concluding chapter.

Computers: In just a few years, the availability, power, and cost of computers and computer services has revolutionized our world. Personal computers, whether in the hands of providers or patients, permit access to the Internet, chat rooms, information services, etc.; a level of access to information and advice that has yet to be fully exploited. Patients, now able to use MEDLINE free or seek help regarding SSRI’s or talk to other patients, are truly “empowered.” Likewise, providers have access to data sets, MEDLINE, drug information and chat rooms to “consult” with others in real time.

Large computers enable insurance companies, MCO’s, MBHO’s and provider groups to perform provider profiling, billing, outcome measurement, etc. While the thorny issues of patient confidentiality and misuse of some provider/outcome data will never be fully resolved, one can only hope that well-protected patient registers will permit ethical providers to know instantly what medications, treatments and case management each patient is receiving. The implication of this trend for psychiatric administrators is that investments in computer technology, training, maintenance and new uses will continue to increase and that staying ahead of the curve will become increasingly important.

Telemedicine: For years we have struggled to provide services and manpower to underserved areas; largely in rural or inner-city areas. Now, through the power of technology, we are able to deal interactively with each other as well as patients and citizens in general. Except for teaching, research and consultation, psychiatry has been seen as a less fertile ground than other medical specialties for development of this technology. However,

there is currently a tremendous push to exploit telemedicine in psychiatry. Interesting cost-benefit questions arise; for instance, a trauma anesthesiologist colleague is assessing whether it is better to train 16,000 military medical technicians in critical airway support, an event they will be faced with at most once in their careers, or supply each with miniaturized cameras linked to experts who can “talk them through the procedure.” The implication of this trend for psychiatric administrators is that as with outpatient C/L or elbow-to-elbow consulting with primary care givers, we must become more skilled in giving advice, supervising others from a distance and conducting “virtual therapy.”

Outcome Measurements/Report Cards: Everyone states that eventually cost will no longer be the only determinant of choice of treatment, plan or provider - quality will become incorporated into the equation. Outcome measurement for individual patients and outcome and cost-outcome analyses for individual or combined treatments will become increasingly critical. On the flip side, report cards on the performance of MCO’s, MBHO’s, insurance companies or provider groups will also become more available and better utilized. The primary obstacle here is the difficulty in cleaning the research data so that apples are being measured against apples; or stated contrariwise, that the treatment of inner-city dually-diagnosed HIV patients is not compared with the treatment of phobias in suburban “soccer-moms.” Nevertheless, the implication of this trend for psychiatric administrators is that the measurement of everything will become more commonplace and again, our ability to articulate key questions and explain the data and their differences will become crucial.

Protocols/Treatment Guidelines/Disease Management: The proliferation of protocols, treatment guidelines and tools to assist in disease management is proof that there is agreement from both industry and professional bodies of the need to standardize treatment, improve outcome and utilize research data on effectiveness. Services research is a relatively new discipline and only in the last few years have results appeared that enable us to translate research into practice. However, the implication of this trend for psychiatric administrators is that we will be increasingly able to use hard data to drive clinical practice. The danger is that there will be confusion on which guidelines to follow if the trend continues toward the development of so many different sets of guidelines, which is the result of intense competition between the authors of the instruments who are affiliated with different professional associations, private groups and the

pharmaceutical industry.

Quality Assurance and Quality Improvement: In my mind, there is a difference between the attempts on the part of clinical administrators to improve the quality of care by measuring outcomes or comparing treatments in patient subgroups in various settings and the slickly-packaged “campaigns” by business administrators and marketing experts using almost incomprehensible jargon that are thinly veiled attempts to appear scientific while intending primarily to compete more effectively in the marketplace. The implication of this split in efforts for psychiatric administrators is that we must encourage attempts to truly improve quality of care that coincidentally can be used in marketing, not vice versa.

Virtually Everything: The combination of technologies, including computers, Internet, CD-ROM’s, television and cellular telephones, etc., is rapidly producing what will become a practice and administrative world in which almost all activities can go on interactively in real time. A danger I see in this “virtual everything” is that as rapidly as events are occurring now, it will soon get even worse and there will be no escaping the pressure to answer questions instantly or to solve problems in seconds. With cellular phones, modems, faxes and Federal Express, there is almost no way anyone can say anymore “let me think about that;” why does one need time to think when the patient and provider are on your video-screen, the data sets are on the Internet, and help, tests and services are available 24 hours a day, 7 days a week. The implication of this trend for psychiatric administrators is a bit frightening; maybe we’ll have to avoid over-virtualizing reality through team-management, shift work and “chunking out” of work. Otherwise, we may have no one willing to become a psychiatric administrator.

Language

It is said that part of the definition of a field or profession is that it has developed its own language or jargon. In the seven years since our last edition, the language we used has exploded exponentially. Whereas at that time we talked about the language of our “alphabet soup” (e.g., HMO’s, PPO’s, IPA’s etc.) that we were using, now we have an “alphabet life” and a jargon-filled day. Some words we use in everyday professional conversations are reflective of our wish/need to talk “business-speak” (e.g., bottom-line or one-stop shopping) and some from the computer world (e.g., “user-friendly services”), but others are true neologisms (e.g., gate-keeping). Leona Bachrach (1995), our field’s William Safire, has written extensively about the words we use

but few others have discussed this issue.

The biggest shift has been that in the references to our titles or roles, e.g., we’ve gone from being physicians or psychiatrists to being providers - and persons with illnesses have gone from being patients through being clients and consumers to being customers.

Then there’s the use of “compressed words;” healthcare and behavioral healthcare being the leading examples. My own institution has created a service called ExpressCare, which with its compression, presumably implies fast, seamless, business-like care.

While I’m discussing behavioral healthcare, let me note that not only does this term replace psychiatry and addictions services but it also has been seen by some as implying deprofessionalization and the replacement of higher-qualified by lower-qualified staff.

Surely, we still have the alphabet soup of organizations we had seven years ago, but we now have new ones, the most recent additions since the last edition being PHO’s, MCO’s, MBHO’s and NCQA. For those readers needing assistance in wending their way through this soup, we have provided a lexicon in the Glossary in the book.

We have also certainly adopted a great deal of business lingo and are heavily involved with “downsizing and rightsizing,” mergers and acquisitions, and markets and capital markets (not to be confused with marketing.) In addition, we no longer refer to bed days, bed occupancy or admissions but to “volumes of service.” Also, we’ve swept away Departments and Divisions and Centers and replaced them with Product lines and Service lines. Some of the business language also reflects our adoration of the “hyphenated R’s”, i.e., retro-fit, re-engineer and re-invent.

The computer industry has provided us with lots of words we’ve borrowed or adapted; we are now “on line” and “interface” with others. An administrative assistant in our institution became so swept up in computer terminology that when she announced a phone call, she would say that so and so was “on line.”

And finally, the neologisms I referred to above. In classical psychiatry these were largely the productions of persons suffering from schizophrenia; no longer! We’ve created words such as carve-in and carve-out or integrated delivery systems, out of necessity more than psychosis, although in truth that too may play a role.

Psychiatric Services: Past, Present, Future

In this concluding section I will try to tie together the themes and trends mentioned in this textbook and derive some implications for the education and training of psychiatric administrators, e.g., ourselves and our

successors.

The Past: In the past, psychiatric administrators had a modicum of certainty: there was a body of knowledge, often derived from classical management theory (from McGregor 1969 to Drucker 1973-74) and business experience (often published in the Harvard Business Review); a set of values shared by most psychiatric administrators (such as fiduciary responsibility and “above all, do no harm”); a series of agreed-upon desirable skills (including the POSDCORB ones of planning, organizing, budgeting, etc.) (Talbot 1988) and a common history.

The Present: At present, however, we are in the midst of a whirlwind and the experiences we share are related to that; e.g., uncertainty about the shape or even continuance of certain types of systems, treatments and practices; threats from above (be it government or academia), below (resentful troops), or outside (society, all levels of government, industry in general and the insurance and managed care industries in particular); as well as enormous changes in funding (risk and shifts and reductions), enormous changes in the structure of the enterprises we administer, and enormous changes brought about by technology.

The Future: One major task we will have in the future is to take those skills, experiences and knowledge bases that are applicable to whatever administrative setting, in whatever era, such as budgeting, a knowledge of systems, “people-skills” and the context of our psychiatric/medical training and blend into them the new elements essential to modern management, be they new treatments, new administrative concepts (networks, partnering, capitation, telemedicine, etc.), new economic forces, new devices and methods, and new methods of measuring ourselves, our systems and our patients.

Implications for Education and Training (Ourselves and Our Successors): Therefore, in medical education, residency and fellowship training, as well as post-graduate/CME/on-the-job-training, we must (1) continue to educate ourselves about basic, core issues as they relate to our changing times and situations (e.g., the “new accountability,” new planning methods, new budgeting techniques, etc.), (2) teach ourselves new skills to handle changing systems (such as technological ones, e.g., information systems), scientific ones (e.g., measurement of true quality of care), and administrative ones (e.g., partnering, merging and acquiring, cost-efficiency, rapid firing/hiring, incentive systems), and probably most important, (3) train ourselves and others how to handle change through preparation, education, experience, supervision, consultation, peer-advice, acquisition of

foreign lingo and blind luck.

The Light At the End of the Tunnel: At present, everyone predicts that we will pass through this period of turmoil into a brighter future and most agree that managed care companies have a time-limited future. But “care” will still be “managed,” hopefully by psychiatric administrators, and a hoping for a return to the past is wishful thinking. Nonetheless, that said, as an old Viet Nam Veteran, I am suspicious of those who already see the light at the end of the tunnel. However, preserving our spirit of inquiry, innovation and creativity in the face of pervasive fear, gloom and despair will get us through. And, we hope that this text, through its presentations of old and new challenges, will help keep psychiatric services strong and able.

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THE FUTURE IS BRIGHT IF WE DO IT RIGHT!

Commentary on the “Future of Psychiatric Services: Is There Any?”

C. Edward Coffey MD, DFAPA

In his wonderfully insightful article “The Future of Psychiatric Services: Is There Any?” John Talbott MD, one of Psychiatry’s (not just administrative psychiatry) finest thinkers, draws attention to a number of important trends, themes and issues which will impact the future of our field. He points out that the good old days of a “modicum of certainty” have been replaced by a world of greater uncertainty and pace of change, the implications of which are that leaders of psychiatric services will need to be comfortable with change, as well as agile in applying multiple technical and interpersonal skill sets to leadership and management challenges in the various settings in which they may occur.

The leadership challenges highlighted by Dr. Talbott are compounded several fold in my view, by an even more fundamental problem, viz. that the health care system in this country is broken and beyond repair. To quote the Institute of Medicine (IOM) (1) “In its current form, habits, and environment, the health care system is incapable of giving Americans the health care they want and deserve ... The current care systems cannot do the job. Trying harder will not work. Changing systems of care will.” In its recent report *A Vision for the Mental Health System* (2), the American Psychiatric Association echoed this view. “The current system is in shambles ... a patchwork relic – the result of disjointed reforms and policies ... that cannot be fixed by traditional reform measures.”

In my view, the unique challenge and opportunity faced by health care leaders of the future is how we *transform* our current “broken” mental health system into one that gives patients the care they want and need, when they want and need it. The operative word here is *transform* – the incremental improvement approaches of the past will not work.

Fortunately, health care leaders of the future have been provided a “roadmap” of sorts to accomplish such a transformation, in the form of the IOM’s recent report *Crossing the Quality Chasm: A New Health System for the 21st Century* (1). The Chasm Report praises the unparalleled advances in medical science in this country, as well as the skill, dedication and self-sacrifice of American health care workers, but it also indicts the health care delivery system for not translating those strengths into meaningfully better *care* for each and every patient.

The report documents the wide variation in health care quality, noting that too many Americans fail to receive safe and effective care. The care is fragmented, the system is full of waste and inefficiency, and too many Americans lack health insurance and therefore are deprived of access to basic care. This gap between what should be possible in health care (given the incredible advances in science and technology), and what the patient actually experiences in the clinic or at the bedside, is the “chasm” referred to in the report’s title.

To remedy this state of affairs, the Chasm Report recommends that **quality be made an explicit priority of the health care system in this country**, and that all constituencies work together to improve the following six dimensions of health care:

- safety (the care should avoid harming patients),
- effectiveness (the care should be evidenced-based, and should avoid overuse or under use),
- patient-centeredness (the care should be respectful of the individual’s preferences, needs and values),
- timeliness (the care should be available when the patient wants and needs it),
- efficiency (the care should be free of waste), and
- equity (everyone should get the best possible care, regardless of age, sex, race, financial status, or any other demographic variable).

These six dimensions of “perfect care” provide a revealing litmus test by which to assess the current quality of psychiatric care in the United States. I have recently discussed the application of these six dimensions to assess the quality of care in the specialties of neuropsychiatry (3) and electroconvulsive therapy (4).

We also have evidence that one can leverage the Chasm Report and these six dimensions of perfect care to dramatically improve health care. In response to the IOM’s *Chasm Report*, in 2001 the Robert Wood Johnson Foundation launched its “Pursuing Perfection Initiative”, which through a competitive grant process funded 12 demonstration (“phase 1”) projects designed to show that rapid, radical improvement in health care was possible. Our own Henry Ford Medical Group’s Behavioral Health Services was one of the 12 grantees. Henry Ford’s grant sought to perfect the care of persons with depression by leveraging the framework of the *Chasm Report*, and in

so doing transform the processes of mental health care within the Henry Ford Health System.

Our team (known as “The Blues Buster”) used the six aims from the *Chasm Report* both to define “perfect” depression care (ie, such care should be safe, effective, patient-centered, timely, efficient, and equitable), and as a strategic framework within which to develop and implement such systems of care. After mapping their current core processes of care, the Blues Busters quickly identified the issue of suicide as a high-leverage opportunity to improve depression care. The Blues Busters reasoned that by focusing upon suicide, they could dramatically improve the overall care of persons with depression or other mental illnesses. In the true spirit of “pursuing perfection”, the Blues Busters set as their main goal the elimination of suicide among their patients. This audacious goal served to galvanize the team, and it sent an important message throughout the health system that this Perfect Depression Care initiative would not be “business as usual”, but instead was the beginning of a journey to transform behavioral health care.

To accomplish their goal of Perfect Depression Care, the Blues Busters re-engineered their behavioral health care delivery system and implemented the Planned (Chronic) Care Model of care as a framework to provide perfect care. The team reviewed the extant scientific literature and then developed and implemented a “Suicide Prevention” clinical pathway (effective care) which included elements of self-management support (patient-centered care) as well as important linkages to community resources. A patient registry was developed by the HFHS Information Technology team to support the pathway. The Blues Busters then re-designed their behavioral health delivery system to ensure that patients had ready “open” access to care (timely, efficient) and that each encounter with a clinician included an evidenced-based assessment of immediate risk for suicide, followed by the appropriate level of intervention.

To date the results have been encouraging. In the two years prior to the launch of the Perfect Depression Care Initiative (ie, baseline), the average running rate in our patient population was approximately 42 suicides per

100,000 covered lives. For reference, the rate in the general population is ~12/100,000, and in a psychiatric population of mixed inpatients and outpatients, the rate is estimated to be about 10 times greater (120/100,000). The Blues Busters launched their initiative in January 2001, and since then the annual running rate has fallen to ~18/100,000, a decrease of approximately 57%!

These preliminary results indicate that rapid, dramatic improvement in depression care is possible, and that the *Chasm Report* framework provides a useful blueprint for conceptualizing and implementing such improvement.

Dr. Talbott concludes his article by noting that to be successful, health care leaders of the future must commit to continual self-education and skill development. I agree strongly with his advice, and would add that such a curriculum include the *Chasm Report* as required reading.

Dr. Coffey is the Kathleen and Earl Ward Professor and Chair in the Department of Psychiatry and Vice President, Behavioral Health Services at Henry Ford Health System in Detroit. He is also the recipient of the American Psychiatric Association’s 2003 Administrative Psychiatry Award.

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WHAT INTERNET2 CAN CONTRIBUTE TO MENTAL HEALTH CARE

John K. Yost, Ph.D., M.Div., C.B.E.

Abstract

The development of the Next Generation Internet, or what has become known as Internet2, differs from the commercial Internet in many ways. This article discusses how internet2 can be important to the practice of mental health care and psychiatrist administrators. Commercializing the Internet in the mid 1990s provided the opportunity for the federal government to work with major research universities having academic medical centers to address the challenges of improving health care quality in this decade. Internet2 means possessing the high performance connectivity requisite for real-time telehealth and high-tech home care treating severe and persistent mental illness, care coordination, illness self-management, and aging issues among priorities thus far identified by the Institute of Medicine. Just this year the major thrust of the privately developed Internet2 has shifted mostly to applications from connectivity giving relevance to this paper.

Charting the course that has led to the post-WWII ARPANET then to NSFnet of the 1980s and finally to the Internet and its commercialization in the mid-1990s has been done from a variety of perspectives that have a number of facets bringing the story to 2002⁽¹⁾. Yet very little has been said or written about Internet2 in regard to what it can do to improve the quality of health care and how it can address the needs of mental health care as the population ages. Perhaps that explanation lies in the disconnect between network engineering and research or education applications of importance in helping to solve major health care problems. Internet2 thus far has focused on advanced networking to the neglect of its research and education applications to top priorities such as health care, mental as well as physical. The time has come to give primary attention to Internet2 applications, and fortunately both the University Consortium for Advanced Internet Development and federal mission agencies, have made that their main aim this year⁽²⁾. Mental health care should benefit greatly from that insofar as nearly half of the 20 priority areas selected for speedy national action require mental health care⁽³⁾.

Thoughts and plans for the Next Generation Internet (NGI) or Internet2 (I2) commenced in the early 1990s with two dozen research universities having a 1995 meeting

in Chicago followed the next year in San Francisco with around 30. Simultaneously, a few leading telecommunication corporations such as Cisco, Quest, and IBM had become interested in supporting the development of the high-speed operation, the high performance connectivity and broad bandwidth of Internet2. The Next Generation Internet got its name from the federal initiatives taken by then Vice President Gore, and Congress ultimately appropriated \$100 million toward the cost of high-speed connectivity for universities with the bulk of it going to the National Science Foundation originally intended for research applications in need of the greater bandwidth. The Next Generation Internet connectivity program provided one-time funding beginning in 1997 and has come to an end at NSF this year with around 206 educational institutions out of 3600 now having grants awards for high performance connectivity. I think the preference of leading research universities belonging to the prestigious Association of American Universities (AAU) might have been to keep Internet2 among themselves, and use it to leverage federal grants and corporate support. But three factors changed that strategy: (1) the digital divide; (2) the competition to establish GigaPOPs with satellite universities in the region; and (3) the reality of the regionalization of higher education with universities being encouraged by local/regional agencies and seeking to become engines of regional economic development in spite of some illusions about the complexities of that.

Even though the statute funding the Next Generation Internet has ended, funds in much smaller amounts remain in the National Library of Medicine (NLM) for connecting hospitals and health education centers to Internet2 universities. And Internet2 connectivity helps, to be sure, in leveraging large grants such as the \$12-13 million that went as a NSF grant in 2003 to the University California-San Diego. The Internet2 grants for telemedicine at major academic health centers in thousands rather than millions came from NLM through the National Institutes of Health. Some of these NLM grant awards have been for mental health care. And the University of Iowa stands out for what it has been able to do statewide for disabilities⁽⁴⁾.

How effective the threefold consortium of universities, government, and corporations has been under the management of the University Consortium of Advanced Internet Development (UCAID), collocated in Ann Arbor and Washington DC remains to be seen. There needs to

be a study of how the Consortium has served to leverage funds matching national priorities and advancing the common good in improving the quality of health care. That would be of help concerning the value of Internet2 for the advancement of mental health care.

Why Mental Health Care and Psychiatrist Administrators Need Internet2

Internet2 has several formal working groups including the one in the Health Sciences. Although this group has been less productive owing to limited funding, that might change with a stronger emphasis now on applications. I have been a member of the Health Sciences Advisory Group since 2002 with responsibility for forming the Bioethics Working Group. Within that area, I have become concerned especially with paucity of attention in medical education to telemedicine and e-therapy. Thanks to Michael Ackerman, Associate Director of NLM, I have learned much about I2 telemedicine research at leading-edge universities.

My research has focused on the ethical framework with emphasis on quality of life issues however much neglected in the federal project called generally the Quality of Health Care in America. That project brought about a nationwide awakening among healthcare professionals concerning the need to avoid medical errors when the Institute of Medicine published *To Err Is Human* in 1999 followed by *Crossing The Quality Chasm* in 2001 ⁽⁵⁾. This national project to improve the health care quality in the U.S. during this decade has been led by DHHS Secretary Thompson working closely with Congress to give responsibility for the studies to the Agency for Health Care Research and Quality(AHRQ). Congress mandated AHRQ to provide a progress report in 2003-2004. And the Third Health Care Quality Summit held in early January of this year considered five of the 20 national priorities among which major depression and related mental health care ones became the focus.

President Bush had announced in February 2001 his New Freedom Initiative to promote increased access to educational and employment opportunities for people with disabilities, specifically including those with psychiatric disabilities. President Bush's Initiative promotes also increased access to assistive and universally designed technologies. The 6th and final goal formulated by the President's New Freedom Commission on Mental Health states: "Technology Is Used to Access Mental Health Care and Information." Goal 6 contains two recommendations. 6.1 have to do with "the use of health

technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations." 6.2 recommends the development and implementation of "integrated electronic health records and personal health information systems." ⁽⁶⁾

These recommendations point directly to the need for use of Internet2 technologies in the service of mental health care by means of telehealth and e-health without mentioning what Internet2 already has accomplished in this area. Georgia, Arizona, Texas, California and Iowa, are among the 25 others with the statewide Internet2 technology to carry out these recommendations. And as mentioned above Iowa, thanks to an NIH grant award to the University of Iowa, has become exemplary in turning these two recommendations into reality. At Georgia Tech in 1998, I observed how Internet2 technology met health care needs in underserved rural areas. The concluding Goal 6 contains language about telehealth and e-health records that I became familiar with through membership on the Health Science Advisory Group of I2/UCAID before the President's Commission on Mental Health made this Report with its recommendations in April 2002. That this kind of progress has come about through the efforts of the President's Commission on Mental Health certainly demonstrates how important Internet2 will continue to be for psychiatrist administrators even though it goes without mention ⁽⁷⁾.

Perhaps I2 technology becomes a given in the APA's *A Vision for the Mental Health System and its Twelve Principles* set forth in April 2003, but it lacks also any specific mention of the technology needed to turn these principles effectively into action. And the discussion of access to care for those individuals in rural areas and among underserved racial groups that precedes the statement of principles leaves technological solutions out of it. The discussion of access to care does mention the IOM report of 2002. Maybe the omission of the latest technology should come as no surprise because the early IOM reports lack discussion of Internet2 mental health care. Truth is that the University Consortium for Advanced Internet Development, which has the responsibility for managing the I2 technology, could do a better job of marketing, and recently has begun to emphasize that as well as putting more emphasis on productive applications than just on technological changes and network engineering. That bodes well for the future of Internet2, and what it can do for mental health care and its administration.

What Internet2 Can Do In Serving Mental Health Care?

Already I have tried to deal with some of the big contributions. These and others need more attention if we want to hasten the progress in serving the needs of mental health care and its administration by using Internet2. Right now many of us still depend largely on the world of electronic mail, file transfers, and distant collaboration. We need to reexamine our mental health care system and to understand how the application of Internet2 can help to overcome whatever fragmentation impedes our progress to improve the quality of care and the quality of life for the mentally ill and developmentally disabled. At best, of course, Internet2 will be only a tool for delivering and administering better mental health care. With proper professional leadership, investment, and commitment, the Cyber age with Internet2 technology opens us to new opportunities for innovative mental health care uses of advanced networking technology.

Internet2 technology can become the standard means of linking psychiatric specialists with other clinicians and patients across the country and even globally. Clear video images in real time will make telecollaboration a standard way of communication. And these clear video images can transfer information needed immediately. Internet2 will make possible new means for the analysis of brain imaging at both ends of the link that will make this kind of mental health practice clearly cost effective.

As I have witnessed, patients will avoid unnecessary travel from distant rural settings to major medical centers. Mental health practitioners will have expert consultation delivered to them in their offices in a highly personalized manner. Psychiatrists and patients will accomplish in a single office visit what now involves multiple visits and major inconveniences.

Psychiatrists will be able to obtain immediate teleconsultation with physicians in other fields of practice, as they deem necessary for their patients. Thus I2 will enable other experts to help in improving the care of patients by using this advanced technology to bring them to the patients instead of sending the patients to them. Again, this process will improve efficiency and reduce costs.

Internet2 can enable patient records to be linked electronically in order for each patient to have a virtual health record instead of numerous ones scattered around the country in a number of offices and hospitals. The patient's virtual health record will be a distributed but unified summary of all the mental health and other care

they have ever received in their lives. This should help the psychiatrist immensely in treating the patient's mental health and relevantly related other care. Improving upon HIPPA, this virtual health record will be secure and confidential, and released to other health care professionals only with the patient's permission or under strictly defined and enforced criteria in times of medical emergency.

The time of high-tech home care has begun and will grow with the use of an advanced network like Internet2. The video link into the home will be 2-way enabling the psychiatrist to move beyond the use of often time-consuming telephone connections and conversations for managing patient problems at a distance to using their visual senses. And this "home visit" via video links will provide new tools for monitoring patient's behavior and allowing more time for preventive care than crisis management.

Internet 2 technology can contribute to the administrative duties of psychiatrists by its speed and being fast owing to the rapid expansion of bandwidth that enables experts to appear on video walls in hospitals and classrooms thousands of miles away. Second, Internet2 will always be on with no need to log on, will enable use to monitor real-time data, and will make possible medical monitoring attached to real people. Third, Internet2 will enable us naturally to ask a question in the language of our choice and have the question routed to the most knowledgeable expert, who will answer in his or her native language, and we will hear the answer in our own language. Third, the search engines of Internet2 will bring us a few relevant matches. The trusted networking of Internet2 will make authentication rather than security the biggest issue but digital IDs will help solve that problem. These will be a few of the advantages Internet2 will bring psychiatrist administrators.

Strategy for Psychiatric Administrators in Quest of Support for Internet2

This year there has been a shift at NSF from high performance connectivity to advanced networking research. The funds from Clinton-Gore administration for NGI connectivity have come to an end, and the Bush administration intends to provide no more. The 206 universities, including all the major academic medical centers have what we commonly call Internet2 connectivity. The annual maintenance cost per institution runs around \$500,000. This means Internet2 universities will need to support maintenance from federal grants or

corporate partners, or users fees. And research and education collaboration between and among Internet2 universities along with corporate partners will be crucial in obtaining federal grants based upon my experience on a NSF Information Technology Research panel last spring. Yet mental health care will be in a relatively good position.

Both the previous administration and the present one have supported strongly the Mental Health Commission and the National Health Care Quality Project. Each of these initiatives requires the high performance connectivity of Internet2. I have dealt already with that need in regard to the Mental Health Commission. The Health Care Quality Project run by AHRQ responded to a DHHS request in 2003 for an action report on national priorities. The 20 priorities for transforming health care quality during this decade include major depression, severe and persistent mental illness, self-management, hypertension, obesity, aging issues, end of life, tobacco dependence, and care coordination, the latter listed as the first priority. At least half of these noted priorities call for some degree of mental health care and the benefits of Internet2 to address them.

Conclusion

Clearly, Internet2 with its high performance connectivity, has the potential to make significant contributions to mental health care. The time has come for I2 applications to mental health care and for exponentially increasing the funding for mental health care priorities. Psychiatrist administrators need to realize both Internet2 potential but also to participate in the process of developing applications commensurate with the challenges of present needs and future expectations. That neither of the federal initiatives to improve health care recognizes the importance of Internet2 for what it can enable us to do makes it all the more necessary to address the matter of Internet2 and mental health care for psychiatrist administrators.

Dr. Yost has served as Principal Investigator of two National Science Foundation (NSF) grants awarded for Internet2 and belongs to the national I2 Health Science Advisory Council with 15 members. He has presented research papers on I2 and biomedical ethics at numerous national meetings. Dr. Yost is a full professor and Associate to the Provost at the Bradley University, Peoria and adjunct at UIC-Medical College.

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2. See NSF web site for the division of Computer and Information Science and Education (CISE). The reorganization of this NSF division reflects this change as do e-mail communications late fall and early spring of this academic year from the leadership of the University Consortium for Advanced Internet Development.
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5. The two volumes are the first reports of the Agency for Health Care Research and Quality done for the Institute of Medicine as mandated by Congress at the initiative of DHHS Secretary Thompson for the improvement of health care quality in this decade.
6. President's New Freedom Commission on Mental Health (www.mentalhealthcommission.gov/reports/FinalReport/FullReport-02), p.25
7. *Ibid.*

SOFTEN UP: THE IMPORTANCE OF SOFT SKILLS FOR PSYCHIATRIST EXECUTIVE

Arthur Lazarus, M.D., M.B.A., C.P.E., F.A.C.P.E.

No one would argue that, to be an effective administrator, a physician needs a keen eye for details and numbers. Knowledge of accounting, finance, and quantitative-based decision sciences are considered prerequisite for managing healthcare systems.¹ But don't be fooled into thinking that "hard skills" alone are sufficient for job success. Today's competitive job market means that minimum acceptable skills are being replaced with higher standards. Among the higher standards are what many call "soft skills" the cluster of personality traits, social graces, facility with language, personal habits, friendliness, and optimism that mark each of us to varying degrees (see Table 1). A review of the careers of executives who have failed to acquire appropriate soft skills reveals they have been tripped up by everything from business meal blunders to ethical lapses in judgment and outright fraud. Those individuals may have been business savvy, but they lacked the soft skills essential for leading and managing people.

While there is no universally established set of core health management competencies, leaders in the field of healthcare administration are beginning to place equal or greater emphasis on soft skills over more traditional clinical, technical, and business skills. It's a given that high-ranking physician executives are experts in their field and have business talent. Soft skills, on the other hand, are difficult to teach (some would argue they're innate) and they're even harder to measure. Soft skills are highly relevant to medical students' and residents' future roles as leaders in a complex and ever-evolving healthcare system. The good news for psychiatrists is that psychotherapy training and practice provide an excellent grounding in soft skills for healthcare administration.²

The Chicago-based National Center for Healthcare Leadership and the Washington-based Accrediting Commission on Education for Health Services Administration have entered into a partnership to define essential competencies for healthcare managers and educational programs. Although the competencies are under consideration and may not be finalized until 2005, thus far they include leadership; collaboration and

communication; management practice; learning and performance improvement; professionalism; and community health services.³ Not surprisingly, these competencies fall under the umbrella of soft skills. Let's examine each one separately and discuss its relevance to psychiatric administration and management.

Leadership

In medical school, many of us learned procedures by the classic "see one, do one, teach one" method. And they called that leadership! While there is no universally accepted definition of leadership, or even general consensus on what constitutes the most effective style of leadership, it is widely recognized that great leaders possess traits in common, for example, wisdom, compassion and a high level of energy.

When Rudy Giuliani was named Time magazine's Person of the Year in 2001, the tribute read: "For having more faith in us than we had in ourselves, for being brave when required and rude where appropriate and tender without being trite, for not sleeping and not quitting and not shrinking from the pain all around him." This is about as good a definition of leadership I have come across. In detailing his own principles of leadership, Giuliani observed that leadership is a privilege but it carries responsibilities—organizing around a purpose, hiring the best people for the job and ensuring they work as a team, taking calculated risks, and articulating and acting on strong beliefs and being held accountable for the results. Giuliani also remarked, "Leadership does not simply happen. It can be taught, learned, developed."⁴

Today's psychiatrists are leaders in Fortune 500 companies, insurance companies, integrated health systems, hospitals, software firms, medical schools, pharmaceutical companies, medical research organizations, managed care companies, and all branches of government and the military. It is important to learn from them by examining the leadership challenges they have faced and by evaluating how they have dealt with those challenges at different points in their career.

Psychiatrists interested in careers in administration and

management need leadership role models to help them make informed decisions and avoid career traps. Psychiatrists may have had role models during residency training, but the process of identifying and selecting mentors other than supervisors can be haphazard. Once in practice, exposure to bona fide leaders in psychiatry may never occur, or it may occur serendipitously. Advice from women who are leaders in the field of psychiatry may be even more difficult to obtain because the “glass ceiling” has thwarted the careers of many women leaders in medicine.⁵ Therefore, early career psychiatrists may need a professional coach to develop personal strategies that allow them to assume positions of authority and influence in the future.

Collaboration and Communication

It is essential for administrators to communicate their thoughts effectively to others. That is why so many job postings for psychiatrist executives ask for candidates with strong written and verbal communication skills. As a group, however, physicians operate with considerable autonomy and have a unique style of communication based on their psychological disposition as measured by the Myers-Briggs Type Indicator.⁶ Awareness of the essential psychological differences between physician executives and non-physician executives, coupled with a motivation to act on it, may serve as a powerful device by which relationships can be strengthened, especially through communication.

A large part of collaboration occurs through teamwork. Team skills have become a necessary part of the practice of medicine and psychiatry. Patients are often aware of underlying tension in group practices. A team that is perceived as dysfunctional may cause patients to question the quality of care received. Physicians must give up the “doctor card” so the team can function at its best. According to Patrick Lencioni, author of *The Five Dysfunctions of a Team*,⁷ team members must also learn to trust each other, resolve conflicts, make commitments, accept accountability, and focus on results. There is nothing that an individual can do that an effective team cannot do better, every time.

Management Practice

The ascendancy of large numbers of physicians to management positions has been truly remarkable. At

the same time, it is problematic whether the education curricula offered in medical schools and residency training programs provide adequate preparation for these expanding roles in the complicated management of health services. While some institutions have developed leadership and management programs on their own,⁸ physicians have increasingly turned to business schools and schools of public health to supplant their medical training. The large number of physicians currently enrolled or who graduated various master’s degree programs in business and health administration or related disciplines suggests that doctors are already preparing themselves to assume additional management responsibilities.

Residency directors and medical directors of managed care organizations appear to value similar competencies for managing care. In one survey,⁹ of the 10 tasks rated most important to residency directors and managed care medical directors, 9 were the same, addressing time management; ethics; case management; practice guidelines; cost-effective clinical decision making; referral management; disease management; patient satisfaction; and clinical epidemiology. Interestingly, negative attitudes toward managed care among academic physicians did not appear to affect their views on the importance of teaching specific managed care tasks related to population health.

Core clinical competencies for providing care to individuals with severe mental illness have been identified by diverse groups of stakeholders.^{10,11} Key areas include patient care, medical knowledge, rehabilitation and empowerment, family and support systems, social and cultural factors, and resources and coordination of care. Mental health treatment organizations that plan to evaluate and improve the quality of their care may be able to use these competencies to inform their efforts. Psychiatric administrators may be instrumental in the design of specific curricula that can be used to train clinicians and ensure that clinicians have access to appropriate educational programs.

Learning and Performance Improvement

Reliable and valid methods for assessing learning must be developed in order to ensure the adoption of core health management competencies by students, trainees, and clinicians. Valid measures must also be developed

to define outcome measures for assessing performance, especially in specialized areas such as mental health. Once this has been accomplished, institutions must demonstrate a commitment to ongoing evaluation and continuous improvement in all facets of learning. The use of new technology and “best practices” should figure prominently in this process

For example, in the managed care study⁹ cited above, residents were taught new competencies (managed care tasks) and were asked to report their level of confidence in performing each of the competencies using a 4-point Likert-type scale (1 = least confident and 4 = most confident). Pre- and post-training comparisons were made within subjects and comparisons were also made to a control group who received no specific training. By choosing tasks that were behaviorally defined and observable, the entire learning process was quantified and measured. By delineating the tasks to be performed, curricular interventions could be focused in those cases where performance was suboptimal.

Corporations as well as individuals are capable of learning new competencies. In contrast to individual core competencies, organizational core competencies represent “the collective learning in the organization, especially how to coordinate diverse production skills and integrate multiple streams of technology.”¹² Most companies build world leadership with only a few fundamental competencies. Examples include Honda (engines and power trains), Canon (fine optics and microelectronics), Sony (miniaturization and video technology), and 3M (substrates, coatings and adhesives). The practice of medicine is similar in that both personal and organizational competencies contribute to successful medical outcomes.

Professionalism

Mary Frances Lyons, a physician, works full-time recruiting other physicians for executive-level positions. She states, “In search work, we are constantly exposed to differing levels of professionalism. There are professional MDs and there are less professional MDs. High levels of professionalism are strong contributors to career success, as it is the major determinant of how those around a person perceive and work with the person.”¹³

Lyons defines professionalism in many ways, for example, by doing what you say you are going to do; showing up for important functions; supporting the leadership of your organization; keeping sensitive information confidential; speaking well of others; and taking responsibility for your mistakes. In my own office, a sign reads: “I am willing to make mistakes if someone else is willing to learn from them.” Admitting mistakes and accepting blame while offering an apology signifies a high level of professional behavior and earns the gratitude of those around you.

Lyons observes, “If you really want to be professional and perceived as such, there is an easy way to keep track of what to do. Whatever would make you feel the best if you were at the other end of the interaction, do that. In other words, ‘Do unto others as you would have them do unto you.’”¹³

Community Health Services

I went to medical school and trained in psychiatry at Temple University School of Medicine in Philadelphia, Pennsylvania. Dr. Anthony Panzetta, my mentor and the former chairman of the department of psychiatry, was a pioneer in the community mental health movement. Although Dr. Panzetta became disillusioned with community mental health in the 1980s, when I was a resident, he continued to stress the importance of working with community leaders and supporting community health initiatives. Panzetta’s classic 1985 article, “Whatever Happened to Community Mental Health?”¹⁴ actually foreshadowed the managed care era. He founded one of the first managed behavioral healthcare organizations in the United States (TAO, Inc.) and modeled it after idealistic principles embodied in the Community Mental Health Act.

I recently reconnected with my medical school alma mater, donated money for building a new medical school, and arranged a meeting with the Dean and other faculty to discuss pharmaceutical research alliances. My previous and present employers, both pharmaceutical companies, have also contributed significantly to their communities in terms of job creation and real dollars, not to mention pharmaceutical relief through indigent care programs and philanthropic endeavors worldwide. There can be no more noble purpose for a psychiatrist executive than to help improve the welfare of a

community and its citizens through charitable community activities.

Soft skills are critical to the success of psychiatrist executives. Soft skills are important when there is intense competition for healthcare positions at the executive level. Invariably, it seems that recruiters like outgoing, friendly, well-adjusted physicians more than those with great qualifications but less acceptable soft skills. Obviously, psychiatrists with a strong complement of soft skills and technical proficiency make ideal job candidates.

Ask yourself, “Do I need to improve my soft skills”? Here are a few things to consider:

- Learn the basics of public speaking. Take a speech communications course or join a local ‘Toastmasters’ group. Practice your telephone skills.
- Pay special attention to your manner of dress and grooming. You only have one chance to make a good “first impression.” Make sure you dress appropriately for job interviews and for the job setting.
- Engage people. Practice your approach in greeting them. Look people in the eye. Smile and offer a firm handshake, but not one that is painful.
- Practice the art of conversation. Become well versed in current events and topics other than medicine. Book clubs and discussion groups are good ways to develop these skills.
- Maximize your leadership potential. Clearly communicate your vision and achieve buy-in of your

Table-1: Illustrative Soft Skills

Work Ethic: Giving a full day of diligent work and following your supervisor’s instructions.

Courtesy: Frequently using the words “please,” “thank you,” “excuse me,” and “may I help you” in dealing with patients, supervisors, and colleagues.

Teamwork: Sharing responsibilities, conferring with other people, honoring commitments, helping others do their jobs, and seeking help when needed.

Self-discipline and self-confidence: Arranging your tasks for best performance, learning from experience, asking questions and correcting mistakes, and absorbing criticism and direction without feeling defeated, resentful, or insulted.

Conformity to prevailing norms: Governing your dress, grooming, body language, tone of voice and vocabulary according to the particular culture of the workplace.

Language proficiency: The ability to speak, read, and write standard English in a businesslike way.

Problem solving ability: Applying creative and innovative solutions to technical and conceptual problems. Using original ideas to frame tactical and strategic plans.

Customer service orientation: Appreciating the needs and requirements of individuals internal and external to your organization, and satisfying those requirements in a timely manner.

Leadership: Creating the conditions that allow people to grow and do their best on behalf of the organization. Training and mentoring new team members.

ideas. Motivate people to do their best. Display your ability to multi-task.

- Enter into long-term strategic relationships. Expand your network and increase your sphere of influence. Learn to manage conflict and change. Negotiate issues fairly.
- Tackle tough situations head on. Be a problem solver. Establish stretch goals. Be honest if you fall short. Be up-front with everyone.
- Keep taking initiative. Volunteer for projects. Help get things done. Take calculated risks to be noticed and get promoted. Learn how to read other people's emotions and feelings.

- Always be polite and courteous. Respect other people's opinions; try and develop consensus. Never compromise your ethics. Do the right thing!

The ability to develop and use soft skills can make the difference between an outstanding job offer and the enjoyment of new employment in a rewarding environment.

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THE EARLY CAREER ADMINISTRATIVE PSYCHIATRY AWARD: Greetings from the APA Committee on Psychiatric Administration and Management

Stuart B. Silver, MD

Early Career Administrative Psychiatry Award

The Committee on Psychiatric Administration and Management (CPAM) in collaboration with The American Association of Psychiatric Administrators has recommended to the American Psychiatric Association (APA) a revision of the Administrative Psychiatry Award. The new award will honor a gifted young administrative psychiatrist and will contrast with the newly named Career Administrative Psychiatry Award that has been bestowed annually since 1983 and which honors a nationally recognized clinician -executive whose effectiveness as an administrator of a major mental health program has expanded the body of knowledge concerning management of mental health services delivery systems, and whose effectiveness has made it possible for him/her to function as a role model for other psychiatrists.

The new award will be inaugurated in 2005 and presented for the first time at the Fall 2006 Institute for Psychiatric Services Meeting (IPS). Entitled the Early Career Administrative Psychiatry (ECAP) Award, it will honor an early career clinician-administrator who has: 1) demonstrated interest in psychiatric administration either by additional training, certification or publication, 2) who has contributed significantly to the field of psychiatric administration and management, and 3) whose creativity and sensitivity promotes interest in improving patient care through psychiatric administration and management. To be eligible for this award, the candidate must be a member of the APA, within ten years of completion of his or her residency in psychiatry, and certified in Psychiatry by the American Board of Psychiatry and Neurology.

The ECAP award will consist of an honorarium: of a check for \$500 and a plaque. It will be presented every third year at the IPS Meeting in lieu of the CAP Award in keeping with the current award rotation schedule. The award recipient may be asked to present a lecture at that meeting. To be considered for the award, prospective candidates should submit to the APA Committee on Psychiatric Administration and

Management letters of nomination and a C.V. by August 1st of the year prior to presentation. The American Association of Psychiatric Administrators provides the honorarium and funding for the plaque.

Examination in Psychiatric Administration and Management

The new, single written examination combining multiple choice and brief essay questions will be administered for the third time in May 2004 at the annual meeting of the APA. The application deadline for the May 2005 examination is February 1, 2005. Early applications are encouraged in order to allow candidates more time to prepare. The new examination process has eliminated the oral portion of the examination; and has changed the application pre-requisites to enable young and early career psychiatrists to pursue certification. Elimination of the oral examination means that candidates could receive certification just a few months after applying, assuming they pass the written test. APA Certification in psychiatric administration and management reflects the candidate's knowledge and skills in four areas: psychiatric care management, administrative theory, budget and finance, and law and ethics, as each applies to mental health administration. APA believes the additional skills and experience found in psychiatrists who fill administrative roles, even part-time, deserve recognition through a certification that recognizes those qualifications. In addition, certification is a visible demonstration of knowledge and skills that may increase a psychiatrist's opportunities for employment or promotion in some settings.

Perhaps most important, persons preparing for the examination go through a substantial educational process which often includes studying texts and articles (some specifically recommended in the application materials), talking with professionals in other fields (e.g., an organization's human resources or budget director, attorney, or senior managers), and/or attending courses, seminars, or workshops on mental health administration.

Prospective candidates for the examination must be

certified in general psychiatry by the ABPN or an equivalent body, and must have at least one year of substantial experience in general or clinical administration (verified by letters of reference). The experience need not be extensive, but should provide familiarity with general management concepts. A year as an assistant unit or program director, for example, may suffice. Applicants may substitute a year of administrative training

during residency or two semesters of graduate-level management courses for the post-residency experience. APA membership is not required to sit for the examination.

Dr. Silver is the Chair of the APA Committee on Psychiatric Administration and Management.

WELCOME NEW MEMBER!

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Changes in the Frequency and Format of **Psychiatrist Administrator**

You probably have noticed a recent change in the frequency of how often the *Psychiatrist Administrator* is delivered to your mailbox. With this issue you probably are also noticing a change in the quality of paper and a few format changes. This is a reflection of the fiscal challenges AAPA faces today. Last year our Council decided to reduce the frequency of the Journal from 4/year to 2/year until we resolved the financial difficulties. As you know, the journal has been funded partially through an inconsistent flow of grants and partially through the membership dues. The Council continues to work on this area. I'd appreciate any suggestions that you may have for this area.

Sy Saeed, M.D.
Editor

LITERATURE SCAN

Welcome to *Literature Scan*, a new column that reviews recent literature of interest to administrators in behavioral health care systems. This first column scans the literature from the past year; future columns will cover a period of approximately 3-6 months. Papers will be selected on such topics as administration, consumer satisfaction, delivery of health care, education, efficacy, ethics, evidence-based practice, leadership, and management. I expect the column to evolve and develop over time as I hear from readers about other topics of interest to them and as I learn more about the association and its membership. The daily demands of administration and practice often leave little time for browsing journals. It's our hope that this column may fill the gap.

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Abramovitz R, Bloom SL. Creating sanctuary in residential treatment for youth: from the "well-ordered asylum" to a "living-learning environment." *The Psychiatric Quarterly* 2003 Summer;74(2):119-35.

This paper identifies changes in the population currently in care and examines the two dominant approaches that have shaped standard treatment models in use. It concludes with a description of the Sanctuary Model, an approach that integrates a variety of treatment approaches, and how it is being introduced by residential centers to provide a systematic treatment model for use in schools, living units, and treatment sessions.

American Geriatrics Society and American Association for Geriatric Psychiatry. Consensus statement on improving the quality of mental health care in U.S. nursing homes: Management of depression and behavioral symptoms associated with dementia. *Journal of the American Geriatrics Society* 2003 Sep;51(9):1287-98. [Consensus Development Conference; Practice Guideline]

American Geriatrics Society and American Association for Geriatric Psychiatry. The American Geriatrics Society and American Association for Geriatric Psychiatry recommendations for policies in support of quality mental health care in U.S. nursing homes. *Journal of the American Geriatrics Society* 2003 Sep;51(9):1299-304. [Practice Guideline]

Bartels SJ, Dums AR, Oxman TE, Schneider LS, Areal PA, Alexopoulos GS, et al. Evidence-based practices in geriatric mental health care: an overview of systematic reviews and meta-analysis. *Psychiatric Clinics of North America* 2003 Dec;26(4):971-90, x-xi. [Review]

This article provides an overview of the emerging evidence base supporting the efficacy of geriatric mental health interventions, including systematic reviews, meta-analyses and expert consensus statements.

Buck JA. Medicaid, health care financing trends, and the future of state-based public mental health services. *Psychiatric Services*. 2003 Jul;54(7):969-75.

The trend for Medicaid to fund public mental health services administered by states represents a major shift in the predominant model by which public mental health services are funded, organized, and delivered. The model in which programs are administered by state mental health authorities and direct funding of designated community providers is being displaced by one associated with state Medicaid programs, which are based on organization and financing methods characteristic of health insurance plans. This shift in models needs to be understood for such implications as administrative authority, funding source, data collection, populations served, and services provided.

Christensen H, Griffiths K. The internet and mental health practice. *Evidence-Based Mental Health* 2003 Aug;6(3):66-69.

The authors consider the internet from the perspective

of the mental health specialist, examining its impact in two domains: a) information resources and b) treatment provision. They also discuss the advantages and major obstacles and disadvantages to using these technologies. A convenient table is provided with names and URLs of popular mental health sites.

Cooper B. Evidence-based mental health policy: a critical appraisal. *British Journal of Psychiatry* 2003 Aug;183:105-13. [Review]

The current evidence-based approach is reliant on meta-analytic reviews, more applicable to specific treatments than to the care agencies that control their delivery. Only 10% of clinical trials and meta-analyses found focused on effectiveness of services, and many reviews proved inconclusive. A broader evidence base is called for, extending to studies in primary care and the evaluation of preventive techniques.

Corrigan P, McCracken S, Blaser B. Disseminating evidence-based mental health practices. *Evidence-Based Mental Health* 2003 Feb 6;4(1):4-5.

This article focuses on barriers to staff use of evidence-based treatments and strategies to reduce these barriers. The two main barriers to staff dissemination are lack of knowledge and skills among individual service providers and organizational dynamics that undermine staffs' ability to implement and maintain innovative approaches.

Corrigan PW, Boyle MG. What works for mental health system change: evolution or revolution? *Administration & Policy in Mental Health* 2003 May;30(5):379-95.

Two fundamental approaches to systems change to adopt standards and practices of quality care for people with psychiatric disability are compared. The authors present the two approaches as naturally occurring change processes that work in tandem in the real world.

Essock SM, Goldman HH, Van Tosh L, Anthony WA, Appell CR, Bond GR, et al. Evidence-based practices: setting the context and responding to concerns.

Psychiatric Clinics of North America 2003 Dec;26(4):919-38, ix.

The authors met with stakeholder groups and recommend that further dialog and planning about evidence-based practices should be inclusive. Involving stakeholders will ensure that practices emerge that represent the integration of the best research evidence with clinical expertise and consumer values.

Fortney J, Sullivan G, Williams K, Jackson C, Morton SC, Koegel P. Measuring continuity of care for clients of public mental health systems. *Health Services Research* 2003 Aug;38(4):1157-75. [Review]

This study identified a set of measures of continuity of outpatient care using administrative data and evaluated the validity of these measures for persons in the community with serious mental illness. The five continuity-of-care measures were found to be relatively easy and inexpensive to generate and may serve useful for identifying individuals at risk for poor outcomes and strategies to keep clients engaged in care over time.

Goldman HH, Arzin ST. Public policy and evidence-based practice. *Psychiatric Clinics of North America* 2003 Dec;26(4):899-917.

For evidence-based mental health practices to be implemented, particularly at the policy level, state and federal support to create the organizational and financial incentives are needed. There is an opportunity to combine quality improvement with accountability through performance measurement and the implementation of effective new services and treatments.

Greenberg GA, Rosenheck RA. Change in mental health service delivery among blacks, whites, and Hispanics in the Department of Veterans Affairs. *Administration & Policy in Mental Health* 2003 Sep;31(1):31-43.

The authors analyzed changes in access to and use of mental health services by minorities in the Veterans Health Administration from 1995-2001. Blacks had poorer

outpatient access than whites, but were not further disadvantaged over time. For Hispanics, there was a trend toward greater inequality in the delivery of care. Of particular concern is whether changes in the U.S. health care system in the 1990s, fostered in part by managed care, may have further adversely affected access to quality mental health care among minorities.

Harwood HJ, Mark TL, McKusick DR, Coffey RM, King EC, Genuardi JS. National spending on mental health and substance abuse treatment by age of clients, 1997. *Journal of Behavioral Health Services Research* 2003 Oct-Dec;30(4):433-43.

This article presents 1997 national expenditures on mental health and substance abuse treatment by three major age groups: 1-17 (13%), 18-64 (72%), and 65 and older (15%). The authors examine how age specific estimates can enable policy makers, providers, and researchers to design programs and studies more appropriately tailored to specific age groups.

Hogan MF. The President's New Freedom Commission: Recommendations to transform mental health care in America. *Psychiatric Services* 2003 Nov;54(11):1467-74.

Hogan, chair of the President's New Freedom Commission on Mental Health, describes the yearlong process that the Commission undertook to develop the report, summarizes its recommendations, and urges all members of the mental health community to make a commitment to transform the system. Other articles in this issue describe goals of the campaign, discuss the report's implications for psychiatry, and offer a view of the report from the perspective of managed behavioral health care. The issue also contains statements from the National Association of State Mental Health Program Directors, the National Alliance for the Mentally Ill, the National Mental Health Association, and the Bazelon Center for Mental Health Law.

Levinson Miller C, Druss BG, Dombrowski EA, Rosenheck RA. Barriers to primary medical care among patients at a community mental health center. *Psychiatric Services* 2003 Aug;54(8):1158-60.

The authors examined barriers to medical treatment among patients at a community mental health center. Patient responses to a validated instrument measuring access to and quality of medical care indicated problems with access. Scores were significantly lower than those of the general population.

Luchins DJ. The qualitative and quantitative traditions within mental health administration. *Administration & Policy in Mental Health* 2003 Nov;31(2):183-86.

Increasingly in mental health, the qualitative approach to measuring and achieving quality is being replaced by the quantitative. This article examines both approaches and offers suggestions as to their appropriate roles.

Marshall T, Solomon P. Professionals' responsibilities in releasing information to families of adults with mental illness. *Psychiatric Services* 2003 Dec;54(12):1622-28.

Confidentiality policies often do not specifically discuss the release of confidential information to the families of persons with mental illness. This study examined how providers and family members interpret and implement confidentiality policies and suggests that these policies may be posing a barrier to collaboration between providers, consumers, and family members.

Mechanic D. Policy challenges in improving mental health services: some lessons from the past. *Psychiatric Services* 2003 Sep;54(9):1227-32.

The author shares lessons he has learned focusing on five areas: research, managed behavioral health care, health insurance and parity, service system availability and linkage, and dignified employment for persons with mental illness. The author concludes that although better treatment tools have become available and services are being provided to more people, many signs of neglect remain, particularly for the most poor and disenfranchised individuals.

Mellman LA, Beresin E. Psychotherapy competencies: development and implementation. *Academic Psychiatry* 2003 Fall;27(3):149-53.

New requirements by the Psychiatry Residency Review Committee of the Accreditation Council for Graduate Medical Education maintain that residents must be competent in five specified psychotherapies: brief, cognitive behavioral, psychodynamic, supportive and combined psychotherapy and psychopharmacology. The American Association of Directors of Residency Training Task Force on Competency has written sample competencies in each of the five areas to assist residency directors.

Munetz MR, Galon PA, Frese FJ 3rd. The ethics of mandatory community treatment. *Journal of the American Academy of Psychiatry and the Law* 2003;31(2):173-83.

The authors present three ethical arguments to address the controversy of mandatory community treatment: rights-based versus beneficence, utilitarian, and communitarian. Each approach suggests that mandatory community treatment can be an ethical intervention for individuals with severe mental disorders in well-defined circumstances. The authors argue for flexible criteria so that mandatory community treatment is used only when alternatives have failed, that treatment should be implemented long enough to be effective, and that consumers be involved in the development and implementation of programs.

Newton DA, Grayson MS. Trends in career choice by US medical school graduates. *Journal of the American Medical Association* 2003 Sep 3;290(9):1179-82.

This article reviews and highlights temporal trends in career choice by graduates of allopathic US medical schools, focusing on US medical doctors (USMDs) entering residencies from 1987. The most notable example is the recent decrease in the percentage of USMDs choosing a primary care career. In the non-primary care and non-surgical specialties, there has been a general increase. However, psychiatry declined from more than 5% in the late 1980s to 3.1% in 1998, followed by a gradual increase to 4.2% in 2002.

Semansky RM, Koyanagi C. Obtaining child mental

health services through Medicaid: the experience of parents in two states. *Psychiatric Services* 2004 Jan;55(1):24-25.

In 2002 the Bazelon Center for Mental Health Law conducted a series of focus groups with parents of children with serious emotional disturbance who were receiving Medicaid. Focus group participants reported that their difficulties began immediately with failure by mental health providers to recognize the severity of disorders and overlook risk factors, delayed diagnosis until years after the parents suspected a disorder, and too few services and the wrong kinds of services to benefit them.

Silk KR, Yager J. Suggested guidelines for e-mail communication in psychiatric practice. *Journal of Clinical Psychiatry* 2003 Jul;64(7):799-806.

Existing general guidelines concerning the use of e-mail in medical practice are useful starting points, but expansion and/or modification to address more directly issues of specific concern in psychiatric practice are needed. Of particular interest to psychiatric practice are the issues of confidentiality, communicative tone, and professional boundaries. Nonetheless, with cautions, e-mail may provide a useful tool for enhancing communication and treatment options for psychiatrists and their patients.

Snowden M, Sato K, Roy-Byrne R. Assessment and treatment of nursing home residents with depression or behavioral symptoms associated with dementia: a review of the literature. *Journal of the American Geriatrics Society* 2003 Sep;51(9):1305-17. [Literature Review]

This extensive literature review was conducted to provide an expert panel with an evidence base for making recommendations on the assessment and treatment of depression and behavioral symptoms associated with dementia. The review concludes that there are sufficient data to formulate an evidence-based approach to treatment of depression and behavioral symptoms, but more research is needed to prioritize treatments. The resulting practice guideline and consensus statement are

published in this same issue.

Srebnik D, Brodoff L. Implementing psychiatric advance directives: service provider issues and answers. *Journal of Behavioral Health Services Research* 2003 Jul-Sep;30(3):253-68.

This article presents and responds to issues raised by psychiatric advance directives (PADs), an emerging method for adults with serious and persistent mental illness to document treatment preferences in advance of periods of incapacity.

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