

Promoting the evolution of flexible models of cost-effective, responsive behavioral healthcare.

## aabh news

### Healthcare Ethicist Emily Friedman to Present Keynote at AABH Conference

One of the highlights of "New Attitude," the AABH conference in August, will be keynote speaker Emily Friedman. Friedman, a highly regarded writer and lecturer, is noted for her work in health policy and the social ethics of health care.

Friedman has written 600 articles and editorials in the past 22 years, including a regular column, "Making Choices," for the *American Health Forum Journal*, where she is a contributing editor. She is section editor for health policy of the *Journal of the American Medical Association* and contributing editor for *Hospitals and Health Networks* and the *American Journal of Medicine*. She is also a consultant on information dissemination to the Agency for Health Care Policy and Research, U.S. Department of Health and Human Services.

A proficient public speaker and university lecturer, Friedman is adjunct assistant professor at the Boston University School of Public Health, where she is one of its highest rated teachers. And for good reason: Friedman's lectures as well as her writing reflect a keen mind,

the courage to tackle thorny issues, and the wit and eloquence to capture the attention — and imagination — of her audience.



Again and again she brings her moral compass to issues as wide ranging as capitation and hospital advertising to whistleblowing and the role of trust in the doctor/patient relationship.

Recent columns in *Healthcare Forum Journal* have included these thoughts:

- "Let's call this what it is. The coverage being sold by altogether too many commercial carriers isn't 'health insurance.' It's accident insurance. If you get hurt or sick despite our obsessive attempts to avoid anyone who is at risk of doing so, then we might pay off. Maybe."
- "I happen to think that capitation can improve the quality of care, because it allows the money to follow the patient. Especially when it is used in truly integrated systems...it allows the system to give the patient whatever kind and level of care he or she needs."
- "...healthcare marketing and advertising, provider claims

and individual discussions between patients and caregivers are too often marked by dishonesty. And in most cases, no matter what we tell ourselves, the dishonesty is practiced in order to protect the caregiver or provider, not the patient."

- "...it is not surprising that healthcare folk are unsure of the appropriate role of money in their work. Should we seek as much of it as we can get? Should we only seek as much as we need to do our jobs? How should the money be spent? How should it be distributed? And is money, in the end, a means or an end?"

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*Integrating Treatment Planning and Connecting with Primary Care Top List of Issues*

# AABH Holds Forum on Integrating Behavioral Healthcare

With over 80 percent of members working in a hospital system or comprehensive CMHC, integrating behavioral healthcare services is a top concern of many AABH members. These managers are now beginning to trade ideas and models, share advice and problem solve together through a new AABH forum. "Can't think of a conference where there was more engagement" and "I'm going home with a lot more ideas than I normally do" were typical participant comments at the end of the first Open Space Conference on Integrated Care held February 22-23 in Alexandria, VA.

Of the 28 people who took part in this forum, most were clinical managers whose hands-on duties demand that they find ways to get services to work together to benefit patients. The common thread of concern among everyone there seemed clearly to be quality care that is cost efficient.

And what did they spend two days sharing ideas about?

A sampling of the 14 sessions included:

- Integrating outpatient programs with established PHPs
- Integrating documentation systems across the continuum
- How to provide quality patient care when demands are great and resources few
- Population-based care
- Centralized intake: What works? What doesn't?



- Integrating behavioral healthcare with primary care
- Treatment planning across an episode of care
- Treatment for the Medicaid-capitated SPMI population
- Measuring outcomes

Using a simple yet powerful meeting format called Open Space Technology, these managers set their own agenda for the two days. How many conferences have you been to where what you wanted to see discussed was put on the agenda? Though initially skeptical of this novel approach to learning together, by lunch the first day everyone was enthusiastic. Comments like "I'm surprised" and "this is so dynamic and productive" prompted nods of affirmation around the circle during the check-in at the end of the first morning. One person noted that "the fluidness and adaptability of this meeting format is consistent with what we need to achieve in our service systems."

These participants have become members in the AABH Special Interest Group on Integrated Care. If you would like to join this networking group within AABH, e-mail (knightm100@aol.com) or fax (703-836-0083) your name, title address, phone, and fax to Mark Knight, who is coordinating this group.

A written summary of each of the 14 sessions was created within the Open Space meeting itself; each participant left with a copy. While it is

no substitute for the being there, this 39-page summary is available from AABH for the cost of photocopying, shipping and handling (\$15.00), prepaid. Is integrating services something you are involved in? This booklet could stimulate your thinking. Fax your request to Joe at (703) 836-0083. ◀

## AABH Board Adopts Fall Election Schedule

A vote by AABH's Board of Directors taken at its biannual meeting in Alexandria, Virginia, on February 21, 1999, has led to a change in the schedule of the annual elections for the association's board.

In prior years, elections were held in the spring, and new board members took their seats at the summer board meeting (held each year in August in conjunction with the annual conference).

The stresses and pressure of those two back-to-back summer events are considerable for a new board member. It was decided by the board that it would be far easier and more effective for new members to concentrate only on learning the ins and outs of board roles and responsibilities during their first board meeting.

Nominations for the 1999 election, which would have been accepted during April and May of this year, will be solicited in the fall, with the election taking place in early January.

## industry news

# AAHP Agrees to Work with NMHA on Mental Health Guidelines for Managed Care

Score another victory for consumer-oriented mental health care. A heated exchange over standards of care for mental health has resulted in the American Association of Health Plans (AAHP) agreeing to work with the National Mental Health Association (NMHA) for the incorporation of the standards into national accrediting processes.

The NMHA issued "Standards for Consumer-Centric Managed Mental Health and Substance Abuse Programs" in September. AAHP, the country's largest managed care association, attacked the guidelines as vague

and lacking measurable, quantitative outcomes. AAHP claimed that some standards were unrealistic and could result in unlimited treatment and costs, and it objected to the NMHA's recommendation that consumers, families, clinicians, and others become involved in developing standards for particular plans.

NMHA – a national network of mental health advocates – developed the standards in response to issues raised by mental health consumers, family members, and advocates at NMHA-sponsored seminars in over 40 states over the past two and a half

years. The organization intends for the standards to influence or be incorporated into managed care contracts and improve quality monitoring. The document addresses such issues as

- Outreach, enrollment, disenrollment and eligibility management;
- Access to providers, services and medications;
- Utilization management/treatment authorization processes;
- Medical necessity definitions and levels of care criteria;
- Rights, appeals and grievances;
- Confidentiality and management of consumer information;

See *GUIDELINES*, page 11

## New Money Available for Model State Programs to Integrate Mental Health Services for Children

Public sector service providers – basically states or political subdivisions of states, as well as Indian tribes or tribal organizations – are eligible to apply for one of 20 to 25 community-based, family-focused program grants for children with serious emotional disturbances and for their families.

The new program grants were announced in January in the Federal Register, and are expected to cost approximately \$1,000,000 apiece. Each will fund a program that will enable communities to integrate child- and family-serving agencies, including health, mental health, substance abuse treatment, child welfare, education and

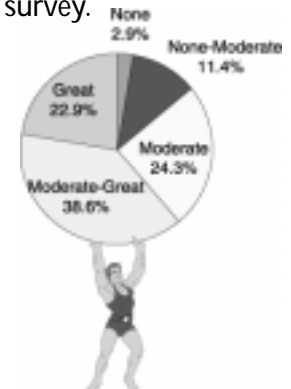
juvenile justice agencies, into a comprehensive local system of care for a state or region.

Linked to the actual development and execution of the new integrated programs will be secondary grantors whose goal will be to evaluate each system's outcomes and to contribute to a best practices model, which will help to shape future programs for children and families.

Applicants may contact IQ Solutions Inc. at 301-984-1471 for the application kit. Deadline for applications for this program is April 21, 1999. ◀

### Is That a Fact?

Feeling pushed to expand your service continuum? Here's how your peers responded to a recent survey.



Question: To what degree is your program experiencing marketplace pressure to diversify?

Source: AABH Trend Survey, August 1998

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# Finally, a Treatment Outcomes Management Tool That is Right for AABH Members

*(In January, AABH signed an agreement with Access Measurement Services (AMS) to make low-cost, JCAHO/ORYX approved outcomes management tools available to AABH members. Through this arrangement AABH members receive substantial savings upon enrollment with AMS for outcome measurement services. The following is the first of a two-part interview with David Kraus of AMS, Mark Knight of AABH and David M. Pratt, Ph.D., Director of Treatment Services at Lake Shore Behavioral Health in Buffalo, NY, a partial hospitalization provider currently using the AMS system.)*

**What is TOPS (short for Treatment Outcomes Package System) and how does it work?**

DK: The TOPS is essentially a clinician-administered instrument that collects data on symptoms and severity, demographics and other variables that affect the course of treatment, such as co-morbid medical conditions, and type and duration of stressors. This instrument takes about 25 minutes for clients to complete. Within 15 minutes, AMS will fax back a report with suggestions for diagnoses, treatment goals and, after repeated admissions, a

graph showing changes in symptoms over time.

The instruments have been normed and well tested for validity, reliability, and sensitivity. Instruments have been developed and are in use for Adults and Children. The measurement system can be tailored to each setting as each involve an initial assessment and a choice of follow-up options, satisfaction scales and scales for substance abuse. It is important to note that the only hardware required to use this program is a fax machine.

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## public policy update

# Domenici, Wellstone to Introduce Mental Health Parity Legislation

As Milieu went to press, Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN) were poised to introduce a mental health parity bill that would significantly expand current law governing coverage of mental health benefits. Sens. Domenici and Wellstone were co-sponsors of the Mental Health Parity Act of 1996, which expires in September 2001.

The bill would provide full parity coverage for severe biologically based mental illness, including

- schizophrenia
- bipolar disorder
- major depression



- obsessive-compulsive disorder
- severe panic disorder, post-traumatic stress syndrome, and other major anxiety disorders
- serious childhood mental disorders such as autism, anorexia, bulimia, attention-deficit/hyperactivity disorder, and Tourette's Syndrome
- other severe and disabling mental disorders, as determined by the Secretary of Health and Human Services.

In addition, for all mental illnesses, the bill would prohibit limits on the number of covered days and outpatient visits and require that co-payments for medication management

visits and access to psychotropic drugs be at parity.

Under the current act, small businesses employing fewer than 50 workers would be exempt. The new legislation would lower that number to 25 employees. In addition, the existing exemption for businesses that incur an increase of more than 1 percent in healthcare costs would be eliminated.

Mark Knight, Executive Director of AABH, said, "Passage of this proposed legislation will be a great step forward and away from stigma in coverage for mental health. The

See POLICY, page 11 ➤



## People are Talking About ...

**Magellan's Withdrawal from Montana's Medicaid Carve-out.** After a long series of problems with one of the nation's most troubled public sector mental health care systems, Magellan Behavioral Health has announced that it intends to terminate its current managed care contract with the state. An earlier pullout was temporarily halted when Montana negotiated several money-saving measures, but these were not sufficient to operate the current program, and Magellan again decided to cut its losses. The announcement followed close on the heels of a vote in the Montana state senate to terminate the contract from the state's side. Industry observers agree that the long saga of woes basically stemmed from expanding the program's coverage and services while simultaneously slashing its budget in expectation of managed care cost savings comparable to those reported under many private managed care contracts. *A detailed analysis of the situation can be found in Mental Health Weekly, March 8, 1999.*



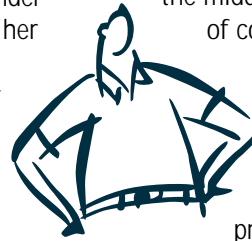
**Virginia's Reorganization of its State Mental Health Oversight Agency.** "Good news for consumers" was the reaction of most advocates to the news that the Commonwealth of Virginia has finally voted to depoliticize its watchdog agency for disabled and mentally ill citizens. It had been one of only nine nationwide that still reported directly to a political appointee, and was criticized as being negligent in its oversight of

conditions affecting persons with serious mental illness. A widely reported incident involving the death of a 31-year-old woman who suffered both mental retardation and mental illness contributed to legislators' interest in the subject. The woman had been under physical restraint at the time of her death. *More information on the changes to Virginia's support for mental illness advocacy issues can be obtained from the Alliance for the Mentally Ill of Northern Virginia at 703-525-0686.*

**The Launch of a New Association for Disease Management.** Reflecting trends in consumer participation in disease management programs over the past few years, a new organization, the Disease Management Association of America (DMAA), was founded this March in Wellesley Hills, Massachusetts. The association is dedicated to educating the health care industry, government, employers and the general public about the role disease management programs play in improving health care quality and outcomes for people with long-term medical conditions like diabetes and asthma. The new association plans its first conference for October 17-20 in San Francisco. *More information on DMAA can be obtained from Ellen Rostand at 314-982-9133.*

**Cultural Competency and Population Trends.** The American Psychological Association, in its December issue of the *APA Monitor*, focused on a new report

featuring demographic projections of both population trends and training of psychotherapists. Today's U.S. population, where people of color constitute about 28 percent of the total, is not representative of the future in this country. By the middle of the next century, people of color are expected to reach almost 50 percent of the total population. Meanwhile, caregivers of both physical and mental health services are training far fewer health professionals of color than such a pattern would suggest are needed. Currently, only 6 percent of psychologists are non-white, and graduate and professional schools show a similar enrollment trend. The report, and APA's response to it, are described in the *APA Monitor, December 1998.*



**Increasing Federal Employment Opportunities for Adults with Psychiatric Disabilities.** In January, President Clinton asked the Office of Personnel Management to examine ways the government can eliminate some of its standards that have a negative impact on persons with psychiatric disabilities. Often, these are stricter than standards that restrict hiring or employment opportunities for people with either mental retardation or severe physical disabilities. This effort to open up employment in the federal government is of significance to people with mental illness because the government is one of the country's largest employers. *For more about this story, see the BNA Monitor, January 25, 1999.* ◀

## consumer corner

## We Need Unity at This Crucial Time

by Wesley Alcorn

*Mr. Alcorn is current chair of NAMI's Consumer Council and an experienced consumer advocate from Montana who spoke as a member of AABH's Access Panel — a plenary session at ACCESS 1998. In his remarks, he drew many parallels between the modern mental health consumer movement and many other social movements of the late 20th century. He also tried to raise awareness of some of the dire potential of allowing the country's critical social networks to unravel by any means — including erosion and neglect based on economic reasons.*

I want to thank Mr. Knight and Mr. Best and CJ Zimmer, the Consumer Council Representative from Nebraska, for the invitation to speak, our distinguished panel and you humanitarian professionals out there or, as you're known in Montana, "whining providers." That's what they call you — they call us the "disruptive consumers," so here we are, together.

We heard a lot about collaboration from one of the keynote speakers — and I think that's something important and something we all have to embrace, and I would submit that we are in the process, whatever our particular perspective on managed care, and mental healthcare and healthcare in general, we're all in the process of trying to remake ourselves in order to best respond to managed care. For my money, corporate sector managed care where it is not regulated (and right now it's not being controlled at the local and state level) is essentially an assault on a community. It is also an assault on our social fabric and our social order, and we had better get a handle on this. The philosophical

presupposition that a certain group of individuals can fall below what I call the Healthcare Insurance Hospital Complex — simply by saying "you cannot have access to that" — that is a Pandora's Box, and I'm not one to always invoke slippery slope arguments, but I think there is an argument to be made that we are indeed flirting with disaster by tolerating this kind of unraveling of our social order.

I sincerely want to thank all of you for your years of service to my constituency. I think we do have a symbiotic relationship, and as we all work on remaking ourselves, I would recommend that all of you as humanitarian providers attempt to reach out — through your professional guilds and your organizations — to this burgeoning, growing consumer movement that's out there. It's coming together roughly out there — I think managed care is forcing it to think in more global terms than it has before, but we are a social movement, and we are in the process of appropriating some of the successful strategies of the other social movements in the last half of the 20th century, and among those are the civil rights movement and the women's movement.

I myself was surprised that I haven't seen more professionals protesting, as your rates have plummeted and your ability to practice an ethical and clinically acceptable standard of healthcare delivery has been constricted more and more by the forces of managed care.

If you were to go before your legislators as I've done in the state of

Montana, you might hear "Well, you're just riddled with self-interest and you're just worried about your own rates, you whining providers." I would suggest that you try another model — that you embrace the consumer community, and that you validate them as being children of God, citizens of the United States, possessing intrinsic dignity, value and worth. You do that, and you can't be accused of self-interest, of just trying to keep your own nest egg going. But for that, it's going to require a little different view of consumers than even some enlightened professionals have — at some level, you're going to have to start meeting us as equals.

That's difficult. But I don't think we have any other choice, because we don't have many other states like the one we heard from today on this panel — the state of Maryland. We're very worried as consumers that some folks' solution seems to be to increase the ability to involuntarily commit folks, while not increasing any place to be committed to. I think it's safe to say that right now, the only place that's taking folks in who have serious mental illness are jails and prisons. That's the only place the government can mandate treatment. So what are the obvious implications of that?

So I would say, consider this new paradigm. I think AABH and its representatives — Mr. Knight and Mr. Best — and CJ Zimmer, have access to the consumer community, the best of it, and I suggest that we start forming

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## technical assistance

# Keeping Your Program Afloat and Your Heads

## Above Water (Part 1 of 2)

*Cataclysmic is not too strong a word to use for the changes that are sweeping the health care industry, and perhaps most dramatically, the field of mental health. All categories of AABH members are experiencing changes that threaten to transform or even eliminate their careers. To help, Milieu is publishing a series of technical assistance articles with practical suggestions.*

*This issue features part 1 of a Q&A with Maggie Moran, RN, MHSA, on marketing ambulatory healthcare programs. Maggie, an AABH Board Member, has more than 25 years of experience in healthcare, including providing nursing and clinical oversight in a number of settings, serving as Director of Managed Care for Blue Cross/Blue Shield of Massachusetts, and as a Senior Vice President of Marketing and Program Development for Choate Health Management, Inc., where she established one of the first innovative continuums of Behavioral HealthCare. She is currently a healthcare consultant specializing in marketing and sales.*



### **Q. What suggestions do you have for uncovering the unmet mental health or substance abuse treatment needs in the community?**

A. I often use the expression that we, in the behavioral healthcare field, need to listen more to the “whispers of the community.” It’s surprising how often what providers think the needs are, does not always match the real needs of the community.

Before you start a new program, you need to go out and talk to individuals/groups — other providers, community mental health centers, home health care agencies, businesses, consumer groups, clergy, and primary care physicians (PCPs) to find out what is working and what is not working. Visit acute general

hospitals with service centers such as pediatrics, cardiology, and oncology. Physicians in these areas often have patients and families who are depressed or stressed. Talk to consumers; find out what’s working or not working for them. Attend provider meetings and listen to their concerns and what they are doing to resolve or attend to these issues. See what synergies might be there for providers to work together to meet a common goal of quality patient/client care.

Speak to different associations, such as local chapters of the Alliance for the Mentally Ill, and to other specialty providers such as substance abuse programs. Talk to managed care organizations and ask them what the barriers are to reimbursement and what their service concerns are.

Looking at data and information to ascertain what types of patients keep coming back into the system or to emergency rooms is important in assessing and evaluating why this is occurring and what needs to change. What is missing within the system needs to be addressed.

As a provider you need to have programs/services that are easily accessible and readily available (24 hours a day, 7 days a week, 365 days a year) to those individuals whom you serve.

A couple of other things are also critical. First, you must develop the new program/s before you go after reimbursement from the payer. You have to have some experience in order to be able to elaborate on the dynamics and results of such programming. You

cannot expect the payer to have confidence in programs that are not tested. Secondly, you don’t have to do everything at once. Start with the services that address the greatest need. Add other services as you can or create partnerships or affiliations with existing service systems that meet your own value system and mission.

### **Q. How can one evaluate the reimbursement climate before setting off to develop a program?**

A. First, talk to MCOs about reimbursement. Explain what you’re thinking of developing, and ask if they would reimburse for it. Have them think about how they would be able to reimburse for these services that may not currently be included in their existing benefit packages/plans. Second, talk to other providers about how a program similar to yours works for them clinically and financially. Ask them what the pitfalls have been and the ones that still remain.

It is also critical to conduct a cost/benefit analysis. Analyze your direct and indirect costs. Determine how many billable slots you will need to break even. How long will it take? If you are a part of a larger organization, see if you can get at least a partial exemption from full overhead allocation for the first year or so. Overhead can kill a new program before it even begins. ◀

*Next month, the second half of this interview will be published, covering such issues as program census management, breaking down reimbursement barriers, and marketing. Keep an eye out!*

## knight's notes

## Pursuing Change During a "Healing Crisis"

We continue to live and work in times of change. As I hear from more and more AABH members who tell me what they are grappling with in their programs and hospitals, I'm constantly reminded of a point made by our keynote speaker Jim Gordon back in August.

Dr. Gordon spoke of the "healing crisis." In times of change, with things breaking apart around us, or people we care about in difficult circumstances, we may find ourselves in the grip of emotions — fear, grief, despair, anger. Out of those emotions sometimes comes the clearest vision — a newly accurate picture of how real change might be possible.

This is a time where things are happening that are both hard and easy, good and bad. Although we can all tell that the pace and degree and depth of change are more intense than they were formerly, it's clear that it's not possible to call it all bad, or all good.

For example, in Maine, there is new funding for community-based services that promises to change the way care is delivered. And in Pennsylvania, the first rate increase in 20 years is about to be implemented.

Before these positive changes emerged, mental health funding somehow had to become so dismal in those two states that it compelled change.

In Jim Gordon's book, he described a medical problem with his back that resisted both diagnosis and treatment, yet left him in such pain that he was driven to continue his search beyond the conventional options, and in fact beyond the

boundaries of conventional medicine, where he eventually found relief.

As an M.D., he was forced to recognize that this demanded a change in his own perspective on medicine — his chosen profession, his basic worldview — everything was called into question by what he experienced as a "healing crisis."

Gordon said that he found himself thinking about the basic dynamic of psychotherapy — that you have to work through emotional pain in order to create change — and that it's somehow necessary to experience an acute phase of any disorder before you can muster the energy resources to fight against it.

It is only in a crisis that we begin to question our old ways of doing things — ways that easily become a straitjacket we get used to living in. However dysfunctional, however unhelpful or debilitating these patterns of behavior have been, we have clung to them throughout all kinds of situations, and they have prolonged our condition, even when that represents a state of chronic underfunctioning. We tolerate our own dysfunction and adapt to it instead of investing energy in changing.

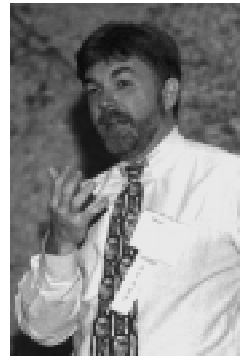
As practitioners, we encounter patients in this kind of crisis all the time. We meet them at a time when their personal anguish is strong enough to cause them to consider making radical change in their lives, preparing them to question their relationships, their eating, sleeping, drinking or working habits — and, when they're able to do that, they get better.

What can we learn from this insight that might help our organizations get through the current time of crisis?

First, I think that the basic approach in a partial hospital program is one to value — and that is working from an emphasis on people's strengths, rather than their weaknesses. These strengths are the things that will help them support different and better adaptations and solutions to their difficult problems.

Also, the shape of the multidisciplinary team approach should help us. You can't afford to confront your organization's challenges in isolation — it's important to build as many bridges as possible, to avoid "turfism" and to abandon unproductive competition in favor of the kind of open, creative attitude that we see in good treatment teams, where it's recognized that any member may have a unique perspective that holds the key to the best intervention or solution.

A third thing to remember is something that Jim Gordon reminded the audience of last summer: Good mental healthcare, he said, begins with self care. Stress takes its toll. In stressful times, you need to take MORE time to nurture yourself and your own resources, so that you and your people can deal with the stresses you are all facing.



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some more linkages, for both of our safety. Some points of hope are the Recovery Model, new research in medications, many of the things we just heard that the Maryland system supports — such as peer case management, peer services, employment, access to education — these are helpful things, and things that every provider can begin thinking of as real options in their own systems.

I think as you'll see also, we're not interested as a movement in simply tinkering with what's left of a crumbled system. We will push for comprehensive reform — we need insurance parity, we need community hospital access, and some form of long-term housing with a treatment component, especially for that 15 to 20 percent of our members who get out of control from time to time. People shouldn't have to take a gun into the Capitol building and shoot innocent strangers to get some help.

It is a dangerous time, with the Contract on America and the emphasis on Trimming the Rolls of Dependency — it's a kind of concentric circle that keeps expanding. First it's the people on welfare, then it's going to be the mental health consumers, then the kids, and the elderly, and this thing is going to keep expanding, and you better find some way of stopping it, here and now, before this thing rolls out and goes further. You as humanitarian professionals can help with that — it won't work if you go before your legislature and tell them "we just can't take this last cut," but if you say "look, this has fallen below our ethical standards to be able to practice medicine and this simply cannot be done," you might get a different response from those folks, so please consider that.

We consumers appreciate you all, and we hope that you will appropriate the moral authority that is vested in you as providers.

Finally I want to remind you of a Gandhi quote — he said "No society can live if it attempts to be exclusive." So really in a strange fashion, those of us who are mental health consumers, and those of you who've spent your time and years in learning and in practice can perhaps function together as the conscience of America at this critical crossroads we're at. But if we stay silent, and remain frozen in the moment, we face consequences that perhaps we can't even comprehend as of yet. ◀

To learn more about NAMI and its Consumer Council, call 1-800-950-NAMI.

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FRIEDMAN, from page 1

"We are extremely pleased to have Emily Friedman kick off the conference," said AABH Executive Director Mark Knight. "She clarifies the issues we struggle with every day, and I know we'll all have more to think about after hearing her speak."

Friedman's many awards and honors include designation as an Honorary Life Member of the American Hospital Association, a Fellow of the Association for Health Services Research, and an Honorary Lifetime Fellow of the American Academy of Medical Administrators. She received the Corning Award of the Society for Health Care Planning and Marketing, and the William R. Haney Award of Merit from the Forum for Health Care Planning.

The AABH conference is scheduled for August 4-7 in Denver. A poster announcing the conference and soliciting workshops was mailed to all members in late January. If you haven't yet seen it, contact AABH to get one. ◀

AABH's 1999 annual conference in Denver is shaping up as a great place to go for practical professional training. The conference will take place from August 5<sup>th</sup> through 7<sup>th</sup>, 1999. Additional in-depth institutes and site visit tours will be offered on Thursday, August 4<sup>th</sup> (the day before the conference itself).



- 2 dynamic keynotes on what's next in healthcare
- 4 days in sunny Denver – a great summer destination!
- over 65 workshop choices
- up to 16 hours of continuing education credit
- 1 evening excursion to picturesque Boulder, Colorado
- 25 workshops tailored for the "veteran" professional
- dozens of valuable ideas on integrating behavioral health services
- 2 site visits to successful programs in the Denver area
- 6 intensive pre-conference institutes
- hundreds of people with whom to exchange ideas

TOPS, continued from page 4

**Why is AABH recommending TOPS to its members?**

MK: Our members have been paying attention to outcomes since 1992. In that time we have searched for an outcomes measurement system that is: 1) savvy about the unique nature of the partial hospital environment, 2) flexible enough for use by programs of different sizes in different settings, 3) able to be adapted as things change, and 4) priced low enough to meet the needs of a majority of our members. With the TOPS program from AMS we have met all of these needs.

**How are new requirements driving the adoption of outcomes measurement in behavioral healthcare?**

DK: Outcome data is now required in many accreditation and contracting efforts in behavioral healthcare. As examples, JCAHO, CARF and COA are all requiring outcomes or performance measurement in the accreditation process. HCFA will be requiring outcome data for Medicaid sometime this year. The United Way is requiring outcome data on all new contracts. Knowing how you rank and what you need to do to stay competitive is vital to your organization's success. In the not too distant future, behavioral health contracts will not be awarded without credible, benchmarked outcome data to support your claims of being a good provider.

**What should a program consider before it starts collecting outcome data?**

DP: Are you prepared to take the risk of evaluating your performance? What will you do if the data are not very favorable? Do you have valid reasons for conducting the assessment? How will you use the data — for quality assurance, program development, marketing? Do you know what you mean to evaluate? What are the relevant outcomes for your program and how can you verify them in a reliable and valid manner? How will the operational systems involved with the outcome assessment project fit in with (or possibly disrupt) your existing information systems?

**Are there any hurdles to starting to use TOPS in a partial hospitalization or IOP program?**

DP: There must be agency "buy-in" at all levels — board, administration, business management, clinical managers and staff, and support staff. Staff at all levels must be trained and involved with the implementation of the project. You must help clinical staff appreciate outcome assessment as a clinically useful tool, and help them interpret test reports and overcome an aversion to statistics and "psychological" tests. Don't use the outcome data as a "report card" with your clinical staff. Emphasize a positive tone, i.e., program development.

**What are the advantages of TOPS over some other outcome measurement tools?**

DK: TOPS is the first outcome management system designed by and for providers. It gives you immediate lab-style client reports that inform and

enrich the clinical process. It builds a set of rich clinical and case-mix data to help you truly manage and plan using data and results. TOPS is flexible and offers choices in how much data to collect. It gives you access to the largest comparative outcome management database in the country for benchmarking purposes.

MK: Its low cost and ease of use are certainly important advantages to our members. From the AABH perspective, there is also the fact that it was developed in and for the ambulatory environment. AMS has addressed the more complex outpatient environment. The TOPS instruments measure factors that are inherently familiar to people who work in partial and intensive-type outpatient services—factors that are irrelevant or not considered in tools designed for the inpatient or residential environment.



**How could AABH members get more information about TOPS or take a look at it?**

DK: Visit our behavioral health products and service information on the world wide web at: <[www.ams-outcomes.com](http://www.ams-outcomes.com)>.

**What is the process for enrolling in the AMS-AABH program?**

DK: Simply call Jeanne Crawford at AMS (1800-329-0949 x129) and ask her help in completing an initial order form. ◀

*[Part 2 of this article will appear in the May/June issue of Milieu.]*

*GUIDELINES, from page 3*

- Quality assurance, quality improvement and outcomes;
- Governance of Medicaid programs.

Examples of the NMHA standards include the following: Under treatment authorization, "In cases of emergency, as determined by a prudent layperson, the organization must cover any services necessary to assess and stabilize the consumer." The section on patient rights calls for consumers "to be fully involved in treatment decisions and to participate in the development of their treatment plans." Under access to providers, the guidelines say, "Adults with serious mental illnesses and children with serious emotional disturbances may have chronic care needs or ongoing special conditions, and they must be able to access an appropriate specialist without first seeking approval and/or referral from a primary care gatekeeper."



The debate between AAHP and NMHA heated up until AAHP retreated from its critical position and

agreed to work with NMHA to incorporate new standards into accrediting processes of the National Committee for Quality Assurance (NCQA) and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

Although AAHP objected to the standards, another managed care organization, the American Managed Behavioral Healthcare Association, told *Private Sector News* that the standards were "for the most part...reasonable."

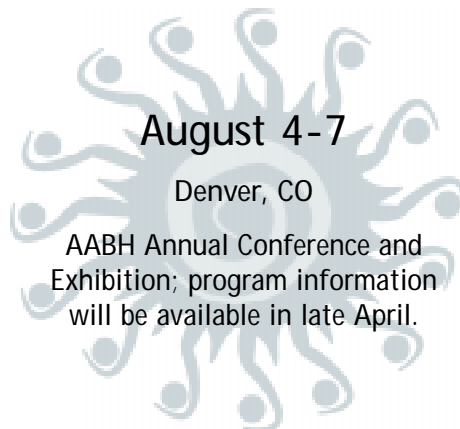
According to NMHA, the standards are an attempt "to raise the bar in the current quality assurance and improvement processes used by managed care," and the organization emphasizes the document is a work in progress, open to discussion and input from all sectors.

For a copy of Standards for Consumer-Centric Managed Mental Health and Substance Abuse Programs, call NMHA at (703) 684-7722. The document is also available at the NMHA web site: <<http://www.nmha.org/shcr/articles/standcons.cfm>>. ◀

*POLICY, from page 4*

provisions of this bill will address arbitrary limitations on coverage for mental health driven by misconceptions about the cost and value of timely and medically necessary mental health care.

"Domenici and Wellstone see a real opportunity for passage, but it will take all of us to get this passed. AABH members will need to be prepared for grassroots action in the months ahead." ◀



## Calendar

April 19-21  
Providence, RI; AABH Spring Training Seminars. To request a seminar brochure, contact the AABH central office at 703-836-2274.

April 21-24  
Boston, MA; 1999 American Alliance for Health, Physical Education, Recreation, and Dance (AAHPERD) National Exposition; call 703-476-3468 for more information.

April 23  
Annual Educational Conference of the Delaware Valley Partners in Healthcare Association. Call 215-579-5669 for more information.

April 29-30  
Annual Meeting of the Ohio Ambulatory Behavioral Healthcare Association; for more information call 1-614-785-7480.

April 29-30  
Springfield, IL; Meeting of the Community Behavioral Healthcare Association of Illinois; for more information call 217-585-1600.

May 10-14  
Minneapolis, MN; Annual Conference for the International Association of Psychosocial Rehabilitation Services. For more information, call 410-730-7190.

May 14  
Orlando, FL; Annual Conference of the Florida Ambulatory Behavioral Healthcare Association; call 407-207-0294.

May 15-May 20  
Washington, DC; American Psychiatric Association Annual Meeting; call (202) 682-6193 for more information.

June 2-4  
Tacoma, WA; Washington State Behavioral Healthcare Conference; for more information call 206-628-4608.

CRISIS, continued from page 8

Take time to laugh. Take time to sympathize. Take time off and take needed breaks, and as you go about your daily activities, take the time to ask people the question "How are you doing?"

We're experiencing so many situations that involve forces beyond our control. Medicaid, managed care, Medicare – these are bigger systems than any of us have the power to control. So, as in a therapeutic setting, it's important to separate out what we can affect from the things we can't. We need to focus on what's under our own control.

Jim Gordon had a final thought on healing that strikes me as relevant. In talking about how he has come to believe the caregiver can foster healing of patients, he put it very simply: Create a place people will want to come to. He linked that idea to the creation of good workplaces, good professional services, and successful therapeutic practices of all sorts. But it is true in the broadest sense. Out of crisis, we create solutions, solutions people will want to come to. And in doing so, we can create a better world. ◀

# next issue →

When Your Job Disappears ...

Ideas on Breaking Down Barriers to Reimbursement

AABH's New Technical Assistance Feature

Details on the White House Conference

A Way to Bring Quality Back to the Forefront

**milieu** — (noun, singular) (*From the French*) Environment, especially social or cultural setting. (*Psych.*) An atmosphere or ambience in which therapeutic progress may (or may not) take place. Sometimes thought of as the sum of the interactions between people in a particular group or social setting. The milieu has been described as "the wellspring of energy or momentum within the treatment program." (*Sociol.*) The collective tone or ambience that develops within an association of people as they work together toward common goals.

**milieu** — the newsletter of the Association for Ambulatory Behavioral Healthcare, is published six times a year as an informational service for its members. Annual membership fees begin at \$95 per year and include valuable discounts on other products and services. Have a comment on an article? Write to the Editorial Team at AABH, 301 North Fairfax St., Ste. #109, Alexandria VA 22314. Copyright 1999 AABH. All rights reserved.



**Association for Ambulatory Behavioral Healthcare**  
301 N. Fairfax Street, #109  
Alexandria, VA 22314

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