

MHSIP UPDATES

December, 2000

Mental Health Statistics Improvement Program

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50th NATIONAL CONFERENCE ON MENTAL HEALTH STATISTICS

"An Information Odyssey: Celebrating the Past 50 Years
and Promoting the Future"

May 29 - June 1, 2001

Marriott Wardman Park Hotel

2660 Woodley Road, N.W.

Washington, DC 20008

Call for Papers - Proposals Due January 2, 2001

The conference will recognize the achievements which have taken place in the mental health statistical field over the past 50 years, celebrate the accomplishments of the Mental Health Statistics Improvement Program (MHSIP) since its origins 25 years ago, and looking to new developments that portend the future. Presentations are being sought for the conference that emphasize how statistical information is used in the following four areas: (1) People First activities and initiatives; (2) Services for adults and children; (3) Applications of information technology, and (4) New domains including housing, employment, pharmacy, and consumer run services.

Abstract forms are available at: www.mhsip.org, or www.mentalhealth.org/cmhs/mentalhealthstatistics/natlconf2001.htm, or by calling (301) 443-3343.

MESSAGE FROM (OUTGOING) CHAIR

The MHSIP Policy Group met in Washington, D.C., in September and elected a new chairperson, Mary E. Smith, Ph.D. Mary is Chief of the Bureau of Evaluation and Services at the Illinois Office of Mental Health and has many years of experience with mental health program evaluation, performance measurement, data system development, and MHSIP. I'm pleased to welcome Mary to her new post and pass the MHSIP baton to her--next newsletter, you'll be hearing from her.

The MHSIP Policy Group continues to be involved in several mental health data projects and updates on members' participation in these activities were reported during the September meeting. One of the projects that several Policy Group members are involved in as state or consumer representatives is the CMHS-sponsored 16-state performance indicators pilot project. Ted Lutterman, NASMHPD Research Institute (NRI), is preparing the end-of-year-2 16-state project report. Olinda Gonzalez, CMHS, noted one of the successes of the 16-state project has been the participation of national experts: Ruth Ralph (recovery), Bruce Dembling (mortality), Molly Brunk (child/parent survey), and John McGrew (PACT). Two important limitations of the work so far were recognized. First, non-participating states need to be informed of the technical work being done on the 16-state project, through the MHSIP website, the national mental health statistics conference, and by incorporation in MHSIP Report Card, version 2. Second, the results of the 16-state project need more analysis and interpretation, e.g., with state-to-state comparisons on indicators. The next State Profile System contract from CMHS, which has now been awarded to NRI, will require compilation of indicators from states, so there will be a resource for future analysis.

The Policy Group again has vacancies for consumer and state members. Letters have been sent to consumer groups, MHSIP regional user groups, NASMHPD and others to solicit member nominations. Selections will be made at the December 11-12 meeting.

The National Conference on Mental Health Statistics planning meeting was held September 11 and Mary Smith was the MHSIP Group representative. The 2001 meeting marks the 25th anniversary of MHSIP and the 50th anniversary of the conference. No other federal conference has such

longevity, so it is a cause for celebration and opportunity to publicize mental health data needs. Technology is a theme of the conference and the Policy Group will collaborate with the Work Group for Computerization of Behavioral Health and Human Services Records to sponsor a vendor fair for organizations that produce behavioral health data systems and related software and equipment. A poster session will also be sponsored.

Significant steps have been taken toward getting the MHSIP Report Card, version 2, project up and running with the meeting of a planning group and development of a charge for the proposed work group. Vijay Ganju, former MHSIP chair, former Texan (Vijay has retired from TXDMMHR and moved to Virginia to work for NRI), chaired this group and drafted the charge.

MHSIP state, local and consumer representatives have been working for the past year with CMHS, AMBHA, NAMI, ACMHA, the Federation of Families for Children's Mental Health, NASMHPD, accrediting organizations, and others, to prepare for the Summit on Common Performance Measures. The aim of the Summit is to reach consensus on a small number of performance measures that can be used in common across the behavioral healthcare field. If consensus can be reached on a few indicators, then implementation issues can be addressed and development, revision and inclusion of a broader set of indicators will follow. Originally planned for the end of October, the meeting has developed so much interest within SAMHSA that it is being postponed to ensure SAMHSA has an opportunity to participate.

MHSIP Policy Group members, with Cecil Wurster, consultant, as primary liaison, are working with CMHS and Abt Associates to guide the ongoing development of the Decision Support 2000+ data prototype project. In previous phases of the project, focus groups were held and policy issues identified and published, and requirements analyses for model components were written. The aims of the current phase are to establish a typology of financing and organization of behavioral health care, and develop core datasets to implement the requirements analyses that match the typology.

The Policy Group has had a continuing interest in the definition and measurement of recovery. Ruth Ralph, former Policy Group member, was previously funded by CMHS/NTAC/HSRI to review literature, compile instruments, and recommend next steps. This past Spring a meeting of

recovery experts was held in Texas to discuss development and piloting a survey of recovery in Texas and other states. Conference calls have been held since that meeting and several states are expected to organize consumer focus groups to develop a recovery instruments.

Finally, Policy Group members were very pleased to have Walter Suarez, MD, Director of the Minnesota Health Data Institute, address the group via speaker phone to discuss HIPAA and its implications for behavioral health data. Dr. Suarez gave us an overview of four major areas of HIPAA impact: standardization of administrative transactions, privacy; security; and standardization of the electronic medical record.

He also offered suggestions about how the behavioral health field could influence the HIPAA standards development process: identify and prioritize needed behavioral health data items and code sets, then work with other groups, like the Public Health Data Standards Consortium, to solicit changes from the national data standard committees that have been given responsibility and authority to set the standards.

This is just a brief summary of the September meeting and the topics that were discussed. As you can tell, there is much work being done and much more to do. Some activities are more fully described in the following pages. For others you can find more information at www.mhsip.org. I encourage you to read on here, browse the website, and get involved where your interests lie.

Steve Davis, Ph.D., MHSIP (Outgoing) Chair,
Oklahoma

MESSAGE FROM CMHS DIRECTOR

The year 2000 has been launched with consistently high expectations for improving mental health outcomes for all Americans. Most of us in the mental health field have been gaining ground in part, because of the essential role that the Mental Health Statistics Improvement Program (MHSIP) plays in the overall mental health system. Even though this essential role carries tremendous demands, you should take considerable satisfaction in the recognition that your work is receiving at both the State and federal levels. In looking at the bigger picture of this success, it might ease your task to review some indicators that our likelihood of success

in mental health promotion, treatment, and preventive interventions continues to be optimistic.

The current Administration has been very supportive of mental health during this past year. They sponsored the first ever White House Conference on Mental Health in June. Several positive developments came out of that meeting, including a national public information campaign that will be launched this summer. Last July, the Surgeon General issued a Call to Action on lowering our national suicide rate, which is unacceptably high -- in fact higher than our homicide rate. The Center for Mental Health Services (CMHS) is a leader in a public-private work group to develop a strategy to prevent suicide. This work has already begun. Also in the past year, the President issued an Executive Order giving Federal employees parity in mental health insurance under their employee benefits. This not only benefits Federal employees, but it creates an excellent national laboratory to test the costs and benefits of parity.

There is a feeling in nearly every office of the CMHS that we are getting more attention and support for problems that have long deserved this focus. We owe much of our success to our partnership with you. As we move forward, we will continue to learn and share with others our belief that the kinds of things that never change still can and will change. We have taken that long-term view, past the immediate mental health needs of all Americans, to the systems that affect their lives in the years to come. Individuals with mental illness deserve to fully participate in America's dream of unending opportunities for prosperity and optimum health. We know that progress is possible if enough ways are tried to get there. We know that while we still have many questions, MHSIP will help us with the answers--so that we can make the best decisions in ushering "in a healthy era of mind and body for the Nation."

Bernard S. Arons, MD, Director
Center for Mental Health Services

USER GROUP NEWS

Southern States MHSIP Users' Group (SoSMUG)

For the second year, the Fall SoSMUG RUG meeting was held in conjunction with the Southern Regional Conference on Mental Health Statistics (SRCMHS). The SRCMHS was held in San Antonio, TX on November 6-8 at the Gunter Hotel. SoSMUG

convened after the close of the Southern Regional conference, on the afternoon of November 8 and met through November 9. The primary focus of the SoSMUG meeting was updates on various State Reform Grant initiatives and state developed performance indicator systems. Of the 14 states that comprise the Southern States MHSIP Users Group, 11 have State Reform Grants and four (OK, SC, TX, and VA) are also participants in the 16 State Indicator Project.

A number of SoSMUG MHSIP representatives were present at the annual State Planners' Conference held in Washington, D.C., July 31-August 2. These included: Patricia Dahlgren and Sheila Duncan (AR), Sen-Yoni Musingo (FL), Randy Lemoine (LA), Ed Payne (MS), Fred Hobbs (SC), Pam Sylakowski (TN), and Vijay Ganju (TX). Also present was Mark Reynolds of OK, a frequent SoSMUG meeting attendee. A draft document outlining the proposed State Uniform Reporting data elements and performance indicators was distributed at the meeting.

The Spring 2000 SoSMUG meeting was held in Nashville on May 18-19. A total of 17 state representatives and guests attended. Steve Davis of OK discussed the Decision Support 2000+ initiative, with Sarah Minden and Marilyn Henderson participating by speaker phone. Pam Sylakowski, MHSIP representative from TN, organized a great set of presentations focusing on some of the service oriented research activities underway in her state. Rex McWilliams of the Cherokee Health Systems gave a presentation on how his company, which participates in the TennCare program as both a medical and behavioral health care provider, is integrating health and mental health data and analyzing the findings. Vanderbilt University was represented by Carol Ann Hefflinger and Ann Doucette. Dr. Hefflinger reported on a project comparing perceptions of children's mental health care services in a managed care state (TN) and a non-managed care state (MS). Dr. Doucette discussed the need for improved outcome measurement in children's mental health care services and spoke about efforts underway to produce newer generation of assessment instruments using Item Response Theory. Tom Doubt, a researcher with the TN Department of Mental Health, gave a presentation about his work in the area of services for persons with co-occurring substance abuse and mental health service needs.

Ed Payne, SoSMUG Chairperson, Mississippi

Western States Decision Support Group

The WSDSG continues to develop the planning and evaluation capacity among western states through meetings and a special project on needs assessments. The group met three times last year. The main focus of the meetings has been state development of performance indicators, particularly indicators whose source is the MHSIP Consumer Survey. Consumers are strongly represented in meetings, and meetings include presentations by consumers about consumer participation in implementing performance indicators.

States continue to gain experience with implementing performance indicators. Some indicators are being raised as "standards". States have reported on a) validity of the data (including sample size and response rate); b) reporting of the indicators (including "risk adjustment"); c) analyzing qualitative data from surveys; d) assessing cultural competence; and e) incorporating performance indicators into a continuous quality improvement process.

States are building networks across systems and improving their understanding of these systems, particularly with other public sector service areas. Both performance indicators and needs have the potential of being viewed from an inter-system frame of reference or even broader, a community frame of reference.

Chuck McGee, WICHE, Colorado

STATE HIGHLIGHTS

Colorado

Colorado researchers have been working since the mid-1970s, toward a general system of mental health data. MHSIP concepts have contributed greatly to the development of this system, especially FN-10. For client data, the effort has focused on creating a client profile system and a client typology. For service data, standard units of service have been defined and in use since the 1970s, but only recently, thanks to a MHSIP Stage II grant, were we able to begin assembling a client level services database. The aim has been to marry the client data with the service / encounter data at the client level and develop a system capable of relating client types to service patterns, tying these combinations to outcome for

purposes of elucidating common practice, 'best practices', cost-effectiveness and understanding system performance. The general system thus becomes a standard system of evaluation with sufficient scope and depth to support the development and testing of performance indicators as they are suggested in-state or in a forum such as the 16-state project. A good performance indicator is one whose role in monitoring all or part of a large, complex, dynamic process is well understood. Colorado's standard system of evaluation will be an essential element for gaining this understanding.

In addition to work on the standard system of evaluation, Colorado has been a very active participant in the 16-State Performance Indicator grants. We have taken the lead on indicators related to consumer perceptions of care, derived from the MHSIP Consumer Survey; indicators related to contact with primary healthcare providers; and indicators related to substance abuse. We have been very active at the national level working with other groups to develop indicators related to children's services, consumer recovery, and consumer functioning. The 16-State Performance Indicator grant has also had tremendous impact within the state. A group of stakeholders has been meeting regularly to develop and guide the performance indicators used within the state. This group has not only refined the ongoing performance measurement system, but has also developed a performance measurement system which was included in the recent RFP for the statewide Medicaid capitation program. In addition, this group is working hard on a report card which will provide information based on performance indicators to various stakeholder and constituent groups. As an offshoot of this group, this summer Colorado will be offering the very first state-wide conference on performance measurement geared toward providers, consumers and advocates. The 16-state Performance Indicator grant has moved Colorado forward in the development of a solid performance measurement system, and has facilitated increased stakeholder involvement in all levels of evaluation.

Judy Hall & Dick Ellis, Colorado

South Carolina

The Department of Mental Health has been collecting BASIS 32 scores on adult consumers in our seventeen mental health centers for approximately two years. The scores are scanned into an NT Server and then electronically transferred to an

IBM RS/6000 which houses DMH's Consumer Database in Informix. Using the reporting tool, MyEureka!, DMH central office and CMHCs are able to obtain reports on BASIS 32 data in combination with consumer demographics and service data. Within the last six months DMH has begun the same process for CAFAS scores for children served by DMH.

In January, 2000, the Continuity of Care module of DMH's Consumer Information System went into production. DMH's Inpatient facilities record referral source and appointment date for inpatient discharges. Community mental health centers record date seen, reasons for missed appointments, method of follow-up, and follow-up comments for inpatient discharges referred to them. DMH monitors the entire process for appointments within 3 working dates of inpatient discharge date, within seven days seen by a CMHC staff, and percentages of appointments kept. Using the reporting tool, MyEureka!, DMH central office, CMHCs, and inpatient facilities are able to obtain reports on Continuity of Care data in combination with consumer demographics and service data.

South Carolina is one of the sixteen states participating in the Performance Indicator Grant Project. With the other fifteen states, CMHS, and NRI we are working through the process of developing a core set of meaningful performance indicators that hopefully all states and territories will be reporting on a yearly basis. The process has speeded the process of developing more accountability measurements for South Carolina. The process has also helped us in South Carolina, understand the complexes of mental health systems from state to state.

Fred Hobbs, South Carolina

DECISION SUPPORT 2000+

MHSIP, CMHS, and DS 2000+ will partner to complete revised data standards.

At its September meeting, the MHSIP Policy Group, CMHS, and representatives of DS 2000+ agreed to work together to fast-track the completion of revised data standards many of which were developed by MHSIP work groups. This action was taken in response to a request from the Western States Decision Support Group (WSDSG) for revised and updated data standards in the format of the

MHSIP data standards in "Data Standards for Mental Health Decision Support Systems" (FN-10), and it formalized the MHSIP role in the DS2000+ development process. DS2000+ is being developed by the Survey and Reports Branch of the Center for Mental Health Services through a contract with Abt Associates, Inc., its subcontractors (National Association of State Mental Health Program Directors, the Harvard School of Public Health, and IDEA Consulting), and consultants (Steve Davis, Vijay Ganju, Tom Trabin, Laura Van Tosh, and Dorothy Webman).

The WSDSG request supports the development of DS2000+ and the plan to develop its components as modules. In this way, the more advanced data sets (e.g. enrollment and encounter) can be separated out from the larger DS2000+ system design, completed quickly, and then folded back into the larger design framework. This approach to the design of DS2000+ provides for earlier delivery of revised data standards to meet the needs of agencies now, as they update data systems or design new data systems.

Initial work will focus on the completion of data standards for the enrollment and encounter component of DS2000+. Data standards for this component were initially developed by a MHSIP work group chaired by Sharon Guidera (OR) and included Peter Steinmann (NV), Ron Tremper (RI), Steve Davis (OK), Kim Willis (HCFA), Ted Lutterman (NASMHPD), E. Clark Ross, Gary Olsen (UT), Robert Anderson (NASADAD), Dorothy Webman (Webman Associates), Laura Milazzo-Sayre (CMHS) and David Brown, Technical Coordinator.

The enrollment and encounter data standards will be completed by a small work group under the leadership of Sharon Guidera and Nancy Callahan, consultants to the DS2000+ project. A MHSIP Policy Group member will be designated for liaison between MHSIP and the work group. Each MHSIP Regional User Group will be invited to select two members to review and comment on draft data standards as they are developed. Review will be encouraged from consumer and family groups and the broader mental health community. The enrollment and encounter data standards will be documented in the format of the FN-10 MHSIP data standards, and a report will be produced for use by the mental health field. The process for completing these standards will serve as a model for developing data standards for other components of DS2000+.

Comments on this effort to complete and publish revised MHSIP data standards should be addressed to Mary Smith, Ph.D., Chair of the MHSIP Policy Group, Illinois Department of Health, Office of Mental Health, 160 North LaSalle Street, 10th Floor, Chicago, IL 60601, telephone 312-814-4948, e-mail address maryesl@earthlink.net.

Cecil R. Wurster & Sarah Minden

HIPAA & Public Sector Mental Health

Administrative Simplification Requirements of the Health Insurance Portability and Accountability Act (HIPAA): Implications for Public Sector Mental Health.

One of the primary aims of HIPAA is to reduce costs through administrative simplification. In essence, what is meant by "administrative simplification" here is the development and implementation of mandatory national standards governing the content, structure, security and privacy of electronic health care data. HIPAA charged the Department of Health and Human Services (HHS) with the task of developing the data standards and, since May of 1998, HHS has published five proposed standards in the Federal Register. They are: a national standard health care provider identifier, standards for electronic transactions and code sets, a national standard employer identifier, security and electronic signature standards, and standards for privacy of individually identifiable health information. Public comment periods have now ended for all the proposed rules, and HHS has now begun to issue final versions of the standards, beginning in August 2000 with the publication in the Federal Register of the final rule for electronic health care data transaction standards. HIPAA requires that any health care plan (including state Medicaid programs), health care provider, or other entity that maintains or transmits individually identifiable health care data in electronic form must comply with the new standards within 24 months of their issuance (small health care plans have 36 months). Thus, the HIPAA administrative simplification requirements will have enormous impact on the entire health care industry, including the public sector mental health community, and, with the recent publication of the first of the final standards, the two year implementation clock is now ticking.

What are the implications of the HIPAA data standards for public sector mental health? On the positive side, the mental health community will share in the benefits the standards will bring, when fully implemented, to the entire health care industry. These include: uniform definitions and structures for a broad range of fundamental electronic health care transactions (including health care claims and service encounters, health plan eligibility determinations, enrollments and disenrollments, and claims payments), a national unique id for each health care provider, industry-wide security standards that will better ensure the integrity and confidentiality of health care information, and wider access by consumers to their health care records. Presumably, the uniformity imposed by the new standards will ultimately result in administrative cost savings. Estimates of annual industry savings are generally in the billions of dollars.

On the negative side, the initial cost of HIPAA implementation will be high, as the standards will require extensive industry-wide information systems modifications. In addition to implementation costs, other negatives of the HIPAA standards for public sector mental health concern code set limitations that, unless overcome, will impede rather than improve mental health service provision and administration. An example: once the final rule for electronic health care transaction standards is adopted, health care plans and providers will be required to use exclusively the procedure code systems maintained by HCFA (the HCPCS codes) and the American Medical Association (CPT-4 codes) to classify outpatient mental health services captured in electronic claim and encounter data systems. Unfortunately, these code sets, which were developed primarily to capture physician-provided services, do not capture the full range of mental health services, such as rehabilitation and support, now routinely provided in the public sector. Most states have developed their own local coding schemes to capture Medicaid-funded and other public mental health services, yet under HIPAA such local codes will no longer be allowed. While HIPAA provides a mechanism for the national code sets to be modified, to date the mental health community has failed to notice or respond to the code set limitations.

Now that HHS has begun to issue the final rules for the HIPAA data standards, the mental health community has two years left to prepare for their impact. This is not much time. State mental health authorities, public sector providers, as well as

advocates and consumers should immediately begin to educate themselves about the standards. Fortunately, information is easily available via the Internet. The best place to start is the administrative simplification web site maintained by HHS, available at <http://aspe.os.dhhs.gov/admsimp>, which includes the Federal Register documents containing the proposed and final standards. The Health Care Financing Administration (HCFA) also maintains a web page containing links to important HIPAA administrative simplification sites at <http://www.hcfa.gov/medicare/edi/hipaaedi.htm>.

After educating themselves, mental health authorities, plans and providers will need to rapidly conduct readiness assessments to determine the magnitude of pre-implementation preparations required. In most cases, the information systems and procedural changes required will be substantial. Beyond these individual preparations, the public sector mental health community needs to develop a national response to the code set limitations noted above. Entities with a national role such as CMHS and the National Association of State Mental Health Program Directors (NASMHPD) should help guide national implementation preparations. For instance, one or both of these organizations could facilitate the development of new procedure codes to capture the full array of public sector mental health services and take the lead in pressing for their inclusion in the national standard code sets. Much work needs to be done quickly if we are to realize the promise and avoid the potential pitfalls posed by HIPAA's administrative simplification provisions.

Chip J. Felton, New York

State Indicator Pilot Project

The 16 State Indicator Pilot grantees continue to meet via monthly conference calls to work on piloting and reporting of 32 performance indicators for comparable reporting across states. The grant project is now in its final (2000-8/2001) year of activities. A recent product that will soon be available is a document on the operational indicator definitions that have been determined for the project.

In terms of performance indicators, pilots in several states are being implemented for the newly developed children's surveys and the PACT and supported employment indicators. Also, a number of states are now gearing up for the piloting of

consumer focus groups to refine recovery questions for a recovery instrument. Data collection is currently taking place in states for atypical medications, seclusion and restraint, mortality, cost, contact within 7 days past hospital discharge, criminal justice contact, and stakeholder participation in mental health state planning. Other indicators being addressed are health care, employment outcome, level of functioning/symptoms, and consumers' living situation. Plans are being considered for presenting 16 state data in the near future for 1998-99 data on hospital and community service penetration rates, 30 and 180 day hospital readmission rates, and the adult consumer survey. A Workgroup will be meeting next month to begin developing a grant final report format.

If you would like more information on the project, you may access 16 State conference call minutes and future documents at www.mhsip.org. For referral or inquiry regarding workgroup information, please contact Olinda González, Ph.D. at ogonzale@samhsa.gov

Olinda Gonzalez, Center for Mental Health Services

CALENDAR OF EVENTS

January 10, 2001

Federal Confidentiality Regulations: New Rights, New Requirements, Many Questions
Live/Interactive "Town Meeting Satellite Broadcast
Noon EST

Association of Academic Health Centers
www.centernet-tv.com
tomshaw@erols.com

January 10-13, 2001

Juvenile and Family Drug Courts: Strengthening Families through Partnerships
National Association of Drug Court Professionals
Miami, FL
877/567-7728

January 31, 2001

The Patients' Bill of Rights: Federal regulation of health plans and providers
Live/Interactive "Town Meeting Satellite Broadcast
Noon EST
Association of Academic Health Centers
www.centernet-tv.com
tomshaw@erols.com

February 25-28, 2001

14th Annual Research Conference: A System of Care for Children's Mental Health: Expanding the Research Base
Research & Training Center for Children's Mental Health/University of South Florida
Tampa, FL
813/974-4649
<http://rtckids.fmhi.usf.edu>

March 21-24, 2001

The Santa Fe Summit on Behavioral Health Financing for Positive Results: Purchasing Quality and Outcomes in Behavioral Healthcare
Santa Fe, NM
American College of Mental Health Administration
(412) 244-0670

March 31-April 3, 2001

In the Public Interest: Strategies and Solutions for Tomorrow
National Council for Community Behavioral Healthcare
Portland, OR
301/984-6200

May 20-22, 2001

Success=Quality Clinical Programs and Quality Business Plans
National Association of Addiction Treatment Providers
Scottsdale, AZ
717/581-1901

May 28-31, 2001

NCDEU: New Developments in Clinical Interventions Research
National Institute of Mental Health
Phoenix, AZ
<http://www.nimh.nih.gov/ncdeu/index.cfm>
703/925-9455

May 29-June 1, 2001

50th National Conference on Mental Health Statistics
Washington, DC
(301) 443-3343

July 11-15, 2001

Consumers and Families: United by Hope, Working for Change
National Alliance for the Mentally Ill (NAMI)
Washington, DC
703/516-7986

August 23-26, 2001

17th Annual Conference: Alternatives 2001
National Mental Health Consumers' Self-Help
Clearinghouse
Philadelphia, PA
800/553-4539, Ext. 293

NEW PUBLICATIONS

Survey and Analysis Branch Documents

A Purchaser's Introductory Guide to Private Sector
Managed Care, July 2000

Integration of Mental Health and Primary Care: A
Technical Assistance Note, March 2000

Survey of State Consumer Surveys, February 2000

Structuring Approaches and Legal Issues for
Provider-Sponsored Managed Care Networks for
Mental Health and Substance Abuse Treatment
Services, September 1999

Mental Health, United States, 1998

Risk Adjustment for Mental Health and Substance
Abuse, February 1999

Fitting the Pieces Together: Building Outcome
Accountability in Child Mental Health and Welfare
Systems, October 1998

To order single copies, please write to:
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Rockville, Maryland 20857
Phone (301) 443-3343 Fax: (301) 443-7926

CREDITS

MHSIP Updates is prepared periodically by members of the Policy Group for the Mental Health Statistics Improvement Program to inform those interested in the mission of MHSIP about recent events, actions, and new directions for MHSIP. The mission of MHSIP is to enhance decision support systems that are focused on meeting the needs of persons with mental disorders. The MHSIP pursues this mission in the spirit of voluntary collaboration and cooperation through the development of data standards; the promotion of integrated data bases; and the encouragement of more effective utilization of data for research, management, and public policy.

MHSIP Policy Group Members: Mary Smith, Ph.D., Chair; Steve Davis, Ph.D., Past Chair; Vijay Ganju, Ph.D., Past Chair; Neal Adams, M.D., (CA); Paolo del Vecchio, (CMHS); Elizabeth Edgar, (NAMI); Olinda Gonzalez, Ph.D., (CMHS); Cynthia Hopkins, (TX); Randy Koch, Ph.D., (VA); Ronald W. Manderscheid, Ph.D., (CMHS); Ruth Ralph, Ph.D. (ME); Peter Steinmann, (NV); Leslie Tremaine, Ed.D., (LA); Ronald Tremper, (RI). The non- voting members are Ted Lutterman, (NASMHPD RI); Cecil Wurster, (Consultant).

The Division of State and Community Systems Development, CMHS, Joyce T. Berry, Ph.D., Director, continues to provide financial support for the MHSIP Policy Group, with primary liaison by Ronald W. Manderscheid, Ph.D. The Policy Group welcomes your questions, comments, and suggestions.

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