Updates

Mental Health Statistics Improvement Program

February 1998

INSIDE UPDATES

1 National Conference Call for Abstracts

2 User Group News

5 State Highlights

6 Consumer Issues

10 MHSIP Grant Awards

11 Managed Care

14 CMHS Outcomes Initiatives

14 Publication Listing

15 Calendar of Events

17 Credits

47th National Conference on Mental Health Statistics

**"Behavioral health Care Confronts a Difficult Future:
Need for Collaboration, Improved Practices, Data, and Analysis"**

Center for Mental Health Services
&
Mental Health Statistics Improvement Program

May 26-29, 1998

Renaissance Mayflower Hotel – Washington, D.C.

CALL FOR ABSTRACTS

Behavioral health care is currently confronting a difficult future. Competition is on the basis of price alone, rather than on the basis of quality. This is causing a serious reduction in resources available for care. At the same time, the consumer and family movements are burgeoning. We are seeking presentations in the following topic areas related to the conference theme:

- **Collaboration**
- **Improved Practices**
- **Data**
- **Analysis**

Presentations may also incorporate two or more topic areas. Topics listed are only illustrative. Case examples and analytical studies are encouraged.

For more information, please call Allen Keme at (301) 443-3343

USER GROUP NEWS

ONE MHSIP

The Northeast Region met on October 23 and 24, 1997 in Philadelphia. Discussion centered around the methodology of doing consumer surveys, technology for collection and analysis of data, reports on research being done, and recovery.

Survey Methodology: We had a rather lively discussion of the value of data derived from our consumer surveys. Glorissa Canino, Puerto Rico, felt that we were getting biased samples because of reading level, the cognitive impairment accompanying mental illness, and that the relatively low rates of return we are getting (Glorissa gets 91% return from random samples in her studies) also threaten our ability to generalize. Steve Banks, NY, suggested that we could find out what the literacy rate is for our states. It should be the same for our consumers as for the general population because the severe onset of mental illness starts in the teens. Delaware is using more than one method (mail, mail with follow-up phone calls, interviews, small groups, computer and audio/computer administration) and will be evaluating which works best for them. They are also looking at software to perform automated analysis of text

Technology: We saw a demo of the OLAP (On-Line Analytical Processing) tool that Connecticut (Lorenzo DeBenedictis) is using to explore data bases. We also talked about the state's experience with Teleform and scanning. Chip Felton, NY, said that they were finding the scanning technology to be inexpensive.

Research: Chip Felton presented a statistical analysis done in NY which indicated that there was no difference in level of functioning for the consumers who were eligible or not eligible for their Special Needs Plans program. What is more, eligibles were not even at the lower end of the functioning scale. There was only a 0.14 correlation between dollars spent on a consumer and their GAF scores. SSI was also not a good predictor of need. Their conclusion was that forcing only low functioning consumers into managed care will undermine the ability of providers to spread out costs. Further, a one rate managed care system will not work. What is needed is case mix or tier rates.

John Pandiani and Steve Banks presented a paper entitled "Three Bottom Line Outcome Indicators for Measuring Community Mental Health Programs Performance: Hospitalization, Incarceration, and Death." They have looked at the Vermont hospital, corrections, and vital statistics data bases and estimated the rates for people with mental illness who are treated at community mental health centers. They found that consumers were substantially more likely to be hospitalized, incarcerated, or to die than the general population.

Recovery: Boyd Tracy (VT) spoke on the history of recovery measurement and the involvement of consumers in the studies. He and John Pandiani have gone through the MHSIP indicators and identified which ones they feel are most recovery indicative. He also recommended Mary Ellen Copeland's new booklet "Wellness Recovery Action Plan" and the work of the Vermont Psychiatric Survivors, Inc.

It was an excellent meeting, packed with information. We look forward to our Spring meeting for more of the same.

Laurie Hutchinson
RI

THE SOUTHERN STATES MHSIP USERS GROUP (SoSMUG)

The SoSMUG held its Fall meeting in Little Rock, Arkansas, November 17-18. Attending were representatives from all member states except Tennessee. Other participants were CMHS liaison Olinda Gonzalez and logistics liaison Pat Smith.

The special topic of this meeting was the ORYX initiative sponsored by the Joint Commission. Doug Hancock, Director of Quality Services Oversight for the Texas Department of Mental Health was the guest speaker. He described the efforts his agency has made over the past several years to incorporate a system of internal self-monitoring within state facilities, combined with external validation reviews. Because it had a performance-based system already underway, Texas has applied to JCAHO for certification as an ORYX bench marking entity.

Vijay Ganju, discussed the efforts NASMHPD has directed towards assisting state psychiatric hospitals with ORYX requirements. It was noted that in its first year, ORYX requires facilities to implement a minimum of two indicators that can be measured across 20% of the population served. NASMHPD has proposed a cooperative venture whereby NASMHPD Research Institute would make application to serve as a bench marking entity and those States choosing to participate would share operational and administrative costs.

Bob Buchanan and Sheila Duncan, MHSIP representatives for the Host State of Arkansas, arranged a demonstration of the Medicaid data analysis system implemented in February 1997. The system encompasses EIS, data mining, and statistical and geographic analysis of Medicaid utilization. The system was developed through a contract with EDS and uses a variety of software packages including Pandora's Box (Codman), SPSS, and MapInfo. Prior to the introduction of the system, information queries usually necessitated programming by data processing staff. In 1996, the Division of Medicaid was able to generate 132 such ad hoc reports. The new system allows end users to construct and process their own data inquiries. At the present rate of utilization, users will generate over 2400 queries and ad hoc reports during the first full year of use.

Ed Payne
MS

WESTERN STATES DECISION SUPPORT GROUP (WSDSG)

Twenty-six people attended the WSDSG meeting on August 21-23, 1997 in Breckenridge, Colorado. For more information on items in this summary, minutes of the meeting are available from Church McGee at WICHE (303) 541-0298.

Reporting on Recovery and Rehabilitation. – John Mudie, consumer representative, California, addressed the importance of reporting the rehabilitation and recovery aspects of persons with severe mental illness. Data obtained drives the output the system produces. Recovery/Rehabilitation Statistics concentrate on measuring outcome variables, with the most important customer of the statistical output being the consumer himself.

State reports were given by Alaska, Colorado, Oregon, Nevada, and Washington. Two states reported on consumer surveys. Dick Ellis (CO) presented results from a survey using the MHSIP instrument. 888 questionnaires, or 20% of those mailed, were completed and returned. Ina Cibas (NM) discussed another survey using the MHSIP instrument with peer interviews of randomly selected consumers. At the time of the report, 423 surveys were completed.

National Performance Indicators for Mental Health: A Feasibility Study – Richard Ellis (CO) reported on the questions raised in the early stages about data, indicators, and politics.

Research on Hope and Choice – Dr. Ed Knight, CEO, Mental Health Empowerment Project, Albany, New York. Dr. Knight was a guest speaker at the conference. His current research focuses on hope and choice as components important to recovery. He discussed a model for recovery, and the results of a focus group identifying actions which helped consumers most in times of stress.

Managed Care in Montana – Dan Anderson (MT Dept. of Public Health & Human Services) discussed the managed care plan in Montana. This is a statewide, integrated mental health system including all ages, and both Medicaid-eligible persons and others in need of mental health under an R&D waiver. Interim lessons are to include 1) an inclusive planning process; 2) precise contract/RFP language; and 3) gradual implementation.

Outcomes in the Frontier – Dennis Geertsen (UT Div. Of Mental health) discussed rural and urban differences in the process of measuring outcomes, and ways of reducing data barriers in rural areas.

Unduplicated Counts of People Admitted to Programs in Alaska – Steve Banks has developed a methodology for estimating the unduplicated count of individuals across several data bases when the data bases do not include unique personal identifiers.

Incidence and Prevalence Rates Based on Household Survey Data – John Whitbeck, (WA State Mental Health Division) discussed a project to measuring "need" for mental health services in Washington State. He presented tables showing the number of individuals served in each region; the number needed to reach parity, and the current difference.

Social Indicator Estimates of Need/Synthetic Estimates of Need – James Ciarlo, Director Mental Health Systems Evaluation Project, University of Denver, presented a model for estimating need based on social indicators. The model was designed to generate prevalence rates for alcohol, drug abuse, and mental health services using three different measures of need – diagnosable disorders, dysfunction in everyday living, and demoralization. There was considerable interest in this presentation and a workshop is being planned for the next meeting.

The WSDSG decided to pursue another research project in the next year: conducting consistent consumer surveys across states using consumer as interviewers.

The next WSDSG meeting January 8-10, 1998 will review research of Courtenay Harding (WICHE Mental Health Program) around adults with serious mental illness and address the question “Are We Really Collecting the Data We Need?” This meeting will also review children’s issues with a Washington Review of Children in the System (John Whitbeck), and Colorado Children’s Data: Mental Health, Child Welfare, and Youth Corrections (Dick Ellis). The meeting will be preceded by a one-day workshop on needs assessment. Three experts will provide technical assistance to participants: Harold Goldsmith will show how to analyze characteristics of a population; Jim Ciarlo will work with Social Indicator Estimates of Need; and Chuck Holzer will show models using Census, ECA and NCS data.

Kathy Styc
CA

STATE HIGHLIGHTS

Alabama: Effective FY 1998, all comprehensive community mental health centers are reporting client, event, and program enrollment data using a uniform data collection format established during MHSIP Stage I grant funding. A total of 13 of the state’s 24 CMHCs will use the software package purchased with MHSIP

Stage I funding to report this data to a central repository at Alabama Department of Mental Health, Mental Retardation. The other CMHCs have modified existing systems to report the data.

Florida: MHSIP funds in the Sunshine State are being used for a Home Page Project. The activities underway include: establishment of an Internet Home Page; publication of an "ADM Report Card;" development of an on-line resource center; establishment of a "chat room" for ADM psychiatrists; publication of standard quarterly reports; and publication of the results of in-house studies and research.

Kentucky: The MHSIP State Reform Grant is being used to implement a comprehensive outcomes system. An adult SMI instrument is being used at a number of sites and pilot work has begun on a children's outcome assessment instrument. Kentucky has also made a submission to the Joint Commission for acceptance of the state's performance measures under the ORYX initiative.

Louisiana: MHSIP representatives have recently completed a review of commercially available comprehensive, integrated data systems. The state is piloting consumer satisfaction teams using GEST model and MHSIP Report Card Survey. Work is also underway to develop a level-of-care system using uniform functional assessments.

Mississippi: With 4 additional CMHCs joining the MHSIP funded uniform data system project, 89% of the state's 15 CMHC regions have voluntarily agreed to adopt a common data system. In 1997, the State Legislature passed the Mental Health Reform Act which grant the DMH greater oversight of community mental health programs. This will translate into a greater need for performance indicator data, which will be made easier by the widespread adoption of a common data system.

South Carolina: Under a State Reform Grant, South Carolina is currently matching Medicaid claims data with DMH data and going through a process of editing the matched data.

Virginia: As one part of a comprehensive systems reform initiative, Virginia is testing performance and outcomes measures. The purposes of the Performance and Outcomes Measurement System (POMS) is to provide a mechanism for continuous quality improvement, outcome-based accountability, and routine performance monitoring to guide current and future planning. This effort is supported in part by a State Reform Grant received in October 1997.

West Virginia: State Reform Grant funds are being used to expand a consumer satisfaction survey administered by the Consumer's Association. Also, since September 1996, the Office of Behavioral Health Services has been receiving demographic and assessment information on all Medicaid individuals receiving behavioral health services. As of September 1997, similar data is being collected on persons receiving services for substance abuse.

Ed Payne
MS

CONSUMER ISSUES

"Effective and Timely Reporting Products for Recipients"

(Reprinted with permission from One MHSIP Newsletter)

I understand I was invited to attend today's discussion group because you folks are interested in hearing about what statistical information clients/consumers/patients would find useful. I'm really glad to have this opportunity to share some of my ideas, but have to preface what I say with the caveat that there are probably as many ideas on

this topic as there are people. So please hear what I say for what it is: ideas from one person with a severe and persistent mental illness. And if you hear nothing else during this discussion group, please hear one thing: without consumers to serve there would be no statistical information to analyze, and I think it is basically unfair to take information from people without giving them some information in return. That may sound harsh, but it is the philosophy that drives my thinking on this topic – so you might as well know it in advance. I think that the uses of statistical information can be broken down broadly into two categories. These two categories could help provide answers to questions with which consumers are occupied. The two questions are:

1) Where can I get the best help for my problem?

2) What can you tell me about myself and my illness that will help me with my recovery?

There is first, and perhaps easiest to implement, the category of global information that can be used to help make decisions about services. Although it is true that in Rhode Island, recipients of services from the public sector are not allowed to choose where they receive services, it is important to provide us with information on our service providers as if we were. It is important for us to draw some inferences about the quality of our CMHCs, and to be able to evaluate the performance of our respective CMHCs and the state as a whole. This kind of information allows us to be the advocates we need to be in order to do our part in improving the overall system of mental health care. Those of us with serious mental illness have a sizable investment in seeing that services on a global level are of the highest quality. Asking for our direct feedback in terms of a satisfaction survey is a great place to start. Providing us with information on staff credentials and experience, level and frequency of training, languages available, and other information from the human resource database would help us to familiarize ourselves with each Center – and if choice ever becomes an option, will provide us with the basic tools necessary for decision making. Reporting on aggregate services to consumers would help familiarize consumers with services that are available, and perhaps help consumers to ask for more or different services depending on need. Under the current system, it falls to the case manager to orient the consumer to available services. This is usually done verbally and probably not comprehensively since case managers themselves do not receive reports on services or human resource characteristics. Perhaps they should, and perhaps just knowing that this information is being disseminated to consumers will help CMHC decision-makers focus more clearly on the needs of the diverse group of consumers they serve.

The second category of information that would be useful to consumers is really quite intimate and individualized, and not easily accessible under the current system. Answers to the question "what can you tell me about myself and my illness that will help with my recovery?" is currently found in the MHSIP Event database. A good start would be a quarterly report on type and frequency of services for each consumer; eventually plotting the previous quarter against the most recent past quarter for the purpose of analyzing trends. Each consumer could be helped immensely to place themselves in the continuum of the illness by being provided information on the frequency and type of services received.

And now for the stuff that does not yet exist, but could revolutionize peoples lives. When I think about the information that has helped me personally over the years, an important characteristic they all share is that they were WRITTEN DOWN. Research has shown that for most persons with severe and persistent mental illness, there exist deficits in what are called executive functions. Executive functions are those

mental tasks upon which we rely for structure: memory, attention, organization, attention to detail is all affected to some degree by mental illness. A hard copy of EVERYTHING should routinely be presented to consumers. Ideally, each consumer would receive a copy of their treatment plan, changes and updates to the treatment plan, and relevant treatment notes. In a perfect world, consumers would be routinely provided with a list of their earliest relapse indicators and the list would be updated as more information was revealed. And in the most perfect of all worlds, consumers would have access to computers in order to do their own research – on their diagnosis, on their needs, on other consumer's experiences.

The world is not perfect, and I realize I've added new demands to a system that is struggling to provide and unify what is currently being asked of it. But please keep these things in mind as you move your ideas forward. Effective and timely reporting products for recipients could exist – and we'd be grateful if they did.

Kathryn Cohan

(The following article is reprinted with permission from **Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals)**

Steps to Recovery

Step Two: Help and Hope

"Came to believe that a Power greater than ourselves could restore us to sanity."

The above words come from *Step Two* of the *Twelve Steps of Alcoholics Anonymous.* The philosophy of the *Twelve Steps* is the foundation for many substance abuse treatment programs including the Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals. (Although the Twelve Step philosophy is important in the Minnesota Program, other philosophies and approaches are also used.) Individuals seeking recovery from alcohol or other drug addiction often begin their work utilizing *Step One,* admitting that they are powerless over their use of mood altering chemicals and that their lives have become unmanageable as a result of their use. Step One is focused on identifying the problem. (See Winter '97 newsletter of Minnesota Chemical Dependency Program for Deaf and Hard of Hearing Individuals)

Once the problem has been identified and accepted by the individual, it is important to focus on solutions. Ideally, clients who do a thorough and honest job on *Step One* know that their use of alcohol or other drugs is out of control. They know that their problems are created or made worse by their use of mood altering chemicals. The problem is clear; now, what does one do about it?

Step Two presents concepts which are new to many people. As with the other steps, work on *Step Two* at the Program begins with education about what these concepts mean. Building on the notion that one is not able to control the use of alcohol or other drugs, *Step Two* stresses the idea of help from a source outside of oneself. Clients are encouraged to begin thinking about some kind of being or power that is greater than themselves and that can sustain them in their efforts toward sobriety. Although some individuals identify someone or something else as their Higher Power. Additional work related to spirituality and expanding on the concept of a Higher Power is done in *Step Three*. Once the concept of help outside of oneself has been established, the work of *Step Two* focuses on help and hope.

- In the Program, clients may work on a variety of tasks to help them understand and apply the concepts of *Step Two. Step Two* assignments, similar to other work in treatment, is individualized to the particular needs of the clients. The following is a list of some of the options which may be utilized to help clients with the concept of "help" in *Step Two* assignments:

- List places you can go to get help with sobriety.
- List people who can help you stay sober.
- Draw times you have received help in the past.
- Tell about times you asked for help and got help.
- Role play of people who helped you in the past.
- Tell people who have helped you in treatment.
- Draw a picture of yourself asking for help.
- Draw or write how it feels to ask for help.
- Tell things that make it hard to ask for help.
- Draw times you will need help after treatment.

Clients are given choices about how they document their work including the use of drawing, role play and writing.

Clients also work on the concept of hope in *Step Two*. Some tasks about "hope" which may be a part of a *Step Two* assignment include the following:

- List things you have accomplished in treatment.
- Draw things you can gain if you stay sober.
- Tell reasons you want to stay sober.
- Draw things you like about yourself as a sober person.
- List goals you have as a sober person.
- Draw pictures of how your life will be better if you are sober.

Through the completion of tasks like those listed above, combined with ongoing education about the effects of alcohol/other drugs as well as group and individual counseling, clients have the opportunity to begin developing skills necessary for sobriety. The ability to recognize one's need for help, the skills to ask for help and the willingness to accept help are crucial in the recovery process. Hope for a better life can help the recovering individual be motivated to maintain sobriety. Upon successful completion of *Step Two* tasks, clients present their work in a group of peers. Moving on to *Step Three*, clients begin to identify a Higher Power and to develop ways of communication with their Higher Power.

MHSIP GRANT AWARDS

Awards in FY '97

State of Arizona
This grant will assist in current refinements being made to further State reform initiatives. The present focus is to stabilize current database integration and quality management processes, which use performance indicator data from various sources to inform policy making, improve the quality of patient care, and guide purchasing/contracting decision. Additionally, the State plans to expand performance indicators to approximate the comprehensiveness of the MHSIP Consumer-Oriented Mental Health Report Card.

State of Georgia
The overall goals of this project are to implement PERMES, a high quality performance measurement system, implement a decision support system which will enable all stakeholders to effectively analyze performance indicator reporting, and apply technical capabilities, including use of LAN and Internet technologies, to make databases more accessible to all stakeholders.

State of Hawaii
The focus of this State grant is performance outcome and intersystem integration of performance measures. In this project the Adult Mental Health Division will initiate a process to explore the coordination and integration of existing databases within the public sector, the private sector providers,

and non-mental health programs. The goal is to develop a management information system, which has the capacity to predict and plan programs in light of pending and current reforms.

State of Kentucky
Given a statewide consensus on preferred mental health outcomes which strongly adopts the MHSIP Consumer-Oriented Report Card indicators, this project will field test, analyze, refine, and move toward statewide implementation of such measures as a component of the transition to managed mental health care. The project includes implementation of a consumer survey. Data from several agencies will be collected and integrated into a central database to allow for more informed decision making and policy development related to the public mental health delivery system.

State of Louisiana
The goals of this project are: (1) to establish a Data Warehouse of integrated administrative databases (including Medicaid), consumer/family responses, census data, and ad hoc reporting; (2) to utilize the data warehouse to implement a Performance/Outcomes Monitoring System and evaluate State mental health system concerns; and (3) to develop and implement formats for a report card of system performance indicators useful in monitoring access, quality, and outcomes of services by service system stakeholders.

State of Minnesota
The Minnesota Department of Human Service's Mental Health Division will integrate several major State, Federal, and local initiatives in Minnesota to improve the State and local stakeholder's use of existing data systems, as well as collect additional information recommended by the MHSIP Consumer-Oriented Report Card. Major activities will include performance outcome intersystem integration, decision support refinement, and application of a Consumer Survey.

State of New Jersey
This grant focuses on developing performance indicators for several key programs under the State Redirection Plan: designing a New Jersey Mental Health Report Card using the MHSIP Consumer-Oriented Report Card as a prototype, piloting the report card in programs developed under the redirection plan, assessing family outcomes of intensive Family Support Services, and working with the State Medicaid agency in developing baseline information of clients in counties scheduled for managed care implementation.

State of New Mexico
The grant goals for this project include data integration and analysis to assist the SMHA to make knowledge based decisions as it transforms to managed care practices, to pilot performance and outcome measures to assure measures that will promote the system's movement toward appropriate performance based contracting, and to partner with all stakeholders in designing and implementing state mental health reform.

State of North Dakota
The scope of the project will be to improve the availability and use of data in decision making and planning efforts of managers and division directors within the Department of Human Services and to establish a performance monitoring system within the public mental health system of the State.

State of Washington
The State of Washington Mental Health Division is creating a seamless system of quality outpatient and inpatient managed care, which is tailored to meet the needs of consumers with mental illness. With grant funding the Division will assist with the creation of a transparent data warehouse of varying levels and types of data in a system of integrated databases, establishment of a decision support system with coordinated series of products such as data, reports,

analyses, graphics, and simulations to enhance informed decision making, implementation of Intranet technology to provide seamless access to this information, and the addition of consumer based information to the data mix.

State of Wisconsin

The primary purpose of this project is to enhance use of the existing mental health consumer and program information by integrating the management information system and building on performance outcome measures. The three goals of the grant are (1) to enhance the existing information system for planning and decision making by managers and other stakeholders, (2) to facilitate the development and implementation of a high quality performance measurement system, and (3) to facilitate effective communication among all stakeholders for enhanced key planning and mental health care reform efforts.

FY 98 State Reform Grant Announcement

We are pleased to inform you of the 1998 State Reform Grant Announcement. Applicants eligible to apply for these grants are States which have not yet received a State Reform Grant in FY 96 and 97. Prospective applicants are invited to attend a one-day Technical Assistance Workshop with Dr. Mandersheid on February 27 to address application requirements. Please contact Pat Smith at 301 429-2300 if you plan to attend. It is anticipated that approximately 10 grants will be awarded in FY 98. The application deadline is April 9. For questions regarding the application, call Olinda Gonzalez, 301 443-3343.

Olinda Gonzalez
CMHS Staff

MANAGED CARE

Analyses for Improved Information in Managed Care: Project Summary

In the absence of national health care reform, states and private organization have proceeded with efforts to change the organization, financing, and delivery of health and mental health care services in the United States. The private sector and states with Medicaid waivers are expanding and developing their use of managed care strategies to try to reduce costs, enhance access to, and improve quality of care. The date necessary for managing mental health care systems effectively and for evaluating the quality of care-enrollment, encounter, cost and population data, as well as system performance and client outcome measures-are not currently available. Furthermore, the data systems necessary for collecting this information in a uniform and comparable way do not yet exist.

The Survey and Analysis Branch (SAB) of the Center for Mental Health Services (CMHS) has awarded a two-year contract to Abt Associates, in partnership with The Research Institute of the National Association of State Mental Health Program Directors, The Work Group for the Computerization of Human Service Information, and the Mental Health Statistics Improvement Program to bring together experts and to conduct a series of analyses to move the mental health field closer to an integrated information system and advance consensus on data standards. A primary focus of this project is the further development of clinical-level and system-level practice guidelines. This project addresses a crucial gap in our ability to evaluate performance and outcomes, namely, the lack of uniform definitions of services and methods for judging whether actual practices conform to them. The major objectives are:

- To understand the current trends and major issues in the development and use of clinical-level and system-level practice guidelines, outcome measurement, and system performance measurement;

- To establish consensus on methods and standards of measurement with regard to guidelines, outcomes, and performance;
- To understand how guidelines, outcomes, and performance measures can be integrated into a prototype information system for managed care; and
- To inform the field about the key issues and next steps in this process.

To accomplish these objectives we will

- Recruit a Technical Coordinating Panel (TCP) to oversee and provide guidance for all aspects of the project;
- Review the literature on the development and implementation of clinical-level and system-level practice guidelines and on information systems within managed behavioral healthcare;
- Convene two Focus Groups, one on clinical-level guidelines and another on system-level guidelines, to discuss issues of development, implementation, measurement of fidelity, and academic research;
- Convene a Technical Expert Workgroup Meeting to discuss the issues involved in measurement at both the clinical and systems levels, including integrating clinical-level and system-level practice guidelines with outcome and performance measures; measuring fidelity between guidelines and actual provider and system practices; and collecting uniform enrollment, encounter, provider, and financial data across organizations;
- Develop the framework for a new data prototype that defines the content areas needed for an integrated information system including population, service, and performance data;
- Conduct case studies in sites that have implemented components of a data prototype such as practice guidelines, outcomes, and systems performance measures to understand issues of development and implementation;
- Prepare policy analyses on the status of clinical-level and system-level practice guidelines and on measurement of fidelity and implementation issues.

The success of this project will depend on the substantive input of all stakeholders in managed behavioral health care including consumers, family members, providers, State and County Mental Health Authorities, managed behavioral healthcare organizations, Medicaid, the Federal Government, and researchers. Many of you will be tapped for your input into this project. We will keep you informed as it progresses.

Marilyn Henderson
CMHS/SAB Staff

CMHS OUTCOMES INITIATIVES

The Center for Mental Health Services (CMHS) continues to provide support for the work of committees charged with addressing outcome measurement issues. In the last edition of *MHSIP Updates*, we reported the initial activities of these committees. Below is a report on recent developments.

The Public Sector Outcome Measurement Interest Group: The committee is promoting values to guide the development of outcomes and performance measures. Some of these values include: person-centered approach, cultural competency and proficiency, focus on content and process measures and outcomes, and sensitivity to unique populations, individuals and their special needs.

A survey on outcome practices in outpatient settings is being conducted. A total of 1,800 outpatient clinics are being surveyed for this information. A concept paper on consumer-centered outcomes is under development.

To facilitate the dissemination of outcomes information, and discussion of outcomes

issues, this committee has created a Public Sector Outcomes Listserver. Readers interested in joining the list should send the message “subscribe puboutcm” to this address “majordomo@world.std.com.” For questions or comments contact “nadamsmd@trail.com” or “hughes@hsri.org”

Draft reports from this committee will be available in the Spring of 1998.

Outcome Measurement Standards Committee:

The first draft of *Methodological Standards for Outcome Measurement* was released in January 1997. The document is being revised based on comments received last Summer. It is anticipated that a final paper will be available during the National Conference on Mental Health Statistics in May.

Outcome Roundtable for Children & Adolescents:

This committee is made up of 3 work groups focusing on (a) defining the target population, (b) development of a conceptual model for interventions, and (c) principles to guide the selection of outcome domains and measures in child mental health and child welfare services. The Roundtable is scheduled to meet in Washington, DC on February 18 and 19 to finalize its report.

David Y. Brown
CMHC Consultant

PUBLICATION LISTING

Lessons Learned from Two Behavioral Managed Care Approaches With Special Implications for Children, Adolescents and Their Families. June 1996.

Final Review of Available Information on Managed Behavioral Health Care.
May 1996.

Mental Health Services Under Eight State Managed Care Contracts. May 1996

The MHSIP Consumer-Oriented Mental Health Report Card. April 1996

Abstract: Workshop – Class Action Litigation: Implications for Managed Care. March 1996

Federal and State Legislative and Program Directions for Managed Care: Implications for Case Management. October 1995.

The State of Computerization Among Managed Behavioral Healthcare Companies: A National Survey. September 1995.

Formation of Networks, Corporate Affiliations and Joint Ventures Among Mental Health and Substance Abuse Treatment Organizations. August 1, 1995.

Speaking With a Common Language; The Past, Present and Future of Data Standards for Managed Behavioral Healthcare. July 1995.

Common Core Health Data Sets Project for Enrollment and Encounter: The Preliminary Results of a National Survey of Leading Experts in Mental Health, Substance Abuse, Chronic Disabilities, Long Term Care and Managed Care Data Collection. June 1995.

Confidentiality and the Appropriate Uses of Data. May 1995.

Managed Behavioral Healthcare: History, Models, Key Issues, and Future Course. October 1994.

Mental Health United States, 1996.

Managed Behavioral Healthcare Procurement: Design, Financing, Procurement, and Monitoring of Managed Behavioral Healthcare Plans. November 1996.

To order single copies, please write to:

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CALENDAR OF EVENTS

The Fifth Annual Behavioral Informatics Tomorrow
March 5-7, 1998
San Antonio, Texas
(415) 435-9821

How to Design & Implement Your Primary Care Behavioral Health Integration program
April 7-9, 1998
Philadelphia, Pennsylvania
June 18-20, 1998
San Antonio, Texas
(415) 435-9821

Southeastern States MHSIP Users Group
April 13-14, 1998
Oklahoma City, Oklahoma
(601) 359-1288
Western States MHSIP Users Group & One MHSIP Joint Meeting
April 23-24, 1998
(916) 327-9320/401 464-1714

MHSIP Midwestern States Users Group
April, 1998
Chicago, Illinois
(608) 267-7231

The Fourth Annual Public/Private Behavioral Healthcare Summit
May 7-9, 1998
Arlington, Virginia
(415) 435-9821

47th National Conference on Mental Health Statistics
May 26-29, 1998
Washington, DC
(301) 443-3343

The Fourth Annual Employer Summit on Productivity and Behavioral Risk Management
May 28-29, 1998
Chicago, Illinois
(415) 435-9821

The Fifth Annual Behavioral Healthcare Quality and Accountability Summit
June 18-20, 1998
San Antonio, Texas
(415) 435-9821

Managed Care and Criminal Justice: obstacles or Opportunities
Spring/Summer 1998
(415) 435-9821

Developing Local Systems of Care in Managed Care Environments For Children and Adolescents with Serious Emotional Disturbances and their Families
June 13-17, 1998
Orlando, Florida
(202) 687-5000

CREDITS

MHSIP Updates is prepared periodically by members of the Ad Hoc Advisory 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 that 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.

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

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