

MILIEU

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

www.aabh.org

AABH is a network of people helping each other thrive in the ambulatory behavioral healthcare industry

**40 Years of AABH
1963-2003**

AABH Annual Conference
New Orleans
August 11-14, 2003



NEWSLETTER OF THE ASSOCIATION FOR
AMBULATORY BEHAVIORAL HEALTHCARE
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AABH Releases National Managed Care Survey

The continuum of outpatient ambulatory behavioral healthcare services is gaining recognition with managed care companies, according to the results of a survey conducted by the Association for Ambulatory Behavioral Healthcare (AABH). Over a third of the survey respondents reported that managed care contracts make up more than half of their business. "This is good news," said Patricia Scheifler, MSW, PIP, who is one of the survey's authors. "It means outpatient mental health services are recognized in the insurance industry as valuable, effective, and medically necessary."

The range of outpatient levels of care surveyed included Partial Hospitalization Programs (PHP), Intensive Outpatient Programs (IOP), Outpatient Programs (OP), Structured Outpatient Programs, and Prevention Services. Survey results indicate that PHP, IOP, and OP services are more fre-

quently covered under managed care contracts than Structured Outpatient and Prevention Services.

A Sampling of Key Findings Average Length of Stay

The survey report offers providers an opportunity to benchmark their program's average length of stay against national data. In general, average length of stay varied to some degree by level of care. For example, most organizations providing Prevention Services reported an average length of stay of 1-5 visits, compared to 4-10 visits in Outpatient services.

Payment Rates

Another data point frequently sought by providers is a benchmark for payment rates.

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The President's Desk

By Karla Gray, President

Of primary importance as we enter into our 40th year of service, is the continuation of support to the membership. This includes providing timely 'alerts' when there are regulatory changes, current 'state of the industry' publications, quality training opportunities, and continuing to develop the internal informational network that is a hallmark of the Association.

It is important that AABH provide quality entry-level training and education to enable new providers to have the best opportunity for success. Requests by payers, families, and advocates for alternative forms of care have resulted in new PHP's and IOP's opening across the country within the past year. Some have contacted AABH for information and we plan to make the Association resources available to many more in the coming months.

Of Primary Concern

Our relationship and ongoing communication with regulatory agencies ensures that we can continue to inform our membership of policy and procedural changes that have the potential to impact their services. These connections also stimulate the development of products that assist members to comply with regulations.

Encouraging lawmakers to appreciate the needs of people who use behavioral healthcare services and to continue to move forward in the pursuit of parity are other areas of focus. Only when there is awareness of the need, can there be understanding of the value of the services AABH members provide.

AABH will continue to join its voice with those of other groups to increase the public's awareness of the need for flexible models of care. As we move forward through the coming months, the challenge for all of us will be to ensure that the services provided meet the needs of the individual receiving them. I look forward to the journey with you. ■

New National Office and National Office Staff

We are pleased to announce that effective January 1, 2003 Jerry Galler was hired as the new AABH Executive Director. His current challenge is to increase the visibility of the Association within the provider community, the ancillary services arena (i.e.: providers of equipment and products used by the membership), and related professional groups. Jerry has been charged with re-energizing the entire membership program, the very popular audio conferences, and our newsletter, Milieu.

He will also reestablish AABH's local involvement in both independent and joint mental health advocacy initiatives. His expertise in marketing will be utilized to increase revenues from conference attendance, sponsorships, and exhibit sales, all of which is designed to achieve improved benefits and services for our membership.

Dan Lopez also joined the AABH team in January as the new Membership Coordinator. Dan's focus is on membership promotion, member customer service, maintaining a current membership database, and coordinating Milieu and Audio-conference production. Both Jerry and Dan are located at our new National Office at 11240 Waples Mill Rd., Suite 200, Fairfax, VA 22030. Our new phone



number is (703) 934-0160. Email addresses include: info@aabh.org, jerry@aabh.org, and dan@aabh.org.

Janice Starbuck has been with AABH for almost a year as the Master behind the AABH web site. The www.aabh.org web site has evolved from one of basic information to one that allows members to converse on a variety of bulletin boards and get information in a timely manner. She and Dan will work together to

enhance the value of the Members Only section of the website.

Those of you who have been to an AABH conference recently will remember Mickey Wright. She continues to be the Association's meeting planner and has arranged for the conference to be held in the Hotel Monteleone in the French Quarter of New Orleans. Don't miss out on reading the 2003 Conference article in this issue of Milieu! ■

The Members Only Area of www.aabh.org Offers Medicare Q&As

If you are a member of AABH, then you can read, post, and answer questions on the Medicare Q&A Bulletin Board. Don't hesitate to ask questions; you can post your messages anonymously! Go to the Bulletin Board today at www.aabh.org. If you lost your member ID and Login, email dan@aabh.org so you can get access.

Here is the question and answer of the month:

Q: What does the CPT code for psychiatric testing require and is it possible to bill this service within a partial hospitalization program? In our PHP every patient completes a battery of self report scales- some on intake and discharge and others on a daily basis. The results are entered into our patient database and each day the patient's primary clinician and psychiatrist receive a report with the patients self reported scores for that treatment day. Does this qualify for psychiatric testing?

A: The billing code for psychological testing CANNOT be used to bill Medicare for any self report scales. This restriction is clearly stated in many Local Medical Review Policies (LMRPs), but not all.

Calling all Journalists!

AABH is requesting articles from members and non-members in the areas of JACHO, CMS, Medicare Transportation, PHP, OPPS, Chemical Dependency, Dual Diagnosis, and Legislative issues before the House and Senate. Of course other topics are also welcome. Check with Daniel Lopez, dan@aabh.org. The next Milieu will be published in July, so get your articles in by the second week of June. Get recognized in the field by sharing your expertise with others!

An Outline for the Draft Report of the Subcommittee on Criminal Justice

December 2, 2002

The Issues and Their Context

There are approximately 1.3 million people in U.S. state and Federal prisons now, and 4.6 million people under correctional supervision in the community. Remarkably, there are approximately 13 million jail admissions annually, with about 631,000 people in jail at one time. The rates of serious mental illness (SMI) for all of these people are about three to four times that of the general U.S. population. This means about 7 percent of all incarcerated people have a current serious mental illness; the proportion with any mental illness is substantially higher. The people with SMI who come in contact with the justice system are typically poor, uninsured, disproportionately members of minority groups, often homeless, and often have co-occurring substance abuse and mental disorders. They are likely to continually recycle through the mental health, substance abuse, and criminal justice systems.

The cost studies available suggest that taxpayers can save money by placing people into mental health and substance abuse treatment programs instead of jails and prisons. There are proven models for diversion programs operating in many areas around the country. The Eighth Amendment of the U.S. Constitution protects the right to treatment for acute medical problems, including psychiatric problems, for inmates and detainees in America's prisons and jails. Several models have been developed providing guidelines for Correctional Mental Health Care and some states have implemented them.

Policy Options

Three major responses are needed:

- 1) Keep people with serious mental illnesses who do not need to be there out of the criminal justice system—diversion programs
- 2) Provide constitutionally adequate services in correctional facilities for

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people with serious mental illnesses who do need to be there—institutional services

- 3) Link people with serious mental illnesses to community-based services when they are discharged—reentry transition programs

The initial policy option is an overarching one of which most of the subsequent ones are specifications for particular federal agencies. **The Executive and Legislative Branches must capitalize on the many opportunities that already exist in federal programs to provide the payment of core services for people with mental illnesses in contact with the criminal justice system.**

1. The Centers for Medicare & Medicaid Services (CMS) and the Social Security Administration (SSA) should work with representatives of state agencies to offer technical assistance regarding provisions of Federal Medicaid and Disability Program rules as they apply to inmates to:

- A) Promulgate a clear statement of the limited requirements for disenrollment from Medicaid for jail detainees and how state rules often result in a narrower interpretation than is required by the Department of Health and Human Services (HHS);

- B) Facilitate the process of application for SSI or SSDI benefits while incarcerated. Incentives for disenrolling recipients should be matched with incentives for enrolling eligible inmates prior to release; and,

- C) Ensure released inmates are returned immediately to Medicaid rolls if previously eligible.

2. The Department of Housing and Urban Development (HUD) should provide guidance in its Continuum of Care application and to HUD McKinney grantees that explicitly recognizes that people who meet the McKinney definition for homelessness upon entry to the criminal justice system are eligible for targeted homeless housing and service programs upon discharge from the criminal justice system.

Although people in jails or prisons who are homeless are already included in the McKinney legislation's definition of homelessness, there is a great deal of confusion in the field about whether or not they are eligible for HUD McKinney housing programs. By making it clearer to HUD McKinney grantees that people exiting correctional facilities are eligible for Shelter Plus Care, the Supportive Housing Program, and others targeted for people who are homeless, the chronically and episodically homeless population can be reduced.

3. HUD should provide explicit guidance to all its programs, including Public and Indian Housing, Section 8, and others, that people with mental illness exiting the criminal justice system are eligible applicants for HUD programs.

There is a great deal of confusion among housing and service

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M E M B E R S H I P

Reasons to get Involved with AABH

There are many things we can do to add value to your membership, and we are making great strides.

We have a new executive director, a membership program coordinator, and new office facilities to better serve you. We are re-instituting the highly popular audio conferences. Every member will now receive six issues per year of Mental Health Tomorrow. System members and Program members will also receive six issues per year of Addiction Professionals. We are constantly improving our web site, including the Q&A section.

But most importantly, we are facing a time of change in mental health legislation, particularly in Medicare and Medicaid reform. Being aware of, and understanding these changes can directly affect the operational success of your organization and the needed recognition of the importance of IOP/PHP programs. We must be able to effectively participate with a collective voice that can be heard in the mental health advocacy community. And we must do it now.

This is where your support is needed the most. The base of knowledge and the issues we face every day reside at the grassroots level. That means you, the member. You need to be heard. It takes funding to do this and our membership dues represent a key component of that funding. Please help your association, yourself, and your mental health community. Make the commitment now to renew your membership and get the most out of your AABH experience.

With AABH membership, your professional development and advocacy goals become much more attainable. Join now for 2003 and plan to attend this summer's training conference (August 11 – 14) in New Orleans, LA.

AABH Election 2003

A number of members and regional presidents have asked how they can be more involved with the national organization. One way is to become a board member. The Board of Directors unanimously approved a working board of 12 plus a treasurer and the president. This year four Board positions open for the term of August 2003 through August 2006. Check www.aabh.org and your email for further information on the 2003 Elections.

Become an Active Member in AABH

There are a number of opportunities for AABH members to become active in the day-to-day operation and management of the Association.

Become the Liaison of a geographic region of AABH members

State Liaisons are an extension of the Board of Directors. They accept input from their constituents – including motions for specific actions – and relay that to the Board, and report the decisions of the Board and the issues facing the Association nationally back to their constituents.

This position requires an average of 2 hours per week of email and telephone contact.

Offer to run for a position on the Board of Directors

There are four positions being vacated this year. To insure representation of the membership, AABH would like to have two or more candidates for each position.

This position requires 5 – 10 hours per week of email, conference calls, and attendance at a mid-winter board meeting, if scheduled.

NOTE: People who accept either position need to be aware that the AABH is a volunteer organization and costs associated with either position are the responsibility of the individual, though some expenses may be tax deductible.

Actively participate in AABH's information exchange venues

AABH members are always encouraged to participate in the various networking and information exchange opportunities including contributing to the Q & A section located in the members-only section of the web site, presenting a workshop at the annual training conference, contributing an article to Milieu, and presenting at an audio conference.

The City of New Orleans

AABH Announces Training Conference in New Orleans, August 11-14, 2003

New Orleans, LA is the perfect place to conduct the 2003 Training Conference and to celebrate AABH's 40th Anniversary. AABH's Board of Directors is pleased to announce the selection of the Hotel Monteleone located in New Orleans' French Quarter as the site of our 2003 Annual Training Conference to be held on August 11-14. The 2003 theme is "Dancing to the New Beat – Behavioral Healthcare in Today's Changing Environment". And speaking of changes, we have made a few for this conference.

First we will not be offering pre-conference institutes. One fee pays for the entire conference, which has been lengthened to accommodate both the workshops and intensive sessions. Conference tracks include clinical, administrative, program development, and special topics. There will be 12 intensive three-hour sessions in addition to 18 ninety-minute workshops. Attendees can receive up-to 20 credit hours to maintain your certification. Speakers of course get FREE conference registration. With a registration fee of \$340.00 for members, that breaks down to only \$17.00 per credit hour. And of course all of the fun New Orleans has to offer including a special event for conference members.

The Keynote speaker will be Michael Hogan, Ph.D, Chairman of the President's New Freedom Commission on Mental Health. Dr. Hogan's discussion of the recommendations developed by the Commission and the current status of those recommended initiatives will be complimented by a host of extraordinary speakers and subjects. There is so much change taking place in the mental health community, you cannot afford to miss this timely and informative event. If you

only attend one conference this year, this is the one to attend.

Education does not end at intensive sessions and workshops. There is more invaluable information to be exchanged amongst yourselves. Networking opportunities with your peers and vendors will abound with three continental breakfasts, refreshment breaks, a networking lunch, and a box lunch, all held in exhibit hall, as well as a fun-filled off-site event. Raffles will be held daily in the exhibit hall with an opportunity to win cash and prizes.

The intrigue of New Orleans will be just outside the conference room doors. Within easy walking distance of the Monteleone are the antique shops of Royal Street, sounds of jazz spilling from Bourbon Street bistros, Jackson Square, outstanding restaurants, and entertainment.

With all of its attractions, the most outstanding feature of the Hotel Monteleone is a great rate. AABH was able to negotiate sleeping room rates of

\$99 a night for a single/double room. So save the dates, August 11-14, 2003, on your calendar now. Reservations must be made by July 19th to secure this rate and a room. Make sure you identify yourselves as attending the AABH conference when making arrangements at the Hotel Monteleone.

Annual Training Conference Registration Rates

Early Bird, by 7/11/03

Member \$280 Non-Member \$330

After 7/11/03 till 8/11/03

Member \$340 Non-Member \$400

On-Site

Member \$365 Non-Member \$430

On-line registration will be available in May, so keep an eye on our web site. Don't forget to visit www.neworleanscvb.com and www.hotelmonteleone.com for more detailed information about leisure opportunities. Check your email and mail for details on this key upcoming event, along with a registration brochure that is due out in May. Contact Daniel Lopez at 703-934-0160 ext.105 or dan@aabh.org for more information about registration, exhibitor, sponsorship, and speaking opportunities at this year's conference. ■





Happy 40th AABH

In 1963, a small group of clinicians who were involved in the relatively new treatment approach of “day hospitals” began meeting on a regular basis to discuss their problems and experiences. There was a shared dissatisfaction with the restrictive, traditional ways in which mental health treatment was organized and delivered. They believed in the common sense notion that individuals with acute mental illness had a better chance of recovery if they could receive treatment in the community in which they worked and enjoyed with their families. By the late 60’s, this group became sufficiently organized to call themselves the Partial Hospitalization Study Group (PHSG).

As the Partial Hospitalization treatment modality began to amass a research base the first group, located in the northeast, linked up with the rest of the country. Members organized a regular annual conference at various cities where regional groups were active. In 1975 the original study group and other similar regional groups formed a national network for the purpose of exploring, sharing, and addressing concerns on both a national and regional level. The group named themselves the Federation of Partial Hospitalization Study Groups, Inc. (FPHSG). A few years later in 1979 the members adopted the new name of: the American Association for Partial Hospitalization (AAPH).

The effectiveness, cost savings, and client support of partial hospital programs was demonstrated throughout the 1980s. The question of “What, exactly, is a partial hospital?” was answered and everyone wanted the great results. Advocacy efforts expanded recognition of the modality among other clinicians, as well as by third party payers such as CHAMPUS, Medicare, and the insurance community. Also partial hospital pioneers continued to apply the same kind of common sense approaches to a broader range of treatment issues. This led to the translation of partial hospitalization concepts to other types of community based services and the forming of connections to the pioneers of other flexible

care alternatives, who also found themselves constrained by an increasingly rigid reimbursement system.

Beginning in the late 80s the AAPH Board of Directors worked consciously to expand the association’s mission and services in response to member needs. This was influenced by the extremely rapid development of a broad new diversified array of ambulatory services, and by the widespread extension of our members’ service delivery programs into new modes or types of care. This expansion of services occurred as part of a movement towards diversified ambulatory care solutions going on throughout the healthcare delivery industry, and not just within the membership. The careful broadening of the AAPH scope prompted discussion about a name change in the early 90s. A member opinion poll was conducted in April 1995 which showed that most AAPH members already offered an expanded range of ambulatory services, and strongly supported the association’s movement to better define and

support the understanding of ambulatory approaches within the healthcare delivery community. In August 1995 the membership voted to change the organization’s name to the Association for Ambulatory Behavioral Healthcare.

Today’s healthcare environment is experiencing dizzying change, rapid evolution, and tremendous levels of confusion. AABH finds itself square in the middle working with JACHO and CMS in developing flexible healthcare solutions that are also profitable.

Renew Your AABH Membership

As we end one year and begin another, it’s time again for members to renew their support for their association, not only by renewing their membership, but also by promoting the organization to other prospective members. As a small organization, AABH listens carefully to each member’s comments and works hard to deliver

May is Mental Health Month!

The National Mental Health Association’s Mental Health Month theme this year is: Mental Health Matters – Every Day. This year’s Mental Health Month guide contains creative suggestions you can use to reach out to the media, employers, consumers, faith and minority communities, young people and families, college students, older Americans and policymakers in May and throughout the year. It provides a variety of resources, messages and activities that will help you attract attention to and build support for mental health and wellness issues.

The guide also provides materials for Childhood Depression Awareness Day; Children’s Mental Health Week, sponsored by the Federation of Families for Children’s Mental Health; and Older American’s Mental Health Week, sponsored by the Older Women’s League (OWL).

To access Mental Health Month materials at <http://www.nmha.org/may/-index.cfm>. If anyone has any questions about Mental Health Month, please contact Kristin Battista-Frazer, NMHA Director of Marketing at 703-837-4787 or kbattista@nmha.org.

Outline of the Final Report for the President's New Freedom Commission on Mental Health

President George W. Bush announced the creation of The President's New Freedom Commission on Mental Health at the University of New Mexico in Albuquerque on April 29, 2002. This President's Commission is the first comprehensive study of the nation's public and private mental health service delivery systems in nearly 25 years. It was established to examine the current gaps in mental illness treatment services and recommend ways in which the federal government can help states increase access to care and improve quality in their public programs. The Commission traveled across the country hearing testimony from various stakeholders that has helped them develop an action plan for the president to improve America's mental health service delivery systems.

In November 2002, the Commission released their interim report outlining the challenges facing our nation's mental health system. The final action plan is to be submitted to the President by the end of April. In the interim, the Commission has released an outline of the final report. It has been taken from the Commission's web site (www.MentalHealthCommission.gov) and is presented below.

Vision Statement: We are committed to a future where recovery is the expected outcome and when mental illness can be prevented or cured. We envision a nation where everyone with a mental illness will have access to early detection and the effective treatment and supports essential to live, work, learn and participate fully in their community.

Goals of Final Report

1. **Mental Health is Essential to Health:** Every individual, family and community will understand that mental health is an essential part of overall health.
 - Everyone takes action to ensure well-being
 - Mental health awareness

Recommendations

Advancement and implementation of national strategies for suicide prevention and national campaign to reduce the stigma of seeking care.

Align Federal Policies with Mental Health System Goals

2. **Early Mental Health Screening and Treatment in Multiple Settings:** Every individual will have the opportunity for early and appropriate mental health screening, assessment, and referral to treatment.

Recommendations

Strengthen early childhood mental health interventions: Implement a national effort to focus on mental health needs of young children and their families that includes screening, assessment, intervention, training, financing of services.

Screening, assessment and treatment for co-occurring disorders will be the expectation in mental health, substance abuse, child welfare, criminal and juvenile justice and primary care settings.

Screening for mental disorders in primary care settings across the life span. Collaborative care models for identification and treatment of mental disorders across the lifespan should be widely implemented in primary care settings and reimbursed by public and private insurers.

Building on "No Child Left Behind Act" and the reauthorization of Individuals with Disabilities Education Act (IDEA), improve and expand mental health programs in schools to ensure that youth with emotional and behavioral disorders succeed and graduate from school.

3. **Consumer/Family Centered Care:** Consumers and families will have the necessary information and the opportunity to exercise choice over the care decisions that affect them
 - Continuous healing relationships will be a key feature of care

Recommendations

States should ensure that each adult with serious mental illness (SMI) and each child with serious emotional disturbance (SED) and his or her family has a single, individualized plan of care.

Create an integrated state plan for treatment and support

Expanding the recovery orientation of the system of care by increasing the opportunities and capacities of consumers to share their inspiration, knowledge, and skills.

Strengthen and expand supported employment

Protect and enhance rights

Expand criminal justice and juvenile justice diversion and re-entry programs.

Medicaid/Medicare/financing reform that includes references to parity, home/community based services, and IMD reform.

Improve access to housing and end chronic homelessness

4. **Best Care Science Can Offer:** Adults with serious mental illness and children with serious emotional disturbance will have ready access to the best treatments, services, and supports leading to recovery and cure. Accelerate research to enhance prevention of, recovery from and ultimate discovery of cures for mental illnesses.

Recommendations

Accelerate research to cure or prevent mental illness. Continue research to improve mental health outcomes and support recovery.

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Freedom Commission, *continued from page 7*

Expand the knowledge base to inform policy designed to reduce mental health disparities, long-term effects of medications, and develop process to study crisis interventions and acute care.

Evidence-based practice interventions should be tested in demonstration projects with oversight by a public-private consortium of all stakeholders. The results of those demonstrations should form the basis for directing support of financing, dissemination and workforce development.

Increase and improve a diverse mental health workforce across the country, through public-private partnerships based on multidisciplinary training models.

5. **Information Infrastructure:** The mental health system will develop and expand its information infrastructure. That infrastructure has many purposes:
- Inform consumers, providers and public policy
 - Improve access, quality, accountability

Recommendations

Use information technology to improve care.

Inform policy by expanding the knowledge base

6. Eliminate disparities in mental healthcare: promote well-being for all people regardless of race, ethnicity, language, place of residence, or age and ensure equity of access, delivery of services, and improvement of outcomes for all communities.

Recommendations

Establish funding incentives for recruitment and retention of mental health professionals in rural settings.

Through a public and private partnership develop and implement comprehensive public health policies which reduce barriers to access, improve community outreach and engagement, and ensure development of culturally competent care to racial and ethnic minorities. ■

Reports From All 16 Subcommittees of the President's New Freedom Commission on Mental Health Available on the Internet

All of the 16 Commission subcommittees have reported their findings to the full Commission. These reports are available on the Commission's web site, www.MentalHealthCommission.gov. The subcommittees are: Acute Care, Children & Families, Co-occurring Disorders, Consumer Issues, Criminal Justice, Cultural Competence, Employment & Income Support, Evidence-Based Practices, Homelessness/Housing, Medicaid, Medication Issues, Mental Health Interface with General Medicine, Older Adults, Rights & Engagement, Rural Issues, and Suicide Prevention. After reaching the home page, click on "Subcommittees". Each subcommittee report may be downloaded by double clicking on the specified subcommittee name.

Audio Conferences Back in Force

Take advantage of the time and cost effective way to stay abreast of important professional issues in ambulatory healthcare - AABH audio conferences. Each audio conference is a 90-minute presentation by a highly qualified professional. Fees range from \$150-\$185 for an AABH member and \$175-\$210 for a non-AABH member and are determined based on the type of handouts provided for the audio conference. For more information on audio conferences please contact Daniel Lopez at 703-934-0160 ext. 105 or email dan@aabh.org.

On April 17, 2003, "Understanding and Operationalizing the UGS LMRP for Partial Hospitalization Programs" was presented by Stephen Michael, MS of Michael Sun Consulting in Tucson, AZ to eight attendees. On April 22, 2003, the subject was "Understanding and Treating Personality Disorders in the Acute Psychiatric Setting". It was presented by Nancy Kennedy of Allegheny General Hospital in Pittsburgh, PA to an audience of five.

Check your email or www.aabh.org for a listing of dates and times on the following audio conference topics:

May 2003

Kevin Bass- Child Adolescence Program Development

Jim Grigsby- Denial Management

Audio Conference topics scheduled for June/July 2003 include:

Other Services You Can Provide to Increase Revenue

Managed Care Contracting & Credentialing

Internet Walk Through

Is there a topic you would like to hear? Please email dan@aabh.org to request that AABH look into adding that topic to the lineup.

Would you like to give an audio conference? Please email dan@aabh.org with your topic name, qualifications, and open-dates to give the audio conference. And, check out our article on our new audio conference revenue sharing program. ■

Draft Report

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providers about eligibility for HUD programs for people who have arrests or convictions. In many instances, local rules that exclude people with arrests or convictions from HUD housing programs are applied across the board without regard to extenuating circumstances, especially the need for reasonable accommodation for people with disabilities. Stable housing is an essential component in the recovery from substance abuse and mental illness.

4. The Bureau of Justice Assistance Edward Byrne Memorial State and Local Law Enforcement Assistance Program guidelines should clearly state that funds can be used for community-based mental health services for inmates released from correctional facilities.
5. The Department of Justice, when investigating institutions under the Civil Rights of Institutionalized Persons Act (CRIPA), should review the extent to which institutional services (per *Ruiz v. Estelle* requirement that treatment is more than mere seclusion or close supervision) are consistent with evidence-based practices. Inmates have a constitutional right to treatment while incarcerated. Numerous lawsuits have identified the obligation of prisons and jails to afford inmates their right to access to care, the right to the care that is ordered, and the right to professional medical judgment. The reentry APIC (Assess, Plan, Identify and Coordinate) model (GAINS, 2002) identifies four core areas for service provision in correctional settings and in discharge planning:
 - Assess the inmate’s clinical and social needs, and public safety risks;
 - Plan for the treatment and services required to address the inmate’s needs;
 - Identify required correctional and community programs responsible

for post-release services; and

- Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services.

The extent to which institutional practices meet this model, or another validated model, should be part of all CRIPA reviews.

6. The Department of Labor should use its national evaluation and technical assistance contractors to assist program grantees in the implementation of supported employment practices for inmates with SMI released from jail or prison.

People with SMI and substance use disorders, including those with histories of homelessness, want and need to work. Employment program models that are effective for people with SMI include transitional employment, supported employment, and individual placement and support.

7. HHS through SAMHSA should provide technical assistance to ADMS Block Grantees to improve access to comprehensive and integrated treatment programs for inmates with mental illness and co-occurring disorders.

This policy option focuses on targeting state-level planners and program managers of the Block Grant to increase two primary areas:

- A) Their awareness of the importance of integrated treatment programs for this target group, and
- B) Their understanding of how communities have expanded these services, and the transferable principles they could use to finance, design, and implement such programs.

8. CMS should work with representatives of state Medicaid agencies to offer guidance and technical assistance regarding revising state

Medicaid plans to cover services provided by Assertive Community Treatment (ACT) teams for persons in contact with the criminal justice system.

The ACT model, which since 1972 has been implemented in 35 states as an evidence-based practice for persons with SMI, is appropriate for high-risk clients, including persons in contact with the criminal justice system. ACT has been associated with an array of positive outcomes, including increased compliance with medications and other treatments, which reduces the likelihood of returning to the criminal justice system.

An impediment to the adoption of ACT models in general has been financing streams shaped by emphasis on hospital and office-based care. CMS should provide assistance to state Medicaid directors on developing financial constructs to cover ACT services, including specialized ACT teams for criminal justice system clients.

9. HHS should prioritize the training of judges for all of its existing and prospective technical assistance centers within SAMHSA.

The burgeoning number of people with SMI and co-occurring substance use disorders in regular court, the rise of specialty courts, and the concept of therapeutic jurisprudence, have raised issues surrounding the specific needs of this population in the courts. We suggest the adoption of multidisciplinary legal education for judges and lawyers on offenders with mental illness and co-occurring substance use disorders. This training would ensure judges and court personnel understand mental illness and are aware of inherent adherence difficulties faced by offenders engaged in alternative programs. ■

AABH National Office Offers New Revenue Sharing Opportunity for Regional Groups

AABH is introducing a new revenue sharing program to encourage member participation as presenters for audio conferences. We recognize that the knowledge base resides in the membership, at the grassroots level. We want that knowledge shared with the rest of the membership. Presenters may be eligible for AABH credit hours you can use towards CEU's for being a presenter. In addition the AABH national office will share all revenues received from your audio conference with your regional group. Any member of the national organization, who is also an active member of a regional group can participate and:

- Earn Credit Hours toward CEU's
- Generate additional revenue for their regional group
- Gain personal recognition within their peer group
- Give some of what they have learned back to the membership and the community

Application for national membership and applications for submission of audio conference presentations can be found on our web site (www.aabh.org). Come join us! ■

Mark your calendar to attend the one behavioral healthcare event you won't want to miss!

2003 AABH Annual Training Conference, August 11-14, 2003
"Dancing to the New Beat - Behavioral Healthcare in Today's Changing Environment"

- \$99 room rates at the Hotel Monteleone, New Orleans French Quarter
- 32 concurrent session in 4 tracks providing the latest information on program development, administration and management, clinical and special topics
- Keynote address by Michael Hogan, Ph.D, Chair, President's New Freedom Commission on Mental Health
- 20 Credit Hours are available toward CEU's
- Vendor and sponsorship opportunities are available

For more information contact Daniel Lopez at
703-934-0160 ext.105

Save \$60: Register by July 11, 2003
(Note: Online registration will be available late May)

Managed Care Report

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The survey report includes payment rates for group and individual therapy across the outpatient continuum. For example, the majority of providers reported that under managed care contracts, payment rates for Individual Therapy in the Out Patient level of care fell within the range of \$51-\$75 per hour for MA/MS therapists.

Provider Friendly

Providers seeking contracts with managed care companies may be interested in knowing which companies are considered provider friendly. Four of the managed care companies were identified as provider friendly by at least 50% of the surveyed programs contracting with those companies. The three managed care companies with the largest number of contracts were identified as provider friendly by 26%-40% of the surveyed providers contracting with them. Survey results also note some of the most common problems with managed care companies. However, due to a small number of survey respondents, it would be difficult to draw any conclusions.

About the Survey

The AABH national survey was distributed to ambulatory behavioral healthcare organizations that were members of AABH during 2002. Like the PHP and IOP surveys that preceded it, this study was intentionally designed to give providers "real time" data against which they can compare their own programs.

The AABH National Managed Care Survey is the third in a series of annual surveys designed to provide a focused snapshot of mental health programs across the treatment continuum. The previous two reports in this series reviewed Partial Hospitalization Programs and Intensive Outpatient Programs.

Copies of the AABH Managed Care Survey may be purchased for \$35.00. Order forms are available on the AABH web site www.aabh.org, or by contacting Dan Lopez at dan@aabh.org. ■

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