

I have been impressed by the respect and the impact that NAPHS has as an advocate on Capitol Hill, within regulatory and accrediting agencies, and with critical constituency groups representing consumers, state leaders, and others.”

—Anil Godbole, M.D.
NAPHS president, 2001–2002

In Our Own Words

Quotes and Perspective from NAPHS members throughout the years

ABOUT THE MEMBERSHIP

“When the association began, nearly all the hospitals represented were owned by psychiatrists who ran the facilities and who became NAPPH members. During the 1950s, many of these facilities shifted from profit to non-profit status. The original owners ran the hospital but did not own it; the hospitals became public trusts with elected boards of trustees. Simultaneously, medical directors and hospital administrators began to take an active role in NAPPH and to attend annual meetings.”

—Mel Herman

NAPPH's first executive director

“[Historically] why did the owners of private psychiatric hospitals think their institutions were different from state psychiatric hospitals and general hospitals with psychiatric beds? Leonard Krinsky, PhD, in “History of Mental Health and Industry,” cited several reasons. First, the freestanding psychiatric hospital's only purpose is treatment of the mentally ill. If the hospital does not meet the patient's needs, the hospital fails. Second, private hospitals can respond quickly to the marketplace because they lack a cumbersome bureaucracy. Third, operating costs are more controllable and

length of stay is often shorter, leading to lower costs to the patient.”

—From *History: The National Association of Private Psychiatric Hospitals, 1933–1988*

“A thoughtful, multi-year strategic planning initiative involving a number of committees and work groups culminated in 1995 with a unanimous membership endorsement of ‘system memberships.’ For the first time in our association's 62-year history, our members are now behavioral health systems—including all behavioral health services that come under one organizational umbrella. This is good news for members who are developing and planning an ever-wider continuum of services to meet community needs. As an association representing the full range of behavioral health care providers—not-for-profit and for-profit as well as all the components of service offered, NAPHS has strengthened its advocacy voice on your behalf.”

—E. Mac Crawford
NAPHS president, 1995

“Our association has accomplished some remarkable, groundbreaking, and even historic things in 1996. And it has set an impressive agenda for 1997. NAPHS has done all of this in a year when dues for the vast majority of members actually decreased dramatically. As a result of proactive management and a clear vision of the future, NAPHS is maximizing your association investment not only for the good of your facilities, but for the good of behavioral health.

I am proud of the statesmanship NAPHS has demonstrated. And, as a psychiatrist who has seen the dramatic changes sweeping our industry, I applaud the forward-thinking foundation set by the Strategic Planning Committee and Board of Trustees that has positioned NAPHS as the advocate for what is right and necessary if high-quality care is to continue to be available for those who struggle with psychiatric and addictive disorders.”

—*Paul J. Fink, M.D.*
NAPHS president, 1996

“As a result of a major reevaluation of our strategic direction in 1996, the Strategic Planning Committee and Board reaffirmed NAPHS’ emphasis on:

- collaboration
- advocacy
- delivery system restructuring.

We’ve said that collaboration is to be valued over competition. We’ve said that having a united voice for the organizations that provide behavioral health care is essential, wherever those organizations fall along the continuum of care. We’ve worked to ensure that our Board represents all levels of care—from outpatient centers to partial hospitals to inpatient providers (both freestanding and units in general hospitals). We’ve worked to include both allies and partners (including consumers, families, employers, and general healthcare organizations) in advocacy. And in 1996, we’ve proved the strength and value of an association that can harness the creative energies of all segments of the behavioral health field.”

—*Paul J. Fink, M.D.*
NAPHS president, 1996

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“Everyone’s job is tougher these days. Behavioral health is in the throes of a major restructuring. That means that everything—from the way care is paid for to the way we deliver care—is subject to tough scrutiny and constant reevaluation. Budgets are tight. Legislative and regulatory policies are multiplying—and often change overnight. Mergers, joint ventures, and other partnerships are being evaluated and formed at a dizzying pace. Yet as life become more complex, there is one constant that helps make sense of the chaos: association membership.

The National Association of Psychiatric Health Systems (NAPHS) has set its sights on being your voice—the provider’s voice—in this increasingly complex world. It has been my privilege to serve as your president, and I am proud to present this wrap-up on what, quite honestly, has been a tough, but groundbreaking year that has helped to solidify the NAPHS role as the voice of our industry.

—*Jean P. Smith*
NAPHS president, 1997

“As a result of a forward-thinking planning process, NAPHS was able to make—and carry out—strategic decisions about what differentiates our organization. The Board and membership agreed on a clear vision of who we are (behavioral healthcare provider organizations) and what we do (advocacy for behavioral health). We walked away from some projects that we could have done, but that others were doing well—such as training and general education. We made some tough decisions, but ones that have paid off and have culminated in this exceptional year. NAPHS has solidified its standing as a strong and effective advocacy force in Washington—a position that will pay dividends for you as members over the next few years.”

—*William Zieverink, M.D.*
NAPHS president, 1998

“Every day decisions are being made that affect the future of behavioral health care. And every day the pace of change quickens. Whether the voice of behavioral healthcare providers will be heard as policy is decided will be determined by the commitment of organizational leaders to stand up today—united—to deliver a clear and consistent message about what we know works....what is in our patients’ best interests...and what is best for our communities. As those on the frontlines, we know only too well the day-to-day realities of staffing, operating, and financing behavioral health facilities within a tough economic and regulatory environment. A host of practical—and sometimes even unpopular—issues requires us to speak out....or risk the loss of valuable and irreplaceable community services. Every day the National Association of Psychiatric Health Systems (NAPHS) is our advocacy voice and our early-warning system—helping us anticipate, impact, understand, and respond to change.”

—*Peter Panzarino, M.D.*
NAPHS president, 2000

“Several years ago when I was evaluating associations, I was impressed by the knowledge and experience that CEO-level medical directors and administrators brought to the association's agenda. Having had the opportunity to serve as your association's President over the course of the past two years, I continue to be in awe of the commitment that our membership brings to improving patient care—the ultimate goal in all we do. And I have been impressed by the respect and the impact that NAPHS has as an advocate on Capitol Hill, within regulatory and accrediting agencies, and with critical constituency groups representing consumers, state leaders, and others.”

—*Anil Godbole, M.D.*
NAPHS president, 2001–2002

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ABOUT ADVOCACY

“The last 25 years have yielded more legislation that directly or indirectly affects the psychiatric hospital industry than did the 50 years preceding them. The community mental health movement, Medicare and Medicaid, the evolution of various payment systems, and the passage of a sometimes bewildering variety of regulations—NAPPH has had to deal with these and many other challenges in quick succession.”

—From *History: The National Association of Private Psychiatric Hospitals, 1933–1988*

“When I took over the Legislative Committee, I asked ‘What will I have to do?’ ‘Not much,’ they said. ‘Just report to the Board on a few pieces of legislation.’ Then along came Medicare....In the original there was a blanket statement that said that Medicare would apply to all institutions ‘except mental or tubercular institutions.’ Psychiatric hospitals were to be excluded from the system. This, of course, caused a huge uproar....I spent a lot of 1965 involved in this fight...trying to put together some sort of battle plan. The folks over at the American Psychiatric Association were

not geared up to do anything. I quickly became the most knowledgeable psychiatrist in the country about Medicare because when the bill came out, no one knew anything about it.” [Dr. Gibson visited many legislators and gave extensive testimony before Congress during the hearing process.] “At one point, a Congressman said, ‘Well, anyone older and mentally ill is hopeless, so why should we fund treatment for them?’ I got our medical records department to dig up prognosis and outcome data for 65-plus patients and found good outcome and cited that to Congress. And I got some other hospitals to look at their data, too. This data is still sometimes quoted.” [Eventually, the legislation passed and—excepting the 190-day lifetime limit, which NAPHS continues to fight—it was pretty close to the NAPPH recommendations.]

—*Robert Gibson, M.D.*
president & CEO, Sheppard and Enoch Pratt Hospital in Baltimore
—*who was the newly selected chairman of the NAPPH Legislative Committee in 1965*

...[responding to this first flexing of NAPPH's political muscle related to the original Medicare legislation]..."The Association has 'come of age.'"

—*Perry Talkington, M.D.*
NAPPH president, 1965

[On landmark passage of the first mental health parity legislation in 1996]: "Not only did NAPHS help to bring together key behavioral health organizations (including the American Managed Behavioral Healthcare Association, American Psychiatric Association, American Psychological Association, National Alliance for the Mentally Ill, National Mental Health Association), but for the first time a behavioral health coalition was able to enlist the support of important players from general health care (including the Federation of American Health Systems and the American Medical Association). Through the Coalition, NAPHS and its partners secured public endorsement of mental illness coverage by small business leaders that countered misperceptions held by many on Capitol Hill that coverage would be too costly or not valued by employers. The Coalition gathered the actu-

arial evidence that made the case for the affordability of parity."

—*Paul J. Fink, M.D.*
NAPHS president, 1996

"In the space of a single year, our alliance with the American Hospital Association has added the considerable clout of the [American Hospital Association's] AHA's voice to a variety of priority NAPHS issues, such as Medicare reform and restraint/seclusion....We have also created a formal exchange of representatives between the AHA's Section for Psychiatric and Substance Abuse Services (SPSAS) and our Board of Trustees. The NAPHS/AHA partnership also bodes well for powerful discussions on the interface between behavioral and general healthcare—a critical topic for the millennium.

—*Tom Bender*
NAPHS president, 1999

"As part of a two-year campaign (including a major study on the impact of the Balanced Budget Act), NAPHS was able to get Congress to recognize that psychiatric hospitals and units were severely hurt by BBA cuts. NAPHS

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was also able to get some financial relief through increased Continuous Improvement bonus payments in FY2001 and FY2002. Although not as much as needed, these dollars are an important step in the right direction. In addition, Congress passed NAPHS-backed legislation to establish a prospective payment system for psychiatric hospitals and units. This has been my top advocacy priority as NAPHS President. Prospective payment has great potential to significantly improve the Medicare payment system for inpatient psychiatric providers. With implementation set for October 1, 2002, there is much work to be done between now and then to develop an implementation plan. This will be a top association priority to ensure that the payment system that evolves is fair and equitable.

—*Tom Bender*
NAPHS president, 1999

“Throughout the multi-year process of developing the [Medicare inpatient psychiatric prospective payment system] PPS, NAPHS has been a leader both out front and behind the scenes representing your concerns as behavioral healthcare providers. The development,

implementation, and ongoing refinement of PPS provide a model of the importance of NAPHS—and the importance of the grassroots involvement of every behavioral healthcare provider organization in NAPHS around issues that matter to them. In the years leading up to the final rule, NAPHS was able to articulate what it would take to create—and to build coalitions to win—a workable system. From the beginning, NAPHS was able to identify core principles necessary for any PPS that rang true with our partners (including the American Psychiatric Association, American Hospital Association, and Federation of American Hospitals). As a result, we have had a consistent message urging a simple-to-use system that takes into account the wide variations in the types of patients served. This principle-based logic has enabled NAPHS and its coalition partners to fight off attempts to superimpose a complex patient-classification system. These principles will continue to provide a solid framework for evaluating any future system refinements—particularly as CMS continues to study the feasibility of patient classification. In the final rule, CMS recognized and took action on all of the major

changes NAPHS and its partners had recommended (including an emergency room adjustment, recognition of additional comorbid conditions, and a separate adjuster for ECT). This success is due in large part to the grassroots advocacy of our members. From written comments on the proposed rule to personal lobbying with members of Congress, our members have provided the real-life examples to help explain how providers are impacted by regulatory decisions. Throughout this process, we have had the able support of the extremely knowledgeable NAPHS staff as well as our lobbyist consultant Mike Bromberg. NAPHS has known when—and how—to gather the data, studies, and case examples to demonstrate how payment-system reform impacts patient care.”

—*Debra Osteen*
NAPHS president, 2004

“Working to ensure that people receive the right care, in the right setting, at the right time, providers know that partial hospitalization is an important part of a continuum of services. But access to partial hospitalization for Medicare recipients was severely threatened when the Centers for Medicare and Medicaid Services (CMS) proposed a 15% cut in the partial hospitalization per diem rate for 2007. NAPHS hired a consulting firm to analyze the CMS data used to determine the PHP payment rates. That analysis distinctly raised some specific points about the accuracy of the CMS cost calculation. In response to the study and major concerns raised by NAPHS and other organizations, CMS decided to substantially rescind partial hospitalization payment cuts in the final rule on the update on payment rates for the Hospital Outpatient Prospective Payment System (OPPS) issued in November 2006. The final rule reduces the per diem by only 5%. This change in a proposed regulation won back an estimated \$6 million to \$10 million for NAPHS members alone.”

—*Mark Covall*
NAPHS executive director
2006 year-end report

Quotes and Perspective from NAPHS members throughout the years

ABOUT QUALITY/ STANDARDS

“I think during my term we effectively moved our relationship with JCAH (The Joint Commission) to another level. There was a lot of turmoil at the time, but our ability to influence the process of change [from the Consolidated Standards Manual to the Accreditation Manual for Hospitals] was good. As a first step in development of a long-range plan for how to deal with coming changes, we also had to grapple with some of the needs within the NAPPH for reorganization. We met with member hospital CEOs and began to realize how we would deal with membership on other than a case-by-case basis. It was the beginning of a transition from the old to the current structure.”

—*Mark A. Gould, M.D.*
NAPPH president, 1982

“As a psychiatrist and a hospital CEO, quality issues have always been first and foremost in my thoughts. Quality—care that changes people’s lives for the better—is our ultimate mission as providers. And in 2005 there have been remarkable advances in the science of behavioral health that make it possible for us to offer more hope, more progress than at any time in history. As I’ve talked with NAPHS members

throughout the country, I know that each one of us wants to provide the best possible care for the children, adolescents, adults, and older adults who come to us for help. But I also know that it is sometimes frustrating to manage a hospital or other clinical service these days. The unintended consequences of conflicting or unfunded regulations and accreditation standards, the scarce dollars available for behavioral health care, the lack of access to alternative placements once people leave the hospital, lingering stigma, and a shrinking workforce are just some of the many system challenges we all face. Quality can exist only in an environment in which behavioral health is recognized, respected, and allocated resources with fairness and equity...and in an environment that allows for innovation and creativity. That’s why advocacy for behavioral health is so important both at the national level through organizations like NAPHS and at the grassroots level. Each and every one of us who is working in behavioral health care today has an opportunity—and a responsibility—to speak out. NAPHS makes it possible.”

—*Patricia R. Recupero, J.D., M.D.*
NAPHS president, 2005

“The credibility of behavioral health has been elevated through our commitment to developing core measures. Our ability to carry out our commitment to developing useful measures has the potential to impact not only quality of care, but reimbursement and accreditation standards in the long run. Our work—and our members’ participation throughout the testing and implementation phases of the project—have positioned behavioral health to enter the era of outcomes discussions on the solid footing of consensus building between the public and private sectors and among all the various stakeholders.”

—*Mark Covall*
NAPHS executive director
2006 year-end report

“Consumers and families are our customers—and our allies—in advocating for the resources that will be necessary to deliver quality behavioral health care. Their opinions and perceptions about treatment—and how well we deliver it—will have a profound

impact in the coming decades. The NAPHS Board recognizes the importance of listening to and working with consumers and families, and we will continue in the coming year to work with critical organizations—including the National Alliance for the Mentally Ill, the National Mental Health Association, and others toward our common goals.”

—*Tom Bender*
NAPHS president, 2000

“As we head into the 2004 election year, the critical role of behavioral health advocacy—and of NAPHS leadership—is once again in the spotlight. The election process is a reminder...of how we need to continually keep the needs of our patients and communities in front of an ever-changing cast of characters at both the federal and state levels...of how forcefully we must make our case to be heard among the many voices...of the positive impact our efforts can ultimately have on improving care and improving lives.”

—*Dennis P. King*
NAPHS president, 2003

ABOUT CONSUMERS

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ABOUT CHANGE

In the midst of change, we must never forget:

We are in the business of helping people. People with psychiatric and addictive disorders face some of the toughest challenges imaginable. Their illnesses put them at risk for family crises, financial hardship, and turmoil at work or school. They are coming to us at a time when they are most vulnerable, and most in need of professional help. As providers, we must fight for adequate access, coverage, and funding to ensure that the help they need is there for them when they need it.

There is strength in numbers. All the noble goals that we each support will ultimately come to nothing without the ability to make our concerns heard. NAPHS understands and has set behavioral health unity as a fundamental strategic goal.

Behavioral healthcare professionals MUST be at the table whenever change is considered. No one organization alone can have the impact that a strong, effective, and credible industry voice can have.

When you are an NAPHS member, you are not alone. NAPHS is your industry voice. As a member myself, I know from experience that NAPHS is a unique source of information, networking, and advocacy savvy. I encourage you to become actively involved in the NAPHS agenda—which is your agenda.

—Jean P. Smith
NAPHS president, 1997

