House Energy and Commerce Democrats Release Alternative to H.R. 2646

House Energy & Commerce Committee Democrats have proposed alternative legislation to Rep. Tim Murphy’s H.R. 2646, the Helping Families in Mental Health Crisis Act.

Co-sponsors Reps. Gene Green (D-TX), Diana DeGette (D-CO), Doris Matsui (D-CA), Paul Tonko (D-NY), Dave Loebsack (D-IA), and Joe Kennedy (D-MA) released the 272-page Comprehensive Behavioral Health and Recovery Act of 2016 for stakeholder comment on February 2.

The measure would make the SAMHSA Administrator an Assistant Secretary of the Department of Health and Human Services in charge of coordinating all Federal mental health and substance abuse programs, expand CMS’ authority to support mental illness demonstrations in Medicaid and provide new funding, and clarify the applicability of the Health Insurance Portability and Accountability Act (HIPAA).

Additionally, the legislation would create an Office of Chief Medical Officer within SAMHSA, and require that the Chief Medical Officer be a psychiatrist and have a staff of mental health and substance abuse providers. Rep. Murphy has been very critical of the absence of licensed mental health medical professionals on SAMHSA’s staff.

The measure’s provisions also would make permanent the mental health block grant set-aside for early intervention, but return it to the 5 percent level that existed prior to the FY2016 appropriation increase to 10 percent.

The “Section 223″ Excellence in Mental Health Act in Medicaid demonstration would be amended to authorize the Secretary of Health and Human Services to permit state participation in the demonstration for an additional three-year period beyond the two-year period already authorized. It would also authorize the Secretary to allow participation in the demonstration by additional states beyond the eight currently authorized. In each case, the Secretary would be required to find that the extension or expansion would measurably improve access to and participation in services provided under the demonstration.

Sen. Ben Cardin’s (D-MD) extension of the Medicaid Emergency Psychiatric Demonstration (MEPD) project, already signed into law by the President December 11, is included in the bill, but provisions of the Cardin bill that would require Congressional approval of an extension or expansion of the MEPD by the Secretary of HHS would be eliminated.

Section 401 of the bill would require State Medicaid programs to allow payment for mental health or primary care services provided at a community mental health center or a federally qualified health center when the mental health services are received on the same day as the primary care service, if those services are not already provided as part of a bundle or other payment arrangement that appropriately accounts for both services. At present, some states prohibit payment for same-day services.

Section 401 would also require states to provide the full range of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to children receiving inpatient psychiatric care at Institutions for Mental Disease (IMDs). The EPSDT benefit provides comprehensive and preventive health care services for all children under age 21 who are enrolled in Medicaid. When Congress, in 1972, first permitted federal financial participation for inpatient psychiatric care provided in IMDs for individuals under age 21, it allowed states to limit the range of Medicaid benefits provided. Children receiving inpatient psychiatric care at an IMD, as opposed to inpatient psychiatric care at a general hospital, may not receive the same access to services. This provision would remove this disparity.

As an alternative to the provisions of the Murphy legislation creating an exception to the prohibition against Medicaid payment for adult stays in IMDs, which the Congressional Budget Office has scored at $40 billion to $60 billion, this section would also codify the IMD provision of the recently proposed Medicaid and CHIP Managed Care rule, which would allow states to include short-term IMD residential stays in managed care capitation payments. Stays would be limited to fewer than 15 days in any one month in hospitals providing psychiatric or substance use disorder inpatient

(cont’d on page 2)
Webinar Scheduled on Initial Findings from Multi-State Evaluation of Self-Direction in Behavioral Health

The Boston College National Resource Center for Participant-Directed Services and Human Services Research Institute (HSRI) are conducting a three-year multi-state Demonstration and Evaluation of Self-Direction in Behavioral Health, funded by the Robert Wood Johnson Foundation with support from the Substance Abuse and Mental Health Services Administration.

Self-direction, also called self-directed care, consumer direction, and participant direction, is a model for organizing services and supports in which the service user manages a flexible budget with assistance from a specially trained support broker.

The evaluation involves two main components, a formative process evaluation and a system-level outcome evaluation focusing on service utilization and cost. Through the process evaluation, HSRI will document program design, implementation successes and challenges, strategies for overcoming challenges, and generate a set of guidelines for program replication and sustainability.

In a February 17 webinar, entitled Exploring Self-Directed Care: Description and Early Implementation Findings from the Demonstration and Evaluation of Self-Direction in Behavioral Health, members of the evaluation team will present early findings from the process evaluation, including a description of current self-direction efforts and key lessons learned in the first year of the project. During the webinar, HSRI will document program design, implementation successes and challenges, strategies for overcoming challenges, and how to generate a set of guidelines for program replication and sustainability.

Registration Open for SAMHSA Electronic Health Record Boot Camp

Providers wanting to learn more about electronic health records may want to participate in SAMHSA's Electronic Health Record (EHR) Boot Camp, a 6-week learning series! Each weekly session will present fundamental considerations and resources to guide the EHR decision-making and implementation process.

Sessions are scheduled for Wednesdays, February 10 through March 16, 3 to 4 p.m. EST. Questions should be addressed to EHRbootcamp@abtassoc.com.

E&C Democrats Propose Omnibus Mental Health Reform Legislation

(Cont’d from page 1)
care or subacute facilities providing psychiatric or substance use crisis residential services.

Section 404 of the proposal would extend coverage of home and community-based services (HCBS) under § 1915(c) Medicaid waivers to individuals who meet the level of care need for services in psychiatric residential treatment facilities. Currently, for an individual to be eligible for a § 1915(c) HCBS waiver, he or she needs to require the level of care provided in hospitals, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities. Because psychiatric residential treatment facilities are not recognized as falling into any of those categories, states have been unable to use the § 1915(c) waiver authority to provide home- and community-based alternatives to institutional care for children receiving care in psychiatric residential treatment facilities. This would rectify that situation.

The Democrats’ bill also drops all of the references to Assisted Outpatient Treatment contained in Rep. Murphy’s legislation.

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**Exploring Self-Directed Care: Description and Early Implementation Findings from the Demonstration and Evaluation of Self-Direction in Behavioral Health**

Webinar Date: February 17, 2016
Time: 2:00 – 3:30pm EST

**~ New Grant, Technical Assistance & Training Opportunities ~**
SAMHSA Webinar Focuses on Lessons Learned from Georgia on Maximizing Medicaid Coverage for Peer Support

SAMHSA and the Georgia Department of Health and Developmental Disabilities will be sponsoring a webinar February 11 on Maximizing Medicaid Coverage for Peer Support Services: Lessons Learned from the State of Georgia.

The state of Georgia has been very successful in securing diverse Medicaid coverage for peer support services in different settings, including mental health, addiction recovery, whole-health and parent/youth peer support activity. Presenter Wendy White Tiegreen, MSW, Director of Medicaid Coordination in the Georgia Department of Health and Developmental Disabilities, will highlight strategies for: working with state Medicaid officials; certification; creating job descriptions; addressing code of ethics issues; exploring varied roles and responsibilities in behavioral health and general health settings; and other details to help facilitate the process of securing Medicaid coverage for diverse peer support services.

Time will be provided during the 2 p.m. to 3:30 p.m. EST webinar for Ms. Tiegreen to respond to questions.

Register for the webinar here.

CMS Webinar: State Medicaid Agencies and the AHC Model

The Centers for Medicare and Medicaid Services (CMS) will hold its third Accountable Health Communities (AHC) Model learning event on February 10 at 3 p.m. EST. The webinar will focus on the role of state Medicaid agencies in the AHC Model. The AHC model addresses a critical gap between clinical care and community services in the current health care delivery system by testing whether systematically identifying and addressing the health-related social needs of beneficiaries’ impacts total health care costs, improves health, and quality of care.

This webinar is open to all interested state Medicaid agencies and potential applicants to the CMS Accountable Health Communities Model.

The AHC team highly encourages state Medicaid agencies to attend. Visit the CMS Innovation Center website here to learn more about the Accountable Health Communities Model.

TO REGISTER, click here.

2016 Center for Justice Reform Youth in Custody Certificate Program

The Center for Juvenile Justice Reform (CJJR) at Georgetown University’s McCourt School of Public Policy is accepting applications now through March 18 for its 2016 Youth in Custody Certificate Program. The program invites leaders and participant teams from around the country to the Georgetown campus for a week of intensive study from May 9 through May 13.

The 2016 Youth in Custody Certificate Program involves comprehensive scholarship and exploration of current research and best practices to support youth in post-adjudication custody, and is conducted in part with support from the Office of Juvenile Justice and Delinquency Prevention’s Center for Coordinated Assistance to States. Through targeted modules and expert instructors, the program shines a light on the high-risk juvenile offender population and helps leaders begin or accelerate systemic change to improve outcomes for youth in custody in their jurisdictions.

The program focuses on youth in post-adjudication custody and provides detailed instruction and discussion on “what works.” Program modules review and integrate best practices such as: family engagement, trauma informed treatment and strengths-based approaches. The program, however, does not stop at the culmination of the onsite instruction. Participants continue their commitment to reform through the development and implementation of a grassroots Capstone Project, and induction into the prestigious CJJR Fellows Network.

Applicants are encouraged to consider passing along information about this opportunity to colleagues and partners. Visit the CJJR Youth in Custody Certificate Program website to find detailed information about the program, including:

- Application and guidelines
- Curriculum and instructors
- Tuition and available subsidies
- Selection criteria

Applications are due by March 18, 2016. Questions should be directed to jjreform@georgetown.edu or directly to Jill Adams at jill.adams@georgetown.edu.
CMS Guidance Outlines Medicaid Rx Strategies to Combat Opioid Abuse


CMS says that of the 43,982 drug overdose deaths in 2013, 37 percent were associated with prescription opioid analgesics (e.g., oxycodone, hydrocodone and methadone). A primary driver of the rapid rise in opioid overdose deaths has been the increased number of prescriptions for opioid pain medications, especially prescriptions associated with high doses, longer course of treatment, and in combination with benzodiazepine use. The bulletin provides examples of methods states can use to target the prescribing of methadone for pain relief, given the disproportionate share of opioid-related overdose deaths associated with the use of methadone for pain.

The agency said the opioid abuse crisis affects Medicaid beneficiaries disproportionately because they are prescribed painkillers at twice the rate of non-Medicaid patients and are three to six times more at risk of a prescription painkiller overdose.

CMS suggests educating providers about the proper use of pain medication. The agency recommends training for health care professionals (such as pharmacists, nurses, and other prescribers), distributing opioid prescribing guidelines which include protocols for safer prescribing of methadone and providing clinician feedback on prescribing.

In addition, CMS suggests states implement step therapy, which requires a patient to provide a reason why another pain medication does not work for them. In Vermont, before methadone is prescribed for pain, patients must document side effects, allergies, or treatment failure with a preferred, long-acting opioid.

CMS specifically urges states to remove methadone use for pain from their preferred drug lists, except at end of life. It notes that the increased risk of morbidity and mortality associated with methadone was evident in a study of the Washington State Medicaid population. Between 2006 and 2010, the rate of methadone overdose in that population was 10 times greater than for other prescription opioids. Further, overdoses involving methadone were more than twice as fatal.

The agency also recommends utilizing prior authorization, quantity limits, drug utilization reviews, and use of State Prescription Drug Monitoring Programs and Patient Review and Restriction Programs.

Older Persons Division Link of Note

Creating Opportunities Now for Necessary & Effective Care Technologies (CONNECT) for Health Act

House and Senate members of Congress introduced a bill this week that would test expanding Medicare reimbursement for telehealth and remote patient monitoring services. S. 2484, introduced February 2, would create a program that would waive for participating providers Medicare’s requirement that telehealth services occur at a “qualified site” and by specific providers.

The program created would require providers to submit annual reports to the Department of Health and Human Services on how their expanded use of telehealth and other technologies affected costs. The bill would also make telehealth a basic benefit under Medicare Advantage.

The Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act was introduced in the Senate by Sens. Brian Schatz (D-HI), Mark Warner (D-VA), Thad Cochran and Roger Wicker (R-MS.), and John Thune (R-SD). An identical H.R. 4442 was introduced February 3 in the House by Reps. Diane Black and Gregg Harper (R-MS) and Peter Welch (D-VT).

Medical Directors Council Links of Note

SAMHSA has just updated its Opioid Overdose Prevention Toolkit designed to equip health care providers, communities, and local governments with material to develop practices and policies to help prevent opioid-related overdoses and deaths. The toolkit addresses issues for health care providers, first responders, treatment providers, and those recovering from opioid overdose.

The toolkit can be downloaded as one document, or in the following individual sections:

- Facts for Community Members
- Essentials for First Responders
- Safety Advice for Patients
- Information for Prescribers, and
- Resources for Overdose Survivors and Family Members.
Cooperative Agreements to Benefit Homeless Individuals

Application Due Date: Tuesday, March 15, 2016 -- Anticipated Award Amount: Up to $1,500,000


Funding Mechanism: Cooperative Agreement -- Anticipated Total Available Funding: $19,576,000

Anticipated Number of Awards: Up to 30 awards -- Anticipated Award Amount: Up to $1,500,000

Length of Project: Up to 3 years – No Cost Sharing/Match Required

SAMHSA is accepting applications for FY 2016 Cooperative Agreements to Benefit Homeless Individuals (CABHI) grants. The purpose of this jointly funded program is to enhance and/or expand the infrastructure and mental health and substance use treatment services of states and territories (hereafter referred to as “states”), local governments, and other domestic public and private nonprofit entities, federally recognized American Indian/Alaska Native (AI/AN) tribes and tribal organizations, Urban Indian organizations, public or private universities and colleges, and community- and faith-based organizations (hereafter referred to as “communities”). CABHI grants will increase capacity to provide accessible, effective, comprehensive, coordinated, integrated, and evidence-based treatment services; permanent supportive housing; peer supports; and other critical services for:

- Individuals who experience chronic homelessness and have substance use disorders (SUDs), serious mental illness (SMI), serious emotional disturbance (SED), or co-occurring mental and substance use disorders (CODs); and/or
- Veterans who experience homelessness or chronic homelessness and have SUD, SMI, or COD; and/or
- Families who experience homelessness with one or more family members that have SUD, SMI, or COD; and/or
- Youth who experience homelessness and have SUD, SMI, SED, or COD.

Grantees are required to locate permanent housing for all individuals or families who experience chronic homelessness and veterans who experience homelessness or chronic homelessness served by the grant project. For families or youth experiencing homelessness, grantees are, at a minimum, required to link these populations to the U.S. Department of Housing and Urban Development (HUD) Coordinated Entry system, but are encouraged to permanently house these populations. Transitional housing is not permanent housing.

ELIGIBILITY

Eligible applicants are:

- States and territories; Eligible state applicants are either the State Mental Health Authority (SMHA) or the Single State Agency (SSA). However, SAMHSA’s expectation is that both the SSA and the SMHA will work in partnership to fulfill the requirements of the grant. To demonstrate this collaboration, applicants must provide a letter of commitment from the partnering entity in Attachment 5 of the application. If the SMHA and the SSA are one entity, applicants must include a statement to that effect in Attachment 5.
- Local governments; and
- Communities, which includes other domestic public and private nonprofit entities (e.g. federally recognized AI/AN tribes and tribal organizations, Urban Indian organizations, public or private universities and colleges, and community- and faith-based organizations).

Consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its approval. A single tribe in the consortium must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the grant requirements.

SAMHSA seeks to further expand the impact and geographical distribution of the CABHI-States program and the Grants to Benefit Homeless Individuals-Services in Supportive Housing (GBHI-SSH) program across the nation. Therefore, grantees that received an FY 2014 (SM-14-010) or FY 2015 (TI-15-003) CABHI-States award or a GBHI-SSH award in FY 2014 or FY 2015 (TI-14-007) are not eligible to apply.

Proposed budgets cannot exceed $1.5 million for states, $800,000 for local governments, and $400,000 for communities in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

For contact information and application materials, go to http://www.samhsa.gov/grants/grant-announcements/sm-16-007
Grants to Expand Substance Abuse Treatment Capacity in Adult Treatment Drug Courts and Adult Tribal Healing to Wellness Courts

Short Title: SAMHSA Treatment Drug Courts
Funding Opportunity Announcement (FOA) Information (FOA) Number: TI-16-009
Posted on Grants.gov: Monday, February 1, 2016
Application Due Date: Monday, April 4, 2016

SAMHSA is accepting applications for as many as 50 FY 2016 Grants to Expand Substance Abuse Treatment Capacity in Adult Treatment Drug Courts and Adult Tribal Healing to Wellness Courts. Grants will be for as much as $325,000 annually for up to 3 years.

The purpose of the program is to expand and/or enhance substance use disorder treatment services in existing adult problem solving courts, and adult Tribal Healing to Wellness courts, which use the treatment drug court model in order to provide alcohol and drug treatment (including recovery support services, screening, assessment, case management, and program coordination) to defendants/offenders.

Grantees will be expected to provide a coordinated, multi-system approach designed to combine the sanctioning power of treatment drug courts with effective substance use disorder treatment services. Grant funds must be used to serve people diagnosed with a substance use disorder as their primary condition. SAMHSA will use discretion in allocating funding for these awards, taking into consideration the specific drug court model (Adult Treatment Drug Courts and Adult Tribal Healing to Wellness Courts), as appropriate, and the number of applications received per model type.

Eligible applicants are tribal, state and local governments with direct involvement with the drug court/tribal healing to wellness court, such as the Tribal Court Administrator, the Administrative Office of the U.S. Courts, the Single State Agency for Alcohol and Drug Abuse, the designated State Drug Court Coordinator, or local governmental unit such as county or city agency, federally recognized American Indian/Alaska Native (AI/AN) tribes and tribal organizations, and individual adult treatment drug courts.

This grant is not intended for Juvenile or Family Dependency Treatment Drug Courts. Applications received for Juvenile or Family Dependency Treatment Drug Courts will be screened out and will not be reviewed.

Listening Ear Crisis Center Joins the Lifeline Network

On February 1, Listening Ear Crisis Center of Mt. Pleasant, Michigan, joined the National Suicide Prevention Lifeline network, the eighth Michigan call center to join the network.

The National Suicide Prevention Lifeline (1-800-273-TALK) is comprised of a network of more than 160 community crisis call centers located throughout the United States. Trained professionals answer hotline calls from people in emotional distress or suicidal crisis. Each center receives calls from designated areas of the country that creates a nationwide public health safety net.

Other Michigan call centers in the network include Child and Family Services of Northwestern Michigan, Common Ground, Dial Help, Gryphon Place, Macomb County Crisis Center, Neighborhood Service Organization, and Network 180.

Since its inception in 1969 at Central Michigan University, Listening Ear has grown and evolved from a single service agency providing 24/7 crisis services for 200 people, to a multi-service organization serving over 30,000 community members annually. The mission of Listening Ear Crisis Center “is to provide citizens of Michigan with human services and affordable housing, including housing counseling, that satisfy, support, and promote the dignity and well-being of those in need.”

Listening Ear’s Crisis Hotline will provide 24/7 Lifeline coverage for Clare, Gratiot, and Isabella counties in Michigan. In addition, the call center will provide an information and referral service, accessible by calling 211.
Dr. Kimberly A. Johnson Named Director of the Center for Substance Abuse Treatment (CSAT)

Kimberly A. Johnson, PhD has been appointed SAMHSA’s new Director of the Center for Substance Abuse Treatment (CSAT), effective February 22.

Dr. Johnson will be responsible for the leadership, management, and operations of CSAT’s more than $2 billion budget, which includes a significant portfolio of grants and contracts to states, tribes, territories, communities, and non-profit organizations.

Dr. Johnson is currently the deputy director for operations of CHESS/NIATx, a research center at the University of Wisconsin, Madison that focuses on systems improvement in behavioral health and the development of mobile applications for patient self-management. She is also co-director of the national coordinating office of the Addiction Technology Transfer Center.

Prior to her move to Wisconsin, she served for seven years as the director of the Office of Substance Abuse in Maine. In her work with the State of Maine, Dr. Johnson provided leadership in identifying and treating the state’s opioid epidemic. This included developing plans to reduce misuse and increase access to treatment including medication assisted treatment, and equipping first responders with Narcan. She also served as executive director of Crossroads for Women, a women’s addiction treatment agency. In addition, Dr. Johnson managed community-based intervention and prevention programs and provided counseling for individuals and families as a child and family therapist.

Her contributions to the field have earned numerous awards – from the Federal DHHS Commissioner’s Award for Child Welfare Efforts to the National Association of State Alcohol and Drug Abuse Directors’ Recognition for Service to the field of Substance Abuse Treatment and Prevention.

Dr. Johnson has authored a variety of publications on topics important to the addiction and recovery field, including e-health solutions for people with alcohol problems, using mobile phone technology to provide recovery support for women offenders, and new practices to increase access to and retention in addiction treatment. She is co-author of a book on the NIATx Model.

Dr. Johnson has a master’s degree in counselor education, an MBA, and a PhD in population health.

SAMHSA Acting Administrator Kana Enomoto said, regarding the appointment of Dr. Johnson, “As we move forward under Dr. Johnson’s leadership, I am excited about the possibilities. Together, there is so much we can do to continue to reduce the impact of substance abuse and mental illnesses on America’s communities.”

12.7 Million Enroll in ACA Healthcare Coverage for 2016

Health and Human Services Secretary Sylvia Burwell announced February 4 that about 12.7 million consumers had selected plans or were automatically re-enrolled in Affordable Care Act Marketplace coverage across all states, either through the HealthCare.gov platform or a State-based marketplace.

Secretary Burwell said 90 percent of Americans are now insured.

The Obama Administration’s goal for the end of 2016 was to have 10 million people enrolled, after accounting for people who drop coverage throughout the year. The administration’s target was lower than the 13 million that the Congressional Budget Office (CBO) projected on January 25 would be enrolled this year.

Of the 9.6 million consumers who got coverage through HealthCare.gov, about 42 percent were new to the Marketplace in 2016. About 7 in 10 consumers with 2015 coverage came back to HealthCare.gov and actively selected a plan for 2016. Last year, only about half of returning consumers actively selected a plan.

Sixty-one percent of new enrollees—2.4 million people—signed up early for January 1 coverage, instead of waiting until the last moment. Secretary Burwell said that indicates consumers are becoming more engaged with, loyal to, and educated about the Marketplace.

With attention focused on the number of younger, healthier consumers enrolling, the percentage of 18 to 34 year-olds in the 38 states using the federal HealthCare.gov enrollment site did not increase from 2015, remaining at 28 percent of enrollees.

However, Secretary Burwell pointed to 4 million new enrollees this year as evidence that the sign-up pool is being refreshed. She suggested those new enrollees are more likely to be younger and healthier.

Some major insurers, such as the giant UnitedHealth, have expressed concerns publicly about the composition of the ACA marketplace enrollee population, saying the current risk pool has too large a share of less healthy people. UnitedHealth CEO Stephen Hemsley said in December that UnitedHealth had suffered one-half billion dollars in losses over two years, and that the company may not offer Marketplace plans in 2017.
A report released February 3 by Families USA, *Medicaid Expansion States Help More People Get Health Coverage*, finds that in 2014, the first year of Medicaid expansion under the Affordable Care Act, the percent of people who were working but had no health insurance dropped by nearly twice as much in states that expanded Medicaid as it did in states that did not expand.

The report’s findings include:

- The number of workers who were uninsured declined from 2013 to 2014 in virtually every state, but the overall rate of decline was substantially higher in expansion states.
- States that expanded Medicaid saw, on average, a 25 percent reduction in the number of residents who were working but uninsured.
- Of the 26 states that expanded Medicaid in 2014, 21 (80 percent) saw a decrease of at least 20 percent in the number of workers who were uninsured. This compares to only two of the 24 non-expansion states (8 percent) that saw a decrease of at least 20 percent.
- In states that chose not to expand Medicaid, the average reduction was 13 percent.
- The average percentage reduction across expansion states was nearly twice the percentage reduction across non-expansion states.
- Eight of the Medicaid expansion states (30 percent) saw the number of working residents without insurance fall by 30 percent or more. None of the non-expansion states saw a decrease of 30 percent or more.
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Children’s Division Links of Note

Follow-Up Care Low Among Adolescents with New Depression Symptoms

Anxiety and Depression Association of America Conference in Philadelphia, March 31 to April 3