CMS Office of the Actuary Publishes Data on State Health Spending Patterns for 2010 to 2014

The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary released, this week, its latest State Health Expenditure Accounts report on the patterns of health spending in the states.

The new study covers 2010 to 2014, a period which included the initial implementation of the Affordable Care Act (ACA), as well as an economic recession and recovery. According to the analysis, although those factors affected overall annual growth in state health spending and the payers and programs paying for that care, they did not substantially change rankings of state per capita spending levels. However, it is notable that annual growth in personal health care spending by payers varied by state depending on how a state implemented the ACA coverage expansions.

State health expenditures are measured at the personal health care level, which reflects all health care goods and services consumed but excludes other components of national health care expenditures, such as government administrative costs, the net cost of private health insurance, government public health activity, and investment (including investment in structures and equipment and noncommercial research). The state health expenditure data include estimates of Medicare, Medicaid, and private health insurance spending. Other payers and programs, including out-of-pocket payments by households, are included in the estimates of total personal health care by state but are not estimated separately.

The national average growth rate from for the period was 3.1 percent, ranging from an annual average of 1.9 percent in Arizona to 4.8 percent in Alaska. The 2014 national average per capita spending was $8,045, with average state spending ranging from Utah’s $5,982 to Alaska’s $11,064.

From a regional perspective, states with spending that was higher than the national average tended to be located in the New England, Mideast, Great Lakes, and Plains regions. States that had relatively higher levels of personal income per capita, greater percentages of the population enrolled in Medicare or Medicaid, and more health care capacity tended to have relatively higher levels of health spending per capita. On the other hand, states that had relatively higher rates of uninsured tended to have relatively lower levels of health spending per capita.

Massachusetts and Connecticut were among the states with the highest per capita spending levels, but their average annual growth rates in per capita spending for 2010 to 14 were among the lowest, at 2.8 percent and 3.6 percent per year, respectively. In contrast, Georgia and Idaho exhibited per capita spending levels that were among the lowest but per capita spending growth rates for 2010 to 14 that were among the highest.

Continued on page 5)
Montana Surveillance Data Shapes State Suicide Prevention Legislation

In an effort to gain a better understanding of Montana's suicide mortality rate—the highest in the nation for nearly 40 years—the state legislature in 2013 passed and funded the Montana Suicide Mortality Review (MSMR) Team Act. The goal of the Team established under the Act was to use data surveillance to make suicide prevention policy recommendations to the state.

Since its inception, the MSMR Team has reviewed 555 suicides from January 1, 2014 to March 1, 2016 to track patterns of suicide deaths, and identify risk factors and possible preventive interventions that would shape future policy-making.

In reviewing the 555 suicides, the Team found that:

- Approximately 80 percent of the suicide deaths occurred among males. Of the 80 percent, 91 percent were Caucasian and half (53 percent) were between the ages of 35 to 64.
- Firearms were used in two-thirds (88 percent) of the suicides.
- A mental health diagnosis was found in 85 percent of the decedents, with depression being found in 70 percent of the 313 cases reviewed where mental health diagnoses were available.
- Nearly 75 percent of individuals dying from suicide had less than a college education level.
- In 74 percent of the cases, the decedents presented at least three of the warning signs of suicide prior to their death.

Among high-risk populations (e.g., Native Americans, Veterans, and youth) in Montana, the surveillance data revealed that:

- Approximately 65 percent of suicides by youth between the ages of 11 and 17 were by firearms. In contrast, the national rate of youth suicides by firearms is 39 percent.
- Roughly 69 percent of veteran suicides were over the age of 55.
- Despite American Indians representing only 6 percent of Montana’s population, their rate and frequency of suicide is higher than for Caucasian residents. On average, 19 American Indians die by suicide each year, for a rate of 27.3/100,000, compared to an annual rate for Caucasians of 200 suicides (22.11/100,000).

Based on these findings, the Team developed policy-level recommendations for the 2017 state legislative session. Some of the recommendations included a focus on lethal means restriction through firearm safety awareness campaigns and access to gun locks, a public awareness campaign on the warning signs of suicide, and the funding of suicide prevention initiatives for the Native American community.

The MSMR Team recommendations led state legislators and the Governor to fund, under H.B. 118, Native American youth suicide prevention, grants to schools targeting youth suicide prevention and other organizations that support general suicide prevention activities, and public awareness campaigns, to renew the authorization for the Team’s surveillance activities. The HB118 activities will be funded by tobacco settlement proceeds in the state's special revenue account and the state’s tobacco tax.

On May 31, Montana Governor Steve Bullock (D) announced a collaboration with the Montana Broadcasters Association and the state’s Department of Public Health and Human Services in releasing a suicide prevention media campaign focused on recognizing the warning signs of suicide and intervening, identifying high-risk groups such as veterans and youth, firearm safety, and connecting to support services, such as the National Suicide Prevention Lifeline.

Senate Finance Committee Approves Trump Nomination of Eric D. Hargan as HHS Deputy Secretary

President Trump's nomination of Eric D. Hargan to serve as Deputy Secretary of the Department of Health and Human Services (HHS) cleared the Senate Finance Committee on June 14 in a 17-9, largely party-line vote.

The nomination still must be approved by the full Senate.

Mr. Hargan, who served on President Trump’s transition team for HHS, is a shareholder in the law firm of Greenberg Traurig, LLP, in its Health & FDA Business practice, based in Chicago. He earned a BA cum laude in philosophy from Harvard University, and a JD from Columbia University Law School. Mr. Hargan previously served the Department from 2003-2007 as Deputy General Counsel, as Principal Associate Deputy Secretary, and as Acting Deputy Secretary. His roles at the Department also included being regulatory policy officer, overseeing the development and approval of all HHS, U.S. Food and Drug Administration and Centers for Medicare & Medicaid Services regulations and guidance.

He is a previous recipient of the HHS Secretary’s Award for Distinguished Service.

In 2014-2015, he served as Co-Chair and Convener of the Healthcare and Human Services Transition Committee for Illinois Governor Bruce Rauner.
Recovery to Practice Announces an On-Demand Continuing Medical Education (CME) Webinar Series  

Clinical Decision Support for Prescribers Treating Individuals with Co-Occurring Disorders

This two-course series offers information and resources for physicians, clinicians, and other practitioners serving individuals with serious mental illness and co-occurring substance abuse disorder.

In this scenario-based series, participants meet "Nick," a young father with many strengths and who is challenged by both substance abuse and mental illness. The course explores the question: How do I approach Nick and help him meet his needs in ways that are both clinically sound and recovery-focused?

The faculty are national experts in recovery, including psychiatrists, a psychologist, a social worker, a nurse, and peers. They offer tools, tips, and strategies for addressing Nick’s needs, and those of other individuals facing similar challenges.

Course 1: Principles, Assessment, and Psychopharmacology in Recovery-Oriented Care  
Course 2: Engagement, Staged Interventions, and Recovery Supports for Co-Occurring Disorders

Watch one or both courses at your convenience! Each course is approved for 1.5 AAFP (American Academy of Family Physicians) prescribed credits.

Course Objectives

After viewing, learners will be able to:

1. Summarize a recovery-oriented approach to the treatment of individuals with co-occurring mental and substance abuse disorders.
2. Describe the process of recovery-oriented, strength-based engagement, assessment, and intervention, including psychopharmacology treatment, for individuals with co-occurring mental and substance abuse disorders.
3. Describe non-medication recovery and support approaches for individuals with co-occurring mental health and substance abuse conditions.

Course Faculty

Curley Bonds, M.D.  
Medical Director, Didi Hirsch Mental Health Services

Wayne Centrone, N.M.D., M.P.H  
Senior Health Advisor, Center for Social Innovation  
Executive Director of Health Bridges International

Chris Gordon, M.D.  
Medical Director and Senior Vice President for Clinical Services, Advocates, Inc.  
Associate Professor of Psychiatry, Harvard Medical School

Jackie Pettis, M.S.N. R.N.  
Advisor and Trainer for Psychiatry to Practice Project

Ken Minkoff, M.D.  
Senior System Consultant, ZiaPartners, Inc.  
Clinical Assistant Professor of Psychiatry, Harvard Medical School

Kim Mueser, Ph.D.  
Executive Director, Center for Psychiatric Rehabilitation, Boston University

Melody Riefer, M.S.W.  
Senior Program Manager, Advocates for Human Potential

Center for Trauma-Informed Care

NASMHPD oversees the SAMHSA National Center for Trauma Informed Care (NCTIC). NCTIC offers consultation, technical assistance (TA), education, outreach, and resources to support a revolutionary shift to trauma-informed care across a broad range of publicly-funded service systems, including systems providing mental health and substance abuse services, housing and homelessness services, child welfare, criminal justice, and education.

June Trainings

Maryland

June 19 & 20 – J.B.S. International, Rockville  
June 22 & 23 – Baltimore City Health Department

Virginia

June 23 – City of Richmond Department of Social Services  
June 29 - Chesterfield County Mental Health Support Services, Chesterfield

For more information on these trainings, please contact jeremy.mcshan@nasmhpd.org.
**Web-Based HHS Federal Partners Integrated Care Meeting**

**State of the Art: Research, Models, Promising Practices and Sustaining Integrated Care**

*Thursday, June 22 and Friday, June 23, 2017*

Over the years, models of integrated behavioral health and primary care have evolved. HHS recognizes the importance of addressing the integration of behavioral health and primary care, including person-centered care for adults living with mental illness – particularly serious mental illness, children and adolescents with serious emotional disturbance, and individuals with substance use disorders. Evidence-based integrated treatment and effective care coordination are key components for improving the health of people with multiple chronic conditions.

Along with host agencies, the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), key partners and presenters include: the Agency for Healthcare Research and Quality (AHRQ), Centers for Medicaid and Medicare Services (CMS), Indian Health Services (IHS), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), the National Institute of Mental Health (NIMH), the Office of the National Coordinator for Health Information Technology (ONC), and the Veterans’ Administration.

The event will highlight models of integrated care, key findings from the research community, examples of diverse grantee practices regarding service delivery, presentations by U.S. Department of Health and Human Services agencies, and a wide range of resources to support efforts to build integrated systems of care.

The Meeting is Free and Open to the Public

Register **HERE** to Receive Log-In Information

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**NASMHPD Annual 2017 Meeting**

**Sunday, July 30 through Tuesday, August 1**

**Renaissance Capitol View Hotel, 2800 S. Potomac Avenue, Arlington, Virginia**

*(Rooms Available at Government Rate at the Renaissance Capitol View)*

The 2017 NASMHPD Annual Meeting will run three full days, in collaboration with the NASMHPD Research Institute (NRI), and include a day of meetings for the NASMHPD Division representatives.

The NASMHPD Divisions include the Children, Youth and Families Division; the Financing and Medicaid Division; Forensic Division; the Legal Division; the Medical Directors Council; the Older Persons Division; and the Offices of Consumer Affairs (National Association of Consumer/Survivor Mental Health Administrators – NAC/SMHA).

The meeting will include extended time for State Mental Health Commissioners and Divisions to meet together as well as separately. There will also be a day with State Mental Health Commissioners and Divisions meeting together on NRI research data and initiatives that tie in with the Commissioners’ and Divisions’ priorities and concerns.

**Registration for State Mental Health Commissioners:** $600  
**Registration for Additional State and/or Division Representatives:** $400

Contact **Yaryna Onufrey** with any questions.
Diagnosis of individuals who present for care in first episode programs can be complex. However, an accurate diagnosis is important in determining eligibility, measuring duration of untreated psychosis and developing a plan of care. Clinicians must balance the need for detailed information about the severity and timing of symptoms with the multiple other demands during an initial assessment. Disentangling the numerous variables that may be causing psychotic symptoms, such as substance use, is not straightforward. Also, not all clinicians who conduct these assessments have received the training and supervision that may be optimal to make clear diagnostic distinctions. In this learning exchange we will discuss these challenges and present strategies that have been employed to improve the accuracy of diagnosis in community programs.

Drs. Rachel Loewy, Associate Professor in the Department of Psychiatry at the University of California San Francisco and John Kane, Professor and Chair of the Department of Psychiatry at Hofstra Northwell School of Medicine will lead the discussion by providing insights from their several years of experience working in First Episode Programs. The program will feature ample time to discuss these issues with Drs. Loewy and Kane.

**CMS Office of the Actuary Publishes Data on Recent State Health Spending Patterns**

(Continued from page 1)

The growth rate in per capita personal health care spending in 2014 was highest in Oregon (7.7 percent) and lowest in New Hampshire (2.4 percent). However, both expanded Medicaid in 2014, suggesting that other factors contributed to the relative differences in growth rates. The authors suggest that, for Oregon, the high per capita growth is attributable to very high total Medicaid spending and enrollment growth rates (46.9 percent and 53.8 percent, respectively), as well as strong spending growth rates for aggregate hospital services (10.1 percent) and retail prescription drugs and other nondurable medical products (13.2 percent). The low growth in New Hampshire is attributed to the state’s delayed expansion of Medicaid and slower spending growth rates for aggregate hospital services (3.1 percent), physician and clinical services (2.9 percent), and retail prescription drugs and non-durable medical products (6.4 percent).

The authors say that state-specific impacts of the ACA coverage expansions are most evident in the underlying trends for Medicaid and private health insurance spending by state. In states that expanded coverage, total Medicaid spending increased 12.3 percent from 2013 to 2014, compared with 6.2 percent in states that did not expand Medicaid. Per enrollee Medicaid spending, however, declined considerably in expansion states (minus 5.1 percent) in 2014 but increased 5.1 percent in non-expansion states. The trends in the per enrollee Medicaid are attributed to the coverage expansion, which increased the share of relatively less expensive enrollees relative to the previous Medicaid beneficiary population mix in expansion states.

Adult enrollees, whose per enrollee spending is 70 percent lower than spending for enrollees with disabilities and 62 percent lower than spending for aged enrollees, accounted for just 17 percent of total Medicaid enrollment in non-expansion states, but 49 percent in states that expanded coverage (up from 32 percent in 2013). In contrast, more costly enrollees with disabilities accounted for 30 percent of total Medicaid enrollment in non-expansion states and just 20 percent in expansion states in 2014. Children—the least costly eligibility group—had per enrollee spending in 2014 that was 43 percent lower than that of the adult expansion population and represented a much higher share of total enrollment in non-expansion states (53 percent) than in expansion states (37 percent) in 2014.

In private health insurance, however, aggregate spending grew more rapidly in states that did not expand Medicaid eligibility by 2014 than in states that did, at rates of 6.8 percent and 4.6 percent, respectively. The authors say a majority of this difference reflects faster private health insurance enrollment growth in the non-expansion states (3.2 percent) compared to expansion states (1.9 percent). This more rapid growth was caused, in part, by enrollment in Marketplace plans, as non-expansion states accounted for 53.4 percent of Marketplace enrollment but 45.5 percent of overall private health insurance enrollment in 2014.

Per enrollee, the growth rate for private health insurance spending in 2014 increased more rapidly for non-expansion states (3.4 percent) than for expansion states (2.7 percent). This faster growth is attributed by the authors, in part, to per-person spending for Marketplace enrollees that was higher than spending for non-Marketplace individual coverage.
SAMHSA Funding Opportunity Announcement

Cooperative Agreements to Implement Zero Suicide in Health Systems (SM-17-006)

Application Due Date: Tuesday, July 18, 2017
Length of Project: Up to 5 years
Anticipated Total Available Funding: $7.9 million ($2 million for tribes and tribal organizations)
Anticipated Number of Awards: Up to 13
Anticipated Award Amount: Up to $700,000/year
Cost Sharing/Match Required? No

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2017 Cooperative Agreements to Implement Zero Suicide in Health Systems (Short Title: Zero Suicide). The Zero Suicide model is a comprehensive, multi-setting approach to suicide prevention in health systems. The purpose of this program is to implement suicide prevention and intervention programs, for individuals who are 25 years of age or older, that are designed to raise awareness of suicide, establish referral processes, and improve care and outcomes for such individuals who are at risk for suicide. Grantees will implement the Zero Suicide model throughout their health system.

Health systems that do not provide direct care services may partner with agencies that can implement the Zero Suicide model. For communities without well-developed behavioral health care services, the Zero Suicide model may be implemented in Federally Qualified Health Centers or other primary care settings.

Eligibility - Eligible applicants are statutorily limited to:

- States, District of Columbia, and U.S. Territories health agencies with mental health and/or behavioral health functions;
- Indian tribe or tribal organization (the term 'Indian tribe' and 'tribal organization' are defined in § 4 of the Indian Self-Determination and Education Assistance Act.);
- Community-based primary care or behavioral health care organizations;
- Emergency departments; or
- Local public health agencies.

Contacts:
Program Issues: James Wright, LCPC, Suicide Prevention Branch, Center for Mental Health Services, by email or at 240-276-1854
Grants Management and Budget Issues: Gwendolyn Simpson, Office of Financial Resources, by email or at 240-276-1408

International Consortium of Universities on Drug Demand Reduction (ICUDDR)
2nd World Conference
Prague, Czech Republic

June 20 and 21, 2017, With Preconference Events & Workshops on Monday, June 19

The organizing theme for this year's conference is University Education and Training programs for Substance Use Professionals: Emerging New Phenomena in a Changing Addiction World. The conference will include keynote presentations on developing sustainable education and training programs and on networking among universities and professional organizations throughout the world. Educational and scientific leaders from around the world will share their experiences in developing academic and other training curricula in addiction studies, and in conducting research related to prevention and treatment of substance use disorders. Sessions will address strategies to increase public knowledge about the consequences of drug use and, more importantly, to build a workforce that is educated and trained in evidence-based addiction prevention and treatment services. For more information, see www.icuddr.com

Supported by the U.S. Department of State, Bureau of International Narcotics and Law Enforcement Affairs

AGENDA HERE
REGISTER HERE
Save-the-Dates

Webinar Series: Trauma-Informed Innovations in Crisis Services
April – September 2017 (4th Monday of each month) 3 p.m. to 4 p.m. E.T.

Register HERE

The Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC) is pleased to announce the opportunity to participate in an upcoming Webinar Series: “Trauma-Informed Innovations in Crisis Services.” The series will run from April – September 2017 on the 4th Monday of each month, from 3:00 to 4:00 p.m. Eastern Time. This webinar series will highlight the innovative work of crisis service providers employing a trauma-informed approach, including prevention, engagement, and inclusion of lived experience and peer support. Each 60-minute webinar will focus on how an agency implements one of the principles from SAMHSA’s Concept and Guidance for a Trauma-Informed Approach: Safety, Trustworthiness and Transparency, Peer Support, Collaboration and Mutuality, Empowerment, Voice and Choice, and Cultural, Historical, and Gender Issues. After the provider presentations, a moderated Q&A will follow. Intended audiences for this webinar series include: state mental health authorities, providers of crisis prevention and intervention services, as well as peers, families, and community members.

According to SAMHSA’s publication: Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies, “National statistics attest to the significant need for crisis services. In 2010, 2.2 million hospitalizations and 5.3 million emergency department visits involved a diagnosis related to a mental health condition. Not everyone will experience a need for crisis services but some factors may increase the risk of crisis such as poverty, unstable housing, coexisting substance use, and other physical health problems. The research base on the effectiveness of crisis service has been growing, with evidence that crisis stabilization, community-based short-term crisis care, peer crisis services, and mobile crisis services can divert people from unnecessary hospitalizations and insure the least restrictive treatment option. A continuum of crisis services can assist in reducing costs and address the problem that lead to the crisis. The primary goal of these services is to stabilize and improve symptoms of distress and engage people in the most appropriate treatment.

In response to these trends and statistics, more and more states/organizations have developed innovative crisis services/teams through the implementation of SAMHSA’s Trauma-Informed Approaches. Crisis Services/Supports may include: short-term crisis residential programs, crisis stabilization programs (i.e., community-based, ER, psychiatric ER), peer-run and other crisis respite programs, comprehensive psychiatric emergency response centers, emergency response recovery/detox programs, mobile crisis outreach programs.

Implementing Trauma-Informed Innovations in Crisis Services:
The Principle of Empowerment, Voice and Choice
Monday, June 26, 3 p.m. to 4 p.m. E.T.

This principle is rooted in the primacy of the people served; in resilience; and the ability of individuals, organizations, and communities to heal and promote recovery from trauma. There is a recognition of the ways in which trauma survivors, historically, have been diminished in voice and choice. Victoria Welle, program coordinator with the Grassroots Wellness Peer-Run Respite and Learning Community in Wisconsin, will share how the peer-run respite fosters empowerment, voice and choice as part of an overall trauma-informed approach, and that people seeking support have the opportunity for shared decision-making and goal setting to determine the plan of action they need to heal and move forward.
The Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Center for Trauma-Informed Care and Alternatives to Restraint and Seclusion (NCTIC) is pleased to announce the second webinar in the 6-part series entitled “Communities Addressing Trauma and Community Strife Through Trauma-Informed Approaches”:

**Trustworthiness and Transparency: Handle with Care**
Monday, June 26, 1:00 – 2:30 PM ET
This webinar offers innovative best practices for helping to mitigate the negative effects experienced by children’s exposure to trauma and highlights a promising initiative (Handle with Care) between schools, law enforcement and treatment providers. Handle with Care, provides the school with a “heads up” when a child has been identified by law enforcement at the scene of a traumatic event. Schools are responding with interventions to help mitigate the trauma and mental health providers are co-locating at the school to provide services. Handle with Care programs promote safe and supportive homes, schools, and communities that protect children, and help traumatized children heal and thrive. Andrea Darr, Director, West Virginia (WV) Center for Children’s Justice, WV State Police, Crimes Against Children Unit, and Lt. Chad Napier, Prevention Resource Coordinator for Appalachia HIDTA will present on this unique collaboration between the educational system and law enforcement and provide guidance for replication for interested communities.

**Learning Objectives:**
1. Better understand the impact of trauma on a child’s ability to learn;
2. Identify crimes impacting local schools and students;
3. Describe proven classroom and school-wide interventions to help students exposed to trauma; and
4. List examples of collaborative efforts to better serve children exposed to trauma.

**Presenters:**

**Lt. Chad Napier (retired)  
Prevention Resource Coordinator for Appalachia HIDTA**

Chad Napier is the Prevention Coordination for Appalachia HIDTA (High Intensity Drug Trafficking Area) for West Virginia and Virginia. Prior to this position, he spent twenty years in law enforcement in 2015

**Andrea Darr  
Director, WV Center for Children’s Justice**

Andrea Darr is the director of the West Virginia Center for Children’s Justice which promotes and supports a statewide trauma-informed response to child maltreatment and children’s exposure to violence. The Center, housed in the Crimes Against Children Unit at the WV State Police, streamlines resources and minimizes duplicative efforts to address challenges, barriers, gaps and needed improvements in working child maltreatment cases. The Center includes the WV Children’s Justice Task Force and the WV Handle with Care Initiative.

**About the Series**
SAMHSA/NCTIC is offering this virtual webinar series highlighting communities working to improve the resiliency of its members and responsiveness to community incidents. The series framework follows SAMHSA’s six principles of trauma-informed approaches as described in [SAMHSA’s Concept of Trauma and Guidance for Trauma-Informed Approaches](https://www.samhsa.gov/trauma-concept).

SAMHSA's NCTIC is tasked with the design and implementation of a technical assistance strategy to assist publicly funded systems, agencies, and organizations across the country in preventing the use of restraint, seclusion, and other forms of aversive practices through trauma-informed approaches. NCTIC supports SAMHSA's Trauma and Justice Strategic Initiative goal of implementing trauma-informed approaches in health, behavioral health and related systems. Specifically, this series addresses SAMHSA’s objective to develop a framework for community and historical trauma and a trauma-informed approach for communities, and is open to all interested in addressing community trauma and healing.
Technical Assistance on Preventing the Use of Restraints and Seclusion
For more than 10 years, NASMHPD has been contracted by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance and support to facilities committed to preventing the use of restraint and seclusion.

The National Center for Trauma Informed Care and Alternatives to Restraint and Seclusion offers on-site staff training and technical support to implement trauma-informed, strength-based approaches to prevent aversive interventions. Our in-house team and national consultants have many years of public hospital experience, both clinically and personally. This assistance is funded by SAMHSA and at no cost to your state.

To Apply for Technical Assistance, Click Here:
We look forward to the opportunity to work together.

Webinar Opportunity

The Importance of Care Coordination: Real-World Considerations for Managing Individuals with Schizophrenia

Tuesday, June 27, 2:30 p.m. to 3:30 p.m. ET

Presented by the National Council for Behavioral Health and funded by Alkermes, Inc.
Program speakers are under contract with Alkermes, Inc.

Schizophrenia is a complex condition associated with a vast array of distinct clinical profiles, co-morbidities and significant medical expenditures. In 2013, the economic burden for schizophrenia in the US was estimated at $155.7 billion. The rapidly evolving healthcare landscape has created new fee schedules and payment models that may require a changed approach to treatment and service delivery. How can payers address the complex challenges of expanding and improving services while simultaneously bending the cost curve? Join the National Council for Behavioral Health to learn about care coordination for people living with schizophrenia. By examining real-world pilot projects, you may be able to garner insights on models of care coordination that may be relevant to plan challenges for the management of people with schizophrenia.

Register HERE.

National TA Network for Children’s Behavioral Health Upcoming Webinars

Early Childhood Evaluation: Improving Policy, Systems, and Services
Monday, June 19, 2:30 p.m. to 4 p.m. ET
Using data can be a powerful tool for advancing early childhood practice in SOCs. This LC session will focus on how to design an evaluation to improve early childhood SOC, and how to translate evaluation findings to effectively describe positive impacts and return on investment to policymakers and other partners. The session will address how data is important in moving the field forward; examples of evaluation approaches used for early childhood systems and services; how early childhood data have been used in the past; and how evaluation findings can be used to promote the benefits of their SOCs.

System of Care Expansion Leadership Learning Community: Governance Structures
Wednesday, June 21, 2:30 p.m. to 4 p.m. ET
SOC Expansion grantees are required to have interagency governance bodies that are responsible for policy-level decision-making. These bodies must represent the cultural and ethnic diversity of their communities and include family members, youth, and young adults. This month’s LC will feature state, tribal, and local grantees who will share their governance structures, roles, and responsibilities. They will also highlight lessons learned and successful uses of governance structures to advance expansion and sustainability efforts.

CLC Peer Learning Exchange: Implementing the CLAS Standards of Recruiting and Hiring a Diverse Workforce
Friday, July 14, 1p.m. to 2 p.m. ET
This webinar is designed to help administrators, service providers, and peer supporters in SOC implement the CLAS standards. This webinar will focus on ways to recruit and hire a diverse workforce.

Don’t miss out on early registration for the National Wraparound Implementation Academy, which will be held at the Renaissance Baltimore Harborplace Hotel on Sept. 11 to 13. The academy will provide individuals in key wraparound roles with opportunities to learn from the field’s foremost experts in wraparound and Systems of Care. This is one of the approved SAMHSA meetings for grantees.

Early Bird Registration (until June 16) is HERE.
State Technical Assistance Available from the State Mental Health Technical Assistance Project (Coordinated by NASMHPD with SAMHSA Support)

NASMHPD coordinates a variety of SAMHSA-sponsored technical assistance and training activities under the State TA Project.

To Request On-site TA: States may submit requests for technical assistance to the on-line SAMHSA TA Tracker, a password-protected system. All of the Mental Health Directors/Commissioners are authorized to use this system, and Commissioners can give authorization to other SMHA staff as well. Once in this system, the user will be asked to identify the type of TA that is being sought, the audience, and the goals the state is seeking to address via the support.

On average, a given TA project includes as many as 10 days of consultant time (including prep and follow-up), along with coverage of consultant travel to your state.

The log-in for the Tracker is: http://tatracker.treatment.org/login.aspx. If a state has forgotten its password or has other questions about accessing the Tracker system, the Commissioner or authorized user can send an e-mail to: tattracker@treatment.org.

Note that technical assistance under this project cannot be specifically focused on institutional/hospital-based settings.

For answers to other questions, contact your CMHS State Project Officer for the Mental Health Block Grant, or NASMHPD’s Pat Shea by email or at 703-682-5191.

Technical Assistance Products for Services to Persons Experiencing a First Episode of Psychosis

With support from the Center for Mental Health Services, NASMHPD and NRI have developed a second set of technical assistance materials that address issues with programming for individuals experiencing a first episode of psychosis. The products are listed below.

> **Policy Brief**: The Business Case for Coordinated Specialty Care for First Episode Psychosis
> **Toolkits**: Supporting Full Inclusion of Students with Early Psychosis in Higher Education
  > o Back to School Toolkit for Students and Families
  > o Back to School Toolkit for Campus Staff & Administrators
> **Fact Sheet**: Supporting Student Success in Higher Education
> **Web Based Course**: A Family Primer on Psychosis
> **Brochures**: Optimizing Medication Management for Persons who Experience a First Episode of Psychosis
  > o Shared Decision Making for Antipsychotic Medications – Option Grid
  > o Side Effect Profiles for Antipsychotic Medication
  > o Some Basic Principles for Reducing Mental Health Medicine
> **Issue Brief**: What Comes After Early Intervention?
> **Issue Brief**: Age and Developmental Considerations in Early Psychosis
> **Information Guide**: Snapshot of State Plans for Using the Community Mental Health Block Grant (MHBG) Ten Percent Set-Aside for Early Intervention Programs (as of September 2016)
> **Information Guide**: Use of Performance Measures in Early Intervention Programs

These products are in addition to those that were developed last year as well as other materials on first episode programming. They can be obtained at http://www.nasmhpd.org/content/information-providers. Any questions or suggestions can be forwarded to either Pat Shea (Pat.shea@nasmhpd.org) or David Shern (David.shern@nasmhpd.org).
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