

U.S. Department of Health and Human Services

Minutes of the Fourth Meeting of the Interdepartmental Serious Mental Illness Coordinating Committee

December 11, 2018, 9:00 a.m. to 5:00 p.m. EST

5600 Fishers Lane, Rockville, MD 20857

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Call to Order/Committee Roll Call

Pamela Foote, Designated Federal Official for the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) called the meeting to order and conducted the roll call to ensure a quorum.¹

Federal ISMICC Members or Designees Present

- Eric Hargan, J.D., Deputy Secretary, Department of Health and Human Services (HHS)
- Elinore F. McCance-Katz, M.D., Ph.D., Assistant Secretary for Mental Health and Substance Use, Substance Abuse and Mental Health Services Administration (SAMHSA)
- Tracy Trautman, Deputy Director for the Programs, Office of the Bureau of Justice Assistance (BJA) for the Attorney General, Department of Justice (DoJ)
- Sandy Resnick, Ph.D., Deputy Director, Northeast Program Evaluation Center (NEPEC), Office of Mental Health and Suicide Prevention, Virginia Central Office (VACO), for the Secretary of the Department of Veterans Affairs (VA)
- Ralph Gaines, M.B.A., Chief Operations Officer, for the Secretary of the Department of Housing and Urban Development (HUD)
- Laurie VanderPloeg, M.S.Ed., Director of Special Education Programs, Office of Special Education and Rehabilitative Services, for the Secretary of the Department of Education (ED)
- Jennifer Sheehy, M.B.A., Deputy Assistant Secretary of the Office of Disability Employment Policy (ODEP) for the Secretary of the Department of Labor (DOL)
- Deidre Gifford, M.D., Deputy Director, for the Administrator of the Centers for Medicare and Medicaid Services (CMS)
- Terry Adirim, M.D., M.P.H., FAAP, Acting Principal Deputy Assistant Secretary of Defense for Health Affairs, for the Secretary of the Department of Defense (DoD)
- Melissa Spencer, Deputy Associate Commissioner, Office of Disability Policy, for the Commissioner, Social Security Administration (SSA)

Non-Federal ISMICC Members Present

- Linda S. Beeber, Ph.D., Distinguished Professor, University of North Carolina-Chapel Hill, School of Nursing
- Ron Bruno, Founding Board Member and Second Vice President, Crisis Intervention Team (CIT) International
- Clayton Chau, M.D., Ph.D., Regional Executive Medical Director, Institute for Mental Health and Wellness, St. Joseph-Hoag Health
- David Covington, L.P.C., M.B.A., CEO/President, Recovery Innovations (RI) International
- Maryann Davis, Ph.D., Research Associate Professor, Department of Psychiatry, University of Massachusetts Medical Center
- Pete Earley, Author
- Mary Giliberti, J.D., Chief Executive Officer, National Alliance on Mental Illness

¹ See Appendix B for the official list of meeting participants.

(NAMI)

- Elena Kravitz, CPRP, Director, New York Association of Psychiatric Rehabilitation Services
- Kenneth Minkoff, M.D., Zia Partners
- Rhathelia Stroud, J.D., Presiding Judge, DeKalb County Magistrate Court
- Elyn Saks, J.D., Ph.D., Orrin B. Evans Professor of Law, Psychology, and Psychiatry and the Behavioral Sciences, University of Southern California Gould School of Law
- Connie Wells, Owner/Manager, Axis Group, LLC

Non-Federal ISMICC Members Not Present

- Paul Emrich, Ph.D., Undersecretary of Family and Mental Health, Chickasaw Nation
- John Snook, J.D., Executive Director/Attorney, Treatment Advocacy Center

Consideration of the Minutes for the ISMICC Meeting of June 8, 2018

Elinore F. McCance-Katz, M.D., Ph.D., Chair, ISMICC, Assistant Secretary for Mental Health and Substance Use, Substance Abuse and Mental Health Services Administration (SAMHSA), asked if ISMICC members had comments or questions about the minutes of the June 8, 2018, meeting. Hearing none, she took a motion to accept the minutes, which ISMICC members approved by a voice vote.

Charge to the Committee and Meeting Overview

Dr. McCance-Katz expressed her belief that the Administration and Congress selected a psychiatrist to serve as Assistant Secretary for Mental Health and Substance Use for very deliberate reasons. Therefore, she is re-orienting SAMHSA to follow a more clinical and scientifically evidence-based approach to its work. This effort has already been demonstrated through numerous activities, including implementing an Evidence-Based Resource Center, supporting programs such as Assertive Community Treatment and Assisted Outpatient Treatment, and refocusing SAMHSA's data collection efforts. Dr. McCance-Katz also believes that SAMHSA should play a central role in building a qualified national workforce trained to work with persons with mental and substance use conditions. Therefore, she has reconfigured SAMHSA's provision of training and technical assistance to an approach that utilizes local and regional expertise and focuses on the field at large, to broaden the audience of persons who benefit from federal resources for training on evidence-based approaches to treating mental and substance use disorders. ISMICC is one of the many tools that we have utilized to advance the use of evidence-based approaches to serious mental illness (SMI).

Dr. McCance-Katz stated that the ISMICC has accomplished much since its inaugural meeting in August 2017. For example, non-federal members developed a compelling set of 45 recommendations to address the needs of people living with SMI and severe emotional disturbance (SED) and their families. These recommendations were reported to Congress in

December 2017 and are being incorporated into the work of the 10 federal departments and agencies that comprise the ISMICC. Dr. McCance-Katz noted that she has been most impressed with the collective interest and dedication to this issue among her colleagues.

Dr. McCance-Katz reminded the non-federal ISMICC members that they are a FACA (Federal Advisory Committee Act) body and that they report to her directly as the Chairperson, designated by the Secretary of the Department of Health and Human Services. This means that any recommendations, progress reports, and updates come directly to her. She also advised the non-federal members that they are not authorized to implement ISMICC recommendations and that it is up to the individual federal agencies that comprise the ISMICC to pursue implementation.

Dr. McCance-Katz stressed the important role of non-federal members as ambassadors across the United States. They can provide insight on what is happening in communities and serve as liaisons to communities about the important steps that the ISMICC is taking. Federal coordination is not the end in itself and meaningful change will result as state and local governments, public and private organizations, and community members are also involved and engaged. She asked participants to consider how the ISMICC and other stakeholders can share this message across local communities.

Dr. McCance-Katz concluded by stating this would be the last ISMICC meeting for CAPT David Morrisette, Ph.D., LCSW, ISMICC Coordinator, and thanked him for his service.

Anita Everett, M.D., DFAPA, the new Director of the Center for Mental Health Services (CMHS), walked the meeting participants through the meeting agenda. She noted that the federal government has expressed a keen interest in the ISMICC, and SAMHSA wants to build on its accomplishments from the past year. She noted that 2018 was a year of alignment, appraisal, and action. We have aligned approaches across federal departments and agencies by identifying common missions and a shared vision; we have appraised programs and approaches to determine the state of knowledge in the field and to identify gaps; and we have established plans for many of the recommendations and acted upon them as opportunities have arisen.

Arne Owens, M.S., the Principal Deputy Assistant Secretary for SAMHSA, stated that he is well aware of the ISMICC's importance and is happy to support the good work and long-needed reforms occurring at SAMHSA.

ISMICC Federal Coordination, Strategy and Evaluation

Dr. Morrisette cited two important mandates for the ISMICC: (1) to improve coordination of federal agencies and departments that touch the lives of people with SMI and SED, and (2) to advance the ISMICC's 45 recommendations. He then guided the group through a visual representation or "roadmap" toward fulfilling the ISMICC mission. The starting point for the "Way Forward" is the ISMICC recommendations, and the final destination is higher-level strategies and actions. The stops along the way are shared vision, shared understanding, and initial strategies and actions. To reach the final destination, the ISMICC must engage federal departments, establish workgroups, seek expert input, identify federal levers, and engage state and local participation.

Dr. Morrisette continued that the aspirational nature of the ISMICC recommendations, combined with Dr. McCance-Katz's approach to engaging federal agencies, set a tone for federal responsiveness and collaboration from the start in early 2018. More than 55 federal staff have been assigned to implementation workgroups—based on their expertise and their department's mission—to support the recommendations. In turn, these workgroups convened expert panels of approximately 30 researchers, consumers, family members, providers, and funders to explore particular topics or concerns. The expert panels contributed to the development of strategies and actions to advance the recommendations. In November 2018, the committee completed an inventory of the federal members' activities that affect the provision of services and is now collating and analyzing the data. Next, the implementation workgroups will review the federal inventory specific to their focus areas and develop higher-level strategies to make the most of federal resources. Dr. Morrisette stressed that state and local public and private agencies must be involved in the process because they deliver most of the relevant services. He cited the National Association of State Mental Health Program Directors (NASMHPD) and the Mental Health America as examples of organizations that would like to support ISMICC's work. An evaluation of the federal effort was called for in the ISMICC authorization and indicators have been incorporated into the overall ISMICC plan.

Matthew Goldman, M.D., M.S., the first Mental Health and Substance Use Policy Fellow, summarized the language in the *21st Century Cures Act* that authorizes the ISMICC and describes the following responsibilities for its members:

- The ISMICC is required to summarize the advances made by federal programs for people with SMI and SED, much of which was completed in the first ISMICC report to Congress.
- The ISMICC is also required to undertake an evaluation of the effect that federal programs have on the health of people with SMI and SED, including:
 - Rates of suicide, suicide attempts, incidence and prevalence of SMI, SED, substance use disorders, overdose, overdose deaths, emergency hospitalizations, emergency room boarding, preventable emergency room visits, interaction with the criminal justice system, homelessness, and unemployment;
 - Increased rates of employment and enrollment in educational and vocational programs;
 - Quality of mental and substance use disorders treatment services; or
 - Any other criteria as may be determined by the Secretary or Chair.

Dr. Goldman added that the statute tasks the ISMICC with developing “specific recommendations for action that agencies can take to better coordinate the administration of mental health services for adults with SMI or children with SED.” The 45 recommendations are designed to improve outcomes for people living with SMI or SED and form the basis for the five implementation workgroups. To ensure that the ISMICC achieves these goals, Dr. Goldman's group developed a logic model to measure the progress of the ISMICC toward achieving its goals.

The logic model draws on an evaluation and management methodology for program evaluation to link the efforts of the ISMICC to actually improve the health, including mental health, of people with SMI and SED. The ISMICC convenes federal and non-federal members to develop

recommendations and strategic plans to advance coordination among stakeholders (Step 1). The federal, state, and local responses to these recommendations and plans should lead to changes in policies and programs (Steps 2a and 2b) that increase access to high-quality care (Step 3) and ultimately improved outcomes for people with SMI and SED (Step 4).

Specifically, Step 1 involves efforts to improve the coordination, alignment, and strategic alliances that are needed to reach a common understanding of the actions that will improve the health of people with SMI and SED. This step is characterized by meetings, reports, consultations, and development of work plans to facilitate coordination. The ISMICC Coordinator will collect data from these activities from the implementation workgroup stewards.

Step 2 represents actual changes at the federal, state, tribal, and local levels that result from improved federal coordination and alignment during Step 1. In Step 2a, federal responses may include the formation of *ad hoc* groups to improve coordination, dissemination of information, and uptake of policy changes. The primary data source for this step will be progress reports filed by federal members. In Step 2b, state and local responses may include dissemination of the ISMICC's activities, especially by the non-federal members, as well as actual uptake of ISMICC activities by state and local policymakers. Data sources for these activities will include a scan of media articles that reference the ISMICC, as well as input from various ISMICC members and partners in the field, such as the following:

- NASMHPD
- National Council for Community Behavioral Health
- Mental Health America
- Treatment Advocacy Center
- Professional Organizations
- Family and Caregiver Organizations

Step 3 links implementation to services, and is measured by indicators of access and availability of behavioral healthcare and quality indicators of treatment services, as mandated in subsections (a) and (c) of the statute that authorizes the ISMICC. Measurement of access draws on data sets such as the following:

- National Survey on Drug Use and Health (NSDUH) (SAMHSA)
- National Mental Health Services Survey (SAMHSA)
- Mental Health Block Grant state reports on health care utilization, (Agency for Healthcare Research and Quality [AHRQ])
- Medical Expenditure Panel Survey (AHRQ)
- Centers for Medicare and Medicaid (CMS) claims, CMS measure reports, and Department of Veterans Affairs (VA) data
- SAMHSA's Behavioral Health Workforce Research Center in partnership with the University of Michigan

The fourth and final step arrives at the impact of this process on the health and mental health of people with SMI and SED, as measured by the patient outcome indicators found in subsections (a) and b) of the statute. These outcomes include rates of suicide attempts and deaths, overdoses

and overdose deaths, incidence and prevalence of SMI and SED, hospitalizations, and social factors such as criminal justice involvement, homelessness, and unemployment. Although data on many of these outcomes are not routinely collected, the implementation workgroup on data, as well as a specialized quality team, are developing a strategy to compile relevant data from sources across HHS, including:

- Multiple Causes of Death, Wide-ranging ONline Data for Epidemiologic Research (WONDER), Centers for Disease Control and Prevention (CDC)
- National Center for Health Statistics (CDC)
- National Vital Statistics System: Mortality (CDC)
- NSDUH (SAMHSA)
- Health Care Utilization Project (AHRQ)
- CMS claims, CMS measure reports, and VA data

This data will inform the evaluation of the effect of federal programs on the health of people with SMI and SED and will lead to recommendations by the ISMICC to better coordinate the administration of mental health services across federal programs.

Discussion

Maryann Davis, Ph.D., Professor and Director, University of Massachusetts Medical School, said that it was helpful to see how each recommendation links to the logic model.

Kenneth Minkoff, M.D., Senior Consultant, Zia Partners, stated that the ISMICC should build on the work that has already occurred since the release of the recommendations by fleshing out the roadmap to better define implementation and evaluation activities within both SAMHSA and each federal department/agency. As an exercise, he suggested selecting several of the recommendations, determining how their final implementation would look (e.g., specific policy action by federal departments/agencies), and then working backward to identify all of the interim steps and actors. The federal departments/agencies must reach consensus on how to monitor and evaluate progress at the federal level and translation at the state and local levels, including metrics and data sources. He referred the ISMICC to Sandy Resnick, Ph.D., with the VA Office of Mental Health and Suicide Prevention, and Deirdre Gifford, Ph.D., with CMS, who could provide insight on strategies and resources to monitor progress. Dr. Minkoff explained that a state-level committee in Texas has created a statewide interdepartmental behavioral health strategic plan (i.e., ISMICC Recommendation 1.2). He relayed that the Texas committee chair would be happy to describe to the ISMICC how the committee developed the strategic plan and how the state legislature uses the strategic plan to structure state efforts.

Dr. Everett reminded the group that the recommendations are a set of content areas that involve many elements and actors, such as states and local stakeholders. The roadmap is a way to capture concrete activities. The project is not linear, and the work of the ISMICC at the federal level will hopefully stimulate activities at the state and local levels. Dr. Everett commented that the ISMICC will have been effective if it influences things much beyond what the actual recommendations are and that we work with what we can in the federal government, but also stimulate activities beyond what the federal government can impact. She suggested that participants discuss this topic in detail during the breakout sessions.

Mary Giliberti, J.D., Chief Executive Officer, National Alliance on Mental Illness (NAMI), said that the roadmap should capture strategies, implementation, and desired outcomes. She suggested that there be a direct link between proposed activities, the strategies they service, and the outcomes of those activities. Dr. Goldman responded that the workgroups could be tasked with thinking about how to concretely measure the actual progress of the ISMICC's work. He added that the logic model is intended to capture overarching themes and to organize tangible outcomes that can be measured. Because it crosses and flows through the committee's priorities, the model could help to identify strategies and activities.

David Covington, LPC, M.B.A., CEO and President, Recovery Innovations (RI) International, commented that the roadmap requires more direct connections to the focus areas and recommendations.

Linda Beeber, Ph.D., Distinguished Professor, University of North Carolina-Chapel Hill, suggested that the ISMICC should develop a baseline measurement table that lists the measurements that will be used right now and then review them annually. Dr. Morrisette replied that the lack of available data often makes it difficult to establish a baseline. In addition, the ISMICC efforts may not be able to influence how federal agencies collect data. Dr. Everett suggested that federal members attempt to stimulate data collection efforts in their departments.

Dr. McCance-Katz noted that no federal funds are available for implementation of the ISMICC recommendations. Although largely developed outside of the federal government, the ISMICC report on the status of mental health in the United States had a positive effect in the past year in several ways. For example, states can now apply for a CMS 1115 waiver to lift the Institutions for Mental Diseases (IMD) exclusion. In addition, the report resulted in reapportionment of funds for education and increased funds for mental health first aid. She maintained that the key to engaging federal departments/agencies is to be collegial and supportive recognizing that the agencies are trying to make changes and there are some limitations, particularly when there is no appropriation. Dr. McCance-Katz closed the session by imploring all non-federal members to continue to engage with state and local governments that have a bigger role to play than the federal government as they actually decide to take advantage of new opportunities such as through 1115 waivers and recent IMD exclusion opportunities.

Public Comments

Ms. Foote opened the telephone lines for public comments.

Karen Kincaid Dunn, Club Nova Community Inc., explained that Club Nova is part of the North Carolina House Coalition and a member of Clubhouse International. It is a comprehensive, highly integrated, community-based program that directly address the needs of people with SMI. Clubhouses predominately work with people with schizophrenia, bipolar disorder, and major depression, some of the most disabling and costly conditions. The Clubhouse model supports comprehensive programs that return members to employment and education and decrease the rates of suicide, homelessness, and incarceration. The model is cost-effective: a member can be supported for one year for less than the cost of one week of psychiatric hospitalization. Club Nova is committed to its members for life, and is known for its advocacy for regulations to support people with SMI. Clubhouse representatives are willing to speak to and serve on

ISMICC committees and workgroups. She thanked the ISMICC for their work. Ms. Foote thanked Ms. Kincaid Dunn for her comments.

Shannon Royce, Director of the HHS Center for Faith and Opportunity Initiatives, explained that the Center, which is the faith and community arm of HHS, invited two ISMICC members to attend a meeting in September to talk about building bridges between the faith community and clinical providers. The goal of these connections is to prevent people from entering the crisis end of the spectrum by getting them into care early. Because people often ask a faith leader for help, the Center provides faith leaders with the information they need to discern who is in need of mental health services. Ms. Royce offered the Center's support to the ISMICC and to share a short video of the Center's work.

Report Out on Expert Panels

Focus Area 1: Data Implementation Workgroup

Melissa Spencer, Deputy Associate Commissioner, Office of Disability Policy, Social Security Administration (SSA), reported that the many measures of SMI collected by each department/agency are not always the same. Two key issues emerged from this panel discussion. The first issue relates to quality measures and data drivers. The workgroup discussed how to drive change and identify useful measures of outcomes, with a focus on data (i.e., what data should be collected, why should it be collected, and how should it be collected). The workgroup agreed that it will be difficult to standardize data collection across departments/agencies, and therefore the workgroup should advocate for people with SMI and should proactively communicate the ISMICC's work and impact to oversight bodies. The workgroup also discussed the utility of a standard definition for SMI. Workgroup members suggested collecting the different department/agency definitions of SMI to determine their alignment and potential for harmonization. The second issue relates to expanding beyond the data currently being collected to measure progress along the roadmap. Ms. Spencer referred to Dr. Minkoff's suggestion to work backwards from an agreed-upon long-term goal to identify the incremental steps.

The workgroup agreed that collecting mortality data is worthwhile to identify connections between people with SMI and higher incidences of smoking, motor vehicle accidents, and mortality in general—acknowledging that recording of deaths differs across federal departments/agencies. The panel also acknowledged that departments/agencies will not change their data collection processes unless they see the benefit in doing so.

Dr. Minkoff mentioned the importance of the work of Clayton Chau, M.D., Ph.D., Providence St. Joseph Health, to identify a set of core quality measures. Although important, death and suicide rates are not collected in a meaningful way for the purpose of measuring and tracking progress. It might be productive to identify quality measures that are already in use (e.g., emergency department visits) and then consider how they can be collected consistently at the national level. Dr. Chau added that New York, Vermont, and California have already worked on a core measure related to the SMI population. Rather than repeat this work, the panel should solicit and agree on recommendations from the states.

Dr. McCance-Katz added that the CDC collects mortality and suicide data. There have been discussions about partnering with CDC to access these data as they pertain to SMI. In addition, CDC could be invited to join the ISMICC, as an expert on data collection.

AT THIS POINT ERIC HARGAN JOINED THE MEETING

Comments by Eric Hargan, J.D., Deputy Secretary, HHS

Dr. McCance-Katz introduced Eric Hargan, J.D., Deputy Secretary, HHS. Mr. Hargan commended Dr. McCance-Katz and the ISMICC members for their progress to date to address the needs of people with SMI and SED across the country, starting with the development of an impressive set of policy recommendations and the formation of implementation workgroups. He thanked all the members of the ISMICC—the non-federal members for devoting considerable time and attention to the committee’s work and the federal members for coming together in this historic collaboration. He said that everyone’s perspective is necessary to address the intersecting challenges of education, employment, housing, law enforcement, and health care that people with SMI and SED face.

Mr. Hargan mentioned the 10/10/10 issue. Each year approximately 10 million Americans live with SMI, which can shorten their lifespan by 10 to 15 years. In a given year, Americans with SMI spend 10 times more time in jail than in inpatient psychiatric treatment. Furthermore, SAMHSA’s annual National Survey on Drug Use and Health has revealed discouraging signs regarding our nation’s mental health. From 2016 to 2017, there was another statistically significant increase in the percentage of 18- to 25-year-olds who have had a major depressive episode within the past year. More than one in eight Americans from that age group now have a major depressive episode in a given year. The share of 18- to 25-year-olds with any mental illness rose to one in four and the share with a SMI rose to one in 15.

In many ways, the U.S. health care system is not well set up to handle SMI and SED. However, the administration is acting to address this reality, including work by CMS with the *21st Century Cures Act* to better support inpatient treatment for persons with SMI. HHS looks forward to working with states on the 1115 waivers, because it is the combined responsibility of the state and federal governments, alongside communities and families, to work together in support of more treatment options, such as inpatient and residential services to help stabilize Americans with SMI.

Mr. Hargan explained that the Federal Commission on School Safety convened by the President in March 2018 has considered mental illness in its deliberations. He stressed the importance of early detection and noted that it will be important to find ways to provide early detection and mental health services in schools. He concluded his comments by noting that with the input of all involved with the ISMICC we can make significant steps under this administration toward creating a health care system that is actually set up to treat serious mental illness.

Focus Area 2: Access Implementation Workgroup

Dr. Everett mentioned that, before the ISMICC began its work almost two years ago, public comments largely focused on the lack of access to services for transition age youth (15-25 years) who were manifesting symptoms of SMI, despite coverage on their parents’ health insurance

policy. Dr. Davis noted that each of the workgroup's recommendations is relevant in some way to transition age youth and suggested that the workgroup add a member with expertise in transition age youth to ensure appropriate attention to their needs. Dr. Everett confirmed that the workgroup could add such a member as the ISMICC moves forward. She added that Dr. Justine Larsen, M.D., M.P.H., M.H.S., Senior Medical Advisor, SAMHSA, is a child psychiatrist, is a very active steward of workgroup three and that CMHS has a strong division on child and family-oriented services.

Connie Wells, Owner/Manager, Axis Group, LLC, suggested that the ISMICC also find ways to increase the involvement of youth, families, and consumers in its work to better model the system and care principles upon which it was founded. In fact, the efforts of workgroups two and three on an earlier initiative will establish some of the groundwork for the tools and places on which the ISMICC might focus, particularly in the pediatric space. Richard McKeon, Ph.D., M.D., Chief, Suicide Prevention Branch, SAMHSA, added that workgroup two is reviewing work by the Department of Defense and the Health Resources and Services Administration (HRSA) that affects youth and families to identify gaps and next steps.

Mr. Covington addressed the "I" in ISMICC, which reflects a major shift in the approach to mental health care in which HHS is playing an integral role. He referenced both a letter about IMD opportunities and integration, as well as a speech by Secretary Azar to CMS directors, highlighting the need for a complete continuum of care and the expectation that states will act to improve community-based mental health care. Mr. Covington listed some of the necessary elements of this continuum of care, such as a crisis call center, community-based care, and facility services that cover acute care. He said that the CMS letter and the Secretary's speech cited the ISMICC recommendations, Crisis Now, and the need for initial baseline assessment of states' crisis continuums, with built-out capacity, particularly for crisis stabilization programs.

Dr. Beeber discussed how to map predictive analytics onto the level of care utilization system tool Level of Care Utilization System (LOCUS) and access the predictive analytics that VA developed through the Vet Reach. These efforts might improve understanding of how risk relates to utilization of care. This workgroup focused on ISMICC recommendations 2.1, 2.2, and 2.5.

- 2.1:** Define and implement a national standard for crisis care;
- 2.2:** Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternative to hospitalization;
- 2.5:** Establish standardized assessments for level of care and monitoring of consumer progress

Mr. Covington mentioned the SAMHSA planning meeting about the *National Suicide Hotline Improvement Act*, which suggests a three-digit emergency telephone number for crisis, mental health, addiction and suicide prevention (akin to 911). The legislation was passed by Congress and signed by President Trump. The VA and SAMHSA are expected to make a series of recommendations to the Federal Communications Commission (FCC) in February 2019 to move

the N11 suggestion forward to link people with needed services. (Currently, 611 is the only N11 number that has not been assigned by the FCC.) A SAMHSA network of 165 crisis centers—the National Suicide Prevention Lifeline—answers calls to 1-800-273-TALK. About two million calls per year are made to that number, of which 700,000 are directed to the VA and its Veteran Crisis Line (by the caller pressing “1”). Another estimated 14 million calls per year go through those 165 call centers, but through myriad local, county, and state crisis lines. The callers who are directed to the VA receive service akin to 911, but the remaining callers receive variable support. Mr. Covington noted that on November 13, 2018, CMS sent a letter to State Medicaid Directors that outlines both existing and new opportunities for states to design innovative service delivery systems for adults with SMI and children with SED. The letter includes a new opportunity for states to receive authority to pay for short-term residential treatment services in an IMD for these patients and this new vision about a three digit number for mental health crisis services indicate ISMICC-connected efforts.

Ms. Giliberti expressed her support for a telephone number for mental health emergencies, which will not only benefit families, but also raise the national consciousness about mental health as equal in importance to physical health. From her experience staffing the NAMI call line, she knows that people fear that a call to 911 could result in a response that harms rather than helps their loved one. She stressed the importance of articulating the standards for services that follow a 611 call, as well as standards for treatment and stabilization in emergency departments (which must be provided regardless of the patient’s ability to pay, per the *Emergency Medical Treatment and Labor Act*). Dr. Beeber added that the 611 concept is good as long as supporting services are available, which is an issue that has been raised repeatedly. She suggested that agencies could coordinate by linking different data sources, such as the National Instant Criminal Background Check with suicide death rates, to better understand how these things predict each other.

Mr. Covington added that each state follows a different approach. He stated that NAMI and others are working to advance first episode psychosis services and to improve the related billing mechanisms HCPCS and CPT codes. He reasserted that the ISMICC must address the continuum, that is, what services are expected, what those services look like, and what are the thoughtful, replicable billing mechanisms that can be scaled across states.

Mr. Covington referenced Case and Deaton’s work about diseases of despair. These investigators amalgamated suicide deaths, opioid overdose deaths, and deaths related to alcohol abuse to show an unprecedented spike in rates, especially among individuals who are white and not college educated. Recent data from the CDC suggest that rates will likely increase. He added that the states’ assessments of their crisis continuum need not be abstract or generic. NASMHPD has launched Crisisnow.com, which links to the Beyond Beds series, which works toward a full continuum of psychiatric care for affected individuals. The site offers a Crisis Resource Need Calculator, which estimates the optimal crisis system resource allocations to meet the needs of a community, as well as the impact on health care costs associated with incorporation of those resources. With this information, states can then stratify demand using a tool such as (LOCUS) to predict the capacity needed across gradients, that is, mobile crisis, call center hubs, and residential and acute care. Mr. Covington clarified that LOCUS is in the public domain and has been the dominant tool in the field for years. The electronic version offers tools to help with treatment planning.

Dr. McKeon asked how emergency department data could contribute to the understanding of how visits are recorded. He added that SAMHSA, VA, FCC, and the HHS Office of General Counsel meet every two weeks to discuss the *National Suicide Hotline Improvement Act*. SAMHSA must submit its report to the FCC in February 2019 and its report to Congress in August 2019.

Dr. Minkoff added that the need for standardization of data tracking and usage will increase as this initiative spans the country, because states and payers do not share a common language for how the different levels of care are named, defined, and reimbursed. He explained that he is co-chair of the Community Psychiatry Committee for the Group for the Advancement of Psychiatry, which is defining objective measures for an ideal crisis system. A draft version will be available in spring 2019 and will address community oversight, monitoring, and funding; performance accountability based on age group and level of care; and the necessary clinical practices.

Focus Area 3: Treatment and Recovery Implementation Workgroup

Jennifer Sheehy, M.B.A., Deputy Assistant Secretary, Office of Disability Employment Policy (ODEP), Department of Labor (DOL), stated that the workgroup utilizes two subcommittees: (1) Housing led by Tracie Pogue, MDIV, LSW, Public Health Analyst, Office of the Chief Medical Officer (OCMO), SAMHSA, and (2) Employment led by Richard Davis, M.S.W., Policy Advisor, ODEP, DOL.

Housing Subcommittee

Ms. Sheehy explained that the subcommittee discussed access, measurement, definitions, best practices, and knowledge gaps. The subcommittee identified two main issues related to access: (1) the capacity of housing authorities, and (2) gaps in knowledge of what is available. She added that discussions about access to housing usually focus on adults and adults with families. However, it is important to consider transition age youth, who often are not eligible for housing programs until age 18, but then face very long wait lists. Providing access to wait lists before age 18 could reduce the amount of time that these youth must fend for themselves.

The subcommittee discussed what should be measured and how. Members suggested counting the number of: (1) calls to emergency lines or for first responders to remove people from the street, (2) homeless people, and (3) people on wait lists. However, these counts would exclude people who live with friends or cobble together housing where they can find it. Measurement is complicated by the fact that agencies have differing definitions of homelessness and program eligibility. Ms. Sheehy suggested that the housing subcommittee and the data workgroup work together to address this definitions issue.

Housing takes many forms (e.g., group, independent, supported), and “one size does not fit all.” For example, designating a transition age youth to live with a group of middle-aged adults is an unsustainable solution. The Department of Housing and Urban Development (HUD) youth demonstrations that explore differing housing models (that could include youth with SMI) might provide insight on this topic. Other topics warranting investigation are (1) the housing needs of families with children with SED, and (2) the extent to which public housing authorities consider people with SMI when making decisions about 811 Housing Choice Vouchers.

Employment Subcommittee

Ms. Sheehy explained that this subcommittee views employment as both a treatment strategy for people in recovery and a prevention and treatment strategy for people experiencing an SMI episode. There is an important need to close the gaps between what is offered and what works. Several provisions in the *Workforce Innovation and Opportunity Act of 2014* are intended to support transition age youth, which will take some time for states to fully implement. Ms. Sheehy reported that DOL has increased its focus on youth in terms of programs and funding. For example, states must direct 75 percent of DOL funds for youth programs to serve disconnected youth. States must also direct funds to school programs and vocational rehabilitation. Citing Maryland as an example, the subcommittee plans to share examples of model programs to ensure that young people, particularly those with disabilities, receive the supports they need to transition to community college, university, or jobs. The subcommittee will also look for best practices from other countries. For example, Australia requires employers to hang posters about mental health services in workspaces (similar to the Occupational Safety and Health Administration requirement for safety posters).

Ms. Sheehy stated that well-intended policies sometimes create unintended barriers to employment. For example, in one state, recovering opioid addicts do not qualify for suboxone if they are not employed, but they cannot work if they do not have suboxone. One possible solution to this “Catch 22” situation would be to link employment services with suboxone clinics. Another barrier relates to language, or semantics. That is, the naming of programs as “disability” programs causes many people with SMI or SED, particularly youth, to not access them because they do not identify as being disabled. Outreach and dissemination of information about programs should be designed so that people with SMI or SED do not self-determine themselves as ineligible. The subcommittee also identified the persistence of stigma in the workplace as a barrier, which can only be overcome if employers work to build trust as a source of mental health services.

Ms. Sheehy referenced DOL’s Job Accommodation Network (JAN). The network is free, accessible by email, text, phone, and askjan.org, and provides one-on-one consultation regarding accommodations for any type of disability or job. JAN also offers videos on training and toolkits specific to accommodation and disability. In addition, DOL’s website, DRIVE, is a comprehensive website of outcome statistics for people with disabilities. Ms. Sheehy requested input on how federal agencies can better disseminate information to all stakeholders.

Peter Earley, Author, stated that another barrier to employment is the restrictions placed on people receiving Social Security Disability Insurance (SSDI) on the amount of income they can earn. Ms. Sheehy responded that the SSA has strived to make work programs flexible, but the message has not been effectively communicated. Elena Kravitz, CPRP, Director, New York Association of Psychiatric Rehabilitation Services, added that a part of the problem is that people receiving SSDI benefits may actually earn more if they do not work than if they do work, if heating expenses, food stamps, housing assistance, and other benefits are factored into the equation.

Ms. Kravitz mentioned that people on Conditional Extension Pending Placement status in hospitals need a lot of wraparound support services, which often are not provided. Similarly, in some state institutions, people cannot leave until they participate in some sort of program, which

is often not available, causing them to decompensate while they wait. Furthermore, very few hospitals/institutions can meet the unique support needs of people with dual diagnoses (DD) or co-occurring disorders. Expanding on this comment, Dr. Minkoff stated that many housing and employment programs do not know how to deal with people who want to be housed and/or work while continuing to actively use substances. Therefore, a worthwhile effort will be to determine strategies to implement an array of services that meet the needs of those people in a way that does not force them to lie about their substance use, which creates a host of unhealthy dynamics. Some of these strategies could also be used to support people with other kinds of co-occurring disorders, such as cognitive disability and mental illness. Dr. Larson explained that SAMHSA had an expert panel to address the gaps in services for the DD population and is looking very closely at the link between substance use and suicide. Ms. Kravitz suggested that another worthwhile effort is to close the training gap for mental health workers, most of whom are not equipped to deal with supported employment.

Mr. Earley noted that people with SMI and in the criminal justice system experience difficulty securing housing, because many public housing authorities immediately reject people with a criminal record. He added that the 30 percent requirement of many states for the Housing First program is too onerous. He encouraged the group to consider the 18-year-olds coming out of foster care. Dr. Larson stated that the workgroup has discussed supported education, as well as supported employment, with a focus on youth leaving foster care and transition age youth who need to work but also need to attend school to improve their chances of success.

Rhathelia Stroud, J.D., Judge, Dekalb County Magistrate Court, also stressed the importance of supported housing for people who are thrust into the criminal justice system. Without housing, they are not eligible for diversion programs or accountability court, where their charges are dropped and their records are restricted. Ms. Kravitz suggested that the committee research some of the better criminal justice reentry programs across the country.

Ms. Sheehy mentioned that DOL has a National Community of Practice with 2,600 members that coordinates policy, funding, and practice at the state level to support employment for people with SMI. Mr. Davis added that Provider VOICE (Visionary Opportunities to Increase Competitive Employment), an ODEP initiative, awarded grants to 11 states in 2018 to engage with the mental health system in awarded states. He added that the gold standard for employment is individualized placement and support (IPS), but less than three percent of people with SMI who would benefit from IPS have access to it. DOL is working with states to identify the barriers to accessing IPS, which likely are a combination of outdated policy, lack of funding, limited availability of practice, and insufficient training of mental health workers.

Mr. Davis stated that more tailored and efficient outreach and marketing to widely disseminate information about, for example, benefits, programs, training opportunities, and technical assistance, could help to move the needle. However, in some cases it is likely that the ISMICC will identify a lack of funding as the true root cause. He wondered whether the ISMICC has a process in place to address that issue. Dr. McCance-Katz reminded the group that there is no committee process for acquiring more funding and that laws restrict lobbying of Congress by federal members.

Focus Area 4: Justice Implementation Workgroup

Mr. Earley introduced the workgroup members (see Appendix B). He organized his report according to the focus area recommendations.

4.1 Support interventions to correspond to all stages of justice involvement. Consider all points including the sequential intercept model.

The workgroup discussed zero intercept and how crisis care lines, mobile crisis response teams, and respite centers can serve to reduce the involvement of law enforcement as much as possible. Implementation of this recommendation will involve the identification of appropriate metrics and ways to leverage federal dollars.

4.2 Develop an integrated crisis response system to divert people with SMI and SED from the justice system; and 4.3 Prepare and train all first responders on how to work with people with SMI and SED.

Mr. Earley explained that recommendations 4.2 and 4.3 cannot be addressed separately. Furthermore, they cannot be achieved without the involvement of the access, crisis, and finance workgroups—that is, any fix to the mental health system must include social connectivity, housing, and jobs.

Ron Bruno, Founding Board Member and Second Vice President, CIT International, added that, although this workgroup is focused on justice, the intent is to separate the criminal justice system from the crisis system. One way to do this is to better train law enforcement (albeit part of the criminal justice system) to become better responders to mental health crises. The workgroup has debated the pros and cons of following a generalist or specialist model to train law enforcement officers.

Mr. Bruno complimented the workgroup's plans to bundle newly developed and already published information, technical assistance toolkits, and other research-based and practical implementation resources. These technical packages will be publicly available and will align with the sequential intercept model.

4.4 Establish and incentivize best practices for competency restoration that use community-based evaluation and services.

Mr. Earley explained that federal members are working to identify best practices. The workgroup has discussed how best to explain these best practices to states during policy planning meetings. The workgroup also discussed where and how competency restoration is accomplished, and whether felonies and misdemeanors are treated differently.

4.5 Develop and sustain therapeutic justice dockets in federal, state, and local courts for any person with SMI or SED who becomes involved in the system.

Mr. Earley stated that no action has occurred on this recommendation. It will be prioritized after actions on the preceding recommendations have been completed.

4.6 Require universal screening for mental illnesses, substance use disorders, behavioral health aids for every person booked into jail.

Mr. Earley explained that Chief Steven Amos of the National Institute of Corrections, Jail Division, will provide advice on this recommendation. It is anticipated that the workgroup will develop a technical package to assist sheriffs and jail administrators. The workgroup has discussed existing programs such as the WONDER Stepping Up initiative and how to engage the states in this effort.

4.7 Strictly limit or eliminate the use of solitary confinement, seclusion, restraint, or other forms of restrictive housing for people with SMI and SED.

Mr. Early explained that the Federal Bureau of Prisons could best lead this effort. However, the Bureau is not involved in the ISMICC. He suggested that ISMICC members encourage the Bureau to accept the invitation to become a member—or to become involved in another capacity.

4.8 Reduce barriers that impede immediate access to treatment or recovery services upon release from correctional facilities.

The workgroup believes that access to treatment and recovery services after release from a correctional facility is primarily a housing issue. Mr. Earley suggested that criminal justice programs could leverage SAMHSA's SOAR (SAMHSA's Outreach, Access and Recovery TA Center) program.

4.9 Build on efforts under the *Mentally Ill Offender Treatment and Crime Reduction Act [MIOTCRA]*, the *21st Century Cures Act*, and other federal programs to reduce incarceration of people with mental illness and co-occurring substance use disorders.

Mr. Earley expressed the workgroup's understanding that some of the MIOTCRA funding was devoted to mental health but at the discretion of the Department of Justice (DOJ). He wondered whether the ISMICC can offer recommendations about the distribution of those funds. Dr. McCance-Katz said that SAMHSA has no purview over how DOJ uses its resources; however, the new relationships and collaborations between SAMHSA and other agencies may contribute to agencies seriously considering ISMICC recommendations. The workgroup agreed that collaboration and cooperation is a key to achieving the ISMICC's goals.

Ms. Spencer stated that her office, the SSA Office of Disability Policy, must provide evidence to support changes to policy and regulations. She noted that groups such as the ISMICC are a great source of information and evidence-based recommendations.

Larke Huang, Ph.D., Director, Office of Behavioral Health Equity, SAMHSA, confirmed that conversations with ISMICC members are valuable for understanding each recommendation. She stated that the workgroup is discovering new information that is valuable not only for inclusion in the technical packages but also to identify policy levers the agencies can collaboratively pull to advance some of these recommendations.

The workgroup is also researching the juvenile justice system with a literature review and environmental scan. Ms. Wells stressed the importance of documenting the good programs and

practices that are identified by research, such as probation officers who model for the parents how to be caregivers and set boundaries.

Focus Area 5: Finance Implementation Workgroup

Ms. Giliberti praised CMS for issuing a well-thought-out state Medicaid Director letter. She organized her comments in the order of this workgroup's recommendations.

Regarding recommendation 5.1, Ms. Giliberti wondered whether alternative payment methods can be used to incentivize or disincentivize the high rates of re-hospitalizations and readmissions for particular SMIs, such as schizophrenia and psychosis. Dr. Gifford mentioned the Medicaid and Children's Health Insurance Program (CHIP) Scorecard initiative to look at state-by-state measures. The first scorecard was issued in June 2018, and two new scorecards will be issued in mid- and late 2019. The scorecard captures follow-up after hospitalization for mental illness, and at least 25 states are reporting on the 7-day and 30-day measures. The purpose of the scorecard is to provide additional transparency and a focus on quality measures in the Medicaid and CHIP program, which aligns well with the work of the ISMICC. In some states, the funding flow for the community mental health provider differs from that for inpatient hospitalization. As a consequence, any incentive for payment strategy would work only if the community mental health provider and the hospital are both included in the same managed care contract for the individual. An additional barrier could be the hospital readmission payment penalty program, which applies to people with SMI.

Ms. Giliberti reported that the workgroup is making progress on recommendation 5.2, quality measurements and standards for CHIP and Medicaid. She said that the workgroup received some information about the report on financing community-based care and certified community behavioral health clinics, which is awaiting clearance.

Regarding payment methodologies, the workgroup discussed bundled payments, with the potential to work with the Center for Medicare and Medicaid Innovation (CMMI) to research coordinated specialty care for first-episode psychosis and other services, such as supported employment and supported housing.

The workgroup thoroughly reviewed the contents of the state Medicaid director letter and how to approach IMDs under the letter's guidelines. CMS is working to refine and finalize the measures that states will need to report on. She mentioned that non-federal members can contribute to the final list of measures for state reporting.

The workgroup also discussed different way to cover housing supports, including a short-term bridge rent payment for people waiting for a voucher. The workgroup also raised the possibility of collaboration between Medicaid directors and housing experts, akin to CMS's Innovation Accelerator Program (IAP).

Dr. Gifford explained that the IAP is a joint partnership between CMMI and the Center for Medicaid and CHIP to provide on-the-ground technical assistance to states in designing and implementing payment and delivery system reform innovations. A popular feature of the program has been the development of partnerships with state housing agencies to maximize the

amount of funding received through Medicaid. Unfortunately, as a time-limited program, the IAP is winding down.

Ms. Giliberti explained that supported housing and employment are often funded under a 1915(c) or 1915(i) waiver programs, which some states have reported barriers to use. The workgroup discussed ways to incentivize states to pay for crisis care, because the ISMICC emphasizes crisis throughout its report.

Dr. Gifford commented that the first half of the State Medicaid Director letter explains how states can use existing authorities to pay for some of the services that are important for people with SMI and SED. A lot can be accomplished under state plan authority, which is not always clear to states. However, just because the authority exists does not mean that the “money” exists to utilize the authority.

Ms. Giliberti said that one ISMICC recommendation calls for payments to behavioral health providers that equal those to other providers. The workgroup discussed the role of parity in addressing rate disparities and the difference between in-network and out-of-network payments to reach the non-quantitative treatment limits. The workgroup considered developing strategies for rate setting.

Dr. Gifford added that with Medicaid, unlike Medicare, CMS cannot influence what states pay providers. However, CMS can influence access; the statute requires that people with Medicaid have access to services equal to those of people without Medicaid in the same geographic area. Therefore, to the extent that access can be measured, this is the mechanism by which CMS can influence how much states pay their providers. However, access to care is difficult to measure.

Dr. Minkoff suggested that the workgroup consider how to systematically involve the state Medicaid directors in understanding the ISMICC’s broader objectives and in considering ways to involve non-Medicaid payers, perhaps through state departments of insurance. He stated that it is difficult for Medicare to pay for the full continuum of crisis services. Dr. Everett responded that no codes reflect this continuum; therefore, a way to characterize what level of service is provided must be established and agreed upon.

Dr. Gifford explained that there is a chronic care management code in Medicare, which is a new development. She added that people must qualify with a certain number of chronic conditions. The provider must also meet certain qualifications to use the care management code in billing. She suggested that the ISMICC engage an expert who can better inform its deliberations about how to broaden the scope of Medicare.

Dr. Minkoff asked whether the number of people who receive high-end psychiatric services and are lost to follow-up is measured and tracked. Dr. Gifford responded that before summer 2018, all of the Medicaid and CHIP measures were voluntarily reported by states. With the CHIP reauthorization in summer 2018, Congress made reporting of the child core measure sets mandatory as of 2024. In addition, in the recently passed bill on opioids, Congress made reporting of the adult behavioral health measure core mandatory. She added that CMS has been working with states to upgrade the national Medicaid dataset (i.e., Transformed Medicaid

Statistical Information System (T-MSIS). CMS will soon be able to calculate some of the claims-based measures without relying on state reporting.

Summary and Final Comments

Dr. Everett thanked the participants for their time and attendance. ISMICC members are welcome to provide feedback about the structure of these meetings, which should serve not only to report progress on the ISMICC's work, but also to foster discussions.

Dr. Everett introduced Dr. Tom Clarke, who directs the SAMHSA National Mental Health and Substance Use Policy Laboratory, and Doug Slothouber, a Public Health Analyst with the Policy Analysis Branch who has supported the ISMICC's work from the very beginning. She also thanked Dr. Arlen Hatch, SAMHSA's Clinical Psychologist, in SAMHSA's Office of the Chief Medical Officer, and Rosemary Payne, SAMHSA's new Chief Nurse.

She informed participants that leadership is working to restructure CMHS activities around the ISMICC, which is where it is now housed. The ISMICC has posted a new leadership position, which will report to Dr. Everett. She hopes that the new person will bring a strength in communications, which is necessary to "get the word out." Dr. Everett again thanked Dr. Morrissette for his commitment and service to the ISMICC.

Dr. Minkoff added that the non-federal members will likely provide organized input on how to best track progress of the recommendations. This will include identifying measurable outcomes, identifying the data that are available to measure the baseline, measuring the baseline, working with each department/agency to determine next steps, and then tracking the process in small iterative steps over time. Dr. Everett said CMHS will carry that process forward.

Dr. McCance-Katz closed the meeting by thanking everyone for attending in person, which she believes adds value to the discussions. She added that all changes to the ISMICC and next steps will be clearly communicated. She restated her goal to keep the federal partners engaged and commended the federal members for their diligent work.

Ms. Foote adjourned the meeting at 4:25 p.m.

Appendix A: Meeting Agenda



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Washington, D.C. 20201

**U.S. DEPARTMENT OF HEALTH AND HUMAN
SERVICES
INTERDEPARTMENTAL SERIOUS MENTAL ILLNESS
COORDINATING COMMITTEE MEETING**

December 11, 2018
9:00 a.m. to 5:00 p.m. (EST)
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Room 05A02 and 05A03 (Pavilion Area on 5th Floor)
Rockville, Maryland 20857
Agenda

Toll Free Number: 800-369-3143; Passcode: 4784259
Live Stream Link: <https://2020archive.1capapp.com/event/ismicc/>

OPEN SESSION

- 9:00 a.m. Call to Order/Committee Roll Call**
- 9:05 a.m. Welcome and Opening Remarks**
- Consideration of the Minutes for the ISMICC Meeting of June 8, 2018**
- 9:15 a.m. Charge to the Committee and Meeting Overview**
- 9:30 a.m. ISMICC Federal Coordination, Strategy and Evaluation**
- 10:15 a.m. Break**
- 10:30 a.m. Break Out by Focus Area**
- Focus Area 1: Data**
Toll Free Number: 888-982-4690; Participant passcode: 2076410
- Focus Area 2: Access**
Toll Free Number: 800-369-3143; Participant Passcode: 4784259
- Focus Area 3: Treatment and Recovery**
Toll Free Number: 888-989-4573; Participant Passcode: 7214379
- Focus Area 4: Justice**
Toll Free Number: 888-957-9872; Participant Passcode: 9818236

Focus Area 5: Finance

Toll Free Number: 888-390-0867; Participant Passcode: 6794706

- 12:00 p.m.** **Lunch Break**
- 1:00 p.m.** **Public Comments**
- 2:00 p.m.** **Focus Area 1: Data. *(Report out and discussion)***
- 2:30 p.m.** **Focus Area 2: Access. *(Report out and discussion)***
- 3:00 p.m.** **Break**
- 3:15 p.m.** **Focus Area 3: Treatment and Recovery. *(Report out and discussion)***
- 3:45 p.m.** **Focus Area 4: Justice. *(Report out and discussion)***
- 4:15 p.m.** **Focus Area 5: Finance. *(Report out and discussion)***
- 4:45 p.m.** **Summary and Final Comments**
- 5:00 p.m.** **Adjourn**

Appendix B: Official List of Meeting Participants

U.S. Department of Health and Human Services
Interdepartmental Serious Mental Illness Coordinating Committee Meeting
December 11, 2018
5600 Fishers Lane
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