NACBHD
National Association of
County Behavioral Health Directors

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Bulletin

HIPAA Gets the Green light; Are You Ready???

"Wake up. Don't wait until it's too late," warns Gary Weiskopf, Executive Director of the New York State Conference of Local Mental Hygiene Directors and Chairman of NACBHD's HIPAA Committee. The Bush Administration has given the go-ahead to the Health Insurance Portability and Accountability Act (HIPAA) and is set to begin implementing the patient privacy rules right away. While HIPAA will take two years to implement and may undergo some changes along the way, Weiskopf stresses that behavioral health providers cannot afford to be complacent but must take steps now to meet the new requirements. "The scariest part," he says, "is that many providers don't even know it exists."

Before putting HIPAA back into play, President Bush made only one change in the Clinton administration regulations giving parents the right to see their children's health records. Beyond that, the rules' core elements are unlikely to change, although there may be some modifications. When he made the announcement in mid-April, HHS Secretary Tommy Thompson said the department will issue guidelines, modifying the regulations and clearing up confusion that still surrounds the complex rules. During the comment period HHS received a flurry of lobbying and 24,000 written comments.

Intensely debated by lawmakers for over ten years, the rules require health care providers to get permission before disclosing personal patient information. While, for the first, patients will have the right to inspect and request corrections to their medical records, fines and other penalties will be exacted from those who improperly disclose medical information. For county behavioral health care providers and their contractors the rules - which apply to every organization that uses computers to manage information related to payment for or delivery of health services - will mean considerable administrative adjustment. Weiskopf says changes will have to be made in three areas:

Code Sets for Electronic Health Transactions. HIPAA "will allow health plans to pay providers, authorize services, certify referrals and coordinate benefits using a standard electronic format for each transaction," says former Chief Counsel in the NY State Office of Mental Health Paul Litwak, who has over 20 years experience in behavioral health care. The standard code sets will be established by HHS. Currently most states have their own local code sets. "There are thousands and thousands of these codes," groans Weiskopf. "It's going to be a big challenge to change them."

The final code sets have not yet been released by HHS. When they are, they will be circulated among Behavioral Health organizations for comment. To Weiskopf the best case scenario is that states, counties, providers, everybody agree on certain code sets. Asked what happens if they don't, Weiskopf says they have to, "there is no choice".

But preliminary code sets released by the agency last August reveal challenges for both health plans and health providers. For instance, says Litwak, "it will be necessary to switch from use of the UB-92 for inpatient billing to the X12N-837 codes, which are used in fewer than three percent of all health transactions. In addition, operating procedures will have to be changed and staff retrained. Health providers will have to modify software systems, a costly process and ensure that purchased software is HIPAA compatible.

The behavioral health system faces a particular challenge because "the code sets selected by HHS do not capture information that is commonly used to manage both public and private behavioral health programs", reports Litwak, adding that it is prohibited to add to or change the standard sets. HHS has acknowledged this problem, saying in effect, that it doesn't know of any code sets that cover behavioral health any better. Litwak says that it would behoove anybody who has developed such sets to bring them to the attention of HHS, but he warns the processes for doing so are "complicated and time-consuming".

Fraud and Abuse. This component of HIPAA is the one that concerns Weiskopf the most. He urges behavioral health care providers to review their fraud and abuse systems and to establish policies and procedures, because without them there is no defense in the case of a mistake. For instance, "if you bill under the wrong code, it could be seen as

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fraud," reports Weiskopf. Not only, he says should behavioral health providers put their own houses in order but they must also ensure that business partners with whom they are linked electronically be in compliance too. The regulations require this be done contractually through "business partner agreements".

The HIPAA security rules fall into four categories, according to Litwak:

Administrative procedures. Health providers must certify that their computer systems meet security requirements, establish formal security policies, appoint a security officer, train staff, conduct regular screening audits, screen personnel with access to protected information, establish procedures for termination of access to information systems when a person leaves employment and enter "chain of trust" agreements with their business partners.

Physical Safeguards. Physical safeguards required by HIPAA include facility security, controls on physical access to workstations and servers that contain protected health information, media controls, equipment inventory controls, data backup and disaster recovery procedures.

Access to Protected Data. Proposed technical security requirements to guard data integrity, confidentiality and availability include access controls (passwords, user identification, etc.), audit mechanisms, authorization control, and entity and individual authentication procedures.

Data Transmitted Over a Network. Proposed technical security requirements, governing data transmitted over a communications network, include access controls and authentication procedures. But they also mandate encryption of protected health information transmitted over an open network, including the Internet. Many health organizations use electronic mail to exchange confidential health information. If e-mail is routed within a "closed" network, which maintains security through appropriate identity authentication and access control procedures, use of e-mail without encryption is okay. If such electronic mail is transmitted over the Internet or another "open" network, the message must be encrypted.

Privacy Rule. "If you send medical records to a doctor, there have to be provisions so that they don't end up in a deli somewhere." Weiskopf puts HIPAA's privacy provisions in a nutshell, adding that there also have to be procedures that allow some medical data to be transmitted but not necessarily everything in a patient's file. For instance, if a doctor needs to know something about a patient's appendix, he should not also be given that patient's HIV status.

To comply with HIPAA all covered entities must "establish detailed privacy policies and procedures, appoint a privacy officer, train staff, post notice of privacy policies and inform patients of policies relating to disclosure of health records," says Litwak. The privacy rule sets a floor of minimum standards governing how health plans and covered health providers protect the privacy of confidential health information. HIPAA supercedes all or part of state privacy laws unless the state laws are more stringent. This provision ensures that privacy laws will vary from state to state, according to Litwak and may lead to confusion in the interpretation of certain requirements, including the following:

- An exception to HIPAA privacy rules allows a covered entity to disclose protected health information without authorization to carry out treatment, payment or healthcare operations. Thus, a mental health professional may keep separate psychotherapy notes of a private, group or family counseling session, but must get patient authorization for release of those notes. However, the exception does not apply to identifying information, medication prescription and monitoring, modalities of treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date. In contrast, federal Substance Abuse Confidentiality regulations prohibit federally funded substance abuse programs from disclosing patient identifying information without the written consent of the patient, except when needed to respond to a medical emergency. Because the substance abuse regulations are more stringent, they apply; the HIPAA regulations

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Bulletin

NACBHD

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HOW TO PREPARE FOR HIPAA COMPLIANCE

Paul Litwak, Attorney at Law

1. Are you a “covered entity” subject to HIPAA? Do you use computers to transmit information to health plans? If not, you may be exempt from HIPPA.

2. If you are a therapist, think about how you keep records. Do you want to maintain personal psychotherapy notes to prevent disclosure of some patient information?

3. If you work for a large organization, brief your Board of Directors and get senior management. “buy-in ” for HIPAA compliance, which may be time consuming and expensive. Get the cooperation of all major departments of the organization, and appoint a senior person to coordinate HIPAA readiness efforts.

4. Have your attorney conduct a detailed review of state privacy law relative to the HIPAA Privacy Rules to determine which law should be followed in the state (or states) in which you do business. —Better yet, encourage a statewide or national trade association to engage an attorney or law firm to prepare this analysis and provide guidance in plain English. This is a lot of work and will be expensive.

5. Look around. Think about privacy. Is personal health information visible on desks or computer screens? Do people keep passwords on sticky notes? Can personal records be retrieved from the trash? What can you do to limit accidental disclosure of confidential information?

6. Appoint a Privacy Officer. Get to work on development of privacy policies and procedures.

7. Have an attorney review your business relationships to determine if business associate agreements are required. Build HIPAA required provisions into new contracts. Revise existing contracts during the next contracting cycle.

8. Develop or purchase consumer oriented communications, including the notice of privacy policies, consent and authorization forms.

9. Develop or purchase HIPAA training programs for your workforce. Complete training before the compliance date.

10. Conduct a security audit of your information systems. Be certain that you have effective identity authentication procedures, role based access controls, audit capability, appropriate physical security, encryption capability, and secure query and reporting functions.

11. This is the big one. Find out whether your computer system is capable of exchanging information in accordance with HIPAA transaction code standards. If not, get help quickly. Work with your software vendor or an information systems company that can provide “translation” capability for legacy software systems.

12. If you are licensing software or entering an arrangement with an application services provider, make sure that software products support HIPAA privacy requirements and that the ASP meets HIPAA security standards. Be sure that license and hosting services agreements address these issues properly.

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do not. Similarly, state laws governing disclosure of mental health records that are more stringent than the HIPAA rules would be applied.

- Individuals are entitled to review their health records unless a healthcare professional determines that release of the record to the individual would be reasonably likely to endanger the life or physical safety of another person. State laws on this subject are not uniform. Some state laws allow treating clinicians to limit access to mental health records if there is a risk of any serious harm to the individual or others, including psychological harm. In that case, the HIPAA rule would supersede state law because it is more favorable to the individual seeking access to his or her record.

Another part of the rule that concerns Litwak is a requirement that covered entities enter into written agreements with any business partner with access to protected health information. The business partner must promise to protect the privacy of health information in a manner consistent with the covered entity. The contract must state that individuals whose health records are disclosed are third party beneficiaries of the business partner agreement. Says Litwak, “The effect of this rule is to open the back door to federal court for individuals who are harmed as a result of illegal disclosure of their health records”. Litwak adds that a number of the written comments submitted to HHS questioned the Secretary’s authority to “create this legal right”.

NACBHD'S WEB SITE UNDERGOES FACE LIFT

We are pleased to announce a major revision of NACBHD's Web Site at www.nacbhd.org. After a year of living with the site and understanding how it is used, we are moving forward to clarify, revitalize and reprioritize the information we select to make sure it is useful to both members and interested individuals. Look for a new look in the next couple of months and further announcements.

The President's 2002 Budget: Taking Away From Mental Health Programs; Adding Funds for Substance Abuse Treatment

Although mental health research will pick up funding through the National Institute for Mental Health, block grant funding has not been increased and SAMSHA is slated to lose $16 million in funding for mental health-related projects, if the President's budget proposal is adopted. In announcing the HHS portion of the budget, Secretary Tommy Thompson put the emphasis on "new and innovative" solutions primarily to promote the health of children and families. The department's $468.8 billion proposed budget (an increase of 8.9%) features an additional $2.9 billion for children's programming.

A more moderate winner in the proposed budget is substance abuse services, which would get an additional $100 million to increase the availability of drug treatment services. This would close the gap between demand for treatment and number of treatment slots. Substance abuse block grant funding would also be increased by $60 million.

But 'mental health' was conspicuous by its absence from Thompson's speech. "The threat is there," says Andrew Sperling, Deputy Executive Director for Policy at the National Association of Mental Illness (NAMI), "the administration has a whole bunch of priorities and mental health does not appear to be one of them."

This point of view is backed up by the numbers from the proposed budget. Mental Health block grants, for example , were level funded. This, says Sperling, is disappointing for two reasons: 1) It doesn't allow for population growth and higher costs. 2) Demand for mental health treatment is growing. He adds that because of the complex block grant funding formula, which takes into account factors like population, relative poverty and unemployment, fast growing states like Nevada will get more money but others will actually receive less. Without an upward adjustment, as many as thirty states may lose block grant money. Sperling, however, is optimistic that Congress will restore some of the funding. He says it's important to make a grass roots effort in states with senators on the key Labor, Health and Human Services Appropriations Subcommittee, including PA, AL, IA and WV.

The budget would also cut $16 billion from SAMSHA in one-year member projects ($11 million) and a number of five-year projects ($5 million), including an evaluation of the homeless program ACCESS, and a demonstration-housing program. In both cases the projects were due to expire anyway, notes Sperling, adding that NAMI would not have chosen to cut there; "there are a lot of other things worthy of being cut or terminated at HHS." President of the National Mental Health Association, Michael Faenza, would agree. Noting that the Bush administration has decided to go ahead with implementation of the Olmstead Supreme Court decision, Faenza expressed concern about cutbacks in housing programs. Olmstead requires states to move people who are inappropriately housed in institutions.

Sperling hopes that mental health advocates will see the President's proposals as a call to action. "It will be easy for these programs to be cut if members of Congress don't hear about it." He says that in the meantime NAMI and other organizations are working to educate the new HHS Secretary and they are finding him "somewhat responsive."

On the plus side, the National Institute of Mental Health is getting a 10.6% increase in funds. While this is substantial, it isn't as large as other institutes at NIH are getting and thus, disappointing to mental health advocates.

Another positive occurrence is President Bush's intent to establish a national commission on Mental Illness Treatment Services. Part of the President's New Freedom Initiative, announced in January, a commission blueprint has yet to be established.

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Budget Surpluses May Mean Opportunities for Mental Health in Congress

If the threat to mental health is the administration's lack of interest, the "opportunity is that we do have a budget surplus," says NAMI Deputy Executive Director for Policy Andrew Sperling. That and some recent declarations of independence in the Senate make Congress the place to watch this spring. While cautioning that Majority Leader Trent Lott (R-MS) does have some ability to push through the President's agenda, Sperling admits that "because of the way the Senate operates, any single senator can seriously dislodge the legislative process." As an example, he points to the reduction made by the Senate in the proposed tax cut as a result of two Senators refusing to go along with the President's proposal. In addition to the 2002 budget, there are other measures to watch in Congress:

Mental Health Equitable Treatment Act. Since its introduction in March, this parity bill has picked up 24 co-sponsors from both sides of the aisle. It would prohibit a health plan from treating mental health benefits differently from medical and surgical benefits. Thus, limitations can only be put on mental health coverage, if they are also applied to medical and surgical coverage. The bill may go in regular order from committee mark-up to the Senate floor or it may be attached to another bill, depending on the discretion of co-sponsors Sens. Pete Domenici (R-NM) and Paul Wellstone (D-MN), says Sperling. "Our job right now is to get more co-sponsors. We have to have a critical mass of co-sponsors (35-40). We're well on our way but we've got a ways to go too."

Family Opportunity Act. This legislation would enable states to offer Medicaid coverage to children with severe disabilities through a buy-in program. It is currently in the budget resolution of both house and senate, which means the money is reserved to pay for it, eliminating objections on budgetary grounds. Introduced last year by Senators Charles Grassley (R-IA) and Edward M. Kennedy (D-MA) the bill would help families, who are sometimes forced to relinquish custody of severely mentally ill children in order to get treatment for them.

Medicare Mental Health Modernization Act. Introduced in early April by Senator Paul Wellstone (D-MN) and Representative Pete Stark (D-CA), the measure would end Medicare's discrimination against individuals with severe mental illness. The bill would remove the 50% co-payment requirement for outpatient mental health services, eliminate the 190-day lifetime limit on inpatient psychiatric care, add coverage of intensive community-based and residential services, and expand the pool of state-licensed mental health professionals covered by Medicare.

The Bush Administration Speeds Up Review of Medicaid Waivers

Since the beginning of February, HHS has approved more than 170 waivers for health plans in 48 states. In a recent speech, HHS Secretary Tommy Thompson said that speeding up waiver approval is part of a new partnership with states that gives state governments more flexibility in running Medicaid programs. According to Thompson, "What works in New York City doesn't necessarily work in Green Bay, WI."

At the end of April the two latest states to receive waivers were PA and CO. PA won an extension of its primary care case management system under which health care services for Medicaid patients are coordinated by one physician. CO received renewal for its state-run managed mental health plan.

Starting Over With the IMD Payment Exclusion

NACBHD has joined other national, state and county organizations in calling for the elimination of Medicaid rules prohibiting payment for behavioral health treatment in residential programs with more than 16 beds. The Institutions for Mental Diseases (IMD) Payment Exclu-

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MAY IS MENTAL HEALTH MONTH

The National Mental Health Association (NMHA) first started Mental Health Month over fifty years ago and since that time it has become one of the country's most recognized health observances and an excellent opportunity to bring mental health concerns and issues to the attention of the American Public.

This year with the help of organizations and communities across the country, NMHA will focus on the critical role mental health plays in the lives of all Americans, using the slogan **Mental Health Matters**.

Mental Health Month materials can be obtained from NMHA at (703) 838-7534 or publicationsales@nmha.org.

NACBHD'S 6TH Annual Conference: Thriving In Turbulent Times

The National Association of County Behavioral Health Directors is pleased to announce its 6th Annual Conference, July 12 – 14 at the Westin Philadelphia Hotel, Philadelphia, PA. This year's conference focuses on workforce issues, examining this critical topic from a variety of aspects. You will hear from a seasoned executive recruiter, the head of a research institute for social and a facilitator who will lead a brainstorming session designed to help us create a statement that reflects a remedy to the recruitment and retention crisis as we experience it. Phil Rosenberg, NACo's own "H.R. Doctor", shows us how to create a compelling environment and other retention strategies. A new session, just added – Henrico County, VA's model for building a diverse organizational structure to provide for more culturally competent staff, leadership team and services.

The Mega Session on Information Technology comprises several intriguing topics from web-based applications to a model system for shared access of Medicaid information in New York. This is a great opportunity to catch up on the latest developments and learn about new technologies in this rapidly changing part of our business.

In line with this focus and in response to growing demand, we introduce The Display Area – a space set-aside for companies to present their products and services. A variety of vendors will be displaying this year – software, publishing, management, and consultants. Browse the tables to find out who is doing what and where the innovations are. Take home samples and bring home new ideas to share.

We are delighted to welcome Ms. Estelle Richman, Director, Social Services, Office of the Managing Director, City of Philadelphia, as our keynote speaker this year. Ms. Richman is formerly the Philadelphia Health Commissioner and will share her thoughts on the current challenges of a large metropolitan county system. She is a dynamic speaker and will provide a wonderful kick-off to the conference. With so much going on in Pennsylvania, you won't want to miss the Pennsylvania State Report. Spend time learning about developments in both MH/MR and drug and alcohol abuse systems as well as the Philadelphia (Medicaid managed care) Story. Finally, hear about one county's provider network.

Children's behavioral health takes center stage with such sessions as school-based mental health models, a presentation on WrapAround Milwaukee and the Juvenile Justice Roundtable. Seasoned professionals will share their experiences, and give you a chance to interact

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sion came breath-takingly close to abolition at the end of the last administration when a federal task force recommended it be revised. The matter was on the desk of HHS Secretary Donna Shalala awaiting action, says Sherry Knapp, CEO, Hamilton County ADAS Board (OH) and Chairman of NACBHD's Substance Abuse Committee, but "she didn't get around to it."

The rule is pernicious not only because it forces small treatment programs to search for other sources of funding (a quest with uncertain results), but it also puts patients in the position of having to chose between different types of health care. A patient who opts for mental health or substance abuse treatment in a facility with 16 beds or less, loses Medicaid coverage for everything. Thus, if the patient has health problems, he or she has a difficult choice to make between treatments for physical or emotional health. Although she has no statistics, Knapp says there have been many anecdotal instances of people who leave residential treatment programs because they need medical attention. Those patients may end up being treated by an outpatient facility but that ignores the reasons they may have been in a residential facility in the first place, which could include homelessness, a negative home environment or a non-supportive family.

The IMD exclusion has always been a particular aggravating factor in the area of treatment for substance abuse. Knapp calls it, "a thorn in our side for 20 years." The exclusion has made it difficult for substance abuse treatment providers to offer treatment as well or as efficiently as they'd like. A 30-bed program, through economy of scale, is cheaper to run than three ten-bed programs. Yet, Knapp asserts, "a 30-bed program can be just as valuable, just as beneficial, just as high quality as a ten-bed one."

Although there have been complaints about the exclusion for years, Knapp says that in the past year a lot of different factors have come together to eliminate it. "The stars", she says, "have aligned." One of those stars was a line in the federal budget last fall, calling on HHS to address the issue, which places an "unfair burden" on the community health system. That, says Knapp, is a pretty powerful thing for Congress to say.

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with them and learn adaptable strategies to take home. There are many other sessions and presenters to hear – don't miss the best show around for county/local behavioral health directors!

The 2nd Annual Thomas E. Wernert Award for Innovation in Community Behavioral Healthcare will be presented during our Awards Luncheon. This proved to be a moving and poignant event last year, and we look forward to celebrating this year's winners.

The City of Philadelphia provides a great backdrop for our conference. Philly is a wonderful city, rich with many historical and cultural locations and events.

I would like to thank this year's Conference Program Committee for their help and support: Chairperson: Deborah Donaldson (KS), Members: Elizabeth Miosi (PA), Mike Chambers (PA), Steve Ashby (NC), Steve Dungan (NY), Barbara Droher (MN) and Sherry Knapp (OH). It is membership participation that makes the conference program informative and relevant.

If you have not already done so, register today. Don't miss this grand opportunity to network with professionals who experience and understand your perceptions and concerns. You can register on our web site at www.nacbhd.org in the conference section or by faxing or mailing the registration form in your brochure. Call the NACBHD office at (202) 234-7543 or Lauren@nacbhd.org to request a form. In order to be registered, you must submit a completed form for every person from your organization who will be attending. The hotel registration number is 1-888- 627-8153. Tell them you are a NACBHD conference participant to get the special rate.

Positions Available

Director Mental Health

Mecklenburg County
Charlotte, North Carolina

Directs business and clinical operations of a large mental health agency comprised of 647 employees and a budget of approximately $78 million. In a managed care environment, provides a variety of services related to mental health, developmental disabilities and substance abuse. Develops strategic direction and collaborates with community leaders and multiple providers to achieve comprehensive implementation of services and agency goals. Reports to an Assistant County Manager and works in partnership with the Human Services Council. Masters degree in mental health, public health, psychology, social work, nursing, business, hospital or public administration and five years professional work experience in a community, business, governmental program or in a human services or health related field including three years supervisory, administrative or consultative experience; or a bachelor of science degree in one of the fields listed above and seven years experience as stated above including three years supervisory, administrative or consultative experience; or an equivalent combination of training and experience. Salary range $70,579 - $119,984 with competitive benefits package including 457or 401K contribution by the county. Qualified candidates should submit resume to:

County Human Resources
600 East Fourth Street, 5th floor
Charlotte, NC. 28202-2836
Internet: http://www.co.mecklenburg.nc.us
EOE M/F/D/V

WELCOME TO NEW NACBHD MEMBERS IN 2001

Henry Stough, Montgomery Area MH Authority, Inc, AL
Ted Citron, Cobb/Douglas CSB, GA
Steven Katkowsky, Fulton County, GA
Don Anderson, Humboldt County, IA
Patricia Murray, Central Kansas MH Center, KS
Rick Gray, Area Mental Health Center, KS
Robert Blankfeld, Baltimore County Bureau of Mental Health, MD
Stanley Groff, Steele County Human Services, MN
Daniel Hanratty, Big Stone County Family Services, MN
Dean Settle, Community MH Center of Lancaster County, NE
Susan Delehanty, Franklin County Services, NY
Jodi Demo-Hodgins, Crawford-Marion ADAMH Board, OH
Michael Schoenhofer, MH & Recovery Board of Allen, Auglaize & Hardin Counties, OH
Bernard LaCasse, Clatsop Behavioral Healthcare, OR
David White, Jefferson County Mental Health, OR
Deborah Wilson, Curry County Human Services, OR
Tom Boshell, Liberty Healthcare Corp., PA
Penn Ketchum, Lancaster County MH/MR, PA
Leonard Lackey, Danville-Pittsylvania CSB, VA
Mark Freedman, Thurston-Mason RSN, WA

CALENDAR OF EVENTS

May 20-23: The National Council of Juvenile and Family Court Judges. Mental Health Issues in Juvenile Justice. Alexandria, VA. Call 775-786-6012.

May 23-26: National Association of Alcoholism and Drug Abuse Counselors. Annual Conference on Addiction Treatment: "Research to Practice." Portland, OR. Call 800-548-0497.

June 6-9: National Mental Health Association. Annual Conference. "Justice for All-Addressing America's Mental Health Disparities." Washington, D.C. Call 800-969-6977.

June 8: Center for Psychiatric Rehabilitation, Boston University. Integrating the Recovery Process into Existing Programs. Boston, MA. Contact Blana Yanulis at 617-353-3549.

June 10-13: New York State Office of Mental Health. Best Practices Conference: A Gathering of Experts in Implementing the Canon of Knowledge Surrounding Effective Treatments for Mental Illness. Brooklyn, NY. Contact Sue Watson at 518-473-3605 concerning conference agenda/activities and Donna Peri at 716-328-5190, ext. 32, concerning registration.

June 18-21: The Substance Abuse and Mental Health Services Administration. National Women's Conference. "A Generational Journey: Women Carrying the Vision." Orlando, FL. Visit www.samhsa.gov

June 23-26: National Association for Rural Mental Health. 21st Century Rural Mental Health: Challenges and Opportunities. Wilmington, NC. Contact LuAnn Rice at 320-202-1820.

July 12-14: The National Association of County Behavioral Health Directors. Sixth Annual Conference. Philadelphia, PA. Call 202-234-7543.

July 29-31: National Association of State Mental Health Program Directors. NASMHPD Summer 2001 Commissioners' Meeting. Call 703-739-9333.

August 23-26: National Mental Health Consumers' Self-Help Clearinghouse. Alternatives 2001. Philadelphia, PA. Call 800-553-4539.

NAMI WELCOMES NEW EXECUTIVE DIRECTOR

Dr. Richard Birkel, formerly President/CEO of the Lt. Joseph P. Kennedy Institute in Washington, DC, began with NAMI on April 23rd. Prior to the Kennedy Institute, Dr. Birkel was a professor at University College, University of Maryland, Director of the Washington Business Group on Health's National Center on Work-site Health Promotion and a faculty member, Pennsylvania State University. "Rick Birkel brings to NAMI proven skills as a strategic leader of non-profit organizations and a keen perspective as a family member of people who live with severe mental illness", says Jacqueline Shannon, President of NAMI's Board of Directors.

NACBHD welcomes Dr. Birkel, and looks forward to a continuing productive partnership.

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