

This issue is funded through a grant from the Agency for Healthcare Research and Quality.

Outlook

FALL 2004



*a publication of the
National Association of State Mental Health Program Directors Research Institute, Inc.*



TABLE OF CONTENTS

INTRODUCTION	3
MEDICAID AND BEHAVIORAL PHARMACY	3
Dr. Richard Surles and Dr. Keith Schafer of Comprehensive NeuroScience, Inc.	
INTEGRATING INFORMATION TECHNOLOGY CREATES SERVICE OPPORTUNITIES FOR PUBLIC AND PRIVATE MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS NATIONALLY	5
Martin Sipkoff	
SYSTEM TRANSFORMATION, STRATEGIES FOR CHANGE, AND DATABASED DECISION MAKING	8
A. Kathryn Power, M. Ed., Director, Center For Mental Health Services Substance Abuse And Mental Health Services Administration U.S. Department Of Health And Human Services	
CONTACT INFORMATION	12

INTRODUCTION

In February 2004, the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) held its Fourteenth Annual Conference on State Mental Health Agency Services Research, Program Evaluation and Policy. The theme of the Conference was: "Dollars and Sense: Using the Knowledge Base to Inform Decisions and Practices in a Time of Limited Resources".

Included in this OUTLOOK are articles highlighting three major issues facing state mental health agencies today: the rapidly rising cost of pharmaceuticals; benefits of integrating information technology; and mental health system transformation toward a system that values the consumer, is recovery-oriented, and guided by informed decision making.

The information offered in these articles is only a small piece of the information shared at the Conference. Abstracts and slide presentations for nearly every session are available on our web site: www.nri-inc.org.

The Fifteenth Annual Conference will be held in Baltimore, Maryland on February 6-8, 2005. Please check our web site for updates (www.nri-inc.org).

MEDICAID AND BEHAVIORAL PHARMACY

Dr. Richard Surles and Dr. Keith Schafer of Comprehensive NeuroScience, Inc.

Drs. Richard Surles and Keith Schafer of Comprehensive NeuroScience, Inc. are pioneers in linking private technologies with public mental health systems. As former commissioners of large state mental health agencies, they are intimately familiar with the intricacies of exploring public sector databases and conducting research on characteristics of persons receiving services from the public mental health systems whose care is paid by Medicaid, the SMHA, or both. Of particular interest is the rise in Medicaid and SMHA expenditures for the latest atypical psychopharmacological agents to treat schizophrenia, bipolar disorder, and severe depression. In addition to their presentation at the

2004 NRI conference on assessing the costs of non-therapeutic levels of dosing with these drugs and its impact on physician practice, patient outcome, and system cost, they provided the following data about the larger costs of pharmacy in the current public mental health system.

Health care spending in the United States reached \$1.6 trillion in 2002, with almost half paid by government. The first half of the \$1.6 trillion purchased hospital care and physician and clinical services. Private expenditures totaled \$839.6 billion, or 54.1

percent of all health spending. Private health insurance paid for 35.4 percent, out-of-pocket sources for 13.7 percent, and other private sources such as philanthropy for 5.0 percent. Then, government paid for the remaining 45.9 percent of spending, or \$713.4 billion, through programs such as Medicaid and Medicare with the Medicaid program accounting for approximately \$249 billion of the government spending in 2002 (Centers for Medicare and Medicaid Services).

The \$1.6 trillion figure means that health care spending averaged nearly \$5,440 per person in 2002. Prescription costs comprise the fastest

continued on page 4

growing component of health care market. For the government, prescription drugs alone accounted for nearly 10% of its total Medicaid spending in

behavioral health has become very significant, accounting for only 12% of all prescriptions and about 30% to 40% of its total Medicaid pharmacy spending.

Medicaid prescription drug coverage has become a principal focus of states' cost-containment efforts since it is the first (second in some states) in cost to states accounting for about 15% to 20% of total state spending.

2002 (\$25 Billion). In 2000, prescription drug sales increased by almost 20% and in 2001 spending on drugs rose about 16%. While the rate of growth on prescription drugs costs slowed in 2002 to 15.3%, drug spending remained the fastest-growing item in health care. That trend is expected to continue for the next 10 years. Thus, Medicaid prescription drug coverage has become a principal focus of states' cost-containment efforts since it is the first (second in some states) in cost to states accounting for about 15% to 20% of total state spending. In particular, behavioral health pharmacy is

patients, the high cost of medications, and the enormous movement of new drugs to the market by pharmaceutical companies. In 2002, there were 99 new medicines in development for mental illnesses alone and in 2003 pharmaceutical companies spent an estimated \$33.2 billion on research and development of new medicines.

States are reacting to increased Medicaid drug costs. In 2002 alone, 210 legislative bills on prescription

drugs were considered in 39 states with 31 passed. In 2003, 49 states reported making Medicaid cost-containment a priority. The states are adopting multiple strategies to control drug use

cial. These strategies include pharmacy management that falls into several categories such as price (e.g. preferred drug lists (PDLs), rebates), drug mix (e.g. generic substitution, step therapy, etc.), utilization (e.g. quantity limitations, drug utilization review (DUR), etc.), clinical management (e.g. profiling, pharmacy case management, disease management, etc.) and limiting product access (e.g. prior authorization, limiting number of scripts, clinical edits, etc.) Currently the focus is on PDLs with supplemental rebates to try bringing down prices and change drug mix. There are risks as well as

A cost-only approach may harm patients since it focuses on drug limitations that could result in increased ER visits or increased hospital admissions.

benefits, and the system is neither data driven nor quality-focused. Targeting essential drug classes with heterogeneous patient responses and side effects could reduce appropriate care, adversely affect health status, and cause shifts to more costly types of care. A cost-only approach may harm patients since it focuses on drug limitations that could result in increased emergency room visits and increased hospital admissions. In the long run, a quality-focused approach is critical to manage costs. This approach would be more clinically grounded and politically palatable. ▲

The most significant drivers of this growth in American pharmaceutical expenditures are the volume of drugs prescribed to and consumed by patients, the high cost of medications, and the enormous movement of new drugs to the market by pharmaceutical companies.

a growing concern to all states. The states' Medicaid spending on

and reduce the rate of annual cost increases, but they are not all benefi-

INTEGRATING INFORMATION TECHNOLOGY CREATES SERVICE OPPORTUNITIES FOR PUBLIC AND PRIVATE MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS NATIONALLY

Martin Sipkoff, Health Care Journalist, Gettysburg, PA

Information technology (IT) — from clinical record maintenance to billing — is becoming increasingly cost effective for community mental health centers and psychiatric facilities, say experts, especially when software functionality is fully integrated. In fact, state mental health program directors are finding it's increasingly difficult for any local program to be successful without integrated IT.

For many mental health program directors, the initial IT investment made by mental health programs is for accounting and billing software. But — primarily because of limited funding — some industry watchdogs estimate that less than half of all behavioral health clinics and small practices have purchased practice management software. And such software is a growing necessity, say experts.

cannot upgrade its current system because of poor purchase decisions at the front-end.

The demand for integrated and comprehensive information systems will only increase over the next few years, according to A. Kathryn Power, M.Ed., director of the Center for Mental Health Services of the federal Substance Abuse and Mental Health Services Administration.

In remarks at the February 2004 14th Annual Conference on State Mental Health Agency Services Research in Washington, D.C., in February 2004, Powers said that "Information technology is the force that can pull and keep all four levels together as we cross the quality chasm. It is the continuous link we need between science to service

"An effectively integrated system leverages the value of all operations within an agency by creating ways to solve problems, not just process information."

—Lonnie Watson,
Chief Technology Officer for Tidgewell Associates Inc. (TAI)

"Tasks are monumentally more difficult without an integrated system," says Lonnie Watson, chief technology officer for Tidgewell Associates Inc. (TAI), behavioral health technology consultants in Cranston, Rhode Island. (TAI was an exhibitor at the 2004 NRI Conference.) "An effectively integrated system leverages the value of all operations within an agency by creating ways to solve problems, not just process information."

Medicare, Medicaid, and private behavioral health insurance plans; managed behavioral health treatment authorizations; certifications; and recertifications.

The cost of integrating an information system that manages the many service and billing components of a mental health/substance abuse center's practice varies widely, anywhere from several thousand dollars to tens of thousands of dollars, and much more if a facility

The demand for integrated and comprehensive information systems will only increase over the next few years...

and service to science, as driven by consumer- and family-driven needs.... Output from online decision support

continued on page 6

systems will have to be responsive to consumer needs on an individual level, while the system itself is based on standardized data that permit comparison with benchmarks and other users.”

The software should collect and report data that reflect diagnosis codes, referral patterns, levels of functionality, individual patient scheduling compliance — virtually any outcomes measure imaginable.

SAMHSA maintains a grant writing assistance program for assisting community mental health centers in obtaining IT funding. Information is available at <http://alt.samhsa.gov/Grants>.

Upgrading and integrating is an investment well worth making, says Mark Tidgewell, TAI President. And funding assistance is obtainable. “The range of applications possible and their importance can’t be overstated. The result of being able to collect and disseminate data within an organiza-

Tidgewell stresses the importance and cost-effectiveness of integrating current software programs.

tion is invaluable to quality, safety and to the bottom line,” he says.

Tidgewell stresses the importance and cost-effectiveness of integrating current software programs. One example is the ability to organize data to

demonstrate outcomes and create claims filtering software that is adaptable to any existing information technology. The software should collect and report data that reflect diagnosis codes, referral patterns, levels of functionality, individual patient scheduling compliance — virtually any outcomes measure imaginable.

That data are used to establish and develop treatment pattern reports for third parties, to project staffing needs and service costs, and assess personnel and individual center performance. Recently TAI used a facility’s current software installation to develop a geographical map of population addiction patterns.

The goal is to get data into the hands of clinicians where and when they need it, especially at the point of care. That results in greater operating efficiency. In addition, public and private payers are increasingly demanding demonstrated outcomes to maintain and renew contracts. That kind of service evaluation is dependent on integrated information technology. “It’s always possible to work with existing systems, to integrate seemingly disparate elements,” says TAI’s Watson. “It’s the most cost-effective way to go.”

Service value notwithstanding, when mental health directors consider

updating their systems, the costs can seem prohibitive. But help is available. For example, the Health Services Research Web Sites of the National Institutes of Medicine National Library of Medicine (<http://www.nlm.nih.gov/nichsr/hsr-sites.html>) lists several helpful resources.

Seacoast Mental Health Center Inc., in Portsmouth, N.H., for example, received state funding to implement an IT system several years ago, money the agency sought aggressively. “All behavioral health organizations are operating on shoestring budgets,” says Chris Drew, Seacoast’s chief information officer. “We all have to be creative. Just about the only way to afford

Service value notwithstanding, when mental health directors consider updating their systems, the costs can seem prohibitive. But help is available.

technology is by looking for grant dollars. The money probably can’t come from patient fees or insurance.”

Drew is correct, according to his peers. A 2004 survey of more than 200 health care facility chief information officers, including mental and behavioral health facilities such as community mental health centers, by the Healthcare Information and Management Systems Society, found that nearly a fourth of CIOs say lack of adequate funding is the single biggest

continued on page 7

obstacle to adequate information technology implementation.

In most cases, information technology ranks near the bottom of behavioral

It's always possible to do it smart and cost-effectively, often by taking advantage of what you already have.

health budget priorities, observers say. "If our grant had not been earmarked for technology, it would have gone to staffing or some other need," says Drew. "The key is to make the most of what you've got."

Seacoast utilizes a thin-client approach to maximize its IT dollars, i.e., it maintains three servers and all existing desktop PCs serve only as terminals. "We have an integrated software package that processes information from scheduling to billing to generating claims," says Drew, "and we do so cost effectively."

There are specific considerations a mental health, mental retardation or substance abuse program should take into account when either installing or upgrading information technology. When an organization or facility makes a software purchase decision, it should consider its flexibility and be certain that the cost of servicing the software is not a prohibitive added cost.

In addition to service requirements, too many mental health program directors fail to consider a system's

ability to expand and its aptitude for increasing productivity when making their initial purchase. Organizations purchase systems often seem to fail when asked to do something that's out of the ordinary, such as ad hoc reporting or adjusting to changes in state contract requirements. It may well be a service that is obtainable in existing software, but

the initial contract didn't call for that kind of help from the vendor. That's the kind of issue to consider when signing a contract.

It's always possible to do it smart and cost-effectively, often by taking advantage of what you already have.

Richard Lieberman is an information systems specialist with the County of Northampton's Department of Human Service in Easton, Pennsylvania. For the last several years, he has been implementing software the county uses to comply with the state's managed mental health initiative, HealthChoices. He agrees that flexibility is critical in purchasing behavioral health software.

"Applicability and the ability to readily modify are the two key elements anyone making a decision about behavioral health software programs should consider upfront," says Lieberman. "States are constantly rewriting compliance requirements, and if you have

to go back and pay your vendor every time, it can become very expensive."

It is critical "not to give the sellers all the power," says Watson. For example, he strongly recommends that facilities demand that vendors provide all applicable source code. "We've had clients that wanted to upgrade and integrate programs for which they spent a fortune," he says, "but they can't because they don't have access to the source code that forms the foundation of their purchase. They have to discard the system and start over. That is expensive and should be unnecessary."

The importance of painstaking front-end decision-making in choosing software, with an emphasis on versatility, can mean thousands of dollars in savings for a facility. The ability to integrate across systems is probably the

The importance of painstaking front-end decision-making in choosing MHSA software, with an emphasis on versatility, can mean thousands of dollars in savings for a facility.

most important element of any software purchase. Using IT in the most productive way possible should be the goal of any purchase. That's achievable, and a necessity. ▲

For more information contact Ann Bennett at www.taisoftware.com or call 877-899-1110.

SYSTEM TRANSFORMATION, STRATEGIES FOR CHANGE, AND DATABASSED DECISION MAKING

By A. Kathryn Power, M. Ed., Director, Center For Mental Health Services
Substance Abuse And Mental Health Services Administration
U.S. Department Of Health And Human Services

*Excerpts of the Keynote address given at the NASMHPD Research Institute's 14th Annual Conference on
State Mental Health Agency Services Research, Program Evaluation and Policy*

February 9, 2004, Arlington, VA

The Center for Mental Health Services (CMHS) is charged with leading the national system that delivers mental health services. I am

informed decision making. In this system, the highest quality of mental health care and information will be available to consumers and families, regardless of their race, gender, ethnicity, language, age, or residence.

Commission recommends changes in how a broad range of data are collected, shared, and used at the national, state, community, and consumer levels.

*This report, entitled **Achieving the Promise: Transforming Mental Health Care in America**, calls for major change in how mental health care services are organized and delivered.*

Achieving this transformation, however, means overcoming existing impediments to high-quality mental health

Achieving the Promise echoes the conclusions drawn earlier by the Institute of Medicine (IOM) in its report called *Crossing the Quality Chasm: A New Health System for the 21st Century*². The IOM report states that, between the quality of health care Americans have, and that which they could and should have, “lies not just a gap, but a chasm.”

charged with leading the agency in addressing the emerging challenges and opportunities presented to this system. My greatest challenge—as well as the greatest opportunity—is to facilitate the transformation of the mental health care system called for in the President's New Freedom Commission on Mental Health report. This report, entitled *Achieving the Promise: Transforming Mental Health Care in America*¹, calls for major change in how mental health care services are organized and delivered. In a transformed system, the Commission envisions that mental health care will be consumer- and family-oriented, focused on recovery, and guided by

care for all Americans. The Commission found that, despite enormous investments in the scientific knowledge base and the development of many effective treatments, many Americans are not benefiting from these investments. Treatments and services based on rigorous clinical research are too slowly applied in practice. Consumers and clinicians alike lack access to the information they need to guide decision making. To eliminate these impediments, the

The Commission found that, despite enormous investments in the scientific knowledge base and the development of many effective treatments, many Americans are not benefiting from these investments.

In terms of databased decision making, the IOM identified two specific forces that are impeding quality health care:

continued on page 9

- The growing complexity of science and technology, with lengthy delays between when an innovation is developed and when it is implemented in clinical practice; and
- The inadequate use of information technology.

So now we have two recent and reinforcing reports, both documenting a

The Federal Government is the single largest payer for mental health and supportive services, including health care, housing, employment, and education.

critical need for system transformation, even within current fiscal limitations. But necessity is a call for action, not a guarantee. I believe that you can answer the call. Your part in crossing the quality chasm to a transformed system is to help create a new policy framework for databased decision making.

Keeping in mind the limited resources we have to accomplish the task, we need to devise a realistic approach to taking what we know—or want to know—and sharing it with those who need to know so that they can use it for data-based decision making.

Some of the questions that we need to answer in developing a new policy framework are

1. How will we approach data collection and dissemination?
2. What is our applied practice/research agenda?
3. What data is needed to support

- this agenda? and
4. How can we access data from all the different groups involved in mental health care? For example, how will we acquire data from agencies such as Medicaid and the Veterans Administration?

The answers to all of these questions lie in the resolution of the much broader problems that affect our mental health care system. The New Freedom Commission defined for us a large-scale problem of fragmented, disconnected, and inadequate services and knowledge.

In the Commission's assessment, these problems — and the need for system transformation — exist at all four levels of involvement: federal, state, community, and consumers and their families.

The federal government is the single largest payer for mental health and supportive services, including health care, housing, employment, and education. Those programs with the most substantial role in financing mental health services, such as Medicare and Medicaid, do not have missions focused on mental health care. Each of the many federal programs contributing to mental health care financing has its own complex, sometimes contradictory, set of rules. They have their own data and reporting systems, and information is seldom collected and shared in a common framework. As a result, services

are fragmented, disconnected, and often not tailored to the needs of individual consumers.

On a national scale, the consequence is that people with mental illnesses are being denied access to quality care and falling deep into the quality chasm. We have nearly 200,000 persons who are chronically homeless in America. A large percentage of persons who are chronically homeless have a mental illness, a substance abuse disorder, or both. Approximately 800,000 persons with serious mental illness are admitted annually to U.S. jails. Jails are not designed to be treatment facilities. One of most distressing and preventable consequences of undiagnosed, untreated, or under-treated mental illnesses is suicide. In the United States, nearly 30,000 persons commit suicide each year.

In a transformed system, the New Freedom Commission envisions that federal programs will be better aligned across agencies to improve access and accountability for mental health services at the federal, state, and community levels. In addition, the federal government will advance and accelerate

...we need to devise a realistic approach to taking what we know—or want to know—and sharing it with those who need to know so that they can use it for data-based decision making.

the transfer of science to service. Technology and telehealth will become major vehicles for informing and coordinating care.

continued on page 10

At the state level, the New Freedom Commission noted that state mental health and behavioral health authorities have an enormous responsibility to deliver mental health care and support services, yet they have limited influence over many of the programs that consumers and families need. The Commission also noted that states lack direct control or accountability for most resources for people with serious mental illnesses, such as Medicaid. As a result, mental health care delivery at the state level faces the same problems affecting the federal level.

The New Freedom Commission envisions that, under a transformed system, states will develop comprehensive state plans outlining how a full range of programs will be coordinated and integrated. In exchange for greater flexibility in determining how federal, state, and

Too often, providers and consumers do not have access to the most recent information about which treatments and services are the most effective.

local funds are combined to meet consumer needs, the states will be more accountable to the federal government as well as to consumers and their families. Clearly, improved performance and outcome data will be critical to this process of transformation.

This brings us to the community level, where policy becomes practice and where the opportunities to improve the lives of persons with mental illnesses are greatest. Unfortunately, this is where the lengthy delay between research and practice is most apparent.

Too often, providers and consumers do not have access to the most recent information about which treatments and services are the most effective. Too often, they lack the very information they need to make informed decisions about care.

In addition, consumers may not have access to the full range of services they need. In the *Olmstead* ruling, the U.S. Supreme Court affirmed a person's right to live and receive appropriate treatments within the community. Consumer recovery hinges on community care plans that take into account the full range of an individual's needs as a whole person. These needs include finding and maintaining housing, finding and keeping a job, and developing a caring social support network. Meeting these needs demands the coordination of a broad-based coalition of community organizations and leaders. All too often, stigma,

ignorance, and lack of involvement by those groups that should be involved are preventing the delivery of high quality care at the community level.

This situation would be drastically altered under a transformed mental health care system. The New Freedom Commission envisions a system in which consumers receive the best possible community-based treatments, services, and supports through individualized plans of care. This care will be culturally competent and extend to geographically remote com-

munities. Necessary care will begin early in the life of an illness because a broad group of community organizations, such as schools and faith-based

The New Freedom Commission envisions a system in which consumers receive the best possible community-based treatments, services, and supports through individualized plans of care.

organizations, will assume a role in helping to detect potential illnesses, advocate treatment, and help achieve and sustain recovery.

At the consumer level, the New Freedom Commission found that a major barrier for those who seek treatment is that consumers and families typically have limited influence over the care they receive. Without choice and the availability of acceptable treatment options, some people with mental illnesses are opting not to engage in treatment or to participate in timely interventions.

Under a transformed system, the Commission envisions that consumers and their families will play a significant role in shifting the focus of treatment to recovery. It will be their role—as well as their responsibility—to participate in evaluation, planning, research, training, and service delivery of mental health care. Consumers also will have greater control over funds spent on their care. This will give consumers an economic interest in obtaining and sustaining recovery, and shift the incentives toward a

continued on page 10

system that promotes learning, self-monitoring, and accountability.

The ultimate goal of system transformation is to bring the four levels — federal, state, community, and consumer— together in crossing the quality chasm, fostering recovery in all individuals.

Little can be accomplished if we are not working together. We have a lot to

Little can be accomplished if we are not working together. We have a lot to do, and little financing to work with.

do, and little financing to work with. In this situation, we need to combine our resources—both financial and human—to leverage their impact. Transforming the mental health care system from the federal to the consumer level is a task that will require all of our talents, all of our resources, and all of our commitment. We need to build partnerships where they haven't occurred in the past. We need to share responsibilities and be accountable to each other. We need to merge our professional identities rather than letting them form barriers to comprehensive behavioral health care. Coordination among the four levels of involvement requires not only new attitudes, but also new ways of working together to accomplish all that needs to be done to collect, disseminate, and take advantage of useful information.

In summary, mental illness can be treated effectively, and people can and

do recover. Most people with mental illnesses experience success at work, raise healthy families, and are contributing members of their communities. However, their recovery depends on getting quality services when and where they are needed — preferably early in the course of an illness and close to home. The need of an individual to obtain quality services should be the driving force behind any data-based decision making system.

In President Bush's State of the Union address he said, "We are living in a time of great change - in our world, in our economy, in science and medicine. Yet some things endure - courage and compassion, reverence and integrity, respect for differences of faith and race." The national mental health care system is also experiencing a time of great change — in our understanding, in our economy, in science and medicine and technology. We need to harness the potential of these changes to create a better world for persons with mental illnesses. And while we are taking advantage of these changes, we must be sure that our system integrates those same qualities of respect for each individual that the President used to characterize our Nation — "courage and compassion, reverence and integrity, respect for differences of faith and race."

Robert Rosenheck, a noted service system researcher with the Veteran's

Administration, has observed that organizational life is composed of routines and beliefs to support those routines. Researchers may find results that infuriate people because they contradict this status quo. Researchers need to be sympathetic toward those whose routines and beliefs are challenged.

Dr. Rosenheck stated that in some instances, one could make the case that changes brought about were a rational response to studies conducted. He points out that this is sometimes true, although often it's just that the changes were already present in the system. Researchers will move things forward at times of crisis, when there are windows of opportunity. If one has innovations that are moving with the grain, then things are likely to happen much more smoothly.

As a final point, Dr. Rosenheck suggested that the key elements for data or research dissemination are training, personal interaction, and sharing experiences and data to monitor imple-

Researchers will move things forward at times of crisis, when there are windows of opportunity. If one has innovations that are moving with the grain, then things are likely to happen much more smoothly.

mentation and move toward acceptance of innovation. ▲

- 1 New Freedom Commission on Mental Health. Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.
- 2 Institute of Medicine. Crossing The Quality Chasm: A New Health System For The 21st Century. Washington, D.C.: 2001.

CONTACT INFORMATION



NASMHPD RESEARCH INSTITUTE, INC.

Noel Mazade, Ph.D. • ext. 113
Executive Director
noel.mazade@nri-inc.org

Theodore Lutterman • ext. 121
Director of Research Analysis
ted.lutterman@nri-inc.org

Lucille Schacht, Ph.D. • ext. 125
Director of Statistical Analysis
lucille.schacht@nri-inc.org

Vera Hollen, M.A. • ext. 116
Project Manager
vera.hollen@nri-inc.org

Marie Huddle • ext. 119
Administrative Specialist/Web Support
marie.huddle@nri-inc.org

Kathleen Monihan • ext. 126
Data Analyst
kathleen.monihan@nri-inc.org

Vijay Ganju, Ph.D. • ext. 132
*Director, Center for Mental Health
Quality and Accountability*
vijay.ganju@nri-inc.org

Jeanne Rivard, Ph.D. • ext. 146
Senior Research Analyst
jeanne.rivard@nri-inc.org

Robert Shaw, M.A. • ext. 124
Data Analyst
robert.shaw@nri-inc.org

Ping Wu • ext. 144
Data Clerk
ping.wu@nri-inc.org

Jacqueline Yannacci • ext. 150
Research Associate
jacqueline.yannacci@nri-inc.org

*For more information about the NASMHPD Research Institute, Inc. and our Research Projects,
visit our web site: www.nri-inc.org or phone us on 703-739-9333.*