Affordable Care Act Insurance Market Remains Operational Despite Ruling by Federal Judge in Texas that Repeal of the Individual Mandate Penalties Renders the Act Unconstitutional

Insurers, advocacy groups, and the Department of Health and Human Services have spent the last week reassuring individuals insured under the Affordable Care Act insurance marketplace that they still have insurance after a Federal District Court judge ruled December 14 in favor of a contention by 20 Republican state attorneys general and governors, led by Texas Attorney General Ken Paxton, that the Act as amended last year is unconstitutional.

U.S. District Court Judge Reed O’Connor (Northern District of Texas) ruled in the case of Texas v. Azar that when Congress eliminated the penalties for failing to obtain ACA-mandated health insurance under § 11081 of the Tax Cuts and Jobs Act of 2017, it rendered the entire Act unconstitutional.

Judge O’Connor said that the mandate without the penalties was unconstitutional because the Supreme Court in King v. Burwell indicated that characterizing the penalties as taxes was what saved the mandate from being an unconstitutional exercise of Federal power. He said the Supreme Court had also made it clear that “the mandate is inseverable from the entirety of the ACA,” making it impossible to maintain the remaining provisions of the law without the mandate.

In deeming the mandate and penalties “essential” to the entire Act, Judge O’Connor said

Congress stated many times unequivocally—through enacted text signed by the President—that the Individual Mandate is “essential” to the ACA. And this essentiality, the ACA’s text makes clear, means the mandate must work “together with the other provisions” for the Act to function as intended. All nine Justices to review the ACA acknowledged this text and Congress’s manifest intent to establish the Individual Mandate as the ACA’s “essential” provision.

In addition to providing subsidized insurance coverage for low-income individuals or coverage under Medicaid expansion, the Act’s provisions allow young adults to stay on their parents’ plans until age 26, eliminate caps on insurance benefits, provide free preventive care, and bar insurers from turning away people with pre-existing conditions or charging them higher premiums.

The ruling was issued the evening before the ACA open enrollment period for 2019 coverage was set to end. It is unclear whether the ruling may have confused potential enrollees in the final day enough to impact sign-ups. However, enrollment for 2019, which had been trailing 2018 enrollment figures by more than 25 percent, finished with 4.3 million enrollments in the final week and a total enrollment of 8.5 million, compared to 8.8 million in 2018..

Margaret Murray, CEO of the Association for Community Affiliated Plans, told Modern Healthcare this week that some of her organization’s not-for-profit safety net health plans were getting calls from health plan members concerned about the Texas ruling and her plans were offering reassurance that nothing has changed.

On December 17, HHS issued a press release stating:

The recent U.S. District Court decision regarding the Affordable Care Act is not an injunction that halts the enforcement of the law and not a final judgment. Therefore, HHS will continue administering and enforcing all aspects of the ACA as it had before the court issued its decision. This decision does not require that HHS make any changes to any of the ACA programs it administers or its enforcement of any portion of the ACA at this time. …"

The decision, which observers for and against the ACA have said is flawed—sometimes in the same published op-ed—can be appealed to the U.S. 5th Circuit Court of Appeals and then to the Supreme Court, so it is unlikely the matter will be settled within the next year. Until the decision is final at all levels, the Act is still operational under law.

The 16 Democratic states, led by California Attorney General Xavier Becerra, that intervened in the case to defend the law after the U.S. Justice Department partially sided with the plaintiffs, were this week seeking the Judge’s direction on when they’d be free to file an appeal.

The decision could be reversed earlier by Congress through legislative action, but with the House in Democratic hands and the Senate led by Republicans, that is unlikely to happen. It is said to be advantageous to Democrats to allow the controversy to linger as long as no one actually loses coverage, and Republicans will not want to be seen fixing a law they have attacked throughout its existence. Senate Republicans on December 19 blocked a vote on a resolution sponsored by Senator Joe Manchin (D-WV) that would have allowed the Senate to intervene in the lawsuit immediately.

LATE BREAKING NEWS: The House and Senate have both approved HR 6615, the Traumatic Brain Injury Reauthorization Act. Funding for the grant programs under the Act will be authorized through 2024 once the President has signed the bill.
# Table of Contents

- Affordable Care Act Insurance Market Remains Operational Despite Ruling by Federal Judge in Texas that Repeal of the Individual Mandate Penalties Renders the Act Unconstitutional
- John Draper BLOG: Combatting Social Disintegration: The Need for Population Approaches to Preventing Suicide
- CMS Comparison of the InCK and MOM Innovation Models
- SAMHSA GAINS Center Criminal Justice Learning Collaborative is Accepting Applications for Competency to Stand Trial and Competence Restoration
- SAMHSA Funding Opportunity Announcement: National Center of Excellence for Infant and Early Childhood Mental Health Consultation (CoE-IECMHC )(SM-19-010)
- TA Network Webinars and Opportunities
  - Upcoming PCORI Funding Announcement: Treatment for Anxiety in Children, Adolescents, and/or Young Adults
- Department of Veterans Affairs Notice of Funding Availability: Supportive Services for Veteran Families Program
- Social Marketing Assistance is Available
- AATOD Call for Presentations at October 2019 Conference
- February 6 AcademyHealth Policy Action Institute: Public Health Under Siege: Improving Policy in Turbulent Times
- The Early Serious Mental Illness Treatment Locator Has Been Updated with NASMHPD/NRI Data
- 2018 NASMHPD TECHNICAL ASSISTANCE COALITION "BEYOND BEDS" WORKING PAPERS
- February 15 to 17, 2019 Pain Management and Addiction Summit in Austin, Texas
- AHRQ Funding Opportunity Announcement: Screening and Management of Unhealthy Alcohol Use in Primary Care: Dissemination and Implementation of PCOR Evidence (RFA-HS-18-002)
- Resources at NASMHPD's Early Intervention in Psychosis Resource Center
- HRSA Notice of Funding Opportunity: Geriatrics Workforce Enhancement Program (GWEP – HRSA 19-008)
- March 24 & 15 Alzheimer's Disease-and Related Dementias (ADRD) Summit 2019 at NIH
- SAVE THE DATE – September 2019 International Initiative for Mental Health Leadership (IIMHL) & International Initiative for Disability Leadership (IIMDL) Leadership Exchange in Washington, DC
- The National Council is Now Accepting Nominations for its 2019 Awards of Excellence & Registration for Its March 26 Annual Meeting!

**NASMHPD Board & Staff**

**NASMHPD Links of Interest**
If meaningful social connectedness is central to preventing suicides, is the increase in U.S. suicides related to a degradation in meaningful social connectedness in our culture? If this is true to some degree, how can the suicide prevention field devise more effective approaches for increasing meaningful social connectedness within and across communities in this country? During an AAS Board dinner about a year ago, Research Chair Jie Zhang—a professor of sociology at State University of NY in Buffalo—said to me: “Suicide is a sociological issue.” When I asked him to elaborate on this, he indicated that the predominance of male suicides suggests that the issue is one related to cultural norms and patterns of social relationships, eg, “sociology.” During our conversation, we reflected on how the 120-year old shadow of Emile Durkheim—the French sociologist who was the progenitor of theories about why people kill themselves—loomed over us. Durkheim posited “social integration” as the primary factor in suicidality, that is, the degree to which people are connected to their community via work, family, friends and other roles and relationships. Perhaps if Durkheim were at that dinner table with us, he might have postulated that our growing suicide rates are the result of a pervasive form of “social disintegration” in our culture.

Is there sufficient data to suggest that some “pervasive form of social disintegration” is occurring in our country? In the September 2017 issue of the American Psychologist, Juliane Holt-Lunstad and colleagues supplied a cogent review of the scientific evidence that provided a strong argument for a need to make advancing social connectedness a national public health priority. Among the data cited, they noted that:

- core social networks have decreased by a third since 1985, and are now less likely to include non-family members;
- marriage rates are decreasing and divorce rates remain at around 40 percent;
- census data shows an increased rate of childlessness, with fewer kids per household and more single-person homes than ever recorded; and
- significant reductions in volunteerism and religious affiliation suggest significant reductions in community involvement. The authors also note that as our population ages, connectedness deteriorates; the older we get, the more our social networks shrink.

This trend towards longer lives with diminishing social connections—combined with smaller families and fewer related familial resources for support—means more will become lonely over time. “More lonely” is an ominous prediction, given that a 2018 survey by the insurer Cigna of 20,000 Americans found that nearly half of respondents reported they sometimes or always feel alone or “left out,” with 13 percent stating that nobody knows them well. It appears we are entering a time when perhaps the most immediate way to bring American people together would be to stage a national sing-a-long to the Beatles’ Eleanor Rigby.

In any case, we must do something more and different. From a public health perspective, enhanced social connection is associated with healthier heart, immune and neuroendocrine systems. We know that social connectedness is a significant mediator of depression, which also has clear implications for health and, of course, suicide. These data indicate our field will need to pay close attention to cultural trends that could further aggravate suicidality among persons becoming increasingly alone in communities across the country. These trends also remind us that we must embrace sociological- and population-based approaches if we ever hope to reduce suicides in America.

How does Durkheim’s social integration theory relate to our contemporary views of suicide, and how might the inclusion of more sociological constructs contribute to our efforts to prevent suicide in this nationally? Until recently, we have been moving away from Durkheim’s suicide and social causes framework and concentrating on what more we can do in doctor’s offices and pharmacies to prevent suicides. As Thomas Joiner noted in his seminal work Why People Die By Suicide, Durkheim’s theory went untested for decades until more individualized factors—such as genes and the role of mental illnesses—became more influential in conceptualizing suicidality.

Later, scientific studies related to mental illness and genes, and psychotherapy and medication became the prominent modes by which we “treat” people who are suicidal, relegating more population-based theories and approaches to the periphery. Nevertheless, the emergence of Joiner’s Interpersonal Theory of Suicide in our 21st Century view of suicide’s etiology has opened the door for both social and individual causes to be examined in suicide prevention work. Joiner has stated that his concept of “thwarted belongingness” is consistent with Durkheim’s “egotistical suicide” (a person isolated and disconnected from others), and his concept of “perceived burdensomeness” resonates with Durkheim’s “altruistic suicides”, or a kind of self-sacrifice made for the benefit of the group (excessive social integration” in a sense). Joiner’s framework reminds us that suicidality is not simply about an individual’s suffering and his/her prescribed treatment regimen; it is also heavily influenced by phenomena that is distinctly “interpersonal” and social in nature.

So what suicide prevention population approaches has our field widely embraced? Over the past fifty years, suicide hotlines have remained the most consistent “community-level” strategy that we have deployed for helping and serving suicidal individuals. Some have stated that these hotline services are too downstream (“at the waterfall’s edge”) to have an impact. However, our crisis lines know that the majority of persons who contact our services are in non-suicidal emotional distress. What undermines the potential of crisis lines the most is the failure to properly resource and promote them as the community crisis, support, and outreach services that they effectively are. When the United Kingdom’s national health districts registered a reduction in suicides, the use of 24/7 crisis outreach services were cited as the most important contributor.

Yet, our culture’s stigma surrounding suicide is reflected in the way hotlines are related to other aspects of behavioral health care—they are relegated to the periphery and grossly underfunded, and often rely on volunteers because behavioral health care professionals fear liability and 24/7 availability. So it remains that—other than hospital emergency rooms—crisis hotlines help the most persons at the highest risk, at the most undesirable hours for a behavioral health care system that has forsaken them, with little to no compensation. At the Lifeline, we see more hotline operations closing their doors every year. Perhaps the recent passage of the National Suicide Hotline Improvement Act and the subsequent SAMHSA/Veterans Administration (VA)/Federal Communications Commission study regarding the

(Continued on page 4)
BLOG: Combatting Social Disintegration: The Need for Population Approaches to Preventing Suicide  
John Draper, Ph.D., American Association of Suicidology, Prevention Division Chair

(Continued from page 3) impact of designating a national 3-digit number for mental health and suicidal crises calls will lead to greater recognition and support for crisis hotlines. If such a 3-digit number were to come to fruition, it would go far in reducing the overall cultural stigma related to mental health problems and suicidal experiences, by validating both the need for a service specific to “psychological emergencies” and a need to provide a caring response different than the indiscriminate (and usually inappropriate) dispatch of police or EMS resources.

Aside from SAMHSA’s support of the Lifeline network, a number of local-, state-, and federally-funded initiatives continue to offer a scattering of population-based approaches. The Garret Lee Smith grants have disseminated community gatekeeper trainings which have been associated with temporary reductions in suicides in counties where they have been provided, effects which evaporate when these funded initiatives end. School-based approaches, which equip student peers and faculty with suicide prevention information and actions--such as Sources of Strength, Signs of Suicide, and Lifelines--hold considerable promise for community “upstream approaches.” Overall, there are 10 states that currently mandate annual suicide prevention trainings of school-based personnel, and another 17 states that require such training without specifying how frequent the trainings must occur.

Harvard’s Means Matter, Washington’s Forefront, NAMI New Hampshire, the VA, and now the American Foundation for Suicide Prevention are among the leaders in promoting community gun safety initiatives intended to reduce firearm suicides. In addition, Suicide Awareness and Voices of Education (SAVE), the Lifeline and the National Action Alliance for Suicide Prevention (Action Alliance) are now working with international partners to establish a uniform framework for positive public health messaging designed to reduce suicide. SAVE, Lifeline, and Forefront have also collaborated closely with Facebook and other social media entities to apply prevention and public health approaches towards enhancing safety and support in online communities. In spite of this growing array of population-based initiatives in the 21st Century, these efforts are fragmented and have not been coordinated as part of a comprehensive, evidence-based, unified, and sustainable strategy designed to reduce community suicide rates.

Without due fanfare, the Action Alliance and the Centers for Disease Control and Prevention (CDC) provided us with an outstanding blueprint for population-based initiatives in March of 2017. The Action Alliance’s document, Transforming Communities: Key Elements for the Comprehensive Community-Based Suicide Prevention, underscores seven essential processes to help prevention programs achieve success: unity, planning, integration, cultural fit, communication, data, and sustainability. The CDC’s complementary work, Preventing Suicide: A Technical Package of Policy, Programs and Practices, determines seven objectives that—if accomplished—could effectively reduce suicides in our communities. These objectives include:

- strengthening economic supports;
- enhancing access to/delivery of suicide care;
- creating protective environments;
- promoting connectedness;
- teaching coping and problem-solving skills;
- identifying and supporting people at risk; and
- lessening harms and preventing future risk.

Of the seven objectives, it is clear to me that most of our field’s efforts have leaned heavily towards making it harder for suicidal people to kill themselves (e.g., reducing access to lethal means), making it easier for suicidal people to access help (e.g., crisis hotlines), identifying and treating persons at risk and, to a lesser degree, reducing harm and future risk (e.g., post-vention and safe media messaging). Fewer community suicide prevention policies, programs, and practices have been designed to promote connectedness, strengthen economic supports, or teach ways to better cope with and solve problems confronting us in everyday life. What new partners and approaches might our field need to scale community-wide efforts to enhance people’s relationships with others (connectedness) and the world of work (economic supports), two aspects of life central to one’s sense of value and purpose? What more can we do to broadly strengthen individual, family, and community capabilities for effectively managing challenges in relationships and work (coping/problem solving skills)? Aside from safe messaging and promoting access to care, how are we proactively using the immense power of media to promote these public health and suicide prevention objectives?

In an attempt to connect disparate dots, we can now see the development of the Colorado National Collaborative (CNC), an action-learning coalition initiated by Colorado’s Office of Suicide Prevention, the Action Alliance, and the CDC-funded Injury Control Research Center for Suicide Prevention (ICRC-S), begun in 2015 and now involving multiple national partners. The CNC now is engaging diverse county- and state-level public and private stakeholders in suicide prevention, human services, business, education, and media to deploy many of the key objectives and processes listed in the aforementioned CDC and Action Alliance technical assistance documents. In a recent email, Eric Caine, Principal Investigator of the ICRC-S and co-chair of the CNC with Jarrod Hindman of Colorado, noted that this ambitious initiative still is a work in progress, in search of major funding to help this collective fully realize its unified vision of reducing suicide in Colorado communities. If this project gets the funding it needs, its lessons could be among the most important we learn in our quest to reduce U.S. suicides by 20 percent by 2025.

In this time of stubborn (and rising) suicide rates, both individual and population-based approaches are essential. However, more efforts need to be made to expand our reach to community stakeholders within and beyond health care systems, into our lives and the social milieu where connections are breaking down and suicides are happening. In an upcoming essay, I will explore ways in which we can (and must) address promoting connectedness within and apart from online communities to prevent suicide. But for now, I leave you with Eric Caine’s editorial message for us all in the November 2017 issue of JAMA Psychiatry:

...it behooves us to look beyond the walls of our clinics and offices to engage vulnerable individuals and families in diverse settings such as courts and jails, social service agencies, and perhaps the streets long before they have become ‘suicidal.’ If we wait until many are considering their options to kill themselves, much like waiting to intervene until someone is in the middle of an occlusion of the anterior branch of his left coronary artery(aka, the widow-maker), it likely will be too late.

John Draper, Ph.D., Chair, Prevention Division of AAS
<table>
<thead>
<tr>
<th>Key Model Elements</th>
<th>InCK Model</th>
<th>MOM Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Focus Population</strong></td>
<td>All attributed Medicaid and CHIP beneficiaries from prenatal stage up to age 21</td>
<td>Pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD) and their infants</td>
</tr>
</tbody>
</table>
| **Model Intervention** | - Population stratification approach that uses a risk assessment strategy for every eligible beneficiary via a comprehensive needs assessment tool.  
- Requires integrated car coordination, and case management of clinical care with seven other cross-sector core child health services. | - Coordinated and integrated care-delivery approach, including addressing beneficiaries' physical and behavioral health needs  
- Requires screening, treatment, and referral to critical wraparound services, with the flexibility to define the specific set of services that satisfy five components:  
  1. Comprehensive care management;  
  2. Care coordination;  
  3. Health promotion;  
  4. Individual and family support; and,  
  5. Referral to family and social services. |
| **Model Goals** | This child-centered local service delivery and state payment model is aimed at reducing expenditures and improving the quality of care for children under 21 years of age covered by Medicaid and CHIP through prevention, early identification, and treatment of behavioral and physical health needs. The model intends to improve performance on priority measures of child health, reduce avoidable inpatient stays and out-of-home placements, and create sustainable APMs. | To address fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder (OUD) through state driven transformation of the delivery system surrounding this vulnerable population. By supporting the coordination of clinical care and the integration of other services critical for health, wellbeing, and recovery, the MOM model has the potential to improve quality of care and reduce costs for mothers and infants. |
| **Payment Model** | State-designed Alternative Payment Models (APMs). | State-designed coverage and payment strategy. |
| **Model Timeline** | Seven-year model, with implementation beginning in Year 3 | Five-year model, with care delivery under the model beginning in Year 2 |
| **Eligible Model Applicants** | State Medicaid Agency or HIPAA-covered local “Lead Organization” | State Medicaid agency that has partnered with at least one “care-delivery partner” |
| **Required Model Partners** | - State Medicaid Agency  
- Local Lead Organization  
- Core Child services: Physical and Mental Health providers, Child Welfare, Schools, Early Care and Education, Food and Nutrition, Housing, Title V programs, and Mobile Crisis  
- Mobile Crisis. | Care-delivery partner(s), such as: Health System or Managed Care Plan |
| **Model Service Area** | Single or multiple sub-state geographic service area(s); cannot be statewide | Statewide or in a sub-state geographic service area |
| **Number of Potential Awardees** | Up to 8 | Up to 12 |
| **Anticipated Posting of Notice of FOA** | Early 2019 | |

**Application Notes**

InCK allows for either the state Medicaid agency or a local Lead Organization to submit a model application. In the MOM Model, only state Medicaid agencies may apply.

An entity that has applied to the InCK model as a Lead Organization may not also be listed in a MOM model application as a care-delivery partner. If a state is the InCK model applicant, however, a Lead Organization in that state (including a proposed Lead Organization if the application is still under review) may be listed on a MOM model application as a care-delivery partner.
CRIMINAL JUSTICE LEARNING COLLABORATIVES
Competency to Stand Trial/ Competency Restoration

Number of Participant Sites to be Selected: 6
Application Due Date: January 22, 2019
Selected Communities to be Notified by February 1, 2019

SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation, operated by Policy Research Associates, (PRA), is known nationally for its work in regard to people with behavioral health needs who are involved in the criminal justice system. The GAINS Center is currently soliciting applications from communities interested in collaborating with subject matter experts through Criminal Justice Learning Collaboratives designed to explore five topics:

- Risk-Need-Responsivity
- Family Treatment Courts
- Equity and Inclusion
- Competency to Stand Trial/Competency Restoration
- SAMHSA’s Eight Guiding Principles for Behavioral Health and Criminal Justice

The Learning Collaborative Model brings together local community teams in a blend of virtual and onsite events to create coordinated local strategic plans and implementation strategies for the topic of focus. Selected teams will work intensively to determine optimal ways to implement best practices and define success indicators for each topic area noted above. Each topic-specific Learning Collaborative will engage subject-matter experts to work with community teams during the implementation process and to facilitate peer-to-peer sharing. The unique blend of virtual and onsite methods will offer selected teams an intimate and familiar environment in which to learn and complete their implementation work, while providing a virtual forum to share with other communities and receive an array of technical assistance from subject matter experts across the country.

Eligibility: The Competency to Stand Trial/Competency Restoration Learning Collaborative is designed for state applicants, and will focus on legal, clinical, and systemic issues including the increase demand for competency evaluations, evidence-based screening and assessment measures, wait lists for competency restoration program beds, best practices for competency restoration programs, building collaborations between state and local agencies, and other relevant issues. It is a requirement that all state applicants identify 1 to 3 local communities that will pilot the proposed changes. The local pilot partners must provide letters of support.

A state submitting an application should strive to include representation from a broad array of key stakeholders. The identification of 20 to 25 state team members and local partners should include:

- State forensic and/or mental health commissioner
- State director of state psychiatric hospitals and facilities
- State director of community behavioral health services
- Judicial leader such as administrative judge or supreme court judge
- Representative from state law enforcement such as sheriffs or chiefs of police associations
- State Attorney General
- Representative from indigent defense/public defenders association
- Representative from district attorneys association
- Director of forensic evaluation
- Representative from advocacy organization (e.g. NAMI)
- A team of local lead representatives in the identified pilot communities whose responsibilities mirror those above.

If multiple communities are proposed, local teams from each should be identified.

SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation will host all activities related to the Learning Collaborative free of charge to selected communities. A Learning Collaborative virtual meeting, in which all Learning Collaborative participant teams must participate, will be held on April 30 and May 1, 2019.

There are no fees for registration, tuition, or materials associated participation in the Learning Collaborative. The GAINS Center will pay all costs associated with pre and post-virtual meeting coordination, conference calls, and GAINS Center staff and/or subject matter expert time and travel.

Up to six sites will be selected through this solicitation. Communities selected for these events must be able to provide facilities and A/V resources to comfortably accommodate up to 25 to 30 event participants. Further details will be provided to communities selected to participate.

Informational webinars were held on December 5 and December 6, 2018. To learn more about the solicitation, stream a webinar recording: December 5 Recording | December 6 Recording.

Please note: If you require an alternative format or captioning, please contact SAMHSA’s GAINS Center.

Email Anthony Fortuna, Program Coordinator, for an application form, or call 800.311.4246 or 518.439.7415, Ext. 5257.
The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) is accepting applications for fiscal year (FY) 2019 National Center of Excellence for Infant and Early Childhood Mental Health Consultation (Short Title: CoE-IECMHC) grant. The purpose of this program is to advance the implementation of high quality infant and early childhood mental health consultation (IECMHC) across the nation through the development of tools, resources, training, and mentorship to the infant and early childhood mental health field. The primary goals of the CoE are to promote the healthy social and emotional development of infants and young children, and to prevent, to the greatest extent possible, the onset of serious emotional disturbance (SED). The CoE has been and will continue to be instrumental in helping states, tribes, and communities to support early childhood providers and help them to achieve their goals of healthy children and families, school readiness, and success in school and beyond.

The mission and work of the Center of Excellence aligns with multiple recommendations put forward by the Interdepartmental Serious Mental Illness Coordinating Committee in its December 2017 report. These include:

2.8 Maximize capacity of the behavioral health workforce;
2.9 Support family members and caregivers; and
3.2 Make screening and early intervention among children, youth, transition-age youth and young adults a national expectation.

In order to maintain the prominence of the Center in the fields of early childhood health and education, SAMHSA will continue to collaborate and partner with the Health Resources and Services Administration (HRSA) and the Administration on Children and Families (ACF) to ensure that child care, Head Start, home visiting, maternal and child health and primary care settings are informed and educated about the value of IECMHC, and mental health consultants are able to serve these systems most effectively.

Eligibility - Eligible applicants are domestic public and private nonprofit entities. For example:

- Public or private universities and colleges.
- Behavioral health care organizations.
- National stakeholder organizations.

Proposed budgets cannot exceed $1,000,000 in total costs (direct and indirect) in any year of the proposed project. Annual continuation awards will depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award.

SAMHSA will hold a pre-application webinar and a conference call for prospective applicants interested in applying for this grant. These events will be led by Center for Mental Health Services staff. The webinar will be held on Monday, December 17, 2018 from 2:00 p.m. to 3:00 p.m. E.T.

Dial in phone number: 888-928-9713 Participant Passcode: 7103267

Direct Web Link: https://www.mymeetings.com/nc/join.php?i=PWXW8519852&p=7103267&t=c

Replay Link: https://www.mymeetings.com/nc/join.php?i=PWXW8519852&p=7103267&t=r (available 24 hours after the webinar)

The conference call to answer remaining questions will be held on Monday, January 7, 2019 from 2:00 p.m. – 3:00 p.m.

Dial in phone number: (888) 928-9713 Participant passcode: 2760975

Note: Registration is not required for these events. The phone line and internet link will be live 30 minutes prior to the start of the webinar.

Contacts - Program Issues: Jennifer Oppenheim, Center for Mental Health Services, SAMHSA, (240) 276-1862
Rural Behavioral Health LC: Creating a More Equitable System for Stakeholders with Diverse SOGIE

This LC focuses on challenges and innovations in developing systems of care for children, youth, and young adults with significant needs and their families in rural areas. This webinar will educate participants about the importance of developing strategies for working with children, youth, and young adults with diverse sexual orientation, gender identities, and gender expression (SOGIE) and provide guidance to communities beginning this work.

Register Now

The Intersection of Equity, Disparities, and the Multi-Dimensions of Family and Community Engagement

The Early Childhood Family Network’s (ECFN) vision is to live in a world where all children from birth to 8 years old are safe, healthy, and inspired to engage in lifelong learning. Join EFCN for its inaugural webinar series for families and partners dedicated to early childhood social and emotional development. Alice Farrell, JD, LCSW, MSW, will present on effective engagement strategies for counteracting the disparities that many families and children experience and how focusing on the use of best practices in engagement can yield positive family and community connections.

Register Now

Clinical High Risk Early Psychosis Learning Community: Connecting the Dots

This webinar will review the work currently being done in the U.S. and internationally on developing and implementing seamless community-based care for Clinical High Risk for Psychosis, common challenges and opportunities across these programs, and opportunities for synergy and learning. It will both introduce participants to important knowledge and resources, and will provide opportunities for networking, sharing and collaboration across sites.

Register Now

Applications are Being Accepted for the Youth in Custody Practice Model Initiative

The Council of Juvenile Correctional Administrators and the Center for Juvenile Justice Reform at Georgetown University’s McCourt School of Public Policy are accepting applications for the Youth in Custody Practice Model initiative. The initiative is designed to assist state and county juvenile correctional agencies and facility providers implement a comprehensive and effective approach to serve youth in residential treatment.

YICPM Cohort III: Application Packet

Upcoming Funding Announcement: Treatment for Anxiety in Children, Adolescents and/or Young Adults

The Patient-Centered Outcomes Research Institute (PCORI) will release a new funding announcement titled Treatment for Anxiety in Children, Adolescents, and/or Young Adults on January 3, 2019. The goal of this announcement is to fund high-quality clinical studies that compare the effectiveness of evidence-based clinical strategies to treat anxiety disorder in children, adolescents, and young adults. The proposed study population will include patients with a confirmed clinical diagnosis of a primary anxiety disorder and who are between 7 and 25 years of age. A town hall for prospective applicants will be held January 22, 2019, from noon to 1 p.m. E.T.
Department of Veterans Affairs Notice of Funding Availability
Supportive Services for Veteran Families Program

Application Due Date: February 22, 2019

The Department of Veterans Affairs (VA) is announcing the availability of funds for supportive services grants for new applicants and existing grantees under the Supportive Services for Veteran Families (SSVF) Program. Awards made for supportive services grants will fund operations beginning October 1, 2019.

The SSVF Program provides supportive services grants to private non-profit organizations and consumer cooperatives that coordinate or provide supportive services to very low-income veteran families who: (i) are residing in permanent housing and are at risk of becoming homeless; (ii) are homeless and scheduled to become residents of permanent housing within a specified time period; or (iii) after exiting permanent housing within a specified time period, are seeking other housing that is responsive to such very low-income veteran family’s needs and preferences. SSVF prioritizes the delivery of rapid re-housing services to homeless veteran households.

Rapid re-housing is an intervention designed to help individuals and families quickly exit homelessness, return to housing in the community, and avoid homelessness again in the near term. The core components of a rapid re-housing program are housing identification, financial assistance with move-in and rental expenses, and rapid re-housing case management and services. These core components represent the minimum that a program must be providing to households to be considered a rapid re-housing program, but do not provide guidance for what constitutes an effective rapid re-housing program.

The principle goal for this NOFA is to provide support to those applicants who demonstrate the greatest capacity to end homelessness among veterans or, in communities that have already met US Interagency Council on Homelessness (USICH) Federal Criteria and Benchmarks, or, alternatively, Community Solutions’ Functional Zero (the latter can be found at https://cmtysolutions.org/sites/default/files/final_zero_2016_metrics.pdf), a capacity to sustain these gains. Priority will be given to grantees who can demonstrate adoption of evidence-based practices in their application.

Under Priority 1, VA will provide funding to existing grantees with 3-year accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) in Employment and Community Services: Rapid Rehousing and Homeless Prevention standards, a 4-year accreditation from the Council on Accreditation’s (COA) accreditation in Housing Stabilization and Community Living Services standards, or a 3-year accreditation in The Joint Commission’s (JC) Behavioral Health Care: Housing Support Services Standards.

Priority 2 includes existing grantees seeking to renew their grants not included under Priority 1.

Under Priority 3, VA will provide non-renewable grants for a 2-year period to eligible entities providing services to very low-income veteran families who are occupying permanent housing in the areas of one of the Continuums of Care (CoC) listed in the Award Information section of this Notice. VA has designed this 2-year effort to provide a surge of resources in communities with high need. Only existing grantees currently providing services in an identified target community are eligible to apply for additional funds in that target community they currently serve under Priority 3.

A CoC plan is a community plan to organize and deliver housing and services to meet the needs of people who are homeless as they move to stable housing and maximize self-sufficiency. The community plan includes action steps to end homelessness and prevent a return to homelessness. Priority 4 is open to new applicants only, who are seeking to provide services in the areas of one of the CoCs listed in the Award Information section of this Notice. These locations have been selected based on the current unmet service needs and the levels of Veteran homelessness, and VA also seeks to ensure that supportive services grants are equitably distributed across geographic regions, including rural communities and tribal lands. Applications for Priority 3 and 4 awards must include a letter of support from the target CoC to be considered for funding. CoC letters of support must contain the information described in the Award Information section of this Notice. (CoC locations and contact information can be found at www.hudhre.nfo/index.cfm?do=viewCocMaps).

Note: VA is considering adding an additional rental subsidy option for Priority 3 awards. Should VA announce this new rental subsidy option it would be noticed through the publication of rulemaking that would amend 38 Code of Federal Regulations (CFR) Part 62,

Copies of the application can be downloaded from the SSVF website at www.va.gov/homeless/ssvf.asp.

Technical Assistance: Information regarding how to obtain technical assistance with the preparation of a supportive services grant application is available on the SSVF Program website at: www.va.gov/homeless/ssvf.asp.

FOR FURTHER INFORMATION CONTACT: Mr. John Kuhn, National Director, Supportive Services for Veteran Families at SSVF@va.gov.
Social Marketing Assistance Available

Social marketing resources for system of care communities were developed by the SAMHSA-funded Caring for Every Child’s Mental Health Campaign team, which was a collaboration between NASMHPD, Vanguard Communications (link is external), Youth MOVE National (link is external), and the Federation of Families for Children’s Mental Health (link is external). The Campaign was funded through Fiscal Year 2018. Below are a sampling of commonly-requested social marketing resources developed by the Campaign.

System of Care Cooperative Agreements that are currently funded by SAMHSA should seek social marketing technical assistance through the University of Maryland’s TA Network.

Other organizations or entities seeking social marketing technical assistance, including State Behavioral Health Agencies, are welcome to contact NASMHPD. Additional social marketing instructional materials, training, and consultation may be available. If you’d like to discuss your needs and/or have questions about how we can help, please contact Leah Holmes-Bonilla at leah.holmes-bonilla@nasmhpd.org (link sends e-mail). If you would like to submit a request for social marketing technical assistance or training from NASMHPD, please fill out this application form.

Tip Sheets and Workbooks

**Getting Started**
- Brand Development Worksheet
- Creating Your Social Marketing Plan
- Developing a Social Marketing Committee
- Social Marketing Needs Assessment

**Social Marketing Planning**
- Social Marketing Planning Workbook
- Social Marketing Sustainability Reflection

**Hiring a Social Marketer**
- Sample Social Marketer Job Description
- Sample Social Marketer Interview Questions

**Engaging Stakeholders**
- Involving Families in Social Marketing
- Social Marketing in Rural and Frontier Communities
- The Power of Partners
- Involving Youth in Social Marketing: Tips for System of Care Communities
- The Power of Telling Your Story

CALL FOR PRESENTATIONS DEADLINE: January 18, 2019
EARLY REGISTRATION DEADLINE: January 31, 2019

The American Association for the Treatment of Opioid Dependence (AATOD) Workshop Committee is now accepting proposals for workshop and poster presentations for the 2019 AATOD Conference. The conference is being held in sunny Florida, October 19-23, 2019, at the Disney’s Coronado Springs Resort.

The opioid epidemic continues to ravage the country and much of the world. The goal of this year’s conference is to educate, and promote acceptance and integration of Medication Assisted Treatment (MAT) options by patients, clinicians, the medical system, judicial systems, government, policy makers, and social service administrations.

We will disseminate innovative, evidence based initiatives and treatment techniques to better serve patients and providers, improve program development and administration, promote integration across the continuum of care, and enhance patient outcomes to assist communities in developing an effective response to the opioid crisis. To do this, we need your help. We cannot accomplish these goals without your willingness to share your expertise and experiences.

The Workshop Committee encourages you to submit an abstract for a workshop or poster session presenting the latest programs, research and regulatory developments relevant to the field of MAT and highlighting innovative treatment techniques and evidence based initiatives. We invite you to present effective and proven strategies to assist healthcare partnerships and collaborations by advancing their understanding and acceptance of MAT for opioid use disorders as a crucial element to community wellness and response to the opioid epidemic. Proposals that focus on reducing MAT-related stigma are also encouraged.

You will note in the on-line Call for Presentations that we are encouraging a broad number of topics for submission in order to provide a rich learning content cutting across multiple disciplines to advance the work of our field. We expect nothing less than to continue to provide the most cutting edge information at the conference. Please join leading experts in the field and consider submitting a proposal highlighting your expertise in research or in the provision of care.

To submit a proposal, please click HERE and follow the on-screen instructions. For questions or additional information regarding the Call for Presentations, please send e-mail to aatod@talley.com or call 856-423-3091.
## 2019 Healthcare.Gov Enrollment Through December 15

<table>
<thead>
<tr>
<th></th>
<th>Week 7 (Dec. 9 to Dec. 15)</th>
<th>Cumulative through Dec. 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Selections</td>
<td>4,322,450</td>
<td>8,454,882</td>
</tr>
<tr>
<td>New Consumers</td>
<td>918,648</td>
<td>2,025,611</td>
</tr>
<tr>
<td>Consumers Renewing Coverage</td>
<td>3,403,802</td>
<td>6,429,271</td>
</tr>
<tr>
<td>Consumers on Applications Submitted</td>
<td>4,291,903</td>
<td>10,612,387</td>
</tr>
<tr>
<td>Call Center Volume</td>
<td>1,783,333</td>
<td>5,249,093</td>
</tr>
<tr>
<td>Calls with Spanish Speaking Rep.</td>
<td>122,278</td>
<td>361,427</td>
</tr>
<tr>
<td>HealthCare.gov Users</td>
<td>5,232,666</td>
<td>15,153,414</td>
</tr>
<tr>
<td>CuidadoDeSalud.gov Users</td>
<td>169,337</td>
<td>551,286</td>
</tr>
<tr>
<td>Window Shopping HealthCare.gov Users</td>
<td>361,976</td>
<td>1,386,990</td>
</tr>
<tr>
<td>Window Shopping CuidadoDeSalud.gov</td>
<td>11,487</td>
<td>38,766</td>
</tr>
</tbody>
</table>

### STATE-BY-STATE CUMULATIVE ENROLLMENT FOR HEALTHCARE.GOV – NOVEMBER 1 THROUGH DECEMBER 15

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>17,825</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alabama</td>
<td>167,087</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arkansas</td>
<td>67,438</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arizona</td>
<td>161,241</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delaware</td>
<td>22,657</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>1,786,679</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>460,139</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hawaii</td>
<td>20,229</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>49,376</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>314,777</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>149,711</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kansas</td>
<td>90,196</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kentucky</td>
<td>85,745</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>93,311</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td>71,577</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>275,996</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missouri</td>
<td>222,621</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>88,371</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td>45,733</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Montana</td>
<td>502,464</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>21,867</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebraska</td>
<td>87,855</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Hampshire</td>
<td>44,930</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>256,674</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>45,232</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Mexico</td>
<td>83,647</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ohio</td>
<td>209,215</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oklahoma</td>
<td>150,849</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>148,479</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>369,954</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td>216,889</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td>29,286</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td>223,320</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>1,089,636</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td>194,813</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td>334,269</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>206,970</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td>22,887</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wyoming</td>
<td>24,937</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** CMS


**Plan Selections:** The cumulative metric represents the total number of people who have submitted an application and selected a plan, net of any cancellations from a consumer or cancellations from an insurer that have occurred to date. The weekly metric represents the net change in the number of non-cancelled plan sections over the period covered by the report. Plan selections will not include those consumers who are automatically re-enrolled into a plan.

**New Consumers:** A consumer is considered to be a new consumer if they did not have 2018 Exchange coverage through December 31, 2018 and had a 2019 plan selection.

**Renewing Consumers:** A consumer is considered to be a renewing consumer if they have 2018 Exchange coverage through December 31, 2018 and either actively select the same plan or a new plan for 2019.
Public Health Under Siege: Improving Policy in Turbulent Times

Don’t miss an exceptional opportunity to engage with public health leaders about critical issues facing the nation today. The APHA Policy Action Institute will build on the 2019 AcademyHealth National Health Policy Conference to offer an additional day of discussions uniquely focused on public health policy. Attendees will interact with and learn from elected leaders and public and private sector policy experts about improving policy in turbulent times and how to take action.

Join us to explore pressing national priorities including environmental health, violence prevention, access to care and women's health.

Wednesday, Feb. 6
7:30 a.m. - 5:30 p.m.
Marriott Marquis Washington, DC
$300 (Breakfast and lunch are included)

Learn more about this event and check back soon for our lineup of exciting speakers.

Policy Action Institute

Register for the event

Book your Housing

Register for APHA's Policy Action Institute and the AcademyHealth National Health Policy Conference at the same time with this online registration.

Tell your peers about this event on Twitter!

Register NOW

SAMHSA’s new Early Serious Mental Illness Treatment Locator is a confidential and anonymous source of information for persons and their family members who are seeking treatment facilities in the United States or U.S. Territories for a recent onset of serious mental illnesses such as psychosis, schizophrenia, bi-polar disorder, or other conditions. These evidence-based programs provide medication therapy, family and peer support, assistance with education and employment and other services.

Individuals who experience a first onset of serious mental illness - which can include a first episode of psychosis - may experience symptoms that include problems in perception (such as seeing, hearing, smelling, tasting or feeling something that is not real), thinking (such as believing in something that is not real even when presented with facts), mood, and social functioning. There are effective treatments available and the earlier that an individual receives treatment, the greater likelihood that these treatments can lead to better outcomes and enable people to live full and productive lives with their family and friends.

SAMHSA has integrated data on first episode psychosis programs that was provided by NASMHPD and the NASMHPD Research Institute (NRI) into its existing treatment locator. Users receive information on Coordinated Specialty Care and other first episode psychosis programs operating in their state. This tool is designed to help quickly connect individuals with effective care in order to reduce the risk of disability.

You Can Access the SMI Treatment Locator HERE.
NASMHPD continues to receive recognition from the behavioral health community at large, including from our friends at SAMHSA, for our 2017 Beyond Beds series of 10 papers highlighting the importance of providing a continuum of care beyond institutional inpatient care.

A 2018 10-paper follow-up to the Beyond Beds series is now up on the NASMHPD website. The 2018 papers take the 2017 theme one step further, to look at specific services offered in the community and factors impacting those services, covering such topics as early psychosis intervention, supportive housing and supported employment, suicide prevention for older persons, children’s crisis care coordination in the continuum of care, and trauma-informed interventions, as well as court-ordered referrals to determine competency to stand trial.

One of those papers, Experiences and Lessons Learned in States with On-Line Databases (Registries) of Available Mental Health Crisis, Psychiatric Inpatient, and Community Residential Placements, authored by Robert Shaw of the NASMHPD Research Institute (NRI), reviews a 2017 NRI survey of the extent to which psychiatric bed registries— a “centralized system that uses real-time tracking to monitor the availability of psychiatric beds” are being implemented in the United States. The study found that 16 states had bed registries and that an additional 8 states were in the process of planning or developing a bed registry. In just over one-half the states with bed registries (9 states), participation in the registry was voluntary and very few states reported having registries that were updated 24/7 with real-time information. The types of beds covered by the registries generally included beds in state and private hospitals, and general hospital psychiatric beds, but only a few covered crisis beds, either for mental illness or substance use disorders, or Veterans Administration beds.

The NASMHPD Technical Assistance Coalition series will continue in 2019 and will center on the conclusions reached in the NRI Bed Registry survey report. If you are interested in helping to craft one of the 2019 papers, please contact NASMHPD Project Director David Miller.

Following are links to the other nine reports (in final draft) in the 2018 Technical Assistance Coalition series.

Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes
Weaving a Community Safety Net to Prevent Older Adult Suicide
Making the Case for a Comprehensive Children’s Crisis Continuum of Care
Achieving Recovery and Attaining Full Employment through the Evidence-Based IPS Supported Employment Approach
Changing the Trajectory of a New Generation: Universal Access to Early Psychosis Intervention
Going Home: The Role of State Mental Health Authorities to Prevent and End Homelessness Among Individuals with Serious Mental Illness
A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness
Medical Directors’ Recommendations on Trauma-informed Care for Persons with Serious Mental Illness
Speaking Different Languages- Breaking Through the Differences in the Perspectives of Criminal Justice and Mental Health Stakeholders on Competency to Stand Trial Services: Part 1
To combat the growing addiction epidemic that has resulted from opioid prescriptions for pain management, building partnerships and collaborations is critical. The Texas Society of Addiction Medicine, Texas Health Institute and Superior HealthPlan have joined forces to host a summit that addresses the state of the science in pain management and actions that can be taken to respond to the crisis.

Superior HealthPlan created an inaugural summit in 2018, “Changing the Paradigm in the Treatment of Chronic Pain and Substance Use Disorder in Texas.” The Texas Health Institute and Texas Society of Addiction Medicine are partnering this year to increase the scope and Summit reach.

History
During the 1990s, there was a movement to label pain as the fifth vital sign in medicine. This required physicians to evaluate and address pain in their patients. As a result, the production and prescription of short-acting opioids increased dramatically. Fast forward almost 20 years and the number of opioid overdose deaths has quadrupled since 1999. In 2017 alone, an opioid overdose was the cause of more than 60,000 deaths in the United States.

Today, physicians’ continuing medical education programs are now deemphasizing the use of opioids in all but acute pain, such as for postsurgical analgesia. However, one of the largest challenges facing physicians is how to reduce opioid use for patients who have been prescribed high levels of opioid analgesics for years.

Who Should Attend
- Physicians
- Medical Directors
- Behavioral Health Directors
- Pharmacists
- Nurses
- Social Workers
- Substance Use & Prevention Directors
- Peer Support Specialist
- Outreach Coordinators
- Psychiatrists
- Psychologists
- Dentists
- Telehealth Directors
- Government Officials
- Law Enforcement Officials
- Recovery Coaches

EARLY BIRD
Before December 31, 2018
Full Conference - $250
One Day- $100
Pre- or Post-Summit Workshops - $50

REGULAR
January 1, 2019 - February 11, 2019
Full Conference - $275
One Day- $125
Pre- or Post-Summit Workshops - $75
The Agency for Healthcare Research and Quality (AHRQ) seeks applications to disseminate patient-centered outcomes research (PCOR) findings directly to primary care practices and support practices in implementing PCOR clinical and organizational findings. Applicants must propose a comprehensive plan that uses evidence-based strategies designed to improve the delivery of patient-centered approaches to identifying and managing unhealthy alcohol use among adults, including screening and brief intervention (SBI) and medication assisted therapy (MAT).

The following types of Higher Education Institutions are always encouraged to apply for AHRQ support as Public or Private Institutions of Higher Education:

- Hispanic-serving Institutions
- Historically Black Colleges and Universities (HBCUs)
- Tribally Controlled Colleges and Universities (TCCUs)
- Alaska Native and Native Hawaiian Serving Institutions
- Asian American Native American Pacific Islander Serving Institutions (AANAPISIs)
- Nonprofits Other Than Institutions of Higher Education

Eligible Organizations: Higher Education Institutions

The following types of Higher Education Institutions are always encouraged to apply for AHRQ support as Public or Private Institutions of Higher Education:

- Tribal Colleges and Universities (TCUs)
- Hispanic-serving Institutions
- Historically Black Colleges and Universities (HBCUs)
- Tribally Controlled Colleges and Universities (TCCUs)
- Alaska Native and Native Hawaiian Serving Institutions
- Asian American Native American Pacific Islander Serving Institutions (AANAPISIs)
- Nonprofits Other Than Institutions of Higher Education

AHRQ’s authorizing legislation does not allow for-profit organizations to be eligible to lead applications under this research mechanism. For-profit organizations may participate in projects as members of consortia or as subcontractors only. Because the purpose of this program is to improve healthcare in the United States, foreign institutions may participate in projects as members of consortia or as subcontractors only. Applications submitted by for-profit organizations or foreign institutions will not be reviewed. Organizations described in section 501(c) 4 of the Internal Revenue Code that engage in lobbying are not eligible.

Unhealthy alcohol use, which affects almost a third of adults, is the third leading cause of preventable death and a major risk factor for many health, social, and economic problems. A study released by the Centers for Disease Control and Prevention estimated the annual economic burden of unhealthy alcohol use at $249 billion in 2010. Unhealthy alcohol use is associated with a wide range of adverse consequences related to physical and mental health (neurologic damage, cardiovascular disease, liver disease, depression, etc.), injuries (due to motor vehicle accidents, falls, drowning, etc.), social outcomes (intimate partner violence, child neglect, etc.), and economic indicators (unemployment, poverty, etc.). According to the 2015 National Survey on Drug Use and Health, 26.9% of adults reported binge drinking or heavy drinking over the past month and 15.1 million adults had alcohol use disorder (AUD). Between 2002 and 2013 the prevalence of AUD increased dramatically in African Americans, older adults, and individuals with lower levels of education and income. Unhealthy alcohol use affects individuals across the lifespan, which requires tailored interventions for prevention, screening, and treatment. Management of unhealthy alcohol use in older adults, for example, is complicated by concomitant medication use, presence of comorbid conditions, and age-related physiologic changes.

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians screen adults for alcohol misuse (the term “unhealthy alcohol use” was used in the 2018 draft recommendation) and provide brief behavioral counseling to persons engaged in risky or hazardous drinking. The USPSTF identified several effective screening tools such as Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) and Single-item Alcohol Screening Questionnaire (SASQ). The USPSTF also found that behavioral counseling interventions vary in their specific components, delivery methods, duration, and intensity. Interventions commonly included providing feedback (e.g., how the patient’s drinking compares to recommended limits, ways to reduce drinking) and other cognitive behavioral strategies (e.g., drinking diaries, action plans), involved the primary care team, and could be office- or web-based.

For individuals with moderate to severe AUD, medication-assisted therapy (MAT) has been shown to be an effective treatment. The U.S. Food and Drug Administration has approved three medications for treating AUD: acamprosate, naltrexone, and disulfiram. An AHRQ evidence report found moderate strength evidence for the effectiveness of oral acamprosate and naltrexone in reducing alcohol consumption for adult patients with AUD. (Evidence related to injectable naltrexone was limited at the time of the evidence review). While evidence did not support the effectiveness of disulfiram in trials, it may be recommended to individuals for whom acamprosate and naltrexone are not suitable and who understand the risk of alcohol consumption while taking disulfiram.

AHRQ Funding Opportunity Announcement (cont'd)
Screening and Management of Unhealthy Alcohol Use in Primary Care: Dissemination and Implementation of PCOR Evidence (RFA-HS-18-002)

(Continued from previous page)

Despite the serious public health impact of AUD and the demonstrated effectiveness of SBI and MAT, only 6.7% of adults with AUD receive treatment. Rates of screening for risky drinking use with standard instruments (13%), brief intervention (18%), and use of MAT (1.3%) are low in primary care settings. The complexity of managing unhealthy alcohol use, including AUD, in primary care may explain why rates of screening, brief intervention, and treatment with either referral or MAT are so low. There are numerous patient-, clinician-, and systems-level barriers, including stigma when seeking care for unhealthy alcohol use, beliefs among patients and clinicians that medications are ineffective, clinicians’ lack of knowledge about pharmacologic treatment options, limited availability of clinical decision support systems, unspecified clinical treatment protocols, limited shared decision making tools to engage patients and elicit their treatment preferences, lack of insurance coverage for AUD medications or complicated pre-authorization requirements, and limited capacity for referral and treatment.

Overcoming these barriers will be challenging, but supporting the use of a stepped approach to identifying and managing unhealthy alcohol use in primary care could have a significant positive impact on drinking behaviors and alcohol-related health outcomes. Screening all adults, brief intervention for patients with unhealthy alcohol use, initiating treatment in primary care for patients with mild to moderate AUD, and referral to treatment when appropriate are approaches to evidence-based models of care. Increasing SBI and MAT in primary care offers several advantages.

- Initiating treatment in the primary care setting may lead to more people treated, especially when access to specialty care is limited and insufficient to meet demand. Primary care clinicians are often the only medical professionals patients with AUD encounter.
- Screening, diagnosis, and treatment of unhealthy alcohol use within one setting can improve patient motivation and cooperation by preventing delays in treatment or referral.
- Unhealthy alcohol use can impact management of many common conditions, including hypertension, diabetes, and liver disease. Integration of treatment for AUD with management of other comorbid conditions can improve treatment adherence and overall patient outcomes.
- Familiarity with primary care settings and “routine” medical management to treat AUD can reduce stigma.
- The ongoing relationship and trust many patients have with their primary care clinicians and teams may help identify unhealthy alcohol use earlier, and, when needed, make treatment and referral more acceptable to patients.
- Patients may not need to travel as far to access their primary care clinicians compared to a specialty clinic, especially in rural communities or other areas where specialty treatment clinics are sparse.

Given the substantial burden of unhealthy alcohol use, increasing the delivery of SBI and MAT in primary care can have a significant impact on population health. However, it is well recognized that primary care is functioning in a complex and changing health care environment. New models for organizing and paying for primary care have changed the landscape of primary care. The movement from volume-based payment to value-based payment, the widespread use of electronic health records and a large number of often unaligned quality improvement programs have impacted primary care practices and clinicians. In addition, a growing opioid epidemic has affected the availability of specialty substance abuse care. The dynamic environment, combined with an ongoing need to integrate mental and behavioral health with primary care, provides a unique opportunity to support primary care’s ability to deliver evidence-based interventions for unhealthy alcohol use.

This Funding Opportunity Announcement (FOA) seeks applications that propose multicomponent strategies to increase the dissemination and implementation of PCOR findings for managing unhealthy alcohol use, focusing on SBI and MAT, in the primary care setting. A wealth of resources are available from federal agencies and other organizations that can be used to help facilitate the uptake and routine use of evidence-based practices for identifying and treating unhealthy alcohol use, including AUD.

Objectives: The goal of this FOA is to fund projects that use evidence-based approaches to disseminate and implement PCOR findings to improve identification and management of unhealthy alcohol use among adults in primary care practices. AHRQ is seeking applications that focus primarily on improving SBI and MAT in primary care, although screening, brief intervention, and referral to treatment (SBIRT) may be incorporated into the project as part of the continuum of care for patients whose needs cannot be adequately met within a primary care setting. AHRQ is not seeking applications that address populations other than adults (e.g., adolescents) or settings other than primary care (e.g., emergency departments, specialty settings). Applications that focus primarily on other populations or settings will not undergo peer review. For this project, applicants must focus on implementation of evidence-based interventions and evaluation of the effectiveness of the implementation.

Applicants should:
1. Convene a team, likely drawing from multiple organizations, with the expertise and experience to achieve the goals of this FOA. The project team should have existing strong relationships with primary care practices within the targeted region, expertise relevant to implementing SBI and MAT in primary care practices, and experience in disseminating and implementing PCOR findings. AHRQ encourages applicants to propose community partnerships with local, state, and/or regional organizations.
2. Define a discrete geographic region and develop a plan for recruiting and working with a minimum of 125 primary care practices that serve adult patients in that region.

For the purposes of this initiative, AHRQ encourages applicants to propose supporting small- and medium-sized practices (=10 lead clinicians) and small networks that are less likely than larger practices and networks to have resources for quality improvement. AHRQ also encourages applicants to propose working with practices that have low rates of screening, have access to community and social supports, and do not have integrated behavioral health services; if practices do not meet these specifications, applicants should explain how the proposed intervention will lead to additional improvements.

If a phased approach for recruiting and working with practices is used, 75% of practices should be engaged with the project within the first two years. (Applicants may propose uneven annual budgets commensurate with their approaches, as described in the Award Budget section.)

3. Develop a process and criteria for identifying PCOR findings and determining what findings will be disseminated to primary care practices. Applicants should plan to identify other PCOR findings to supplement the aforementioned PCOR findings related to the effectiveness of SBI and MAT for adults. Other PCOR findings may include additional evidence related to screening for and management of unhealthy alcohol use, findings regarding organizational practices related to implementation, findings on how primary care practices can engage patients, and findings on the use of technology to support implementation.

4. Define a comprehensive, evidence-based dissemination and implementation strategy to increase the use of SBI and MAT in primary care practices. (The implementation strategy may include referral to specialty treatment as an important step in the continuum of care. However, the strategy should focus primarily on providing MAT within the practice whenever appropriate.) While applications must focus on SBI and MAT, strategies related to other PCOR findings may be proposed in addition to the strategies to increase the use of SBI and MAT.

Applicants may propose a tailored approach to selecting an implementation strategy across practices, or they may propose multiple implementation strategies that vary in type, duration, and intensity.

Applications that use practice facilitation as a central and unifying strategy within the comprehensive approach are encouraged. (To learn more about practice facilitation, please visit: https://pcmh.ahrq.gov/page/practice-facilitation.) The comprehensive approach may also include other evidence-based strategies, such as practice assessment; the use of data, feedback, and benchmarking; the incorporation of electronic clinical decision support; peer-to-peer local learning; and expert consultation. To learn more, visit: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/capacity-building/pcmhqi2.html.

Applications that increase opportunities for shared decision making as patients select among options based on their own values, preferences, and goals as well as applications that increase the use of team-based delivery of services are encouraged.

Applicants planning to incorporate health information technology and computer-based clinical decision support (CDS) as part of their approach may want to visit http://cds.ahrq.gov. Resources exist (e.g., a CDS authoring tool) to help build interoperable CDS in standards-based formats to make it easier to implement CDS within electronic health records (EHRs) and to share CDS across disparate EHRs. Further, applicants can consider the CDS Connect repository (http://cds.ahrq.gov/cdsconnect ) as a potential dissemination mechanism for CDS artifacts developed over the course of their project.

5. Propose a robust, internal evaluation that addresses one or more evaluation questions of interest.

6. Plan to participate in a separate, more comprehensive program evaluation to be conducted by an external contractor selected by AHRQ.

To support the evaluation, applicants should plan to collaborate with the evaluator and other grantees, and plan to collect and share with the evaluator the following types of indicators:

- Number and types of personnel working with practices to support implementation
- Number and type of interactions between project staff/consultants and practices
- Type and quantity of strategies implemented
- Number of practices reached by the implementation
- Number of clinicians engaged
- Number of patients in target population
- Number and percent of patients screened in each practice
- Number and percent of patients who screen positive
- Number and percent of patients who received brief counseling intervention
- Number and percent of patients who received MAT
- Number and percent of patients referred to specialty clinics

Applicants are not expected to propose measuring patient-level health outcomes. However, since improving health outcomes is an important ultimate goal of PCOR, applicants that are able to efficiently and effectively measure one or more health outcomes (for example, reduction in alcohol intake) are encouraged.

Applicants should not plan to pay practices for participating in the project, but may compensate practices for data collection activities.

7. Propose a dissemination plan in conjunction with AHRQ (including the Office of Communications) and/or its contractors. The plan should consider dissemination of interim findings while the project is still in progress.

Plan to complete all work within 36 months of the project start date.

Visit the New Resources at NASMHPD's Early Intervention in Psychosis (EIP) Virtual Resource Center
These new TA resources, developed with support from the U.S. Substance Abuse and Mental Health Services Administration, are now available for download!

Snapshot of State Plans for Using the Community Mental Health Block Grant 10 Percent Set-Aside to Address First Episode Psychosis (NASMHPD/NRI)


Training Guide
Training Videos: Navigating Cultural Dilemmas About –
   1. Religion and Spirituality
   2. Family Relationships
   3. Masculinity and Gender Constructs

Transitioning Clients from Coordinated Specialty Care: A Guide for Clinicians (Jessica Pollard, Ph.D. and Michael Hoge, Ph.D.)

Best Practices in Continuing Care after Early Intervention for Psychosis (Jessica Pollard, Ph.D. and Michael Hoge, Ph.D.)

Training Webinars for Receiving Clinicians in Community Mental Health Programs:
   1. Overview of Psychosis
   2. Early Intervention and Transition
   3. Recommendations for Continuing Care

Addressing the Recognition and Treatment of Trauma in First Episode Programs (Andrea Blanch, Ph.D., Kate Hardy, Clin. Psych.D., Rachel Loewy, Ph.D. & Tara Neindam, Ph.D.)

Trauma, PTSD and First Episode Psychosis
Addressing Trauma and PTSD in First Episode Psychosis Programs

Supporting Students Experiencing Early Psychosis in Schools (Jason Schiffman, Ph.D., Sharon A. Hoover, Ph.D., Samantha Redman, M.A., Caroline Roemer, M.Sc., and Jeff Q. Bostic, M.D., Ed.D.)

Engaging with Schools to Support Your Child with Psychosis
Supporting Students Experiencing Early Psychosis in Middle School and High School

Addressing Family Involvement in CSC Services (Laurie Flynn and David Shern, Ph.D.)

Helping Families Understand Services for Persons with Early Serious Mental Illness: A Tip Sheet for Families
Family Involvement in Programming for Early Serious Mental Illness: A Tip Sheet for Clinicians

Early Serious Mental Illness: Guide for Faith Communities (Mihran Kazandjian, M.A.)

Coordinated Specialty Care for People with First Episode Psychosis: Assessing Fidelity to the Model (Susan Essock, Ph.D. and Donald Addington, M.D.)

For more information about early intervention in psychosis, please visit https://www.nasmhpd.org/content/early-intervention-psychosis-eip
Alzheimer's Disease and Related Dementias (ADRD) Summit 2019
March 14 & 15, 2019
Natcher Conference Center, NIH, Bethesda, MD

The Alzheimer’s Disease-and Related Dementias (ADRD) Summit 2019 will be held on March 14-15, 2019, at the NIH. The summit will update national research priorities for ADRDs including frontotemporal, Lewy body, mixed, and vascular dementias. Organized by the National Institute of Neurological Disorders and Stroke with collaboration across the NIH, the summit will be held in response to the National Plan To Address Alzheimer's Disease.

The goal of the 2019 Summit is to review and assess the progress made for each of the research recommendations developed by previous summits, amend or add recommendations based on recent scientific discoveries, solicit input from diverse stakeholders, and update priorities and timelines for addressing the Alzheimer’s disease-related dementias.

Registration is open and trainees can also find information on the ADRD Summit 2019 Trainee Travel Scholarship.

Merry Christmas & Happy New Year from the NASMHPD Staff!!

The Weekly Update will return January 4, 2019.
Final Day (September 14) Will Be a NASMHPD Commissioner- & Division-Only Annual Conference Meeting

Discounted Government Rate Room Block at the nearby Madison Hotel in D.C. (a 5-minute walk),

Exclusively for All NASMHPD Attendees

Contact Meighan Haupt, NASMHPD Chief of Staff, With Any Questions

DRUM ROLL, PLEASE!

The National Council is now accepting nominations for its 2019 Awards of Excellence!

National Council calls its Awards of Excellence program the Academy Awards of behavioral health, and since this is the organization’s 50th year, it is rolling out the red carpet to celebrate!

National Council is celebrating you – the individuals and organizations pushing the boundaries to improve care. This year there are award categories recognizing clinicians, organizations, doctors, caregivers, treatment teams, peers, and more. If you are or know a deserving individual or organization, nominate them by Monday, January 7, 2019!

The National Council is celebrating the 50 years it has put behavioral health care on the map, improving the lives of millions of Americans living with mental illnesses and addictions, as well as CEO Linda Rosenberg, who is stepping down after 15 years at the helm of the National Council, which she led to unprecedented growth and helped to become the voice of the behavioral health community.

The Awards of Excellence celebration will have it all – topnotch entertainment, heartfelt speeches, and golden trophies. Join the National Council in Nashville on Tuesday, March 26, 2019, during NatCon19 as it celebrates the Awards of Excellence honorees!

After you submit your nomination, register for NatCon19 and get your seats for the Awards of Excellence celebration.
NASMHPD Board of Directors

Wayne Lindstrom, Ph.D. (NM), NASMHPD President
Valerie Mielke, M.S.W. (NJ), Vice President
Marie Williams, L.C.S.W. (TN), Past President
Stephanie Woodard, Psy.D., (NV) Western Regional Representative
John Bryant (FL), Southern Regional Representative
Kevin Moore (IN), At-Large Member
Sheri Dawson, R.N. (NE), Secretary
Terri White, M.S.W. (OK), Treasurer
Mark Hurst, M.D. (OH), Mid-Western Regional Representative
Barbara Bazron, Ph.D. (MD), Northeastern Regional Representative
Doug Thomas, M.S.W., L.C.S.W (UT), At-Large Member

NASMHPD Staff

Brian M. Hepburn, M.D., Executive Director
Jay Meek, C.P.A., M.B.A., Chief Financial Officer
Meighan Haupt, M.S., Chief of Staff
Kathy Parker, M.A., Director, Human Resources & Administration (PT)
Raul Almazar, RN, M.A., Senior Public Health Advisor (PT)
Shina Animasahun, Network Manager
Genna Bloomer, M.P.H., Technical Assistance Research Associate
Cheryl Gibson, Senior Accounting Specialist
Joan Gilleece, Ph.D., Director, Center for Innovation in Trauma-Informed Approaches
Leah Harris, Trauma Informed Care Peer Specialist/ Coordinator of Consumer Affairs (PT)
Leah Holmes-Bonilla, M.A., Senior Training and Technical Assistance Advisor
Christy Malik, M.S.W., Senior Policy Associate
Stuart Yael Gordon, J.D., Director of Policy and Communications
Kelle Masten, Senior Project Associate
Jeremy McShan, Program Manager, Center for Innovation in Trauma-Informed Approaches
David Miller, MPAff, Project Director
Yaryna Onufrey, Program Specialist
Brian R. Sims, M.D., Senior Medical Advisor (PT)
Greg Schmidt, Contract Manager
David Shern, Ph.D., Senior Public Health Advisor (PT)
Timothy Turner, M.S.W., Ph.D., Senior Training and Technical Assistance Advisor
Jennifer Urf, J.D., Project Director, Training & Technical Assistance
Aaron J. Walker, M.P.A., Senior Policy Associate

NASMHPD Links of Interest

Benzodiazepine Use and Misuse Among Adults in the United States, Maust D.T., M.D., M.S., Lin L.A., M.D. & Blow F.C., Ph.D., Psychiatric Services, December 17
Decision Making About Pathways Through Care for Racially and Ethnically Diverse Young Adults With Early Psychosis, Myers N., Ph.D. et al., Psychiatric Services, December 17
Medicaid Providers Operating Under the Radar, Michael Hochman & Michelle Levander, Health Affairs Blog, December 18
Round-Up of 2018 Approved State Telehealth Legislation, Center for Connected Health Policy, December 5
Behavioral Health Workforce Projections, 2016-2030, Health Resources and Services Administration (HRSA), December 2018
Women Veterans: Managing Post-Deployment Stress, Department of Veterans Affairs, December 18
Is Treatment Adherence the Goal of Shared Decision-Making, Robert E. Drake, M.D., Ph.D., Psychiatric Services, December 1
Report to Congress on the Runaway and Homeless Youth Program for Fiscal Years 2014 and 2015, Department of Health and Human Services Administration for Children and Families, Family and Youth Services Bureau, December 2018
What a Barefoot Patient Taught Me About Health Equity, Michelle Byrne, M.D., M.P.H., Leader Voices Blog, American Academy of Family Physicians Website, December 18
10 Opportunities to Better Serve Individuals Dually Eligible for Medicaid and Medicare, State Medicaid Director Letter 18-012, Centers for Medicare and Medicaid Services, December 19
Archived Webinar: Supporting Children Who Lose Parents to Accidental Overdose, Institute for Research, Education & Training in Addictions, November 30