Study Finds Public Service Anti-Smoking TV Ads Featuring Former Smoker with Depression Successfully Influenced Consumers with Mental Illness to Consider Tobacco Cessation

A study published in the November 28 issue of Nicotine and Tobacco Research reports that a television advertisement in the Centers for Disease Control and Prevention’s (CDC’s) Tips from Former Smokers ad campaign featuring a former smoker with depression had an increased influence in convincing smokers with mental illness to stop smoking.

The study, conducted by Stanford University Prevention Research Center’s Judith J. Prochaska, PhD, MPH and colleagues, measured respondents’ intentions to quit and past 6-month quit attempts lasting at least 24 hours reported in a two-wave longitudinal online survey conducted before and after the 2016 20-week Tips campaign featuring “Rebecca” and other former smokers with various smoking-related health conditions. The study’s authors surveyed a nationally representative sample of 2,583 U.S. adult cigarette smokers, 77 of whom had mental health conditions (MH+) in their lifetimes and 1,806 of whom did not (MH-).

People living with mental health conditions are more likely to smoke cigarettes than people without mental health conditions and to experience significant tobacco-related health disparities. In the United States, from 2009 to 2011, nearly 20 percent of adults reported that they had some form of mental health condition in the past year. Among MH+ people, 36.1 percent of adults reported smoking cigarettes as compared with 21.4 percent of MH- people. Diagnosis of any mental health condition has been found to be associated with a higher smoking prevalence, heavier smoking, a higher level of nicotine dependence, more intense withdrawal symptoms when quitting, and lower quit rates. The smoking prevalence is particularly high among those living with schizophrenia, bipolar disorder, post-traumatic stress disorder, and alcohol or illicit drug use disorders. Depression is the most common mental health condition among smokers and is twice as common in smokers than nonsmokers and four times as common in heavy smokers, defined as smoking more than 20 cigarettes/day.

The Tips campaign’s former cigarette smokers with smoking-related illnesses were identified through a voluntary recruitment process. To participate in the campaign, participants had to have quit smoking more than 6 months previously and have a smoking-related health condition, verified by their physician, that motivated the individual to quit. For the mental-health-focused ads, an additional criterion was that the former smoker had to have been diagnosed with depression or anxiety.

The Tips campaign, which CDC has run since 2012, primarily targets smokers between the ages of 18 and 54 and, secondarily, family members, health care providers, and faith communities who can help reach smokers. Campaign goals include building public awareness of the immediate health damage caused by smoking and exposure to secondhand smoke, encouraging smokers to quit and making free help available, and encouraging smokers not to smoke around others and nonsmokers to protect themselves and their families from exposure to secondhand smoke.

The study examined quit intentions and quit attempts associated with exposure to the 2016 Tips campaign ads among MH+ and MH− cigarette smokers. Specifically, the authors examined whether the “Rebecca” Tips ads were associated with future quit intentions and quit attempts among MH+ and MH− smokers and whether the other (non-mental-health-related) Tips ads were associated with future quit intentions and quit attempts among each group.

The study authors found that, among MH+ respondents, greater exposure to the “Rebecca” ads was significantly associated with increased odds of intending to quit in the next 30 days and with reporting a quit attempt in the past 6 months. Among MH− respondents, greater exposure to the non-mental-health-related Tips ads was associated with increased odds of making a quit attempt.

The study’s authors conclude that mass media tobacco education campaigns can serve a critical role in reducing smoking overall, as well as among specific populations with a greater burden of smoking, including smokers with a history of mental illness in the United States.

The authors identify the following limitations to the study: First, data were self-reported via an online survey, which may be subject to recall bias. Second, “mental health condition” was defined using self-reported prior diagnosis of any one of several conditions, which may be subject to bias. Third, survey respondents lived in the community and did not include individuals institutionalized or incarcerated. Fourth, the “Rebecca” ad centered only on depression. Finally, the survey did not assess to what participants attributed their increase in quit intentions or quit attempts, nor did the survey assess other factors that could influence quitting behaviors, such as health insurance status or alcohol and drug use.

Congress yesterday unanimously passed a Continuing Resolution funding the Federal agencies that remained unfunded for Fiscal Year 2019 through December 21. President Trump is expected to sign the bill today.
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### 2018 NASMHPD TECHNICAL ASSISTANCE COALITION “BEYOND BEDS” WORKING PAPERS

- February 15 to 17, 2019 Pain Management and Addiction Summit in Austin, Texas
- 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
- Coming Soon: CSC On Demand, A New Coordinated Specialty Care Online Learning Platform
- Submit an Abstract to Present at the 10th Anniversary NIMH Conference - Global Mental Health Research Without Borders
- March 24 & 15 Alzheimer's Disease and Related Dementias (ADRD) Summit 2019 at NIH
- HRSA Notice of Funding Opportunity: Geriatrics Workforce Enhancement Program (GWEP – HRSA 19-008)
- NIMH (NIDA) & SAMHSA Funding Opportunity Announcement: HEALing Communities Study: Developing and Testing an Integrated Approach to Address the Opioid Crisis (Research Sites)
- NADD Fall Webinar Series
- The National Council is Now Accepting Nominations for its 2019 Awards of Excellence & Registration for Its March 26 Annual Meeting!
- SAVE THE DATE – September 2019 International Initiative for Mental Health Leadership (IIMHL) & International Initiative for Disability Leadership (IIMDL) Leadership Exchange in Washington, DC
- The Early Serious Mental Illness Treatment Locator Has Been Updated with NASMHPD/NRI Data
- NASMHPD Board & Staff
- NASMHPD Links of Interest
U.S. Life Expectancy Drops for Third Straight Year Due to Drug Overdoses and Suicides

For the third consecutive year, the U.S. life expectancy has dropped, from 78.9 years in 2014 to 78.6 years in 2017. The continued downward spiral is driven by the rising number of deaths from suicides and drug overdoses, according to a series of reports released by the Centers for Disease Control and Prevention (CDC). The last multiyear life expectancy drop recorded by CDC occurred in the early 1960s.

The latest CDC mortality report, released November 29, found that over 2.8 million deaths occurred in 2017, marking 2017 as the single year with the highest number of deaths. Male life expectancy decreased by one month from 2016 to 2017 (76.2 to 76.1, respectively), while female life expectancy remained unchanged at 81.1 years. The age-adjusted death rate increased for 7 of the 10 leading causes of death: 4.2 percent for unintentional injuries, 0.7 percent for chronic lower respiratory disease, 0.8 percent for stroke, 2.3 percent for Alzheimer disease, 2.4 percent for diabetes, 5.9 percent for influenza/pneumonia, and 3.7 percent for suicide. In contrast, life expectancy for cancer decreased by 2.1 percent. Heart disease and kidney disease did not significantly change.

According to a second data brief released by the CDC's National Center for Health Statistics (NCHS) on suicide mortality in the U.S. from 1999 to 2017, 47,000 Americans died by suicide in 2017—2,000 more suicides than in 2016. The age-adjusted suicide rate increased by 33 percent from 10.5 per 100,000 in 1999 to 14 per 100,000 in 2017.

The report also found that the age-adjusted suicide rate for rural counties was 1.8 times higher than in most urban counties (20.0 and 11.1 per 100,000, respectively). Similar to 2016, suicide is the second leading cause of death for ages 10 to 34 and the fourth leading cause for ages 35 to 54. Suicide rates were higher for both males and females in all age groups from 10 to 74 years in 2017, compared to rates in 1999.

The third CDC data brief showed that drug overdoses claimed 70,237 lives in 2017. The age-adjusted rate of drug overdose deaths in 2017 was 9.6 percent higher in comparison to 2016. The 9.6 percent increase was significantly lower than the 21 percent rise that occurred from 2015 to 2016, an indicator that the opioid epidemic might be stabilizing. Most alarming was that the age-adjusted rate of drug overdoses involving synthetic opioids (fentanyl, fentanyl analogs, and tramadol) increased by 45 percent from 2016 to 2017. The average rate of drug overdose with synthetic opioids increased by 8 percent per year from 1999 to 2013, with a jump of 71 percent per year from 2013 to 2017.

In contrast to gender differences in suicide rates, rates of drug overdoses were significantly higher for males than females. For males the rate was 29.1 per 100,000, whereas the rate was 14.4 per 100,000 for females. However, the report noted that the rate for females rose more sharply. In a CDC press release, CDC Director Robert Redfield commented,

The latest CDC data show that the U.S. life expectancy has declined over the past few years. Tragically, this troubling trend is largely driven by deaths from drug overdose and suicide. Life expectancy gives us a snapshot of the Nation’s overall health and these sobering statistics are a wakeup call that we are losing too many Americans, too early and too often, to conditions that are preventable. CDC is committed to putting science into action to protect U.S. health, but we must all work together to reverse this trend and help ensure that all Americans live longer and healthier lives.

Federal Health Insurance Exchange 2019 Open Enrollment Ends in 8 Days!!!

The Federal Health Insurance Exchange (also known as the Marketplace) Open Enrollment Period runs from November 1, 2018 to December 15, 2018, for coverage starting on January 1, 2019. Similar to last year, the Centers for Medicare & Medicaid Services (CMS) is taking a strategic and cost-effective approach to inform individuals about Open Enrollment, deliver a smooth enrollment experience, and use consumer feedback to drive ongoing improvements across the Exchange platform. Consumers can visit HealthCare.gov and CuidadodeSalud.gov to preview 2019 plans and prices before Open Enrollment begins.


To preview 2019 plans & prices now, visit: https://www.healthcare.gov/
Cigarette use among individuals with alcohol use disorders in the United States, 2002-2016: Trends overall and by race/ethnicity (November 2018)

Key findings:
- Cigarette use was persistently over twice as common among those with alcohol use disorders (AUDs) compared to without AUDs.
- The prevalence of smoking decreased significantly over time among respondents with and without AUDs; however, there were differences by race (see next bullet).
- There was no decline in smoking prevalence among non-Hispanic Black respondents with AUDs over time in contrast to a significant decrease for every other racial/ethnic group with and without AUDs.
WHAT WE KNOW
Tobacco Use and Quitting Among Individuals With Behavioral Health Conditions

SMOKING AMONG PEOPLE WITH BEHAVIORAL HEALTH CONDITIONS...

1) Exacerbates symptoms of behavioral health conditions.
Smoking is associated with worse symptoms and outcomes among people with behavioral health conditions, including greater depressive symptoms, greater likelihood of psychiatric hospitalization, increased suicidal behavior, and drug- and alcohol-use relapse.1,2

2) Reduces effectiveness of some medications.
Smoking can interact and interfere with psychiatric medications, often resulting in the need for higher medication doses to achieve the same therapeutic benefit.18

THE CASE FOR TOBACCO CESSATION TREATMENT

Behavioral health treatment settings have permitted tobacco use among clients, in part because of misperceptions that smoking could alleviate symptoms of mental health conditions and that cessation could interfere with treatment.1,2 However, research has shown that smoking can worsen symptoms and behavioral health outcomes, and quitting can improve mental health and substance use disorder treatment outcomes.1,2,8,9,10

QUITTING TOBACCO...

1) Supports behavioral health treatment.
Growing evidence indicates that quitting smoking has positive effects on and is associated with improvements in mental health. Quitting smoking does not interfere with behavioral health treatment and does not worsen or impede recovery from substance use disorders.1,2,7,13,14

2) Could improve mental health.
Quitting smoking is associated with a decrease in depression, anxiety, and stress, and can increase quality of life.2,7,9

3) Could make relapse less likely.
Quitting smoking is associated with an increase in long-term abstinence from alcohol and other drugs8 and a reduction in substance use disorder relapse.10

4) Has immediate physical health benefits.
Quitting smoking dramatically reduces the risk of heart disease, stroke, and cancer. For example, the risk for a heart attack drops sharply just one year after quitting.14


Key finding:
In the US, quit rates among individuals with past-month SPD are approximately half that of those without SPD and have not increased over the past decade.
SAMHSA FUNDING OPPORTUNITY ANNOUNCEMENT

National Center of Excellence for Infant and Early Childhood Mental Health Consultation (CoE-IECMHC) (SM-19-010)

Funding Mechanism: Grant
Anticipated Total Available Funding: $1,000,000

Anticipated Number of Awards: 1
Anticipated Award Amount: Up to $1,000,000 per year

Length of Project: Up to 5 years
Cost Sharing/Match Required?: No

Application Due Date: Tuesday, January 29, 2019
Anticipated Project Start Date: April 30, 2019

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
TA Network Webinars & Opportunities

**Adapting Wraparound for Older Youth and Young Adults Webinar**

Wraparound providers generally find that it is essential to adapt their process to better engage and retain older youth and young adults in Wraparound. This webinar describes the ways providers are adapting Wraparound for this population, and the challenges related to making adaptations. The webinar also outlines key research and practice questions that need attention in the future.

[Register Now](#)

**Direct Connect LC: Creating a Career Ladder for Youth Positions**

Led by Youth M.O.V.E. National, this LC is a virtual forum for youth and young adults to develop professional skill sets via virtual training opportunities, connect as a community to share and gather new resources, and unite with other youth advocates and professional peers from across the country. In this Direct Connect session, participants will learn how to create, identify, and support youth career advancement within organizations.

[Register Now](#)

**System of Care Expansion Leadership LC: Operationalizing Social Marketing, Strategic Communications, and National Children's Mental Health Awareness Day**

This LC will focus on how to strategically use social marketing to achieve system of care (SOC) expansion goals. The TA Network will provide an overview of technical assistance and resources on social marketing that will be available this year. Presenters will then focus on National Children's Mental Health Awareness Day in May 2019. Current plans for the national event will be shared, along with examples highlighting effective approaches in states, communities, and tribes to use Awareness Day activities and materials to engage stakeholders and generate support for children’s behavioral health and SOCs.

[Register Now](#)

**Faith-Based Engagement and Behavioral Health in Urban Communities: Model Programs and Strategies**

This webinar will focus on providing concrete strategies to engage faith based organizations in the development and implementation of services and supports for children, youth and young adults with mental health needs.

[Register Now](#)

**Early Psychosis Clinical High Risk LC: State of the Science**

Jr. Robert Heinssen, Director of the Division of Services and Intervention Research at the National Institute of Mental Health (NIMH), will present the “State of the Science” as a kick-off to the TA Network’s Early Psychosis Clinical High Risk LC. This new LC will include opportunities for accessing on-line resources and networking across communities. For more information, please contact Tamara Sale at salet@ohsu.edu.

[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. Applications are due: Jan. 11, 2019

[YICPM Cohort III: Application Packet](#)
People affected by mental illness and/or a substance use disorder smoke at far higher rates than the general public. Despite this, they are less likely to make quit attempts using evidence-based treatment. There is a compelling need to integrate tobacco policy and tobacco dependence treatment into the behavioral healthcare system. These two courses address this need. Through these courses, you will learn how to successfully address tobacco in your clinical setting.

TARGET AUDIENCE
Practitioners who provide health care to people with mental illness/substance abuse disorders, obligated to address the nicotine addiction of their patients as part of their scope of practice, including physicians, nurses, physician assistants, social workers, and mental health and substance abuse providers. Program Directors and Quality Improvement staff will also benefit from this activity, as they are obligated to adopt policies regarding the use of tobacco.

LEARNING OBJECTIVES
Upon completion of this activity, learners will:
1. Be able to articulate what constitutes evidence-based tobacco dependence treatment
2. Have developed a plan to integrate evidence-based tobacco dependence treatment and policy that is tailored to their setting
3. Within one year of completion, have a tobacco policy in place in their treatment setting and more evidence-based tobacco dependence treatment will be provided to patients.

Register/Enroll HERE

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 1

<table>
<thead>
<tr>
<th></th>
<th>Week 5 (Nov. 25 to Dec. 1)</th>
<th>Cumulative through Dec. 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Selections</td>
<td>773,250</td>
<td>3,198,163</td>
</tr>
<tr>
<td>New Consumers</td>
<td>224,132</td>
<td>812,263</td>
</tr>
<tr>
<td>Consumers Renewing Coverage</td>
<td>549,118</td>
<td>2,385,900</td>
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<tr>
<td>Consumers on Applications Submitted</td>
<td>1,071,125</td>
<td>5,126,236</td>
</tr>
<tr>
<td>Call Center Volume</td>
<td>701,277</td>
<td>2,676,812</td>
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<tr>
<td>Calls with Spanish Speaking</td>
<td>45,786</td>
<td>181,704</td>
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<tr>
<td>HealthCare.gov Users</td>
<td>2,435,992</td>
<td>9,059,798</td>
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<tr>
<td>CuidadoDeSalud.gov Users</td>
<td>84,459</td>
<td>337,524</td>
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<td>Window Shopping HealthCare.gov</td>
<td>200,172</td>
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<tr>
<td>Window Shopping CuidadoDeSalud.gov</td>
<td>6,707</td>
<td>26,052</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>State</th>
<th>Plan Selections</th>
<th>New Consumers</th>
<th>Renewing Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>7,065</td>
<td>29,802</td>
<td>66,329</td>
</tr>
<tr>
<td>Alabama</td>
<td>63,751</td>
<td>23,809</td>
<td>51,169</td>
</tr>
<tr>
<td>Arkansas</td>
<td>22,201</td>
<td>96,042</td>
<td>56,060</td>
</tr>
<tr>
<td>Arizona</td>
<td>55,090</td>
<td>77,912</td>
<td>123,918</td>
</tr>
<tr>
<td>Delaware</td>
<td>7,706</td>
<td>35,445</td>
<td>82,402</td>
</tr>
<tr>
<td>Florida</td>
<td>799,188</td>
<td>15,529</td>
<td>11,155</td>
</tr>
<tr>
<td>Georgia</td>
<td>182,018</td>
<td>184,891</td>
<td>75,729</td>
</tr>
<tr>
<td>Hawaii</td>
<td>7,806</td>
<td>8,184</td>
<td>414,350</td>
</tr>
<tr>
<td>Iowa</td>
<td>18,999</td>
<td>38,407</td>
<td>75,197</td>
</tr>
<tr>
<td>Illinois</td>
<td>100,218</td>
<td>15,255</td>
<td>100,457</td>
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<tr>
<td>Indiana</td>
<td>47,974</td>
<td>89,712</td>
<td>82,493</td>
</tr>
<tr>
<td>Kansas</td>
<td>35,783</td>
<td>16,935</td>
<td>7,728</td>
</tr>
<tr>
<td>Kentucky</td>
<td>30,172</td>
<td>31,068</td>
<td>10,214</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.
The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), is accepting applications for fiscal year (FY) 2019 Healthy Transitions: Improving Life Trajectories for Youth and Young Adults With Serious Mental Disorders Program grants (Short Title: Healthy Transitions). The purpose of this program is to improve access to treatment and support services for youth and young adults, ages 16-25, who have a serious emotional disturbance (SED) or a serious mental illness (SMI), hereafter referred to as serious mental disorders. It is expected that this program will improve emotional and behavioral health functioning so that this population of youth and young adults can maximize their potential to assume adult roles and responsibilities and lead full and productive lives.

Youth and young adults with SMI or SED between the ages of 16 and 25, including those with intellectual developmental disabilities, may not be working, in school, or in vocational and higher education programs. Some face the additional challenge of experiencing homelessness, or being in contact with the juvenile or criminal justice system, thereby increasing the likelihood of admissions to hospitals, mental health, and/or correctional facilities. Unfortunately, these same youth are among the least likely to seek help and may “fall through the cracks” and not receive the services and supports they need to become productive and healthy adults. It is imperative that appropriate outreach and engagement processes are developed and implemented to create access to effective behavioral health interventions and supports.

The overall goal of Healthy Transitions will be to provide developmentally appropriate, culturally and linguistically competent services and supports to address serious mental disorders among youth 16 to 25 years of age. This will be accomplished by increasing awareness, screening and detection, outreach and engagement, referrals to treatment, coordination of care, and evidence-informed treatment.

### Eligibility

Eligible applicants are:

- The state/tribal/territorial agency that oversees delivery of mental health services to youth and young adults, ages 16-25, with serious mental disorders. Territories include: Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

- Federally recognized (as defined in Section 4[b] and Section 4[c] of the Indian Self-Determination Act) American Indian/Alaska Native (AI/AN) tribes, tribal organizations and consortia of tribes or tribal organizations.

- Tribal organization means the recognized body of any AI/AN tribe; any legally established organization of AI/ANs which is controlled, sanctioned, or chartered by such governing body, or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of AI/ANs in all phases of its activities. Consortia of tribes or tribal organizations are eligible to apply, but each participating entity must indicate its approval. A single tribe in the consortium must be the legal applicant, the recipient of the award, and the entity legally responsible for satisfying the grant requirements.

Eligibility is limited because SAMHSA believes that only state/tribal/territorial agencies overseeing the delivery of mental health services to youth and young adults are in the unique position to leverage community agencies that can support the wide scale adoption of Healthy Transitions programs and services. The state/tribal agency has the capacity, knowledge, and infrastructure to assist communities with successful implementation of effective practices and strategies at the community level while also sharing and implementing effective and successful statewide strategies. Through the building of interconnected partnerships, Healthy Transitions can promote systems integration and strengthen the ability of states/tribes and communities to integrate prevention, intervention, and treatment services for youth and young adults with serious mental disorders.

Recipients who received funding under SM-18-010 Healthy Transitions are not eligible to apply for funding under this FOA. Recipients who received funding under SM-14-017 Now is the Time: Healthy Transitions are eligible to apply for funding under this FOA but must select two different communities with whom to partner with.

### Contact Information

**Program Issues:** Email Diane Sondheimer, or phone 240-276-1922 or Emily Lichvar or phone 240-276-1859.

**Grants Management and Budget Issues:** Email Eileen Bermudez, Office of Financial Resources, Division of Grants Management, SAMHSA, or phone 240-276-1412

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<table>
<thead>
<tr>
<th>Funding Mechanism: Grant</th>
<th>Anticipated Total Available Funding: $14,130,226</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticipated Number of Awards: Up to 14</td>
<td>Anticipated Award Amount: Up to $1,000,000 per year</td>
</tr>
<tr>
<td>Length of Project: Up to 5 years</td>
<td>Cost Sharing/Match Required?: No</td>
</tr>
<tr>
<td><strong>Application Due Date:</strong> Friday, December 21, 2018</td>
<td></td>
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</tbody>
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CMS Innovation Center Unveils New Maternal Opioid Misuse (MOM) Model

The Center for Medicare and Medicaid Innovation (Innovation Center) on October 23 announced a new Maternal Opioid Misuse (MOM) model as the next step in the Centers for Medicare & Medicaid Services’ (CMS) multi-pronged strategy in combating the nation’s opioid crisis.

The model is intended 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 vulnerable pregnant and postpartum Medicaid beneficiaries, supporting the coordination of clinical care and the integration of other services critical for health, wellbeing, and recovery for mothers and infants.

Substance use is now a leading cause of maternal death. Pregnant and postpartum women who misuse substances are at high risk for poor maternal outcomes, including pre-term labor and complications related to delivery and problems frequently exacerbated by malnourishment, interpersonal violence, and other health-related social needs. Infants exposed to opioids before birth also face negative outcomes, with a higher risk of being born pre-term, having a low birth weight, and experiencing the effects of neonatal abstinence syndrome (NAS). Medicaid pays the largest portion of hospital charges for maternal substance use, as well as a majority of the $1.5 billion annual cost of NAS.

Under the MOM model, the innovation Center will award as many as 12 cooperative agreements to states whose Medicaid agencies agree to implement the model with one or more “care-delivery partners” in their communities. The Medicaid agencies will have to develop and implement coverage and payment strategies, ensure provision of usable claims and encounter data to operate and evaluate the model, and coordinate with care-delivery partners to support information-sharing. The state will be expected to complete the application, which must demonstrate that it has partnered with at least one care-delivery partner.

Care delivery partners will provide services to beneficiaries, directly or through clinical partners. Their primary responsibilities will include establishing relationships with clinical partners, building capacity at the service-delivery level to support care delivery transformation, and implementing a coordinated and integrated care-delivery approach. The care-delivery partner may be a health system or a payer, such as a Medicaid managed care plan (MCP). The primary MOM model goals are to:

1. Foster coordinated and integrated care delivery: Support the delivery of coordinated and integrated physical health care, behavioral health care, and critical wrap-around services;
2. Utilize Innovation Center authorities and state flexibility: Leverage the use of existing Medicaid flexibility to pay for sustainable care for the model population; and
3. Strengthen capacity and infrastructure: Invest in institutional and organizational capacity to address key challenges in the provision of coordinated and integrated care.

The MOM model will require that pregnant and postpartum women with OUD receive a comprehensive set of services delivered in a coordinated and integrated approach. The necessary physical and behavioral health care (e.g., maternity care, medication-assisted treatment, mental health screening and treatment, etc.) would be provided by a team of healthcare professionals (e.g. maternity care and behavioral health providers) with the different specialties part of a single-delivery model. States will have the flexibility to define a specific set of services that satisfy the following five components:

1. Comprehensive care management;
2. Care coordination;
3. Health promotion;
4. Individual and family support; and
5. Referral to community and social services.

States will not be permitted to use MOM model funding to supplant or duplicate Medicaid-funded services already provided.

The Innovation Center will support states with three types of funding: implementation funding during Year 1, transition funding during Year 2, and milestone funding in Years 3 through 5 designed to encourage positive outcomes and help sustain care transformation through the use of a limited number of quality metrics.

CMS anticipates releasing a Notice of Funding Opportunity (NOFO) in early 2019 to solicit cooperative agreement applications to implement the MOM model. A maximum of $64.6 million will be available across the maximum of 12 state awardees, over the course of the five-year model. The NOFO, when published, will explain model requirements and eligibility criteria for potential applicants.
National Institute for Mental Health Request for Information (RFI):
Guidance on Current Clinical Experience with the Use of Ketamine for Suicide Prevention (NOT-MH-18-068)

Response Date: December 10, 2018

This Request for Information (RFI) seeks input on current clinical experiences in the use of ketamine (and/or related compounds) to reduce and prevent suicide ideation and behavior. NIMH seeks to identify research gaps in the clinical applications of these treatments.

**Background:** Suicide is the 10th leading cause of death, with rates increasing over several decades for all age groups, even while rates of many other major causes of premature mortality have declined. Despite increasing numbers of effective psychosocial interventions for suicide ideation and prevention of repeat suicide attempts, rapid, effective treatment options for individuals with acute/emergent suicide risk are limited.

The off-label use of ketamine for severe, and/or treatment resistant depression is occurring despite a limited evidence base that describes approaches to appropriate patient selection (e.g., exclusion criteria), safety data, and the duration of treatment needed to maintain the reported acute and dramatic relief from depression and suicide ideation. A recent consensus statement on the Use of Ketamine in the Treatment of Mood Disorders by the American Psychiatric Association noted that there are no post-marketing surveillance data on the on safety and effectiveness of ketamine for any psychiatric indication.

NIMH has declared suicide prevention research as a high priority and through this RFI, NIMH is seeking information on clinical experience in the use of ketamine (and/or related compounds) to reduce suicide events (ideation, attempts, and acute crisis care such as emergency care visits), and prevent relapse, with or without treatment-resistant depression (TRD). Experience with treatment modalities (infusion, nasal spray, oral pill form) that utilize ketamine across a number of clinical contexts (emergency departments, outpatient settings, inpatient settings, rehab settings) are of interest.

**Information Requested:** There are key questions to be addressed to build the evidence base for ketamine as rapid treatment to reduce suicide risk. In particular NIMH is interested in the community’s experience that could inform research that examines appropriate suicide risk treatment groups, treatment protocols, approaches to gathering safety information (during and post treatment), and approaches to examining treatment effects. This RFI seeks information from the community about experiences in current practice for using ketamine to treat suicide risk in the following areas:

- Clinician team training for/in infusion administration (e.g., anesthesiology, psychiatry), health care setting environments (e.g., supportive and calm setting; cardiac monitoring), and understanding the responsible parties to support the patient if in an outpatient setting;
- Clinical treatment indications (e.g., acute/emergent suicide risk per se; TRD [including definitions of TRD] plus suicide ideation; suicide risk plus PTSD, bipolar disorder, etc.);
- Clinical contraindications, including estimating rates of substance misuse that may be associated with treatment, and moderators that may be associated with later substance misuse;
- Exclusions for treatment (e.g., history of psychosis; recent substance use disorder; medical conditions; current benzodiazepine use; age groups);
- Drug administration issues such as delivery (e.g., IV, oral, nasal), dosing, sequencing, duration;
- Indicators of acute response such as self-reported increased energy, decreased depression and suicide ideation; objectively recorded physiological responses;
- Approaches to defining non-responders, and strategies for initial non-responders;
- Approaches to defining duration of response, and indicators of durability of response;
- Continuation interventions that are offered after initial response, including adjunct medications and/or neurocognitive/psychosocial interventions;
- Approaches for safety monitoring of side effects (hemodynamics; nausea; dissociation; muscular weakness; suicide ideation; extreme anxiety) at the time of drug administration; and
- Approaches for safety monitoring post drug administration, after acute and repeated treatments (e.g., how often and for how long)

**Submitting a Response:** All comments must be submitted via email as text or as an attached electronic document. Your responses should be addressed to: ResearchRTF@mail.nih.gov by December 10, 2018. Please include the Notice number in the subject line. Response to this RFI is voluntary. Responders are free to address any or all of the categories listed above. The submitted information will be reviewed by the NIH staff.

This request is for information and planning purposes only and should not be construed as a solicitation or as an obligation on the part of the Federal Government. The NIH does not intend to make any awards based on responses to this RFI or to otherwise pay for the preparation of any information submitted or for the Government's use of such information.
NASMHPD TECHNICAL ASSISTANCE COALITION WORKING PAPERS – BEYOND BEDS—2018

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
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 (neuropathological 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.

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)

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/pcmhqil2.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. Additional information is at https://grants.nih.gov/grants/guide/rfa-files/RFA-HS-18-002.html#_Part_1._Overview.
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)

**Windows of Opportunity in Early Psychosis Care: Navigating Cultural Dilemmas** (Oscar Jimenez-Soloman, M.P.H, Ryan Primrose, B.A., Hong Ngo, Ph.D., Ilana Nossel, M.D., Iruma Bello, Ph.D., Amanda G. Cruz, B.S., Lisa Dixon, M.D. & Roberto Lewis-Fernandez, M.D.)

**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](https://www.nasmhpd.org/content/early-intervention-psychosis-eip)
COMING SOON!

CSC OnDemand: An Innovative Online Learning Platform for Implementing Coordinated Specialty Care

The Center for Social Innovation, in partnership with experts from OnTrack, Navigate, and other CSC programs, has developed CSC OnDemand, a robust, multi-faceted online learning product.

The tool will offer scalable, efficient professional development for CSC teams.

We are seeking new CSC teams interested in participating in a research study. Our goal is to test this new training tool with practitioners in the field. Your feedback will help us refine the tool, share what we learn, and improve services for people experiencing first episode psychosis.

What can teams EXPECT?

- Participating sites will receive free CSC training, either standard training in-person or the CSC OnDemand, which combines multimedia content and expert-led online courses
- The training will be held in February 2019 (specific dates TBD)
- Participation will provide a unique opportunity to provide critical feedback on a new CSC training tool
- We plan to recruit 30 CSC teams to participate in this pilot

HOW CAN MY AGENCY TAKE PART?

Formal recruitment for CSC OnDemand pilot study will begin in November. Questions? Interested? Call Effy: 347-762-9086 or email at csccstudy@center4si.com
Health Resources and Services Administration (HRSA) Notice of Funding Opportunity
Geriatrics Workforce Enhancement Program (GWEP – HRSA 19-008)

Application Accepted: 11/08/2018 to 02/06/2019
Projected Award Date: 07/01/2019

The purpose of this program is to improve health outcomes for older adults by developing a healthcare workforce that maximizes patient and family engagement, and by integrating geriatrics and primary care.

Eligibility
Eligible applicants are accredited health professions schools and programs. The following entities are eligible applicants:

- Schools of Allopathic Medicine
- Schools of Dentistry
- Schools of Osteopathic Medicine
- Schools of Pharmacy
- Schools of Optometry
- Schools of Podiatric Medicine
- Schools of Veterinary Medicine
- Schools of Public Health
- Schools of Chiropractic
- Physician Assistant Programs
- Schools of Allied Health
- Schools of Nursing

The following accredited graduate programs are also eligible applicants:

- Health Administration
- Behavioral Health and Mental Health Practice, including:
  - Clinical Psychology
  - Clinical Social Work
  - Professional Counseling
  - Marriage and Family Therapy

Additional eligible applicants are:

- a health care facility
- a program leading to certification as a certified nurse assistant
- a partnership of a school of nursing such and facility
- a partnership of such a program and facility

Technical assistance (TA) webinar sessions for the GWEP will be held Wednesday, November 21 at the following times:

- 2:00 p.m. to 3:30 p.m. EST;
- 3:00 p.m. to 4:30 p.m. Atlantic ST;
- 1:00 p.m. to 2:30 p.m. CST;
- Noon to 1:30 p.m. MST;
- 11:00 a.m. to 12:30 p.m. PST;
- 10:00 a.m. to 11:30 a.m. Alaska ST; and
- •9:00 a.m. to 10:30 a.m. Hawaii ST

Adobe Connect URL for Participants: https://hrsa.connectsolutions.com/gwep_nofo_ta_11_7_18
Audio Conference details: Dial-in: 800-779-1443; Participant Code: 6613948

Alzheimer's Disease-and Related Dementias (ADRD) Summit 2019
March 14 & 15, 2019
Natcher Conference Center, National Institute of Health, Bethesda, MD

The Alzheimer's Disease-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.
The National Institute on Drug Abuse (NIDA), in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) is soliciting cooperative agreement applications with the intention of ultimately funding up to three research sites to participate in the ‘HEALing Communities Study: Developing and Testing an Integrated Approach to Address the Opioid Crisis’. The HEALing Communities Study will test the immediate impact of implementing an integrated set of evidence-based interventions across healthcare, behavioral health, justice, and other community-based settings to prevent and treat opioid misuse and Opioid Use Disorders (OUD) within highly affected communities. Highly affected communities of interest are counties or cities within states that are burdened with higher than average rates of overdose mortality and opioid-related morbidity, and other complications. Combined, all the communities participating in a single research site application must demonstrate having experienced at least 150 opioid related overdose fatalities (15% of these fatalities must be in rural communities) and a rate of 25 opioid related overdose fatalities per 100,000 persons or higher in the past year, based on the most recent complete year of data available. Communities within states ranking within the top third for age-adjusted drug overdose death rates in 2016, (per the Centers for Disease Control and Prevention) are of special interest. The integrated set of evidence-based prevention and treatment interventions should be designed to achieve the following goals: reduce overdose fatalities (by 40% in a 3-year period), and events; decrease the incidence of OUD; and increase the number of individuals receiving medication to treat OUD, retained in treatment beyond 6 months, and receiving recovery support services, and the distribution of naloxone compared to baseline.

Matching Requirement: A grantee from a for-profit organization funded under this funding opportunity announcement must match funds or provide documented in-kind contributions at a rate of not less than 50% of the total-Federally awarded amount, as stipulated by Public Law 115-141, the Consolidated Appropriations Act of 2018. The applicant will be required to demonstrate that matching funds and/or in-kind contributions are committed or available at the time of, and for the duration of, the award. Applications must identify the source and amount of funds proposed to meet the matching requirement and how the value for in-kind contributions was determined. All matching funds and/or in-kind contributions must be used for the portion of allowable project costs not paid by Federal funds under the grant award. NIH will not be the recipient, nor serve as a pass-through entity, of any such matching funds and/or in-kind contributions required under this announcement. See 45 CFR 75.306 for additional details.

Objectives and Scope: The objectives of this multi-site research cooperative are to support rigorous research to: 1) determine the health impact of implementing a data-driven multi-pronged approach to opioid misuse and OUD by enhancing the systematic delivery of evidence-based prevention and treatment interventions across multiple settings (required settings include healthcare, behavioral health, and justice); 2) identify facilitators and barriers to implementation and sustainability, including relevant payment policy strategies; 3) determine the incremental cost and cost-effectiveness of this multi-pronged approach; and 4) develop an evidenced based model for deploying effective data-driven multi-pronged approach(es) to reduce overdose deaths and prevent and treat opioid misuse and OUD in affected communities across the U.S.

Highly affected communities of interest could include counties, towns or cities (or a justified aggregate of counties, towns, or cities functioning as one community) within states burdened with higher than average rates of opioid-related overdose morbidity and mortality and other health consequences associated with opioid misuse. For this FOA there is a special interest in states ranking in the top third of age-adjusted drug overdose death rates in 2016, per the Centers for Disease Control. For a particular application, all of the communities participating in the research must be located in the same state and 30% of them must be rural. For this FOA, the minimum threshold for “highly affected” communities is having at least 150 opioid related overdose fatalities (15% of these fatalities must be from rural communities) and a rate of 25 opioid related overdose fatalities per 100,000 persons or higher, based on most recent complete year of data available. States within the top third for age-adjusted drug overdose death rates in 2016, (per the Centers for Disease Control and Prevention) are of special interest. For this FOA, opioids include prescription opioids and illicit opioids, such as heroin and illicitly made fentanyl (and related analogs). OUD refers to the clinical diagnosis defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

Applications must include plans to target multiple communities within a single state. The communities must be highly burdened by mortality, morbidity, and other health and psychosocial complications related to opioid misuse and OUD, and meet the minimum threshold specified above. The integrated set of evidence-based prevention and treatment interventions should be designed to reduce opioid overdose fatalities by at least 40% in three years (See Research Strategy section 2. Content and Form of Application Submission), across the combined communities participating in the cooperative agreement. Secondary aims of interest should be part of a linked pathway to reducing overdose fatalities. Required secondary outcomes to be addressed in communities participating in the research site include: reducing number of overdose events; decreasing the misuse of opioids, decreasing incidence of OUD and progression in severity to OUD or injection drug use; increasing the number of individuals (and percentage of individuals with OUD) receiving medication (methadone, buprenorphine, or naltrexone) and behavioral treatment; increasing the number of individuals and percent of individuals receiving medication and/or behavioral treatment that are retained in treatment beyond 6 months; increasing the number and percent of individuals participating in or completing treatment that are receiving recovery support services; and increasing access to naloxone.

In addition, applications must include structural aims that could decrease overdose fatalities and impact secondary outcomes. Required structural aims include approaches for:

- changing prescribing patterns to reduce the supply of prescription opioids;
- increasing the number of specialty treatment programs that provide medications for OUD;
- increasing the number of providers (doctors, nurses, nurse practitioners, physician assistants, pharmacists) prescribing and/or monitoring medications for OUD;
- increasing the number of providers (physicians, nurse practitioners, physician assistants) with a DATA 2000 waiver to prescribe buprenorphine in the office-based setting;
- increasing the availability of naloxone across a community to reduce fatal overdose fatalities;
- creating programs that can readily link individuals to treatment following an opioid overdose;
- increasing the use of screening to identify opioid misuse and intervention(s) to address misuse within healthcare and other settings;
- increasing evidence-based school and community-based opioid prevention services;
- increasing number of formal linkages between the justice system and healthcare and behavioral health.

Other secondary aims and outcomes would target other health conditions related to opioid misuse and OUD including but not limited to: monitoring the incidence of hepatitis C, HIV, endocarditis associated with injection drug use, neonatal abstinence syndrome, and improving access to prevention and treatment services for these conditions. Optional secondary aims, including structural aims, must be justified in the application.

Applications must include data in each community related to the primary outcome of opioid overdose fatalities and rates. Applicants should include the past two years of data available for communities to characterize opioid specific and other drug related overdose fatalities and rates to begin characterizing the trend. They should also include plans for improving the collection and quality of that data. Applicants must also propose how they will collect other data related to the required individual and structural level secondary outcomes and any optional outcomes included in the application. In addition, they must describe and ensure high quality data for all outcomes proposed in the study.

NIDA and SAMHSA recognize the complexity and heterogeneity of the opioid crisis across the country involving: variations in drug markets, demographics of individuals misusing opioids or with OUD, prevention and treatment infrastructure and capacity, legal and regulatory issues associated with OUD treatment, structure of financing and availability of health insurance, severity of stigma, justice system approaches, and socio-economic and policy differences within communities. This heterogeneity requires research sites to work with highly affected communities to understand the unique aspects of their opioid crisis, available resources, and develop a tailored approach to effectively address local needs.

Research site applicants are therefore required to propose a conceptually driven approach (e.g. the Communities that Care model for integrating evidence-based prevention, https://www.communitiesthatcare.net, or other comprehensive community implementation models) to guide communities through the process of 1) organizing and implementing a local coalition to provide local leadership and context for the interventions; 2) using standardized data to explicate the nature, severity and trends of the local opioid crisis, including prevention and treatment resources and gaps; 3) developing a data-driven strategic plan to implement evidence-based prevention and treatment interventions linked to local needs across multiple systems with goals, milestones, training, and technical support; 4) deploying the strategic plan; 5) measuring the impact; and 6) adjusting interventions based on these assessments of impact.

Specific evidence-based prevention and treatment interventions will vary according to community need and infrastructure but at a minimum must include interventions aligned with the required study aims above in the following areas: prevention efforts related to opioid use, misuse, OUD, and overdose; screening and assessment of opioid misuse and OUD; linkages and engagement in treatment; use of medications and behavioral therapies to treat OUD; and ongoing recovery support services. Applications also must specify plans to deliver these integrated evidence-based interventions across multiple settings and are required to include healthcare, behavioral health, and justice settings. Other community based settings should be included as appropriate to their role in addressing the prevention and treatment of opioid misuse and OUD and the reduction of opioid overdose.

Each research site is required to select at least 15 communities, of which at least 30% must be rural, within a single state to participate in the research. There are a number of geographic classifications for "rural". For additional information see: https://www.ruralhealthinfo.org/am-i-rural/help . A community may be a county, a city or town, or a well justified collection of counties, cities, and/or towns that will be treated as a single community. The research plan must include a clear justification for selection of these communities based on overdose mortality, and opioid-related morbidity, and other complications associated with the opioid crisis and the infrastructure and resources leveraged to collect data, provide services, train clinicians, conduct the research, etc. Applicants are also encouraged to include communities with Native American/American Indian populations and work with local tribal leaders to include tribal communities in the study. Also, the research plan must address how variability in population size for the communities will be addressed since this impacts study power (e.g. aggregating communities with a smaller population into a single unit, so that all proposed communities or community aggregates are of similar size).

NIDA and SAMHSA anticipate reaching a total of 40-50 communities through all funded HEALing Communities Study research sites. In considering what communities to include in the study, applicants must demonstrate a strong understanding of the magnitude of the opioid problem in the proposed study communities and ensure that sufficient numbers of individuals and a sufficient rate of individuals per 100,000 are affected by opioid misuse, OUD, and opioid related overdose fatalities to have reliable estimates of impact. This is
(Continued from previous page) particularly true for opioid overdose fatalities, a relatively rare outcome. Thus, applicants must document that a total of at least 150 opioid related overdose fatalities (at least 15% of the fatalities occurred in rural communities) and a rate of 25 opioid related overdose fatalities per 100,000 persons or higher were reported across the combined proposed study communities, based on most recent complete year of available data. Communities within states ranking in the top third of age-adjusted drug overdose death rates in 2016, per the Centers for Disease Control and Prevention are of special interest.

Applicants must provide plans for leveraging toolkits, decision support tools, platforms, infrastructure, data collection initiatives, and prevention, treatment, and recovery support services funded via federal, state, local, foundation, and other entities to address the opioid crisis (e.g. services supported by state, local, and philanthropic initiatives, justice-led initiatives, Centers for Disease Control and Prevention programs, Health Resources and Services Administration funding, etc. These platforms and resources should address both data collection and the delivery of prevention and treatment services.

Applicants should specifically demonstrate how they plan to reduce health coverage payment barriers related to medication for OUD and supporting services, such as behavioral health services, including through the state Medicaid program. The Centers for Medicare and Medicaid Services (CMS) has established opportunities for state Medicaid agencies through 1115 demonstration waiver authority to have greater flexibility to tailor their Medicaid programs to address OUD. has issued clarifications on using Medicaid funding to enhance technology systems used to address the opioid epidemic, and has outlined a framework for states to provide Medicaid services related to authorities. States interested in technical assistance related to these activities can review online resources or email: sudcms@us.ibm.com

In addition, applicants should demonstrate how they plan to reduce health coverage payment barriers related to medication for OUD and supporting services, such as behavioral health services, including through the state Medicaid program. The Centers for Medicare and Medicaid Services (CMS) has established opportunities for state Medicaid agencies through 1115 demonstration waiver authority to have greater flexibility to tailor their Medicaid programs to address OUD. has issued clarifications on using Medicaid funding to enhance technology systems used to address the opioid epidemic, and has outlined a framework for states to provide Medicaid services related to authorities. States interested in technical assistance related to these activities can review online resources or email: sudcms@us.ibm.com

Applicants must propose a cluster study design (e.g. a parallel group- or cluster-randomized trial, or a cluster stepped wedge design) to test effects of the “intervention” in the communities participating in the research. The proposed study, data analyses, and publications must be completed within the funding period for this opportunity announcement. Study designs proposing “control” communities should propose how all communities would receive some benefit and not be harmed from participating in the research. In addition to the detailed study design, applicants must provide an analysis plan and power calculation for the multi-site study (i.e. for the three research site grantees combined). Sufficient detail should be provided on study design, analysis plan, and power calculations to replicate power calculations and evaluate the assumptions and parameter estimates used in the calculations. Applicants should specify data sources used to determine mortality and morbidity and estimate the magnitude of the population of individuals reporting misuse and those with OUD in research communities, including the number of overdose deaths and rates to ensure sufficient case counts and base rates to detect differences and deploy interventions. Applicants should justify the quality of drug-specific mortality data used and whether it is currently being collected or will need to be collected de novo. Plans for dealing with confounders including time, secular events, contamination, varying intervention effects, treatment and site heterogeneity, etc. must be addressed.

Researchers should partner with multiple communities and organizations within those communities willing to collaborate in delivering an integrated evidence-based prevention and treatment system to meet the needs of their population. These organizations will be expected to adapt, change, and integrate efforts across multiple sectors. Applicants are required to partner with healthcare, behavioral health, and justice settings. They should also partner with other community based organizations necessary to implement the multi-pronged approach (e.g. police, fire department, faith based organizations, schools, affordable housing, social services, business and economic developers, etc.) to meet the needs of the study. Applicants are encouraged to collaborate with one or more members of each community participating in the research with the ability to influence contracting and the type, quality, and support for prevention and treatment services. Documentation of these partnerships is essential and includes an understanding and willingness by community partners to participate in the research. This documentation should be included in letters of support. Applications must include a list of these partners (with rationale) for each community partner participating in the research. Finally, each research site must convene a Community Advisory Board comprised of representatives from communities involved in the research, consumers of services, and other subject matter experts to provide guidance and recommendations for study design, execution, and dealing with any problems encountered in the conduct of the research.

Each research site must include one highly involved governmental official (e.g., high-level official in the state substance abuse agency) as key personnel. This person must have the documented ability to influence the contracting, type, quality, and integration of multiple systems across all communities involved with the research site to develop a systematic approach to opioid overdose fatalities, opioid misuse, OUD treatment, and prevention and answer research questions described below. This person must be included among the key personnel on the research study and to be involved in all aspects of study design and execution. Applicants should designate a level of effort for this person and as allowable include funding for time and research-related activities for this person in the research site budget. Other areas of expertise for research sites might include epidemiology and modeling, public health and healthcare data systems, data harmonization and integration, health services research, drug abuse prevention, OUD and treatment, systems science, community-based participatory research, implementation science, and health economics.

In addition, if present in the state where the research will take place, applicants are strongly encouraged to take advantage of NIDA’s Clinical Trials Network (https://www.drugabuse.gov/about-nida/organization/cctn/crn) and the Clinical and Translational Science Award Program funded by the National Center for Advancing Translational Sciences (https://ncats.nih.gov/ctsa/about).

2018 NADD Fall Webinar Series

From the convenience of your own office or conference room, you and your colleagues can participate in a multitude of educational resources; varying in experiential degree. All without having to leave the office! A learner may sign up for a single webinar or for as many as he or she wishes to take.

Register HERE Not Later Than Five Days Prior to a Scheduled Webinar

Webinar registration is open to all participants.

### Tuesday, December 11, 3:00 p.m. E.T.
**Making an Impact: How Managed Care Organizations Can Enter the Equation**

**Level:** Intermediate  
**Presenters:** Renea Bentley, Ed.D., LPC-MHSP, Sr. Manager of Behavioral Health Programs; Amy Eller, MS, LPC-MHSP, Amerigroup Tennessee, Nashville, TN

This session will share Amerigroup’s integrated care coordination approach for individuals with Intellectual and developmental disabilities. We will outline our approach to addressing the physical, behavioral, and social needs of individuals with IDD holistically, providing access to a wide array of services through a single coordination point—supporting meaningful community integration and reducing complexity not only for the individual, but for their families and caregivers.

### Thursday, December 13, 3:00 p.m.
**This Can’t Wait! Disability Education for First Responders: A Train-the-Trainer Session**

**Level:** Beginner  
**Presenter:** Shannon Benaitis, PHR, Albatross Training Solutions, Darien, IL

Police officers in communities where we provide services become default responders to mental health crises. These encounters are statistically more likely to result in use of force or shots fired when they involve people with developmental disabilities and/or mental illness. It’s up to us, as provider agencies, to educate first responders on those we serve. Leave this Train-the-Trainer session with a training you can take to your local police and fire departments to get these informative and necessary conversations started.

### Wednesday, December 19, 3:00 p.m.
**Wellness Recovery Action Plans (WRAP®)**

**Level:** Beginner / Intermediate  
**Presenters:** Stan Schmidt, Community Integrated Work Program, Inc., North Highlands CA; Susan O’Nell, DirectCourse Content Quality Assurance & Enhancement, Research and Training Center on Community Living (NIDILRR), Institute on Community Integration, University of Minnesota, Minneapolis, MN

Wellness Recovery Action Planning (WRAP®) is an evidence-based practice in the area of mental health. It is a self-directed, peer-facilitated and person-centered planning process. Join Stan and Susan as they share lessons learned from their first seminar in 2018 to a core group of people affiliated with CIWP (service participants and staff).

**Cost for Individual Webinars**
- NADD Members - $78  
- Non-Members - $98

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**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.
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

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.
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NASMHPD Links of Interest

INTRODUCTION TO “MEDICAID’S INSTITUTIONS FOR MENTAL DISEASES (IMD) EXCLUSION RULE: A POLICY DEBATE,” Lisa B. Dixon, M.D., and Howard H. Goldman, M.D., Ph.D.; MEDICAID’S INSTITUTIONS FOR MENTAL DISEASES (IMD) EXCLUSION RULE: A POLICY DEBATE ARGUMENT TO RETAIN THE IMD RULE, Jennifer Mathis, J.D.; and MEDICAID’S INSTITUTIONS FOR MENTAL DISEASES (IMD) EXCLUSION RULE: A POLICY DEBATE ARGUMENT TO REPEAL THE IMD RULE, Aaron Glickman, B.A., and Dominic A. Sisti, Ph.D., PSYCHIATRIC SERVICES, December 3

WHEN WILL WE SOLVE MENTAL ILLNESS?, Benedict Carey, New York Times, November 19

CAN WE STOP SUICIDES?, Moises Velasquez-Manoff, New York Times Opinion Section, December 2

ADOLESCENT BRAIN COGNITIVE DEVELOPMENT (ABCD) STUDY COMPLETES ENROLLMENT, ANNOUNCES OPPORTUNITIES FOR SCIENTIFIC ENGAGEMENT, National Institutes of Health News Release, December 3

REFORMING AMERICA’S HEALTHCARE SYSTEM THROUGH CHOICE AND COMPETITION, Secretaries of Health and Human Services, Treasury, and Labor Departments, December 3

HOW STATES USE MEDICAID MANAGED CARE TO DELIVER LONG-TERM SERVICES AND SUPPORTS TO CHILDREN WITH SPECIAL HEALTH CARE NEEDS, Kate Honsberger, Erin Kim & Karen VanLandeghem, National Academy for State Health Policy, December 3

VA-LED STUDY ASKS: IS ALCOHOL HEALTHY?, Michael Richman, Vantage Point, U.S. Department of Veterans Affairs, November 2018 & DAILY DRINKING IS ASSOCIATED WITH INCREASED MORTALITY, Hartz S.M., et al., ALCOHOLISM: CLINICAL & EXPERIMENTAL RESEARCH, November 2018

PROPOSED PUBLIC CHARGE RULE COULD JEOPARDIZE RECENT COVERAGE GAINS AMONG CITIZEN CHILDREN, Genevieve M. Kenney, Jennifer M. Haley & Robin Wang, Urban Institute, December 4

NOW MENTAL HEALTH PATIENTS CAN SPECIFY THEIR CARE BEFORE HALLUCINATIONS AND VOICES OVERWHELM THEM, Pam Belluck, New York Times, December 3

GOVERNMENT FAVORED TO ENSURE HEALTHCARE, BUT NOT DELIVER IT, Frank Newport, Gallup, December 3

FOR THE POOR, OBAMACARE CAN REDUCE LATE RENT PAYMENTS, Kriston Capps, CityLab, December 4

HEALTH PLANS WITH MORE RESTRICTIVE PROVIDER NETWORKS CONTINUE TO DOMINATE THE EXCHANGE MARKET, Elizabeth Carpenter & Chris Sloan, Avalere Health, December 4