Behavioral health issues are sending more and more kids and teens to hospital emergency rooms, and that increase has been most dramatic among minorities, a new report shows.

Between 2012 and 2016, admissions shot up more than 50 percent in the United States, according to study author Dr. Anna Abrams who investigated data on mental health-related visits to emergency departments by children up to age 21 that was collected from the reports of 45 hospitals within the Pediatric Health Information System. Dr. Abrams is a resident pediatrician and health care disparities researcher at the Children's National Health System in Washington, D.C.

Dr. Abrams told NBC News the findings were “disheartening” and “shocking”. She said “Community resources for mental health, especially for youth, are incredibly scarce.” Dr. Abrams launched her national study after she started to see, in her clinical practice, increasing rates of mental health presentations.

"Prior to our study, we knew that an increasing number of children with mental health concerns were coming to the nation's pediatric emergency departments. What this new research demonstrates is that not only are these visits increasing at a staggering rate, but that there are significant racial and ethnic disparities in the trends of who visits pediatric emergency departments for mental health issues," Dr. Abrams told Health Day News reporter Alan Mozes in an article published November 2.

Dr. Abrams says the reasons for the increase are unclear. "Our study really was an effort to characterize the frequency of these emergency department visits," Abrams explained. "It was not designed to investigate the potential reasons that triggered these visits. We do plan to investigate this question in future work."

But she suggested to NBC News' Maggie Fox in an interview published November 2 that it could be due to the scarcity of mental health professionals who can help children. There's also clearly a real increase in some mental health issues. She also noted that people are talking more openly about depression, anxiety, and other common mental health problems and that may make parents feel more comfortable about seeking help for their children. But it can be difficult for those parents to find specialized care outside the E.D.

Abrams and her colleagues presented their preliminary findings last Friday at an American Academy of Pediatrics meeting, in Orlando, Fla.

The study team said that more than 17 million American children struggle with some form of psychiatric illness. In recent years, that has meant that somewhere between 2 percent to 5 percent of all pediatric visits to the emergency department have been related to mental illness concerns. The mental health issues covered by the analysis included:

- acute anxiety and delirium states;
- adjustment disorders and neuroses;
- alcohol abuse;
- drug abuse (including opioid abuse);
- bipolar disorders;
- childhood behavioral disorders;
- depression;
- major depressive disorders;
- disorders of personality and impulse control;
- eating disorders;
- psychosis; and
- schizophrenia.

During the study period, investigators determined that more than 293,000 children -- who were an average age of just over 13 -- had been diagnosed for some type of mental illness in a pediatric emergency room between 2012 and 2016, with the number of visits rising significantly during the study period, from about 50.4 visits for every 100,000 children in 2012 to 78.5 visits per 100,000 by 2016—a 55 percent increase over the period.

When sorted by race, the investigators found that the increase was higher for black and hispanic children than or white children. Nearly 52 out of every 100,000 white children were visiting an ER for a mental health issue by 2016. But among black children, that figure shot up to 78 per 100,000, a 64 percent increase over the five years. Among Hispanic youth, the increase was 77 percent over the study period.

The majority of all pediatric mental health visits (55 percent) were covered by some form of public insurance.

(See page 3 for related story.)
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Coming Soon: CSC On Demand, A New Coordinated Specialty Care Online Learning Platform–Recruitment Begins in November

Submit an Abstract to Present at the 10th Anniversary NIMH Conference - Global Mental Health Research Without Borders

Call for Presentations for NICWA’s 37th Annual Protecting Our Children National American Indian Conference on Child Abuse and Neglect, March 31 to April 3, 2019

March 24 & 15 Alzheimer's Disease-and Related Dementias (ADRD) Summit 2019 at NIH

The Early Serious Mental Illness Treatment Locator Has Been Updated with NASMHPD/NRI Data

National Institute on Aging’s Alzheimer's and Related Dementias Clinical Trials are Looking for Volunteers

The National Council is Now Accepting Nominations for its 2019 Awards of Excellence & Registration for Its March 26 Annual Meeting!

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

SAVE THE DATE – September 2019 International Initiative for Mental Health Leadership (IIMHL) & International Initiative for Disability Leadership (IIMDL) Leadership Exchange in Washington, DC

Federal Health Insurance Exchange Open Enrollment Has Begun

NASMHPD Board & Staff NASMHPD Links of Interest
New MHA Report Finds Mental Illness, Suicidal Ideation Increasing in Youth

The U.S. has seen an alarming rise in mental health conditions and suicidal thoughts among youth, according to Mental Health America’s (MHA) fourth annual The State of Mental Health in America (2019) report.

Most alarming for youth:

- Rates of youth with at least one Major Depressive Episode (MDE) in the past year increased from 11.93 percent to 12.63 percent in comparison to last year’s report. The number of youths (ages 12 to 17) experiencing MDE increased by 175,000 from last year’s report.
- Sixty-two percent of youth with MDE didn’t receive any mental health treatment.
- Twenty-five percent of youth with severe depression received ongoing treatment (7 to 25 visits per year).
- Fifty percent of screened teen-agers ages 11 to 17 reported they often had thoughts of suicide or self-harm.

According to the report, more than 44 million adults in the United States have a mental health condition. Of those, approximately 4.13 percent report experiencing a severe mental illness. Over 9.8 million (1 in 5) adults report having serious suicidal thoughts—an increase of 200,000 from last year.

Some encouraging news is that mental health and substance use disorders decreased slightly within the last five years (18.19 percent to 18.07 percent, 8.76 percent to 7.93 percent, respectively). Another glimmer of hope was a 2.5 percent decrease in the number of adults with mental health conditions who were uninsured. But 57 percent of adults (over 24 million) report not receiving any mental health treatment.

The report also spotlighted childhood trauma by detailing its long-term impact, noting CDC’s estimate of 1 in 4 children experiencing maltreatment in their lifetime, with 1 in 7 experiencing trauma in the past year. The report cites a 3.8 percent increase in childhood abuse cases from 2011 to 2015 reported by the U.S. Department of Health and Human Services Children’s Bureau.

The authors highlight that trauma can cause permanent changes to a child’s brain and affect a child’s ability to process and retain information, regulate negative emotions, and process or respond to environmental threats. The impact of the trauma may surface when a child enters the school system because “they are expected to adhere to practices and policies that conflict with their emotional and behavioral functionalities.” MHA’s data from 561 youths interviewed found that survivors of trauma reported feelings of hopelessness, and showed signs of depression and anxiety. Further analysis found that mood disorders often precede behavioral issues among youth trauma survivors.

The report analyzed 15 mental health measures to rank all 50 states and the District of Columbia using national survey data from SAMHSA’s National Survey of Drug Use and Health (NSDUH) and CDC’s Behavioral Risk Factor Surveillance System (BRFSS). The authors say these national measures “provide a strong foundation for understanding the prevalence of mental health concerns, as well as issues of access to insurance and treatment.” But limitations to the national data include not capturing high-risk populations such as people who are homeless, in active duty military service, or institutionalized in jails and hospitals; the inclusion of those individuals would raise the percentage of people with a mental illness.

The goals of the annual MHA report are to: provide up-to-date data and information on the mental health status among youth and adults for policy and program planning, analysis, and evaluation; track changes in the prevalence of mental health conditions and access to insurance and treatment; examine how current national data impacts legislation and policies; and improve dialogue to increase awareness on the mental health needs of adults and youth.

In an MHA press release, Paul Gionfriddo, MHA president and CEO concluded, “We must continue to improve access to care and treatments, and we need to put a premium on early identification and early intervention for everyone with mental health concerns.

Voters in Three Republican-Held States Chose Medicaid Expansion, but Montana Voters Roll it Back

Voters in three Republican-held western states voted on November 6 to expand the Medicaid programs in their states to low-income adults.

Voters in Nebraska approved a Medicaid expansion ballot measure, 53 to 47 percent, despite opposition from the state’s Republican governor and legislators. Gov. Pete Ricketts (R) had actively campaigned against expansion, but has not said he would oppose the measure if it passes.

Bills to expand eligibility for Medicaid have been introduced, and failed, in the Nebraska legislature for six straight years. The approval of the ballot measure means an estimated 90,000 people will now be eligible for Medicaid coverage.

Idaho voters on Tuesday also approved their ballot measure expanding Medicaid coverage, 61 to 39 percent, Supporters turned to a ballot initiative after years of failing to get expansion through the Republican-controlled state legislature. The campaign got a boost when Governor Butch Otter (R) endorsed expansion last week. Supporters say the measure will expand coverage to 62,000 low-income adults.

Expansion also gained approval in Utah with 54 percent of the vote. Meanwhile, 55 percent of Montana voters rejected continuing a 2015 expansion that is due to sunset if not funded by a proposed $2 per pack additional tax on cigarettes and e-cigarettes. With that vote, coverage will end in June 2019 for 100,000 Montanans currently covered if the legislature does not find another source of funding in its upcoming session.
2018 Gubernatorial Election Results

Parties Changed

<table>
<thead>
<tr>
<th>State</th>
<th>Outgoing</th>
<th>Incoming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>Bill Walker (I)</td>
<td>Mike Dunleavy (R)</td>
</tr>
<tr>
<td>Illinois</td>
<td>Bruce Rauner (R)</td>
<td>J.B. Pritzker (D)</td>
</tr>
<tr>
<td>Kansas</td>
<td>Jeff Colyer (R)</td>
<td>Laura Kelly (D)</td>
</tr>
<tr>
<td>Maine</td>
<td>Le Page (R)</td>
<td>Janet Mills (D)</td>
</tr>
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<td>Michigan</td>
<td>Rick Snyder (R)</td>
<td>Gretchen Whitmer (D)</td>
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<tr>
<td>Nevada</td>
<td>Brian Sandoval (R)</td>
<td>Steve Sisolak (D)</td>
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<tr>
<td>New Mexico</td>
<td>Susanna Martinez (R)</td>
<td>Michelle Lujan Grisham (D)</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Scott Walker (R)</td>
<td>Tony Evers (D)</td>
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Parties Unchanged, Governor New

<table>
<thead>
<tr>
<th>State</th>
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<tbody>
<tr>
<td>California</td>
<td>Jerry Brown (D)</td>
<td>Gavin Newsom (D)</td>
</tr>
<tr>
<td>Colorado</td>
<td>John Hickenlooper (D)</td>
<td>Jared Polis (D)</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Dannel Malloy (D)</td>
<td>Ned Lamont (D)</td>
</tr>
<tr>
<td>Florida</td>
<td>Rick Scott (R)</td>
<td>Ron DeSantis (R)</td>
</tr>
<tr>
<td>Georgia</td>
<td>Nathan Deal (R)</td>
<td>Brian Kemp (R) (pending)</td>
</tr>
<tr>
<td>Idaho</td>
<td>Butch Otter (R)</td>
<td>Brad Little (R)</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Mark Dayton (D)</td>
<td>Tim Walz (D)</td>
</tr>
<tr>
<td>Ohio</td>
<td>John Kasich (R)</td>
<td>Mike DeWine (R)</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Mary Fallin (R)</td>
<td>Kevin Stitt (R)</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Dennis Daugaard (R)</td>
<td>Kristi Noem (R)</td>
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<td>Tennessee</td>
<td>Bill Haslam (R)</td>
<td>Bill Lee (R)</td>
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<tr>
<td>Wyoming</td>
<td>Matt Mead (R)</td>
<td>Mark Gordon (R)</td>
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Governor Unchanged

<table>
<thead>
<tr>
<th>State</th>
<th>Outgoing</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>Kay Ivey (R)</td>
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<tr>
<td>Arizona</td>
<td>Doug Ducey (R)</td>
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<tr>
<td>Arkansas</td>
<td>Asa Hutchinson (R)</td>
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<td>Hawaii</td>
<td>David Ige (D)</td>
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<tr>
<td>Iowa</td>
<td>Kim Reynolds (R)</td>
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<tr>
<td>Maryland</td>
<td>Larry Hogan (R)</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Charlie Baker (R)</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Pete Ricketts (R)</td>
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<tr>
<td>New Hampshire</td>
<td>Chris Sununu (R)</td>
</tr>
<tr>
<td>New York</td>
<td>Andrew Cuomo (D)</td>
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<tr>
<td>Oregon</td>
<td>Kate Brown (D)</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Tom Wolf (D)</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Gina Raimondo (D)</td>
</tr>
<tr>
<td>South Carolina</td>
<td>Henry McMaster (R)</td>
</tr>
<tr>
<td>Texas</td>
<td>Greg Abbot (R)</td>
</tr>
<tr>
<td>Vermont</td>
<td>Phil Scott (R)</td>
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</table>
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.

### Healthcare.Gov Enrollment Information for Week 1 of the 2019 Exchange Enrollment Season

<table>
<thead>
<tr>
<th>HealthCare.gov Platform Snapshot</th>
<th>Week 1: November 1 through 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Selections</td>
<td>371,676</td>
</tr>
<tr>
<td>New Consumers</td>
<td>89,282</td>
</tr>
<tr>
<td>Consumers Renewing Coverage</td>
<td>282,394</td>
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<tr>
<td>Consumers on Applications Submitted</td>
<td>802,068</td>
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<tr>
<td>Call Center Volume</td>
<td>293,664</td>
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<tr>
<td>Calls with Spanish Speaking Representative</td>
<td>19,329</td>
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<tr>
<td>HealthCare.gov Users</td>
<td>1,553,171</td>
</tr>
<tr>
<td>CuidadoDeSalud.gov Users</td>
<td>48,427</td>
</tr>
<tr>
<td>Window Shopping HealthCare.gov Users</td>
<td>226,408</td>
</tr>
<tr>
<td>Window Shopping CuidadoDeSalud.gov Users</td>
<td>7,024</td>
</tr>
</tbody>
</table>

Every week during Open Enrollment on the Affordable Care Act Individual Insurance Exchanges, the Centers for Medicare & Medicaid Services (CMS) releases enrollment snapshots for the HealthCare.gov platform, which is used by the Federally-Facilitated Exchanges, the State Partnership Exchanges, and some State-Based Exchanges. These snapshots provide point-in-time estimates of weekly plan selections, call center activity, and visits to HealthCare.gov or CuidadoDeSalud.gov.

In Week 1 of Open Enrollment for 2019, 371,676 people selected plans using the HealthCare.gov platform. As in past years, enrollment weeks are measured Sunday through Saturday. Consequently, Week 1 was only three days long this year - from Thursday to Saturday. Last year, the website saw an average 150,366 enrollees per day in the first week compared to 123,892 average enrollments this year, suggesting a drop in enrollment uptake.
Early Childhood System of Care Learning Community: Home Visiting

This Learning Community (LC) will focus on the intersection of home visiting and systems of care. The presenter will share information on the benefits of providing evidence-based home visiting services to strengthen maternal child health and well-being. Participants will have an opportunity for questions, peer sharing, and dialogue about using evidence-based home visiting strategies as part of a systemic approach to early childhood mental health.

Presenters:
Kate Wasserman, Co-Director of Parent Infant and Early Childhood Program;
Janet Horas, State Home Visitation Director, Iowa Department of Public Health; and
P.J. West, Home Visitation Program Manager, Mental Health Consultation Lead, Iowa Department of Public Health

Register HERE

System of Care Leadership LC: Developments and Opportunities in Financing Systems of Care

This LC session will provide information on changes and opportunities in the financing landscape for children’s behavioral health to advance system of care reforms, particularly within Medicaid and child welfare delivery systems. Participants will be able to ask questions and discuss their ideas for leveraging these financing changes and opportunities.

Presenter: Sheila A. Pires, MPA, Partner, Human Service Collaborative and Partner, TA Network for Children’s Behavioral Health

Register HERE

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 Due: Jan. 11, 2019
Notice of Finalists Selection: Jan. 16, 2019
Readiness Assessment Interview: Jan. 22-25, 2019
Notice of Selection Decision: Jan. 30, 2019
Cohort III Orientation Call: Feb. 11-15, 2019
Full Payment Due: April 1, 2019
TTA Commences: April 1, 2019

Resources:
YICPM Cohort III: Application Packet
YICPM: An Abbreviated Guide
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

**Anticipated Total Available Funding:** $14,130,226

**Anticipated Award Amount:** Up to $1,000,000 per year

**Cost Sharing/Match Required?:** No

**Application Due Date:** Friday, December 21, 2018

**Length of Project:** Up to 5 years

**Anticipated Number of Awards:** Up to 14
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 combatting 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:

- Foster coordinated and integrated care delivery: Support the delivery of coordinated and integrated physical health care, behavioral health care, and critical wrap-around services;
- Utilize Innovation Center authorities and state flexibility: Leverage the use of existing Medicaid flexibility to pay for sustainable care for the model population; and
- 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.
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 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

Register HERE

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<thead>
<tr>
<th>Registration Type</th>
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<th>Regular</th>
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<td>Pre- or Post-Summit Workshops - $50</td>
<td>Pre- or Post-Summit Workshops - $75</td>
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Assistant Secretary for Planning and Evaluation (ASPE) Request for Information (RFI)

IMPACT ACT Research Study: Provider and Health Plan Approaches to Improve Care for Medicare Beneficiaries with Social Risk Factors

Section 2(d) of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 calls for the Secretary of Health and Human Services (HHS), acting through the Assistant Secretary for Planning and Evaluation (ASPE), to conduct a study evaluating the effect of individuals’ socioeconomic status (SES) on quality measures and measures of resource use under the Medicare program. The first component of the required work, a 2016 Report to Congress, focused on socioeconomic information currently available in Medicare data.

This request for information is part of the second component, which expands the analyses by using non-Medicare datasets to quantify SES, and will be completed no later than October 2019 as required by the authorizing legislation. Following up on ASPE’s first Report to Congress, HHS is interested in how plans and providers serving Medicare beneficiaries:

- Identify beneficiaries with social risk factors;
- Approaches plans and providers have used to address the needs of beneficiaries with social risk factors;
- Evidence regarding the impact of these approaches on quality outcomes and the total cost of care; and
- Disentangle beneficiaries’ social and medical risks and address each.

There is growing recognition that social risk factors – such as income, education, race and ethnicity, employment, housing, food, community resources, and social support – play a major role in health. Despite ongoing efforts, significant gaps remain in health and in life expectancy based on income, race, ethnicity, and community environment.

At the same time, the health care system is increasingly moving towards higher levels of provider accountability for the quality, outcomes, and costs of care. Value-based or alternative payment models, which tie payment to the quality and efficiency of health care delivered, are in place in nearly all Medicare settings, including in hospitals, outpatient settings, and post-acute facilities. In many ways, beneficiaries with social risk factors may benefit the most from value-based purchasing programs and other delivery system reform efforts, since improved care coordination and provider cooperation will be of the highest utility to the most complex beneficiaries with the most care needs. In the 2018 Medicare payment rules, CMS solicited comments on when and how the Medicare program should account for social risk in quality measures and programs.

The definition of social risk provided by the National Academies of Science, Engineering, and Medicine (NASEM) under contract to ASPE is being used for this request. These social risk factors include:

- Socioeconomic position (income, wealth, insurance status, education, occupation, food insecurity);
- Race, ethnicity, and community context (race and ethnicity, language, nativity, acculturation);
- Gender (gender identity, sexual orientation);
- Social relationships (marital/partnership status, living alone, social support); and
- Residential and community context (physical environment, housing, and social environment).

In the first Report to Congress, ASPE found that beneficiaries with social risk factors were also medically complex. As part of the second Report to Congress, ASPE is looking at additional measures of medical risk, including disability, functional status, and frailty, and the interaction of medical and social risk.

**Overall Question**

How are providers and health plans serving Medicare beneficiaries working to improve health outcomes for beneficiaries, especially those with social risk factors?

**Delivery of Services**

HHS is interested in understanding services targeted to Medicare beneficiaries with social risk factors. The 2016 Report to Congress found that providers that disproportionately cared for beneficiaries with social risk factors tended to perform worse than their peers on quality measures. However, in every setting, be it hospital, health plan, ACO, physician group, or facility, there were some providers that served a high proportion of beneficiaries with social risk factors who achieved high levels of performance.

To better understand these findings, ASPE asked the NASEM to identify best practices of high-performing hospitals, health plans, and other providers that serve disproportionately higher shares of socioeconomically disadvantaged populations and compare those best practices to practices of low-performing providers serving similar patient populations. The NASEM determined that the following six practices show promise for achieving high levels of performance for beneficiaries with social risk factors:

(Continued on next page)
Commitment to health equity: Value and promote health equity and hold yourself accountable;

Data and measurement: Understand your population’s health, risk factors, and patterns of care;

Comprehensive needs assessment: Identify, anticipate, and respond to clinical and social needs;

Collaborative partnerships: Collaborate within and across provider teams and service sectors to deliver care;

Care continuity: Plan care and care transitions to prepare for patients’ changing clinical and social needs; and

Engaging patients in their care: Design individualized care to promote the health of individuals in the community setting.

ASPE also contracted with RAND to conduct interviews and case studies with Medicare Advantage (MA) plans to understand how the plans address dually enrolled beneficiaries social and health needs. High-performing, high-dual and special needs plans (SNP) were found to implement multi-pronged approaches and strategies. Through this work, we developed a taxonomy for MA plans addressing social needs that includes strategies and interventions that focus on:

1. Needs identification and targeting;
2. Care management and coordination;
3. Directly addressing social needs; and
4. Integration of Medicare and Medicaid.

HHS is requesting information on how providers and health plans are implementing these approaches and principles for Medicare beneficiaries with social risk factors. HHS is also interested in approaches beyond the NASEM principles and health plan taxonomy that work to improve care for Medicare beneficiaries with social risk factors.

- Are social risk data being used to target services or provide outreach? If so, how?
- How are beneficiaries with social risk factors identified?
- Are there especially promising strategies for improving care for patients with social risk?
- How are costs for targeting and providing those services evaluated? What are the additional costs to target services, such as case management, and to provide additional services (e.g., transportation)? What is the return on investment in improved outcomes or reduced healthcare costs?
- What are the best practices to refer beneficiaries to social service organizations that can address social risk factors?
- What lessons have been learned about providing care for patients with social risk factors?
- What are barriers to tailoring services to patients with social risk factors? How can barriers be overcome?
- For patients with social risk factors, how does patients’ disability, functional status, or frailty affect the provision of services?

Data

As part of the second Report to Congress, HHS is requesting information on how providers and health plans capture beneficiaries’ social risk. The Medicare program captures limited information on beneficiary social risk, but there is potential for additional information to be collected by health plans or providers at the point of care. In particular, the NASEM identified electronic health records (EHRs) as a potential source of social risk data. In earlier work, a separate NASEM committee recommended that certain social and behavioral health domains be collected in EHRs.

ASPE also contracted with NORC to conduct a qualitative study of EHR vendors’ incorporation of social determinants of health in EHRs. Among the 6 vendors interviewed, all were incorporating social determinants of health into their systems in response to client demand, although the type of product varied greatly across the vendors.

HHS is requesting information on how providers and health plans are collecting and using data on Medicare beneficiaries’ social risk factors:

- Which social risk factors are most important to capture?
- Do you routinely and systematically collect data about social risk? Who collects this data? When is it collected? Is it collected only once or multiple times for a beneficiary? Is it collected consistently across populations (i.e. Medicare beneficiaries, Medicaid beneficiaries, patients receiving specific services, etc.)? What are the burdens of this data collection on plans, providers, and beneficiaries?
- Would standardized data elements for EHRs help you to collect social risk data? If so, how could these data elements be standardized?
- What are barriers to collecting data about social risk? How can these barriers be overcome?
- What do you see as promising future opportunities for improving data collection? For using existing or future data to tailor services?

Submitting Comments

Comments will be received until November 16, 2018. Submit electronic comments via email to ASPEImpactStudy@hhs.gov.

This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant or cooperative agreement award. Further, HHS is not seeking proposals through this RFI and will not accept unsolicited proposals.
AHRQ Funding Opportunity Announcement
Screening and Management of Unhealthy Alcohol Use in Primary Care: Dissemination and Implementation of PCOR Evidence (RFA-HS-18-002)

The Agency for Healthcare Research and Quality (AHRQ) seeks applications to disseminate patient-centered outcomes research (PCOR) findings directly to primary care practices and support practices in implementing PCOR clinical and organizational findings. Applicants must propose a comprehensive plan that uses evidence-based strategies designed to improve the delivery of patient-centered approaches to identifying and managing unhealthy alcohol use among adults, including screening and brief intervention (SBI) and medication assisted therapy (MAT).

Open Date (Earliest Submission Date): December 4, 2018
Application Due: January 4, 2019, by 5:00 PM local time of applicant organization. Applicants are encouraged to apply early to allow adequate time to make any corrections to errors found in the application during the submission process by the due date.

Scientific Merit Review: Generally, four months after receipt date. Earliest Start Date: Generally, four months after peer review date.
Expiration Date: January 18, 2019

Eligible Organizations:
Higher Education Institutions
Public/State Controlled Institutions of Higher Education
Private Institutions of Higher Education
The following types of Higher Education Institutions are always encouraged to apply for AHRQ support as Public or Private Institutions of Higher Education:
Hispanic-serving Institutions
Historically Black Colleges and Universities (HBCUs)
Tribally Controlled Colleges and Universities (TCCUs)
Alaska Native and Native Hawaiian Serving Institutions
Asian American Native American Pacific Islander Serving Institutions (AANAPISIs)
Nonprofits Other Than Institutions of Higher Education
Nonprofits with 501(c)(3) IRS Status (Other than Institutions of Higher Education)
Nonprofits without 501(c)(3) IRS Status (Other than Institutions of Higher Education) Governments
State Governments
County Governments
City or Township Governments
Special District Governments
Indian/Native American Tribal Governments (Federally Recognized)
Indian/Native American Tribal Governments (Other than Federally Recognized)
Eligible Agencies of the Federal Government
U.S. Territory or Possession
Native American Tribal Organizations (other than Federally recognized tribal governments)
Faith-based or Community-based Organizations
Regional Organizations

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

Unhealthy alcohol use, which affects almost a third of adults, is the third leading cause of preventable death and a major risk factor for many health, social, and economic problems. A study released by the Centers for Disease Control and Prevention estimated the annual economic burden of unhealthy alcohol use at $249 billion in 2010. Unhealthy alcohol use is associated with a wide range of adverse consequences related to physical and mental health (neurological 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.

(Continued on next page)

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)

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/pcmhqi2.html.

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

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

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

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

To support the evaluation, applicants should plan to collaborate with the evaluator and other grantees, and plan to collect and share with the evaluator the following types of indicators:
- Number and types of personnel working with practices to support implementation
- Number and type of interactions between project staff/consultants and practices
- Type and quantity of strategies implemented
- Number of practices reached by the implementation
- Number of clinicians engaged
- Number of patients in target population
- Number and percent of patients screened in each practice
- Number and percent of patients who screen positive
- Number and percent of patients who received brief counseling intervention
- Number and percent of patients who received MAT
- Number and percent of patients referred to specialty clinics

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

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

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

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

Visit the New Resources at NASMHPD's Early Intervention in Psychosis (EIP) Virtual Resource Center

These new TA resources, developed with support from the U.S. Substance Abuse and Mental Health Services Administration, are now available for download!

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

**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)
- Recruitment will begin in November 2018
- 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 Eddy: 347-762-9086 or email at cscstudy@center4si.com
Submit an Abstract to Present at the 10th Anniversary NIMH Conference
Global Mental Health Research Without Borders

Abstracts Due by 1 Dec 2018

NIMH will post the link for submitting abstracts electronically in the coming weeks, but you can begin preparing now. See instructions below.

We are trying something new for the 10th-anniversary conference! This year, we invite researchers to submit abstracts to present original and innovative global mental health research at the Global Mental Health Research conference. The conference will take place on 8-9 April 2019, at the Natcher Center, National Institutes of Health, Bethesda, Maryland, United States.

The conference will be co-hosted by the NIMH Center for Global Mental Health Research and Grand Challenges Canada to showcase findings from cutting-edge science and identify opportunities for groundbreaking research to address the grand challenges in global mental health. The grand challenges, identified in 2011, are research priorities for achieving mental health equity worldwide, with focused attention on low- and middle-income countries and other low-resource settings. The grand challenges span the research pipeline from preclinical questions about etiology, to translational questions about developing more effective preventive and treatment interventions, to service delivery and implementation questions. These challenges require global cooperation to share research expertise, facilitate data sharing and use of common measures, amplify research capacity-building opportunities, and involve the full range of the world’s researchers, populations, environments, and cultures.

Help us showcase cutting-edge science in six research tracks derived from the grand challenges in global mental health:

- Root causes of mental illness and key targets and times for intervention
- Prevention of mental illness and the delivery of early interventions
- Improved treatment quality, value, and effectiveness
- Integration of mental health services into existing healthcare platforms (e.g., HIV/AIDS, primary care, etc.)
- Implementation of sustainable, evidence-based mental health care
- Sustainable research capacity where it is underdeveloped

Presentation Types: We invite abstract submissions for three presentation types: Symposium, paper, or poster.

- Symposium - A symposium comprises a group of paper presentations that focus on a single topic or theme. Each symposium will have a total of 90 minutes (70 minutes for paper presentations, 20 minutes for discussion). A symposium may have up to five presenters, including a chair/moderator. To highlight diverse perspectives and feedback on the research, we highly encourage inclusion of one or more presenters/discussants who: (a) represent a developing country or low-resource setting; (b) are a provider, an individual with lived experience of mental illness, an advocate, or a policymaker; or (c) represent the perspectives of an underserved community or population in a developing country or other low-resource setting.
- Paper - A paper presentation will involve one speaker who will have 10 minutes to present. Conference organizers may cluster individual paper presentations into various panels, based on research topics.
- Poster - We invite graduate students, trainees, postdocs, and early-career investigators (i.e., within 10 years of terminal degree) to submit an abstract to present a research poster (36 x 60 inches maximum size) at the conference poster session (day and time to be determined). Conference organizers will award a limited number of travel stipends for poster presenters from low- and middle-income countries receiving the highest review scores.

Abstract Content: Abstracts for paper and poster presentations should be no more than 250 words. Abstracts for symposia should include an overview that is no more than 250 words, and individual presentation descriptions should be no more than 150 words each. Presentation topic, title, presenter names, and funding are not included in the word limit.

Abstract submissions should include the following information:

- Presentation type: Symposium, paper, or poster
- Track(s)
- Title
- Presenter name(s), degree(s), affiliation(s), and email address(es) for all presenters
- Research objective(s); study method; summary of study findings; and implications for future research, practice, and/or policy, especially in low-resource settings
- Primary funding source

Abstract Review: The criteria listed below will be used by an independent panel to review and score abstracts. Submissions with the best scores will be selected for presentations at the conference.

- Importance of research objective(s)
- Innovativeness of ideas, methods and or approach
- Presentation of findings
- Clarity of writing
- Relevance to the conference theme and designated track(s)
- Rigor of scientific methods and approach
- Implications for future research, practice and/or policy

Submit abstracts by 1 Dec 2018, 5:00 p.m. U.S. Eastern Time. We will post the link for submitting abstracts electronically in the coming weeks, so stay tuned.

Important Dates and Deadlines:
Abstract Submission Open Call: 3 Oct 2018
Conference Registration Open: Coming soon
Abstract Submission Deadline: 1 Dec 2018 at 5:00 p.m. U.S. Eastern Time
Abstract Acceptance Notices: 10 Jan 2019

If you have any questions, please send an email to GlobalMentalHealthWorkshop@mail.nih.gov.
Presenters at NICWA's 37th Annual Protecting Our Children National American Indian Conference on Child Abuse and Neglect, this year being held in Albuquerque, New Mexico on March 31–April 3, 2019, are the heart and soul of this annual event, increasingly recognized as the premiere national gathering dedicated to tribal child welfare and well-being. Each year over 70 presenters are selected to lead vigorous dialogue about best practices, current research, advocacy efforts, policy implications, and other lessons learned with over 1,200 conference attendees.

**About the Workshops:** The highly competitive selection process aims to select presenters who represent an expertise and mastery of innovative and effective developments in these key areas:

- Children's Mental Health
- Child Welfare, Foster Care, and Adoption Services
- Judicial and Legal Affairs
- Youth and Family Involvement

Workshop sessions will be 90 minutes in length. Participation varies depending on the topic, but on average workshops will have between 20–70 participants. NICWA highly values interactive and participatory workshops. Please share in your submission how your workshop will help conference attendees learn through interactive learning.

**Registration Requirement:** All presenters of selected workshops are required to register for the conference. NICWA offers a reduced registration rate for up to three presenters per workshop. You may register at the presenter rate once your workshop has been accepted. Additional presenters must register at the prevailing rate. By submitting a proposal, presenters agree to pay registration and travel costs.

The richness of our conference is a direct reflection of the diversity of presenters who come to share their experience and contributions to the field. NICWA truly values a wide representation of presenters from varied backgrounds and communities.

**Submission Process**

You may prepare your information using this submission form worksheet. All final submissions must be made online by November 15.

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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](https://www.ncbi.nlm.nih.gov/books/NBK219026/) 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 (https://www.ruralhealthinfo.org/am-i-rural/help). 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 Additional Information is at https://grants.nih.gov/grants-guide/rfa-files/RFA-DA-19-016.html
Applicants must specifically demonstrate how they plan to leverage SAMHSA funding provided to states and local jurisdictions for the provision of evidence-based prevention, treatment, and recovery support services. SAMHSA funding includes grant programs such as the State Opioid Response grants, State Targeted Response Grants, Medication-Assisted Treatment Prescription Drug and Opioid Addiction, CARA First Responders and state-based naloxone programs, drug court and offender re-entry programs, Building Communities of Recovery, and programs for pregnant and postpartum women programs. Information on all of SAMHSA grant programs can be found at [https://www.samhsa.gov/grants.](https://www.samhsa.gov/grants).

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, and has outlined a framework for states to provide Medicaid services related to 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](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](https://ncats.nih.gov/ctsa/about)).
**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 – top notch 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.

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**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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**Alzheimer’s and Related Dementias Clinical Trials Nationwide are Looking for Volunteers Just Like You!**

Many people say participating in a clinical trial is a way to play a more active role in their own health care. Other people say they want to help researchers learn more about certain health problems. Whatever the motivation, when you choose to participate in a clinical trial, you become a partner in scientific discovery. And, your contribution can help future generations lead healthier lives. Major medical breakthroughs could not happen without the generosity of clinical trial participants.

Participate in a clinical trial to:

- Play an active role in your health care
- Help future research
- Help future generations
- Be a part of scientific discovery

Learn more about participating in Alzheimer’s research: [https://www.nia.nih.gov/health/participating-alzheimers-disease-research](https://www.nia.nih.gov/health/participating-alzheimers-disease-research).

**Check out our website** for information on: What happens in a clinical trial? Where to find a trial? How do researchers choose study participants? You can also find a trial near you using our Clinical Trials Finder or join a registry or matching service.

**National Institute on Aging**
Join the 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.

Thursday, November 15, 3:00 p.m. E.T.
Longitudinal Trends from the Residential Information Systems Project about Services and Supports to People with IDD – How States Vary Compared to Other States and the U.S.
Level: Intermediate
Presenter: Heidi Eschenbacher, University of Minnesota, Minneapolis, MN
The Residential Information Systems Project (RISP) has been tracking supports and services, particularly deinstitutionalization, for over 40 years. Comparing states across the United States to overall trends within the country can be revealing about how government service models differ in the types of supports and services they provide.

Thursday, November 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.

Thursday, December 13, 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
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

Federal Health Insurance Exchange 2019 Open Enrollment Has Begun

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/
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Aaron J. Walker, M.P.A., Senior Policy Associate

NASMHPD Links of Interest

SAMHSA Strategic Plan, FY 2019 to FY 2023, Substance Abuse and Mental Health Services Administration, November 2


Stigmatization of War Veterans with Posttraumatic Stress Disorder (PTSD): Stereotyping and Social Distance Findings, Crosby Hipes & Darren Goets, *Society and Mental Health*, October 12


A Pay-for-Performance Initiative to Reduce Pediatric Psychiatric Inpatient Length of Stay, Timothy Schmutte, Psy.D. *et al.*, *Psychiatric Services*, November 5

Living Well: An Intervention to Improve Medical Illness Self-Management Among Individuals With Serious Mental Illness, Anjana Muralidharan, Ph.D., *et al.*, *Psychiatric Services*, October 24


One Type of Brain Cell Might Hold Key to Inflammation after Head Injury: Study in Mice Suggests Potential Target for Treating Traumatic Brain Injury, Jonathan Godbout, Ohio State University Institute for Behavioral Medicine Research Press Release, November 6