Trump Administration Proposes Regulations Loosening Medicare Restrictions on Use of Telehealth, but Not Restrictions on Audio-Only Telehealth

The Trump administration on August 3 issued its annual proposed Medicare Physician Fee Schedule and Quality Payment Program regulations for the coming benefit year, containing a loosening of long-existing Medicare restrictions on the use of telehealth.

The proposed regulations were issued contemporaneously with a Presidential Executive Order on Improving Rural Health and Telehealth Access.

The Executive Order noted that a Centers for Medicare and Medicaid Services (CMS) internal analysis showed a weekly jump in virtual visits for beneficiaries, from approximately 14,000 prior to the declaration of the COVID-19-related Public Health Emergency (PHE) to almost 1.7 million in the last week of April and that a recent report by HHS shows that nearly half (43.5 percent) of Medicare fee-for-service primary care visits were provided through telehealth in April, compared with far less than one percent (0.1 percent) in February before the PHE. Telehealth visits continued to be common even after personal visits resumed in May.

Based on those findings, the Executive Order directed:

- the Secretaries of HHS and Agriculture to, within 30 days of the Executive Order, consistent with applicable law and subject to the availability of appropriations, and in coordination with the Federal Communications Commission and other executive departments and agencies, as appropriate, develop and implement a strategy to improve rural health by improving the physical and communications healthcare infrastructure available to rural Americans;
- the Secretary of HHS to, within 30 days, submit a report to the President, through the Assistant to the President for Domestic Policy and the Assistant to the President for Economic Policy, regarding existing and upcoming policy initiatives to increase rural access to healthcare by eliminating regulatory burdens that limit the availability of clinical professionals; and
- the Secretary of HHS to, within 60 days, review the following temporary measures put in place during the PHE, and propose a regulation to extend those measures, as appropriate, beyond the duration of the PHE:
  - the additional telehealth services offered to Medicare beneficiaries; and
  - the services, reporting, staffing, and supervision flexibilities offered to Medicare providers in rural areas.

The proposed regulations would add 9 Healthcare Common Procedure Coding System (HCPCS) codes to cover telehealth services analogous to the flexibilities provided under the March 31 “Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency” interim final regulations, which are scheduled to be in place until the end of the declared PHE, which is now scheduled to last until at least October 25.

The original interim final regulations allowed the use of telehealth for:

- Group Psychotherapy (CPT code 90853);
- Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136- 96139);
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507);
- Assessment and Care Planning for Patients with Cognitive Impairment (CPT code 99483);
- Emergency Department (ED) Visits, Levels 1-5 (CPT codes 99281-99285);
- Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217- 99220; CPT codes 99224- 99226; CPT codes 99234- 99236);
- Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238- 99239);
- Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316);
- Critical Care Services (CPT codes 99291-99292);
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327- 99328; CPT codes 99334-99337);
- Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes 99347- 99350); and
- Initial and Continuing Intensive Care Services (CPT codes 99477- 994780).

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Mental Healthcare Leaders Call for Parity With Physical Health Emergency Care

On August 4, the National Association of State Mental Health Program Directors (NASMHPD) and its Crisis Now partners is joining leaders in mental health and substance use around the world to release the Washington DC International Declaration, the first ever international declaration on mental health crisis care, giving healthcare leaders, governments and community organizations a blueprint for quality crisis care that must be available for everyone, everywhere, and every time.

The Declaration comes at a critical time in world history as health systems strive to respond to COVID-19, businesses face uncertain economic futures and families and communities lose crucial social connections. However as physical distancing rules are relaxed, the focus on flattening the curve on mental ill-health is vital by ensuring mental health crisis care is available and accessible in the short and long term.

No matter the nation or territory, a comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, extraordinary and unacceptable loss of lives and the waste of resources. Effective crisis care that saves lives and dollars requires a systemic approach. Research has demonstrated the effectiveness of the core elements of systemic quality crisis care as being:

- High tech crisis call centers,
- 24/7 non-law enforcement mobile crisis team,
- Crisis stabilization centers, and
- Essential principles and practices governing care pathways.

These quality crisis systems are further enhanced by harnessing data and technology, drawing on the expertise of those with lived experience, delivering services where the person is and providing evidence-based suicide prevention. Such change also requires support from the government and partnership with stakeholders. A national policy approach will drive consistent, quality crisis care, allowing health services translate the declaration's principles into practice in their local context. Furthermore, for people in need of crisis care there must be a no-wrong-door policy with services accepting all referrals without question. Access to mental healthcare over the short and long term will be critical as the fallout from Covid-19 widens.

The mental health experts, people with lived experience, and essential partners involved in writing the declaration agree that mental healthcare must be moved out of the shadows and into mainstream care and focus on the whole person. Parity with physical health should be the norm for individuals experiencing a crisis, which means access to timely and effective care based on the person's needs.

Brian Hepburn, M.D., Executive Director of NASMHPD, the lead organization for Crisis Now, says that when leaders from across the world met last September to develop the Washington DC International Declaration, it was to foster a much-needed shift in mental healthcare. “Our objective, no matter the nation, is for people in crisis to receive the level of care that best aligns with their needs instead of defaulting to the emergency room or jail.” As the COVID-19 pandemic rages on, Dr. Hepburn states that the declaration’s tenets “are more vital than ever.”
#CrisisTalk is Transforming Dialogue in Behavioral Health

The National Association of State Mental Health Program Directors (NASMHPD) and its Crisis Now partners—the National Suicide Prevention Lifeline and Vibrant Emotional Health, the National Action Alliance for Suicide Prevention, the National Council for Behavioral Health, and R.I. International—have launched the #CrisisTalk website, sparking much-needed dialogue on behavioral health crises. The new publication provides a platform for diverse experts and people with lived experience to exchange thoughts, knowledge, and innovations. Each article shares a person’s perspective, whether that’s an emergency department doctor who tells her story, revealing the challenges emergency physicians experience when faced with a patient in crisis, or a student with suicidal ideation and his university choosing legal self-protection over doing what was best for him.

The objective is to facilitate conversations about mental health crises, including missed opportunities, gaps, tools, and best practices. #CrisisTalk is sharing the diverse stories of people affected by behavioral health crises, including those who have experienced one, loved ones, and stakeholders who need to be part of the conversation, swinging the pendulum worldwide toward awareness and change. #CrisisTalk interviews reflect the perspectives of mental health experts and first responders. They point out common misconceptions and challenges in their fields and the communities they serve. This includes why some locations do not develop a full continuum of crisis care services. The discussions transcend geography and illustrate ways to make positive changes in the crisis space. Simply having a conversation with a person in crisis, a non-judgmental, empathic approach, along with a willingness to listen and sit with someone, can go a long way.

#CrisisTalk is part of CrisisNow.com, a roadmap to safe, effective crisis care that diverts people in distress from the emergency department and jail by developing a continuum of crisis care services that match clinical needs to care. To learn more, visit www.CrisisNow.com/talk.

**THIS WEEK:** NO MATTER THE NATION, QUALITY MENTAL HEALTHCARE FOR EVERYONE, EVERYWHERE, EVERY TIME

In January this year, the world watched Australia as homes burned to the ground, businesses were lost, and wildlife struggled to survive the terrible fires that engulfed the country. On the other side of the world in the United Kingdom, houses were awash with floodwaters, and livelihoods were lost. These very visible events clearly show the impact that climate change is having on the lives of people across the globe. What is not clear is the longer term impact that these tragedies have on the lives of individuals, families, and whole communities. Now we are dealing with a global pandemic: COVID-19. A virus we don’t understand that might attack communities and nations over and over.

When the flames die down, when social distancing is retracted, when the virus and water recede, and the visible signs are gone, it’s all too easy to forget the impact on people—both their physical and mental health needs. Good crisis care should be available for everyone, everywhere, and every time. This, however, raises the question of what is optimal care for those experiencing a mental health crisis? It was this question that a gathering of mental health and suicide prevention leaders from 12 countries grappled with during the International Initiative for Mental Health Leadership (IIMHL) and Crisis Now Summit meetings held jointly in Washington DC in September 2019. #CrisisTalk sat down with program committee members Dr. Caroline Dollery and Dr. Phil Moore, from the U.K., to discuss the meeting and its outcomes.

Dr. Dollery and Dr. Moore agreed that the meetings were an opportunity for country leaders to come together to share knowledge and design a better model of mental health crisis care. One that ensures people with mental ill health crises receive a response to treatment and recovery that is equitable with the care delivered to patients diagnosed with cancer and other chronic medical emergencies. There was universal agreement from the meeting that influencing health systems in a way that provides parity with a medical emergency was a key requirement.

**Learn More**

Crisis Now Partners:
- The National Association of State Mental Health Program Directors (NASMHPD), founded in 1959 and based in Alexandria, VA, represents the $41 billion public mental health service delivery system serving 7.5 million people annually in all 50 states, 4 territories, and the District of Columbia. NASMHPD (pronounced “NASH-bid”) is the only national association to represent state mental health commissioners/directors and their agencies, and serves as the lead for [www.CrisisNow.com](http://www.crisisnow.com).
- The National Suicide Prevention Lifeline and Vibrant Emotional Health provides free and confidential emotional support and crisis counselling to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week, across the United States. Funded by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by Vibrant Emotional Health, the Lifeline engages in innovative public messaging, development of best practices in mental health, creative partnerships, and more to improve crisis services and advance suicide prevention for all. [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org) [www.vibrant.org](http://www.vibrant.org) [www.twitter.com/800273TALK](http://www.twitter.com/800273TALK).
- The National Action Alliance for Suicide Prevention is the public-private partnership working with more than 250 national partners advancing the National Strategy for Suicide Prevention with the vision of a nation free from the tragic experience of suicide and a goal of reducing the annual suicide rate 20 percent by 2025. Administered by EDC, Inc., the Action Alliance was the catalyst for the Zero Suicide Healthcare and Crisis w: Transforming Services innovations. [www.theactionalliance.org](http://www.theactionalliance.org) [www.edc.org](http://www.edc.org) [www.twitter.com/Action_Alliance](http://www.twitter.com/Action_Alliance).
- The National Council for Behavioral Health is the unifying voice of America’s health care organizations that deliver mental health and addictions treatment and services. Together with their 3,000 member organizations serving over 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery. The National Council introduced Mental Health First Aid USA and have trained more than 1.5 million Americans. [www.thenationalcouncil.org](http://www.thenationalcouncil.org) [www.mentalhealthfirstaid.org](http://www.mentalhealthfirstaid.org) [www.twitter.com/NationalCouncil](http://www.twitter.com/NationalCouncil).
- RI International (d/b/a for Recovery Innovations, Inc.) is a global organization that offers more than 50 programs throughout the United States and abroad, characterized by recovery and a focus on what's strong, not what's wrong. More than 50% of employees report a lived experience with mental health, and the “Fusion Model” crisis stabilization programs are featured in Crisis Now. The Company also provides training and consulting internationally and supports Zero Suicide International, a partnership with Behavioral Health Link. [www.rinternational.com](http://www.rinternational.com) [www.zerosuicide.org](http://www.zerosuicide.org) [www.twitter.com/RI_International](http://www.twitter.com/RI_International).
Preventive Executive Order 13861, issued by President Trump in March 2019, established a three-year effort entitled the President’s Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS).

PREVENTS created a cabinet-level inter-agency Task Force to lead the development and implementation of a national, comprehensive roadmap for a federally coordinated national public health strategy to address suicide. The Task Force is co-chaired by the Secretary of Veterans Affairs, Robert L. Wilkie, and Brooke L. Rollings, Assistant to the President for Domestic Policy and includes representatives from more than 15 Federal agencies in its membership.

The Task Force delivered a PREVENTS Roadmap to the President on June 17. Over 150 subject matter experts from those Federal agencies identified the most critical problems for existing suicide prevention efforts, studied existing background information to understand the current state, conducted detailed analysis of potential solutions, and recommended next steps for solving the problem.

Under the Executive Order, PREVENTS was to build on previous Federal work to elevate and amplify existing suicide prevention efforts and address identified gaps within the existing environment of suicide prevention. The PREVENTS Task Force was directed to elevate the national conversation around mental health and suicide, build on existing best practices, and expand on impressive research and programs underway in communities.

Among the deliverables to be produced under the roadmap were a national research strategy and a legislative proposal that included grants to increase the capacity for communities to collaborate and integrate veteran service delivery.

The recommendations made by the Task Force include:

1. Create and implement a national public health campaign focused on suicide prevention for Veterans and all Americans.
2. Identify and prioritize suicide surveillance and research that focuses on a Veteran’s unique combination of individual, relationship, community, and societal factors to deliver the most effective intervention(s) tailored to meet their needs and circumstances.
3. Promote foundational changes to the way research is conducted — including improving the speed and accuracy with which research is translated into practice, improving efficiency through data-sharing and data curation practices, and using innovative funding techniques to drive team science and reproducibility.
4. Develop effective partnerships across government agencies and nongovernment entities and organizations to increase capacity and impact of programs and research to empower veterans and prevent suicide.
5. Encourage employers and academic institutions to provide and integrate comprehensive mental health and wellness practices and policies into their culture and systems.
6. Provide and promote comprehensive suicide prevention trainings across professions.
7. Identify, evaluate, and promote community-based models that are effectively implementing evidence-informed mental health and suicide prevention programs across the country. In doing so, relationships with community-based efforts, non-profit organizations, faith-based communities, VSOs, and MSOs should be leveraged to focus on saving the lives of veterans.
8. Increase implementation of programs focused on lethal means safety (e.g., voluntary reduction of access to lethal means by individuals in crisis, free/inexpensive and easy/safe storage options).
9. Develop a coordinated, interagency Federal funding mechanism to support, provide resources for, and facilitate the implementation of successful evidence-informed mental health and suicide prevention programs focused on Veterans and their communities at the State and local levels.
10. Streamline access to innovative suicide prevention programs and interventions by expanding the network of qualified healthcare providers.

Suicide Prevention Resource Center On-Line Course: Locating and Understanding Data for Suicide Prevention

Effectively preventing suicide requires an understanding of who is attempting and dying by suicide, where the problem is most severe, and under what circumstances attempts and suicide deaths occur. But how do you find the data you need to answer these questions and others? Locating and Understanding Data for Suicide Prevention presents a variety of data sources that are useful for finding information about suicide deaths, suicide attempts, and suicidal ideation. This course also explains key concepts that will help you better understand the data you find.

After completing this course, attendees will be able to:

- Define and understand the difference between suicide deaths, suicide attempts, suicide ideation, and risk and protective factors for suicide;
- Explain key terms essential to accurately interpreting data and making meaningful comparisons;
- Identify commonly used and readily accessible online national data sources, and the type of data that is available from each source.
- Identify alternative data sources that may be available in states and communities, the type of data available from these sources, and considerations when approaching organizations and agencies for these data.
- Think critically about the strengths and limitations of a given data source.

This course is open to anyone. We highly recommend it for any professional involved in national, state or community suicide prevention.

Course Length: This course can be completed in approximately two hours. You do not have to complete the course in one session. You can exit the course at any time and return later to the place where you left off.

Certificate of Completion: To receive a certificate of completion, you must do the following online: complete each lesson, pass the posttest (passing score is 80 percent or higher), and answer the feedback survey questions. You can earn a certificate of completion once per year for each course. We do not offer continuing education credits for any of our courses.
The proposed regulations would allow the use of telehealth for the process.

CMS suggests that, before eliminating the full range of the services added by waiver during the PHE from the Medicare telehealth services list and potentially jeopardizing beneficiary access to those services that have been clinically beneficial, based primarily on the timing of annual rulemaking it would be prudent to collect information from the public regarding which, where, and how various telehealth services have been in use in various communities during the COVID-19 response. It says feedback from patients and clinicians is essential to help CMS understand how the use of telehealth services may have contributed positively to, or negatively affected, the quality of care provided to beneficiaries during the PHE for the COVID-19 pandemic in order to understand which services should be retained on the Medicare telehealth services list until the agency can give them full consideration under the established rulemaking process.

The proposed regulations would allow the use of telehealth for the following procedures and HCPCS codes:

- 90853, for Group Psychotherapy (other than of a multiple-family group);
- 96121, for neurobehavioral status exams (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report;
- 99483, for assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: cognition-focused evaluation including a pertinent history and examination; medical decision-making of moderate or high complexity; functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity; use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]); medication reconciliation and review for high-risk medications; evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); evaluation of safety (e.g., home), including motor vehicle operation; identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; development, updating or revision, or review of an Advance Care Plan; creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes spent face-to-face with the patient and/or family or caregiver;
- GPC1IX, for visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services;
- 99xxx, for prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service;
- 99334 & 99335, domiciliary and rest home visits for evaluation and management of an established patient; and
- 99347 & 99348, home visits for evaluation and management of an established patient.

The regulations note that while the patient’s home generally cannot serve as an originating site (where the patient is located) for purposes of most Medicare telehealth services, the SUPPORT for Patients and Communities Act amended §1834(m)(4)(C) of the Social Security Act and added a new paragraph at § 1834(m)(7) to remove geographic limitations and authorize the patient’s home to serve as a telehealth originating site for purposes of treatment of a substance use disorder or a co-occurring mental health disorder, furnished on or after July 1, 2019.

CMS says it believes that, due to the vulnerability of this particular patient population, it should maximize the availability of telehealth services for the treatment of substance use disorders and co-occurring mental health disorders.

Currently, there are two categories of services added to the Medicare telehealth services list:

- Category 1: Telehealth services that are similar to the office visits that are already on the Medicare telehealth services list.
- Category 2: Services that are not similar to those on the current Medicare telehealth services list, but where the service is accurately described by a corresponding code when furnished via telehealth and the use of a telecommunications system to furnish the service produces demonstrates clinical benefit to the patient. These are services recommended in a public comment response where submitted evidence includes both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings, and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. The clinical benefit cannot be minor or incidental.

CMS proposes to create a third category of criteria for adding services to the Medicare telehealth services list on a temporary basis that would include the services that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria.

Recognizing that the services added on a temporary basis under Category 3 would ultimately need to meet the Categories 1 and 2 criteria to be permanently added, prior to proposing the interim final regulations, CMS conducted a clinical assessment to identify those services with a foreseeable reasonable potential likelihood of clinical benefit when furnished via telehealth outside the PHE. When assessing whether there was a potential likelihood of clinical benefit for a service such that it should be added to the Medicare telehealth services list on a Category 3 basis, CMS considered the following factors:

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Trump Administration Proposes Regulations Permanently Loosening Medicare Restrictions on Use of Telehealth, but Not Audio-Only Telehealth

(Continued from page 6)

- Whether, outside of the circumstances of the PHE, there are increased concerns for patient safety if the service is furnished as a telehealth service;
- Whether, outside of the circumstances of the PHE, there are concerns about whether the provision of the service via telehealth is likely to jeopardize quality of care; and
- Whether all elements of the service could fully and effectively be performed by a remotely located clinician using two-way, audio/video telecommunications technology.

CMS says adding services to the Medicare telehealth services list on a temporary Category 3 basis will give the public the opportunity to gather data and generate requests to add certain services to the Medicare telehealth services list permanently, which would be adjudicated on a Category 1 or Category 2 basis during future annual rulemaking, while maintaining access to telehealth services with potential likelihood of clinical benefit. CMS says it does not have the ability to authorize audio-only services even on a Category 3 basis because of Medicare’s statutory requirement that telehealth services be furnished using an interactive telecommunications system that includes two-way, audio/video communication technology.

CMS proposes to add the following services on a Category 3 basis for now, with the intent to collect public comment on whether to make the furnishing of those services by telehealth permanent:

- HCPCS Codes 96130 through 96133, Psychological and Neuropsychological Testing Evaluation Services, by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed;
- HCPCS Codes 99336 & 99337, Domiciliary, Rest Home, or Custodial Care services, Established Patients;
- HCPCS Codes 99349 & 99350, Home Visits, Established Patient;
- HCPCS Codes 99282 & 99283, Emergency Department Visits; and
- HCPCS Codes 99315 & 99316, Nursing Facility Discharge Day Management.

CMS says it is seeking comments from the public by October 5 to help inform its decisions about proposed additions under Category 3:

- By whom and for whom are the services being delivered via telehealth during the PHE;
- What practical safeguards are being employed to maintain safety and clinical effectiveness of services delivered via telehealth; and how are practices quickly and efficiently transitioning patients from telehealth to in-person care as needed;
- What specific health outcomes data are being or are capable of being gathered to demonstrate clinical benefit;
- How is technology being used to facilitate the acquisition of clinical information that would otherwise be obtained by a hands-on physical examination if the service was furnished in person. Certain services on the Medicare telehealth services list prior to the PHE, specifically the office/outpatient E/M code set, involve a physical exam. With the telehealth expansions during the PHE, clinicians may have had valuable experience providing other telehealth services to patients in higher acuity settings of care, such as an emergency department, that involve a hands-on physical examination when furnished in person;
- Whether patient outcomes are improved by the addition of one or more services to the Medicare telehealth services list, including whether inclusion on the Medicare telehealth services list increases access, safety, patient satisfaction, and overall quality of care;
- Whether furnishing this service or services via telecommunication technology promotes prudent use of resources;
- Whether the permanent addition of specific, individual services or categories of services to the Medicare telehealth services list supports quick responses to the spread of infectious disease or other emergent circumstances that may require widespread use of telehealth; and
- What is the impact on the health care workforce of the inclusion of one or more services or categories of services on the Medicare telehealth services list (for example, whether the health care workforce and its capabilities to provide care are expanded).

In addition, CMS wants to know how the new temporary services meet the following agency goals:

- Maintaining the capacity to enable rapid assessment of patterns of care, safety, and outcomes in the Medicare, Medicaid, CHIP and Marketplace populations;
- Establishing system safeguards to detect and avert unintended patient harms that result from policy adjustments;
- Ensuring high quality care is maintained;
- Demonstrating ongoing quality improvement efforts by Medicare participating providers, while maintaining access to necessary care;
- Establishing protections for vulnerable beneficiary populations (those with multiple chronic conditions, functional limitations, heart failure, COPD, diabetes, dementia), and sites of heightened vulnerability (such as nursing homes, rural communities) with high risk of adverse outcomes;
- Ensuring appropriate resource utilization and supporting cost efficiency;
- Supporting emergency preparedness and maintaining capacity to surge for potential coronavirus resurgence or other healthcare issues; and
- Considering timing and pace of policy corrections in light of local and regional variations in systems of care and the impact of the COVID-19 pandemic.
**NASMHPD NEWS BRIEFS**

**Kentucky, Michigan Join the §223 Excellence in Mental Health CCBHC Pilot Program**

The Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse & Mental Health Services Administration (SAMHSA) announced August 5 that the states of Kentucky and Michigan have been selected as additional participants in the §223 Certified Community Behavioral Health Clinic (CCBHC) Demonstration, an expansion mandated by the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

The §223 demonstration was established as a comprehensive effort to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high quality care for people with mental health and substance use disorders. While this demonstration was initially created for a two-year period under § 223 of the Protecting Access to Medicare Act of 2014, the demonstration has been extended several times.

Kentucky and Michigan join the original participants selected in 2016. Those states were Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon and Pennsylvania. Kentucky and Michigan were among the 25 states that initially received planning grants, the first stage in implementing the pilot; planning grant participation was one of the conditions under the CARES Act for the selection of the additional two states for the demonstration.

Since the demonstration program was created, over the last three funding years, Congress has been funding, through direct grants, community behavioral health centers that meet the standards for certification set out in the original § 223 language, rather than through the eight (now ten) states participating in the demonstration program.

**CMS Increases Medicare Reimbursement for 2021 for Inpatient Psychiatric Facilities**

On July 31, 2020, the Centers for Medicare & Medicaid Services (CMS) finalized regulations providing a 2.3 percent or $95 million increase in reimbursement to inpatient psychiatric facilities (IPFs) under the Prospective Payment System (PPS) for Fiscal Year 2021.

The IPF PPS regulations apply to approximately 1,550 inpatient psychiatric facilities.

Within the regulations, CMS also finalizes a proposal to adopt revised Office of Management and Budget (OMB) statistical area delineations which it says will result in wage index values being more representative of the actual costs of labor in a given area.

In addition, the regulations allow advanced practice providers, including physician assistants, nurse practitioners, psychologists, and clinical nurse specialists, to operate within the scope of practice allowed by state law by documenting progress notes in the medical record of patients, for whom they are responsible, receiving services in psychiatric hospitals. CMS says the restrictions imposed under the existing regulations are inconsistent with other recent changes finalized throughout the hospital conditions of participation and unnecessarily impose regulatory burden on psychiatric hospitals.

**CMS and CDC Make Provider Reimbursement Available for Counseling Patients to Self-Isolate**

On July 30, the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) announced that payment is being made available to physicians and health care providers to counsel patients, at the time of coronavirus disease 2019 (COVID-19) testing, about the importance of self-isolation after they are tested and prior to the onset of symptoms.

CDC models show that when individuals who are tested for the virus are separated from others and placed in quarantine, there can be up to an 86 percent reduction in the transmission of the virus compared to a 40 percent reduction in viral transmission if the person isolates after symptoms arise.

Provider counseling to patients, at the time of their COVID-19 testing, will include the discussion of immediate need for isolation, even before results are available, the importance to inform their immediate household that household members should also be tested for COVID-19, and the review of signs and symptoms and services available to them to aid in isolating at home. In addition, test subjects will be counseled that if they test positive, to wear a mask at all times and they will be contacted by public health authorities and asked to provide information for contact tracing and advised to tell their immediate household and recent contacts, if test results are positive, to be tested for the virus and to self-isolate as well.

CMS will use existing evaluation and management (E/M) payment codes to reimburse providers who are eligible to bill CMS for counseling services no matter where a test is administered, including doctor’s offices, urgent care clinics, hospitals, and community drive-thru or pharmacy testing sites.

Further information and resource links are available in A CMS Counseling Check List:

**Provider Relief Fund Application Deadline for Medicaid Providers Extended to August 28; Portal to be Reopened to Providers Not Previously Receiving Full Limit of 2 Percent of Reported Revenue**

CMS has announced that the deadline for Medicaid and CHIP providers to apply for payment through the Provider Relief Fund Portal for payments to offset lost revenues or uncompensated care attributable to the COVID-19 pandemic has been extended to August 28.

CMS says it will also shortly re-open the portal for providers who did not previously receive the full amount being made available, an amount equivalent to 2 percent of reported revenue from patient care.
Areas of interest include, but are not limited to:

- to ensure that the proposed technologies address an unmet need or substantially enhance existing capabilities.

Potential applicants seeking to develop technologies for remote monitoring or treatment delivery should have performed sufficient due diligence that address more long-standing barriers to SUD treatments or tackle issues with predominately in-person clinical trials research.

We expect this NOSI to accelerate the development of (1) remotely-delivered SUD treatment interventions, and (2) remote methods for collecting outcome measures evaluating the safety or efficacy of SUD treatments. These advances will facilitate the delivery of effective treatments to those in need and permit the execution of clinical trials when physical access to clinical research sites is limited. Ultimately, both these advances will lead to improved treatment options for individuals with SUD.

Research Objectives

NIDA encourages the submission of applications that will rapidly improve the ability to: (1) offer remotely-delivered SUD treatments to patients, including efforts to bring access to difficult to reach populations, and (2) conduct clinical trials of novel treatments using remote patient safety and clinical outcomes monitoring to reduce the need for in-person clinical visits.

This NOSI encourages research among subgroups that have been disproportionately impacted by COVID-19 or have difficulty accessing SUD treatment/research programs, including racial/ethnic minorities, socioeconomically disadvantaged individuals, and rural populations. This NOSI will also prioritize applications that have an impact beyond the circumstances created by the COVID-19 pandemic, for example, applications that address more long-standing barriers to SUD treatments or tackle issues with predominately in-person clinical trials research.

Potential applicants seeking to develop technologies for remote monitoring or treatment delivery should have performed sufficient due diligence to ensure that the proposed technologies address an unmet need or substantially enhance existing capabilities.

Areas of interest include, but are not limited to:

- Development and evaluation of new or existing remote-delivery of treatments for SUD.
- Development and evaluation of new or existing remote-delivery interventions for SUD among patients with or at risk of limitations of mobility, such as:
  - Pregnant or recently postpartum women
  - Older adults
  - Low SES populations
  - Racial/Ethnic minority, or health disparity populations
  - Rural populations
  - Individuals living in Native-American nations
  - Comorbid medical or mental health conditions
- Development and evaluation of new or existing tools and methods for remote monitoring of SUD treatment recruitment, adherence, tolerability, and outcome measures.
- Development and evaluation of research designs that may enhance the implementation of clinical trials that can be conducted remotely, in full or partially, and reduce the number and frequency of in-person clinical visits. These may include recruitment from a larger geographical area, or of patients who live in more rural areas, have disabilities, or have other specific barriers/challenges regarding attending in-person clinical visits (e.g., work during clinic hours, lack childcare, etc.).

Scientific/Research Contact: Evan S. Hermann, PhD. National Institute on Drug Abuse (NIDA), Email: evan.herrmann@nih.gov
A Whole Person Approach to Working with Individuals Who Are Living with Serious Mental Illness

**Tuesday, August 11, 2:30 p.m. to 4:00 p.m.**

Presented by the National Council for Behavioral Health

This webinar will discuss strategies for developing and implementing a whole person approach when serving individuals who are living with serious mental illness (SMI). Key considerations include access to basic needs and social determinants of health when treating and managing SMI; access to community-based supports to reduce barriers to resources; and access to peer support through Warm Lines and other crisis service systems.

Allie Franklin, CEO of Crisis Connections, will provide an overview of the whole person/integrated care approach to treating SMI and the types of crisis line services provided by Crisis Connections. She will also discuss best practices in leveraging technology to coordinate care and connect to resources in the community. Topher Jerome, Director of Lived Experience Integration at Jaspr Health, will focus on strategies for incorporating peer support services in crisis line systems. As a person with lived experience, he offers a unique perspective and expertise around the impact of peer support in behavioral health. Karis Grounds, Vice President of Health and Community Impact at 2-1-1 San Diego, will discuss how community information exchanges can leverage resource databases to improve referrals and care coordination with community services, as well as promote cross-sector collaboration to improve whole health.

**Presenters**
- Allie Franklin, LICSW, Chief Executive Officer of Crisis Connections
- Topher Jerome, Director of Lived Experience Integration at Jaspr Health
- Karis Grounds, MPH, Vice President of Health and Community Impact at 2-1-1 San Diego

**Register HERE**

Improving Access to Care Through Creating Certified Family Peer Specialists Across the Lifespan

**Wednesday, August 12, 2:00 p.m. to 3:30 p.m. E.T.**

Developed under contract by the National Association of State Mental Health Program Directors (NASMHPD) and presented by the National Federation of Families for Children’s Mental Health

Family Peer Support services have been available in many states for several years. While this service began organically, it has matured and is now a recognized Medicaid-billable support for families. While Family Peer Support was originally developed as a support for families with school-aged children in child-serving systems, the service has evolved in response to reflect a more robust understanding of family dynamics and the cultural shift towards more children remaining with their families into adulthood.

This webinar will explore the dimensions of family support across the lifespan. Our presenters will speak from three unique perspectives. We will highlight the subtle differences in providing supports for families with very young children, those with school-aged children and youth, and those families caring for their adult children. Presenters will offer real-life examples and tools that should prove useful for participants. The challenges faced by families as they transition through the various service systems will be highlighted and the importance of family support throughout the lifespan will be described.

**Presenters:**
- Joy Hogge, Ph.D., Executive Director, Families as Allies, Mississippi
- Zira Franks, MSC, BHT, Program Director, Family Involvement Center, Arizona
- Cindy Seekins, CFPS, Executive Director G.E.A.R. Parent Network, Maine

**Moderator:**
- Lynda Gargan, Ph.D., Executive Director, National Federation of Families for Children’s Mental Health

**Register HERE**

Closed-captioning is available for these webinars. We do not offer CEU credits. However, letters of attendance are offered upon request.

*If you have any questions please contact Kelle Masten via email or at 703-682-5187.*
Mental Health America's 2020 Summer RPC meeting: Addressing Mental Health Impacts of COVID-19, Entrenched Inequities, and Policing Practices will be a completely virtual meeting, in a change from previous years, to accommodate physical distancing during the ongoing pandemic.

Registration for this meeting is now live and open to all affiliates and partners for free!

The Legislative Awards Ceremony honoring state legislators will begin at 11:00 a.m. E.T., followed by the policy meeting at 12:00 p.m. to 4:00 p.m. E.T. MHA affiliates, industry partners, and national experts and stakeholders will come together to explore: how MHA's screening data reflects a second national crisis during the pandemic; how criminalization and the health care system disproportionately harm people with mental health conditions and black and brown people; and which crisis models need more investment to scale broadly across states.

Policy content will be just as deep and engaging as always so you will not want to miss the line-up of luminaries, including Dr. Arthur Evans, CEO of American Psychological Association, speaking about inequities, reaching all community members, and the invaluable contributions of peers. Attendees will learn about policy conclusions in the Mind the Gap report on perinatal mental health and hear about how Minneapolis is leading policy reform from Willie Garrett, President of the Minnesota Association of Black Psychologists. Dr. Jennifer Wood, a leading researcher on the intersection of mental health and criminal justice, will discuss her study of Minor Charges with Major Impacts. And, participants will learn about several extraordinary crisis intervention models and criminal justice alternative programs from RI International, MHA of Nebraska, and MHA of Greater Dallas.

We are excited to bring to you an agenda that focuses on the most pressing mental health issues of the time as the effects of the COVID pandemic continue to evolve. We will:

- Highlight alarming trends in MHA's national screening data during COVID-19, one of the few real-time mental health data sources;
- Discuss how policy and practices disproportionately impact communities of color and people with mental health conditions; and
- Identify some of the best crisis intervention models, including peer-led programs.

Please note, this meeting will be held through a browser-based virtual platform which registrants will join through an emailed link. Participants must use the same email address as was registered to access the live event stream on August 12. Any non-registered email addresses will not have access to participate.

AGENDA

11:00 a.m. -- Pre-meeting Mental Health Champion Legislative Awards
12:00 p.m. -- Welcome and Introductions
12:05 p.m. -- Setting the Stage
12:15 p.m. -- Framing the Issues: What MHA Screening Shows
12:30 p.m. -- Keynote with Dr. Arthur Evans, CEO of American Psychological Association
1:15 p.m. -- Maternal Mental Health in the time of COVID: Mind the Gap Report
1:45 p.m. -- Minneapolis Leading Police Reform
2:15 p.m. -- Minor Charges with Major Impact
3:00 p.m. -- Panel: Crisis Stabilization Models with Outstanding Outcomes
3:50 p.m. -- Conclusion

Inquiries about participation in the RPC meeting may be made to MHA's Debbie Plotnick at dplotnick@mhanational.org or Caren Howard at choward@mhanational.org.
An Important Grant Award Announcement

SAMHSA's First National Family Support Technical Assistance Center (NFSTAC)

A coalition led by the National Federation of Families for Children’s Mental Health, in partnership with the Center on Addiction, C4 Innovations, SAFE Project, and Boston University has been awarded SAMHSA's first National Family Support Technical Assistance Center (NFSTAC). NFSTAC is committed to providing tiered training and technical assistance (TTA), using a lifespan approach, that focuses on supports for families caring for loved ones who experience serious emotional disturbances, serious mental illness, and substance use disorders. This approach is anchored by the underlying principles that families play a vital role in supporting their loved ones, are the experts regarding their family support needs, and can be productively engaged to play a central role in treatment and recovery services.

NFSTAC will deliver comprehensive TTA that:
- Advances partnerships between clinical and peer providers and family members of individuals experiencing SED/SMI/SUDs
- Promotes stronger and more sustainable recovery-oriented outcomes
- Focuses on adapting and implementing recovery-oriented services
- Targets emphasis on workforce capacity and competencies
- Trains and certifies family peer specialists
- Delivers field-requested and on-demand resources for families and the general public
- Offers a multimodal platform including virtual trainings, mobile apps and social media

The NFSTAC team is comprised primarily of family members with loved ones of varying ages who experience SED/SMI/SUDs as well as individuals in recovery. This lived experience, combined with collective decades of experience as researchers, practitioners, TTA providers, and leaders in family engagement, will inform every aspect of NFSTAC. The effect of entrusting this agenda to a family-run organization, in collaboration with local, state and national family-centered partners, and strong alignment with professionals who advance the importance of family engagement in their work, will be transformational in the delivery of TTA. It will also emphasize to all stakeholders that lived experience and authentic family voice are cornerstones of the NFSTAC approach.

For more information, please contact Lynda Gargan, Executive Director, at lgarman@fcmh.org.

Center on Addiction C4 Innovations SAFEProject Boston University

SAMHSA

NFFCMH | 15800 Crabbs Branch Way Suite 300, Rockville, MD 20855
Establishing and Building Bed Registry Systems Highlighting the Success Outcomes of the 2019 Transformation Transfer Initiative (TTI) Projects

Wednesday, August 19, PART ONE – Understanding the Essential Elements of an Effective Statewide Bed Registry

Thursday, August 20, PART TWO – Establishing and Building Statewide Crisis Service/Bed Registries: Three Different Models for Success

In a continued effort to assist states in transforming their mental health systems of care the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Center for Mental Health Services (CMHS) created the Transformation Transfer Initiative (TTI). The TTI provides competitive funding awards to States, the District of Columbia, and the Territories to identify, adopt, and strengthen innovative initiatives.

TTI 2019 recipients used the funds to establish and expand comprehensive crisis psychiatric bed registry programs by tracking and monitoring the availability of psychiatric beds. Efforts also included tracking other crisis service supports such as crisis assessment centers, crisis residential programs, respite, mobile crisis teams, and centralized crisis call centers. Recipients used TTI funds to identify, adopt, and strengthen bed registry systems through either a new initiative or expansion of an existing one.

These two webinars will provide insight into how recipients created or expanded their bed registry systems in the hope that their experiences will offer guidance for other states and communities undertaking similar projects.

PART ONE – Understanding the Essential Elements of an Effective Statewide Bed Registry

In this webinar, 2019 TTI states Georgia and Delaware will illustrate the key components of a successful Crisis Services/Psychiatric bed registry and its role in improving crisis services in their states.

Through their experiences, speakers will demonstrate that to develop a successful registry, it is critically important to establish early and ongoing communication with all internal and external organizations and partners, as well as incorporate their input and feedback throughout the process.

States will also share information regarding choosing and adapting technology to meet the needs of partners and end-users, creating training and implementation strategies, and collecting data. Finally, speakers will share lessons learned, successes in sustainability, and forecasts for the future. Each state will offer concrete examples, specific information on their methodologies and technological strategies, and important insights to their process.

Presenters:

Delaware
• Lisa Johnson, Informatics Consultant, HEALTHe Insights
• Kris Fraser, Manager, Research and Evaluation, Delaware Division of Substance Abuse and Mental Health

Georgia
• Debbie Atkins, LPC, Director, Office of Crisis Coordination, Georgia Department of Behavioral Health and Developmental Disabilities
• Jill Mays, LPC, Director, Office of Prevention & Federal Grants, Georgia Department of Behavioral Health and Developmental Disabilities

Register HERE for PART ONE

(Continued on Next Page)

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If you have any questions please contact Kelle Masten via email or at 703-682-5187.
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**PART TWO – Establishing and Building Statewide Crisis Service/Bed Registries: Three Different Models for Success**

In this webinar, 2019 TTI states Rhode Island, North Carolina, and New Mexico will showcase their bed registry efforts, each using a different model for success. The three models for bed registries used by TTI 2019 recipients are: 1) search engine system, 2) referral system, and 3) referral network.

Rhode Island will explain its use of the search engine system, in which a platform refines searches by different terms relevant to patient placement, allowing providers to call the appropriate center. North Carolina will discuss the referral system, in which professionals make an assessment and then refer the patient to a hospital or crisis center. Finally, New Mexico will describe the referral network system. This model operates as a bi-directional referral system that refers patients to hospitals and allows hospitals to refer patients to other treatment centers. Each state will discuss how their model works and highlight unique and helpful features.

**Presenters:**

**Rhode Island**
- Olivia King, Behavioral Health IT Coordinator, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

**North Carolina**
- Krista Ragan, MA, BH-CRSys Program Manager, North Carolina Division of Mental Health, Developmental Disabilities & Substance Abuse Services/North Carolina Department of Health and Human Services

**New Mexico**
- Tiffany Wynn, MA, LPCC, Acting Deputy Director, Treatment & Programs Bureau, BHSA
- Hazel Mella, PhD, Staff Manager and Project Director, New Mexico BH Referral Network, BHSA

**Register HERE for PART TWO**

Closed-captioning is available for these webinars. We do not offer CEU credits. However letters of attendance are offered upon request. If you have any questions please contact Kelle Masten via email or at 703-682-5187.
Webinar Series: Implementing the Principles of a Trauma Responsive Service System

REGISTER FOR SERIES HERE

The SAMHSA Concept Paper on Implementing a Trauma Informed Approach will provide the basis for this four-part series designed to create a values-based framework for moving from theory to practice. The six principles for creating a trauma responsive service delivery will be presented. Organizations that serve victims of crime and those that have used their services will lend their voices and their experiences to share how they used the principles in creating trauma responsive services. Discussions on the importance of recognizing and addressing unconscious or implicit bias and its impact on services will also be discussed. The principles serve as a non-prescriptive road map to assist with the implementation of trauma responsive services and creating an atmosphere where all victims of crime want to come for help/services.

<table>
<thead>
<tr>
<th>Sessions</th>
<th>Dates</th>
<th>Speakers</th>
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<tr>
<td>Empowerment/Voice/Choice &amp; Collaboration/Mutuality</td>
<td>August 11, 12:00 p.m. to 1:30 p.m. E.T.</td>
<td>William Kellibrew, Baltimore City Health Department; Devika Shankar, LA LGBT Center</td>
</tr>
<tr>
<td>Lessons Learned: Increasing Access to Mental Health Services to Traditionally Underserved Victims of Crime through implementation of trauma-responsive services. The purpose of addressing the trauma experienced by victims of crime is not always understood by their providers. By understanding the impact of trauma on victim survivors, responding in ways that enhances the realization that behavior is frequently an adaptation to trauma and that healing must be the focus of service and support is key to ensuring organizations create an atmosphere where all victims of crime want to come to you for help/services. Grantees will discuss challenges and how they applied a trauma-informed lens to successfully overcome obstacles</td>
<td>September 10, 12:00 p.m. to 1:30 p.m. E.T.</td>
<td>OVC Purpose Area 3b Grantees from Los Angeles LGBT Center, Clinical and Support Options, Inc (MA), and Center for Trauma &amp; Resilience (CO)</td>
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Register HERE

This product was supported by grant number 2017-VF-GX-K142, awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this product are those of the contributors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Additional NASMHPD Links of Interest

New IPS Supported Employment Video Library Website, IPS Works Employment Center
Want Schools to Open? Get Serious About Outbreaks, Scott Gottlieb & Michael R. Strain, Wall Street Journal, August 2
Income Disparities in Access to Critical Care Services, Kanter G.P., Segal A.G., & Groeneveld P.W., Health Affairs, August 2020
Staying Connected In The COVID-19 Pandemic: Telehealth At The Largest Safety-Net System In The United States, Lau J., et al., Health Affairs, August 2020
Rapid Expert Consultation on Staffing Considerations for Crisis Standards of Care for the COVID-19 Pandemic, National Academies of Sciences, Engineering, and Medicine’s (NASEM’s) Standing Committee on Emerging Infectious Diseases and 21st Century Health Threats, July 28
Exploring Drug Repurposing for COVID-19 Treatment, Dr. Francis Collins, Director’s Blog, National Institutes of Health, August 4
We Have Added a Virtual HCBS Conference Option - Registration Opens This Month

Early Bird rates for the 2020 HCBS Conference: $625 for ADvancing States members, nonprofits, government attendees, and speakers; $1050 for corporate attendees.

Notice of Upcoming Targeted PCORI Funding Announcement
Suicide Prevention: Brief Interventions for Youth -- Cycle 3 2020

Announcement Type: Research Award
Total Funds Available: $30 Million
Maximum Project Period: 5 years
Applicant Town Hall Session: September 2020
Letter of Intent Deadline: September 29, 2020, 5 p.m. E.T.
Total Direct Costs: $10 million
Earliest Start Date: November 2021
Application Deadline: January 12, 2021, 5 p.m. E.T.

This notice provides information about an upcoming Targeted Patient-Centered Outcomes Research Institute (PCORI) Funding Announcement (PFA), which will be released by PCORI on September 1, 2020. Through this initiative, PCORI seeks to fund large randomized controlled trials (RCTs) and/or observational studies that compare the effect of brief interventions on acute suicide risk in youth ages 15 to 24.

Suicide rates in the US have increased by over 35 percent from 1999 to 2018. Of notable concern is the 46 percent increase in rates for youth ages 15 to 24 during this same time period (from 9.9 to 14.5 per 100,000). While suicide rates have risen across race/ethnicity, gender, and geographical groups, rates remain highest in boys/males, LGBTQ, rural, and American Indian/Alaska Native populations. Additionally, recent trends indicate an increasing suicide rate for Black and Latina adolescents.

Brief interventions (e.g., Teachable Moment Brief Intervention, Motivational Interviewing, Safety Planning) are often the first intervention patients presenting with suicidality receive. These interventions are designed to reduce acute suicide risk and direct patients to appropriate treatment, and can be delivered in a variety of settings (e.g., emergency departments, primary care, schools, mobile crisis units, community-based settings, home, inpatient care, juvenile detention centers) and by a range of healthcare professionals. The evidence base of brief interventions for suicidality comes primarily from studies done with adults. There is some evidence for youth, but which interventions work best for which populations of youth is not clear.

This Targeted PCORI Funding Announcement will solicit applications that respond to the following question:

What is the comparative effectiveness of different brief interventions to reduce suicidality and improve outcomes for youth ages 15 to 24?

PCORI is particularly interested in the comparative effectiveness of tailored approaches to brief interventions. Tailoring may include involvement of people with lived experience, telehealth (e.g., apps, text-based, web-based, phone calls, video calls), cultural factors (e.g., language, family involvement, rituals), and specific settings (e.g., primary care, school, home, community) or other cultural adaptations.

Applicants should consider the following outcomes: suicidal ideation, self-harm, engagement in mental health care, functional measures, school participation, employment, skills to manage suicidality, connectedness, quality of life, and healthcare utilization (hospital or ED use). Applications should include follow-up for up to one year.

Interventions must be evidence-based and/or in widespread use and reproducible. This Targeted PFA preannouncement is provided to allow potential applicants additional time to identify collaborators, obtain stakeholder input on potential studies, and develop responsive, high-quality proposals.
The Department of Behavioral Health and Developmental Disabilities and the Department of Public Health invite you to participate in our **2x2 Series: Self-Care Tips and Support for Managing Life**. These engaging and interactive sessions may be just the break you need from a challenging workday. They are designed to promote wellness and provide self-care tips and support for managing life during these unprecedented times. Each session offers mental health tips and information about reducing/managing stress, working through grief, improving work/life balance, enhancing personal and professional relationships, having fun, and other hot topics.

**NOTE:** The sessions use the WebEx webinar online conferencing system. WebEx allows participants to log on to a website from their computer and view the facilitator's information online, while listening to the facilitator through the use of a simultaneous telephone conference call.

The 2x2 Series is held LlVE twice weekly, on Tuesdays and Thursdays at 2:00 p.m. Below is the date, time, session title and registration link for this week’s sessions (the password for each session is “2by2”):

All participants must use the links above to register for the 2x2 sessions. Additionally, please note that it is strongly encouraged that you join the webinar 10-15 minutes prior to the start time to ensure that you do not experience any connectivity issues. Although all attendees will be muted, the chat box will be functional, and all attendees are encouraged to ask questions and share thoughts through the interactive chat. The facilitator will allot time for Q&A at the end of the presentation.

**Want to be a 2x2 Presenter?** The 2x2 Planning Team is recruiting new presenters to share their knowledge and experience with our growing audience. If you are interested, please click on the following link, and complete the Speaker Application. A member of our team will contact you to begin the vetting process. [https://www.surveymonkey.com/r/2x2_Series_Speaker_Application](https://www.surveymonkey.com/r/2x2_Series_Speaker_Application)

If you cannot attend the live sessions, each one will be recorded and available for review on the DBHDD website: [https://dbhdd.georgia.gov/2x2-series](https://dbhdd.georgia.gov/2x2-series)

**Questions?** Please email DBHDDLearning@dbhdd.ga.gov

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**The MHTTC Network – School Mental Health Initiative**

The **Mental Health Technology Transfer Center (MHTTC) Network**, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), is a collaborative Network that supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. The Network includes 10 Regional Centers, a National American Indian & Alaska Native Center, a National Hispanic & Latino Center, and a Network Coordinating Office.

The MHTTC Network has supplemental funding to focus on the need for further implementation of mental health services in school systems. The Regional and National Centers provide technical assistance and develop resources, trainings and events around various school mental health topic areas, including evidence-based identification, early intervention, and treatment practices, youth suicide prevention, school wellness, and trauma-informed practices in schools.

During the current COVID-19 public health crisis, the MHTTC Network remains open and available to assist the school mental health workforce. While in-person learning opportunities are postponed until further notice, the Network is working quickly to offer virtual learning opportunities in the interim.

To view a compilation of MHTTC resources specific to school mental health during the COVID-19 pandemic, please visit our [website](https://www.surveymonkey.com/r/2x2_Series_Speaker_Application). For access to all MHTTC trainings and resources, visit the Training and Events Calendar [here](https://www.surveymonkey.com/r/2x2_Series_Speaker_Application) and the Products and Resources Catalog [here](https://www.surveymonkey.com/r/2x2_Series_Speaker_Application).

**Stay informed! Subscribe to MHTTC Pathways HERE**

**MHTTC Pathways** is a monthly eNewsletter that keeps you informed about what is happening within the MHTTC Network. It highlights events, training opportunities, resources, and the latest Network products. Special features help you stay updated on the latest on evidence-based practices, implementation science, and workforce development.
Disasters have the potential to cause emotional distress. Some are more at risk than others:

- Survivors living or working in the impacted areas (youth & adults)
- Loved ones of victims
- First Responders, Rescue & Recovery Workers.

Stress, anxiety, and depression are common reactions after a disaster.

Warning signs of distress may include:

- Sleeping too much or too little
- Stomachaches or headaches
- Anger, feeling edgy or lashing out at others
- Overwhelming sadness
- Worrying a lot of the time; feeling guilty but not sure why
- Drinking alcohol, smoking or using tobacco more than usual;
- Feeling like you have to keep busy
- Lack of energy or always feeling tired
- Eating too much or too little
- Not connecting with others
- Feeling like you won’t ever be happy again
TIPS FOR COPING WITH STRESS AFTER A DISASTER:

Take care of yourself. Try to eat healthy, avoid using alcohol and drugs, and get some exercise when you can- even a walk around the block can make a difference.

Reach out to friends and family. Talk to someone you trust about how you are doing.

Talk to your children. They may feel scared, angry, sad, worried, and confused. Let them know it’s okay to talk about what’s on their mind. Limit their watching of TV news reports about the disaster. Help children and teens maintain normal routines to the extent possible. Role model healthy coping.

Get enough ‘good’ sleep. Some people have trouble falling asleep after a disaster, others keep waking up during the night.

If you have trouble sleeping:

- Only go to bed when you are ready to sleep
- Don’t watch TV or use your cell phone or laptop computer while you’re in bed
- Avoid eating (especially sugar) or drinking caffeine or alcohol at least one hour before going to bed
- If you wake up and can’t fall back to sleep, try writing in a journal or on a sheet of paper what’s on your mind.

Take care of pets or get outside into nature when it’s safe. Nature and animals can help us to feel better when we are down. See if you can volunteer at a local animal shelter- they may need help after a disaster. Once it’s safe to return to public parks or natural areas, find a quiet spot to sit in or go for a hike.

Know when to ask for help. Signs of stress can be normal, short-term reactions to any of life’s unexpected events- not only after surviving a disaster, but also after a death in the family, the loss of a job, or a breakup.

It’s important to pay attention to what’s going on with you or with someone you care about, because what may seem like “everyday stress” can actually be:

- Depression (including having thoughts of suicide)
- Anxiety
- Alcohol or Drug Abuse.

If you or someone you know may be depressed, suffering from overwhelming feelings of anxiety, or possibly abusing alcohol or drugs ...

Call 1-800-985-5990 or text ‘TalkWithUs’ to 66746.

You Are Not Alone.
Emergency Award: RADx-UP Coordination and Data Collection Center (CDCC) (U24 Clinical Trial) (RFA-OD-20-013)

Application Due Date: August 7, 2020
Letter of Intent Date: July 6, 2020
Earliest Estimated Award Date: September 2020

Estimated Total Funding: $7.5 million
Expected Number of Awards: 1
Earliest Start Date: September 2020

NIH is issuing this FOA in response to the declared public health emergency issued by the Secretary, HHS, for 2019 Novel Coronavirus (COVID-19). This emergency cooperative agreement funding opportunity announcement (FOA) from the National Institutes of Health (NIH) provides an expedited funding mechanism as part of the Rapid Acceleration of Diagnostics-Underserved Populations (RADx-UP) initiative, a consortium of community-engaged research projects to understand factors that have led to disproportionate burden of the pandemic on the underserved and/or vulnerable populations so that interventions can be implemented to decrease these disparities. This FOA seeks to fund a single Coordination and Data Collection Center (CDCC) as an integral part of the consortium. The funding for this supplement is provided from the Paycheck Protection Program and Health Care Enhancement Act, 2020.

The CDCC will serve as a national resource, working with NIH scientific staff and consortium members to coordinate and facilitate research activities. The CDCC will also serve as a spoke in the larger NIH initiatives by providing de-identified individual data to an NIH-based data center. The RADx-UP CDCC will provide overarching support and guidance in the following four domains: (1) Administrative Operations and Logistics, (2) COVID-19 Testing Technology, (3) Community and Health System Engagement and (4) Data Collection, Integration and Sharing. The CDCC will facilitate RADx-UP collaborative research by providing organizational and analytical infrastructure and expertise, supporting data integration and analysis, and coordinating across RADx-UP projects and the NIH-supported RADx initiatives that are developing and validating new COVID-19 testing technologies.

This FOA is therefore released in parallel with three companion emergency Notices of Special Interest (NOSIs):

1. Notice of Special Interest (NOT-OD-20-121): Solicits emergency competitive revision applications to existing awards for large consortia, multi-site trials, centers and other current networks that have adequate capacity, infrastructure, and established community-engaged relationships to support large-scale COVID-19 testing interventions or have the capacity to ramp up quickly to reach underserved or vulnerable populations. The single submission date is August 7, 2020. See: https://grants.nih.gov/grants/guide/notice-files/NOT-OD-20-121.html

2. Notice of Special Interest (NOT-OD-20-120): A complementary emergency competitive revision opportunity that shifts eligibility to collaborative and individual research awards, generally focused on smaller underserved or vulnerable populations. The two submission dates are August 7, 2020 and September 8, 2020. See: https://grants.nih.gov/grants/guide/notice-files/NOT-OD-20-120.html


Researchers planning to apply are strongly encouraged to read all four of these interrelated funding opportunities.

Eligible Entities

Public/State Controlled Institution of Higher Education
Private Institution of Higher Education
Nonprofit with and without 501(c)(3) IRS Status (Other than Institutions of Higher Education)
Small Businesses
For-Profit Organization (Other than Small Businesses)
State Governments
County governments
City or township governments
Special district governments
Independent school districts
Public housing authorities/Indian housing authorities
Indian/Native American Tribally Designated Organization (Native American tribal organizations (other than Federally recognized tribal governments)
U.S. Territories or Possessions
Indian/Native American Tribal Government (Other than Federally Recognized)
Faith-Based or Community-Based Organizations
Regional Organizations

Foreign Institutions

Non-domestic (non-U.S.) Entities (Foreign Institutions) are not eligible to apply.
Non-domestic (non-U.S.) components of U.S. Organizations are not eligible to apply.

Foreign components, as defined in the NIH Grants Policy Statement, are not allowed.

NIH will hold two pre-application webinars:

- Friday, June 26, 2:00 p.m. to 4:00 p.m. E.T., an overview of the RADx-UP initiative, followed by presentations on each funding opportunity and question and answer sessions; and
- Wednesday, July 1, 3:00 p.m. to 5 p.m. E.T., focusing on applications for the Coordinating and Data Collection Center Registration is required. Register and learn more about these webinars at https://www.nih.gov/research-training/medical-research-initiatives/radx/events.

Questions can be pre-submitted for these sessions at RADXinfo@nih.gov by June 24 for the first session and June 29 for the latter session.

Contacts (All National Institute on Minority Health and Health Disparity (NIMHD)

Scientific/Research Contact: Dorothy Castille, 301-594-9411, dorothy.castille@nih.gov
Peer Review Contact: Maryline Laude-Sharp, 301.451.9536, maryline.laude-sharp@nih.gov
Financial/Grants Management Contact: Priscilla Grant, 301-594-8412, pg38h@nih.gov
Research on Co-Morbid Substance Use, Substance Use Disorders, and Other Psychiatric Disorders

The purpose of this Notice is to encourage the submission of research project grant applications that address co-morbid substance use and/or substance use disorders, and other psychiatric disorders. Research in response to this NOSI may include etiologic investigations to inform prevention intervention, intervention development and testing, and research to address service delivery strategies to address co-morbid conditions. The intent is to encourage a broad portfolio of research, that enhances understanding of risk, etiology, prevention, treatment and service delivery related to co-occurring conditions.

Background:

The association between substance use, substance use disorders, and psychiatric disorders, including depression, anxiety, bipolar disorder, ADHD and other externalizing disorders, has been well established through population based epidemiologic surveys. Numerous developmentally focused theory-based approaches have been proposed, including shared underlying vulnerabilities or risk factors. From a disorder perspective, prevalence can be expressed as either the prevalence of other psychiatric disorders among substance using populations or the prevalence of substance use among individuals with other psychiatric disorders, leading to variability in rates. Mental illness is often characterized as a risk factor for substance use initiation and for transition from use to misuse and disorder, though the exact sequence and relationship between substance use, substance use disorders and psychiatric co-morbidity is unclear and may vary by disorder. For some substances and disorders, it may be the substance use that precedes the onset of other psychiatric symptoms. Additional research is needed to determine the various trajectories of substance use and psychiatric symptoms, as well as strategies for intervention to change trajectories.

Research Objectives:

The National Institute of Drug Abuse (NIDA) is interested in research project grant applications that would further our understanding of co-morbidity through studies that test etiological theories and interventions (treatment and prevention), across the lifespan.

NIDA interest includes, but is not limited to, applications in the following areas:

- Epidemiologic studies of the etiology of co-morbidity that directly lead to the development of targeted preventive intervention research projects; of priority are studies that include prevention scientists as part of the research team, to facilitate the application of findings into next phase prevention intervention development. These can include primary data collection or secondary data analyses.
- Studies of the trajectories of the development of co-morbid substance use, substance use disorders and psychiatric disorders and the ways in which their interactions influence the onset, course and recovery of both; of interest are studies which additionally identify potentially effective points and models of intervention.
- Intervention research to directly address common mechanisms/dimensions that may underlie both substance use disorders and other psychiatric disorders. Among treatment seeking populations, studies to determine whether or how the receipt of evidence-based treatments for psychiatric disorders impact substance use initiation/and or progression to misuse and disorder.
- Strategies for augmenting psychiatric care to prevent substance use initiation and/or progression from use to misuse or disorder. This could include research to test whether and how models of care delivery for mental illness (e.g., the collaborative care model, coordinated specialty care for first episode psychosis) could be leveraged for substance use prevention among at-risk individuals.
- Studies to further understand and prevent suicide and other adverse outcomes (morbidity and mortality) among individuals using illicit substances.
- Research that uses clinically validated digital therapeutics, including mobile applications and other platforms, virtual reality, wireless monitoring and biofeedback, imaging tools for biofeedback to develop, improve and systematically measure behavioral interventions for substance use and psychiatric conditions. Additionally, neuromodulation devices to augment behavior therapies.
- Studies to evaluate the use of medications to improve the efficacy of behavioral interventions for co-morbidities.
- Research to promote adherence to pharmacotherapies, such as buprenorphine, methadone, depot naltrexone, Lofexidine, naloxone, or HAART, in substance abuse treatment populations with comorbidities.
- Studies that develop safe and effective psychosocial interventions to improve the outcomes of pharmacotherapies for substance use disorders including opioid use disorder, overdose reversal, and preventive efforts for psychiatric and suicide risk.
- Research on tobacco harm reduction strategies such as switching from combustibles to e-cigarettes with special attention to individuals with severe mental illness (e.g., schizophrenia, bipolar depression).
- Services research to develop and test strategies to improve system- or provider- capacity for treating and managing co-occurring conditions.

(More on following page)
Notice of Special Interest (NOSI)

Research on Co-Morbid Substance Use, Substance Use Disorders, and Other Psychiatric Disorders

Application and Submission Information

This notice applies to due dates on or after October 05, 2020 and subsequent receipt dates through May 8, 2023

Submit applications for this initiative using one of the following funding opportunity announcements (FOAs) or any reissues of these announcement through the expiration date of this notice.

- **PA-20-185**: NIH Research Project Grant (Parent R01 Clinical Trial Not Allowed)
- **PA-20-183**: NIH Research Project Grant (Parent R01 Clinical Trial Required)
- **PA-20-184**: Research Project Grant (Parent R01 Basic Experimental Studies with Humans Required) Research Project Grant (Parent R01 Clinical Trial Required)
- **PA-20-200**: NIH Small Research Grant Program (Parent R03 Clinical Trial Not Allowed)
- **PA-20-196**: NIH Exploratory/Developmental Research Grant Program (Parent R21 Basic Experimental Studies with Humans Required)
- **PA-20-195**: NIH Exploratory/Developmental Research Grant Program (Parent R21 Clinical Trial Not Allowed)
- **PA-20-194**: NIH Exploratory/Developmental Research Grant Program (Parent R21 Clinical Trial Required)
- **PA-18-775**: Pilot and Feasibility Studies in Preparation for Drug and Alcohol Abuse Prevention Trials (R34 Clinical Trial Optional) or any re-issuances

All instructions in the [SF424 (R&R) Application Guide](#) and the funding opportunity announcement used for submission must be followed, with the following additions:

- For funding consideration, applicants must include "NOT-DA-20-004" (without quotation marks) in the Agency Routing Identifier field (box 4B) of the SF424 R&R form. Applications without this information in box 4B will not be considered for this initiative.

Applications nonresponsive to terms of this NOSI will be not be considered for the NOSI initiative.

Inquiries: Please direct all inquiries to the contacts in Section VII of the listed funding opportunity announcements with the following additions/substitutions:

**Scientific/Research Contact:** Amy B. Goldstein, Ph.D., National Institute on Drug Abuse (NIDA), 301-827-4124, amygoldstein@nih.gov.
Now Virtual !!!

32nd Annual Tuerk Conference
on Mental Health & Addiction Treatment

SEPTEMBER 10, 2020

RECORDED PLENARIES AND WORKSHOPS: Available to access online for two weeks after the conference, so you can attend all in one day or spread it out over two weeks.

Super Saver
$165 includes Lunch and 6 CEUs

2020 Vision Working Together

Sponsored by
The National Council on Alcoholism and Drug Dependence, Maryland
University of Maryland, School of Medicine, Department of Psychiatry
Division of Addiction Research and Treatment

We strongly encourage you to register online at our website for the fastest and most efficient process.

SEPTMBER 10, 2020

8:00 am – 5:00 pm

Conference Sponsors
Premier
Ammon Analytical Laboratory
Platinum
Ashley Treatment Centers ▪ Behavioral Health System Baltimore
Clinic Management and Development Services, Inc. (CMDS)
Delphi Behavioral Health Group ▪ Gaudenzia, Inc.
Kolmac Outpatient Recovery Centers ▪ Maryland Addiction Recovery Center
Maryland Center of Excellence on Problem Gambling ▪ Medmark Treatment Centers
Mountaion Manor Treatment Centers ▪ Pathways / Anne Arundel Medical Center
Powell Recovery Center ▪ Project Chesapeake ▪ Recovery Centers of America
Recovery Network ▪ Total Health Care ▪ Tuerk House ▪ Turning Point Clinic
University of Maryland, Drug Treatment Centers
University of Maryland Medical System, EAP
University of Maryland, Psychiatry, Division of Addiction Research and Treatment
Warwick Manor Behavioral Health
Public health officials are on the front lines of the coronavirus response: but how are their tools, policies, and practices keeping up? How are state and local leaders innovating to increase public healthcare capacity and care for patients and quarantine workers alike? This Town Hall will explore the people and technology behind the most dextrous response plans, and lessons learned from state and local responses so far. Attendees will leave the town hall better equipped to stand up procedural and tech-centric response tactics in their own communities.

**AUGUST 11**

**12:00 p.m.- 3:15 p.m. E.T.**

**REGISTER NOW**

**Online Operation: The Telehealth Revolution (Part 1)**

In February of 2020, telehealth was just a convenient way to see a doctor from home. By the end of March 2020, telehealth had become a crucial tool in minimizing disease spread, and was adamantly encouraged by medical experts across the United States. How did state and local encourage this massive shift to telehealth? What worked, and what didn’t? Come visit the telemedicine doctors with us to explore how various components like broadband access intersect with telemedicine access, and what role telemedicine will likely play across states and localities in the future.

- **Dr. Judd Holland**, Associate Dean, Strategic Health Initiatives, Department of Emergency Medicine, Thomas Jefferson University
- **Moderator: Alisha Powell Gillis**, Senior Editor, *Route Fifty*

**Online Operation: The Telehealth Revolution (Part 2)**

On May 1, the City of El Cajon launched an app to promote civic engagement. While it was perfectly timed for getting information to their citizens amid the COVID-19 pandemic, the city hadn't originally intended the app for public health resources alone. Join us to hear about how this app went from an idea, to a reality, to a necessity for boosting communication and involvement between El Cajon residents and their government.

- **Sara Diaz**, Director of IT, City of El Cajon, CA
- **Graham Mitchell**, City Manager, City of El Cajon, CA
- **Moderator: Alisha Powell Gillis**, Senior Editor, *Route Fifty*

**Editorial Session #3: Mental Health and Wellness**

The pandemic has taken an immense toll on everyone’s mental health. Public health officials have carried the brunt of the trauma associated with the coronavirus response causing extreme stress and burn out. One way to help public health officials and all residents maintain their mental health and wellness is through the adoption of technology tools like meditation apps and online therapist visits to offer support and care. We’ll explore the future of how state and local governments can leverage technology to promote mental health and wellness.

- **Dr. Nicolette Louisainst**, Executive Director, Healthcare Ready
- **Lori Tremmel Freeman**, CEO, National Association of County and City Health Officials (NACCHO)
- **Michael Fraser**, CEO, Association of State and Territorial Health Officials
- **Lisa Carlson**, Executive Administrator, Research Programs and Operations, Emory University School of Medicine
- **Moderator: Alisha Powell Gillis**, Senior Editor, *Route Fifty*
NASMHPD continues to receive recognition from the behavioral health community at large, including from our friends at SAMHSA, for our 2017 and 2018 Beyond Beds series of papers highlighting the importance of providing a continuum of care beyond institutional inpatient care.

A 2019 multiple-paper follow-up to the Beyond Beds series is now up on the NASMHPD website. The 2019 papers take the Beyond Beds theme to look at additional innovative approaches offered in the community and factors impacting those services, covering such topics as early antipsychotic prescribing practices in nursing homes, developing a behavioral health workforce, a public health approach to trauma and addiction, addressing behavioral health in traumatic brain injury treatment, recovery-oriented cognitive therapy, integration of mental health and substance use services for those with co-occurring conditions, schools as part of the continuum of care for children and adolescents, and addressing social and mental health needs in transition-age homeless youth.

One of those papers, Lessons from the International Community to Improve Mental Health Outcomes, authored by Deborah Pinals, M.D., chair of the NASMHPD Medical Directors Division and Medical Director, Behavioral Health and Forensic Programs in the Michigan Department of Health and Human Services, pivots from NASMHPD’s previous work in this series to look beyond the borders of the United States to other countries for examples of successful and promising strategies across nine areas of focus. The paper’s highlighted examples from the international community aim to further illuminate strategies and inspire ongoing crucial dialogue in an effort to improve mental health in the United States.

Following are links to the other reports in the 2019 Technical Assistance Coalition series.

- Effects of CMS’ Measure of Antipsychotic Prescribing Practices for Nursing Facilities on Utilization of Antipsychotic Medications and Changes in Diagnostic Patterns
- Developing a Behavioral Health Workforce Equipped to Serve Individuals with Co-Occurring Mental Health and Substance Use Disorders
- A Public Health Approach to Trauma and Addiction
- Traumatic Brain Injury and Behavioral Health Treatment
- Recovery-Oriented Cognitive Therapy: a Theory-Driven, Evidence-Based, Transformative Practice to Promote Flourishing for Individuals with Serious Mental Health Conditions that is Applicable across Mental Health Systems
- Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What’s Known, What’s New, and What’s Now?
- Schools as a Vital Component of the Child and Adolescent Mental Health System
- Addressing Intersecting Social and Mental Health Needs among Transition-Aged Homeless Youth

The NASMHPD Technical Assistance Coalition series will continue in 2020.
Student Mental Health: Responding to the Crisis

Mary Ward House Conference & Exhibition Centre, London

Tuesday, October 6, 2020

This conference will break-down the cultures, economic factors, social and institutional pressures contributing to dramatic rises in disclosures of mental health issues at universities and student suicides.

Delegates will explore why more students are turning to unconventional incomes like gambling and sex work during their studies, how the university experience can compound cultural and environmental conditions that lead students to access and supply drugs; and discussing how cross-institutional co-operation as well as legislative review of attitudes towards information sharing could prevent students reaching a point of crisis.

With just over two months to go to this expected sell out event places are now at a premium. However you can still...

| View Event | View Programme | Register Interest | Book A Place |

Student Mental Health: Responding to the Crisis is our third national conference bringing together domestic and European HE institutes, students, academic/policy researchers, health, social care and counselling services to develop pragmatic approaches to:

- Transitions of otherwise non-criminal student populations into drug use and supply created by financial instability, distance from guardians and the interconnected nature of student life.
- Preventing student suicides; developing best practices in data sharing between institutions and families – measuring the importance of student safety and public interest against data protection, as well as investing in welfare support services and advanced planning.
- Isolation and instability created by increases in students engaging with sex work and gambling as a means of meeting the cost of university life.
- Cultures of anxiety driven by transitions in curriculum and lifestyle, persecutory perfectionism, unrealistic expectations projected on new media platforms, institutional pressures and uncertainty around post-university employment opportunities.
- Normalization of competitive and insecure working cultures in the HE sector – how does this impact the human value of academic labor and the support available to young people struggling with their studies.

2020 Attendee Breakdown by Sector.

Curious about who else will be in attendance on the day?

WEBSITE FOR THE SAMHSA-SPONSORED

Center of Excellence for Protected Health Information

Fundied by the Substance Abuse and Mental Health Services Administration (SAMHSA)
Altering Our Course:
NASHIA's Virtual SOS Conference

Feature Event: Sept. 22 and 23, 2020
Workgroup Sessions: Sept. 24, 25, 28, & 29, 2020
Podcasts Available: Beginning Sept. 22, 2020
Post Intensive Workshop: Sept. 29, 2020

Format
This event will include a combination of live and recorded sessions in a variety of formats and an exhibit hall for event sponsors and attendees to network and collaborate.

Rate (Covers the entire event.)
$250 for Members
$300 for Non Members
CEUs applied for APA, SW, and CRC.

Location
All events are virtual.

Agenda
Sponsorship Opportunities
Join NASHIA for 2020

Contact Us
For more information, contact info@nashia.org.


A premier event with premier presenters for premier leaders (that's you). Reserve your seat today!

Register and Sponsor HERE
SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation uses its Virtual Learning Community (VLC) model to deeply explore topics of interest to the field centered around a common theme. VLCs are composed of a series of webinars, small discussion groups, and webinar supporting materials. These communities are open to the field at no cost to the participant.

Each webinar provides an opportunity to hear from national experts and state representatives. The presenters offer guidance on best and promising practices as well as practical lessons learned from on-the-ground experience. Selected webinars are followed by a small-group discussion, where audience members can engage directly with the presenters to learn more about the topics of discussion.

**Transform to Teleservices: Innovative Approaches to Substance Use Disorder Treatment Happening Now in Drug Courts**

**Part I - Tuesday, August 11, 1:00-2:30 p.m. E.T.**

As technological innovations in health care continue to emerge, and as research is confirming the effectiveness of these approaches that rely on both new and established technologies, drug courts across the country are starting to transform the way they work by implementing teleservices in order to improve access to medication-assisted treatment (MAT) as well as a range of evidence-based psychosocial supports for the treatment of substance use disorders (SUD). Part I of this Virtual Learning Community webinar series will provide an overview of the emerging teleservices landscape and the opportunities brought about by this shift in methodology, review the evidence base for SUD treatment services delivered via teleservices technologies, and share potential strategies for the implementation of SUD teleservices in drug courts, including a review of the types of SUD services that can be effectively leveraged via telehealth along with models of care that highlight the mechanisms of collaboration between drug courts and community-based treatment providers.

Additional topics to be addressed include rolling redesign pertaining to telehealth regulations, reimbursement, and confidentiality, focusing on emerging opportunities for the expansion of teleservices in drug courts.

**PRESENTERS**

- Michael Chaple, Ph.D., Assistant Professor of Clinical Psychiatry, New York State Psychiatric Institute, Columbia University Medical Center
- Maryellen Evers, LCSW, CAADC, Telebehavioral Health Trainer, Center for the Application of Substance Abuse Technologies at the University of Nevada, Reno
- Nancy Roget, M.S., M.F.T., LADC, Executive Director, Center for the Application of Substance Abuse Technologies at the University of Nevada, Reno

**Register HERE for Part I**

**Part II - Tuesday, August 18, 1:00-2:30 p.m. E.T.**

Several drug courts across the country have successfully leveraged teleservices in order to increase client access to medication-assisted treatment as well as a range of evidence-based psychosocial supports for the treatment of substance use disorders (SUD). Part II of this Virtual Learning Community webinar series will feature presentations from drug court practitioners and substance use treatment providers who will outline the various approaches they have taken to integrate teleservices in drug court. Case examples will illustrate several unique models of implementation, including:

- development of a comprehensive teleservices track in drug court,
- drug court partnerships with distance-based SUD telemedicine providers,
- drug court partnerships with community-based SUD treatment providers who offer remote services, and
- the integration of virtual counseling platforms.

**Register HERE for Part II**
Multi-Part Virtual Learning Community
Webinar Series
Implementing A Peer Mentor Program: Strategies for Engaging Peer Recovery Support Specialists in Adult Treatment Courts
Monday, August 31, 12:30 p.m. to 2:00 p.m. E.T.

Learn how to engage Peer Recovery Support Specialists (PRSSs) in adult treatment courts to support people with substance use disorders and co-occurring mental disorders.

Peer Recovery Support Specialists (PRSSs) working in treatment courts are people with lived experience of behavioral health disorders and criminal justice involvement who are key members of the clinical team serving those participating in drug court and mental health court programs.

This webinar covers strategies for how to engage PRSSs in adult treatment courts to support people with substance use disorders and co-occurring mental disorders. Topics covered will include training peers to work in treatment courts, identifying key community partners for an effective peer mentoring program, defining core activities of peers working in treatment courts, the peer certification process, and oversight and management of peer programs. Real-life examples of successful implementation in the state of Oklahoma will be shared.

Register HERE

Understanding and Addressing Criminal Thinking
Tuesday, September 1, 2:00 p.m. to 3:30 p.m. E.T.

Learn about the concept of criminal thinking as a means of describing, understanding, assessing, and changing criminal behavior

Register HERE

AHRQ Announces New Challenge Competition Focusing on Postpartum Mental Health Care for Rural Families

The Agency for Healthcare Research and Quality (AHRQ) has announced a challenge competition to highlight local innovations to improve postpartum mental health care for rural American families. The total prize pool for the competition is $175,000.

The two-fold purpose of the challenge is to amplify innovative programs that rural communities already are implementing to address challenges to postpartum mental health diagnosis and treatment and elicit new solutions. AHRQ plans to share the information with rural communities, healthcare systems, healthcare professionals, local and state policy makers, federal partners, and the public. Rapid shifts in the healthcare landscape have highlighted the need to create solutions to support community-based, digital, and non-traditional solutions to provide services to mothers experiencing postpartum mental health issues in rural America.

One in seven mothers experiences a postpartum mental health condition, defined as the onset of depression or anxiety within one year of giving birth. Rural women and families face barriers to accessing adequate care for postpartum mental health problems. Such barriers may include limited availability of mental health care providers, and difficulties arranging for child care, transportation, and payment. The current COVID-19 pandemic, with its disruption of traditional employment and social supports, highlights the need for new solutions to a longstanding problem. Prior research suggests that higher levels of stressors during pregnancy and the delivery period are associated with greater prevalence of postpartum depression.

Through this new challenge, AHRQ is interested both in success stories that highlight community achievements and new program proposals that demonstrate innovative planning for community action to improve postpartum mental health. Organizations that serve rural communities, including health care providers, community-based organizations and clubs, faith-based groups, cooperative extension services, schools, hospitals, local health departments, and state, territorial, and tribal organizations are eligible to submit proposals that highlight successful or promising programmatic interventions to improve rural postpartum mental health.

AHRQ is hosting this challenge during Women’s Health Month as a single-phase competition with two categories: success stories and proposals. Applicants may only submit proposals in one category. Submissions are due in September, and AHRQ plans to announce challenge winners during Rural Health Month (November).

There will be five winners in the Success Story Category, with each receiving $15,000.

There will be two winners in the Program Proposal Category, with each receiving $50,000.

For more information, visit the AHRQ Cross-Sectional Innovation to Improve Rural Postpartum Mental Health Challenge website.
Training and Technical Assistance Related to COVID-19 Resources


Responding to COVID-19: highlight products and resources that can be useful when coping with the effects of widespread public health crises such as:

- Psychosocial Impacts of Disasters: Assisting Community Leaders
- Supportive Practices for Mental Health Professionals During Pandemic-Related Social Distancing

Recorded Webinars: • Substance Use Disorder Services in the Days of a Pandemic: You Need A Bigger Boat!

ATTC Resources: OTP Questions Regarding Sustaining Operations During the Uncertain and Turbulent Times
AATOD, ATTCs, and AAAP are collecting questions from OTPs related to sustaining care, providing support and maintaining a safe work environment for staff during these turbulent and uncertain times. We will compile all questions, work with field experts to determine responses, and develop and disseminate a "FAQ" document.

https://attcnetwork.org/centers/global-attc/otp-questions-during-challenging-times-form

Compassion Fatigue and the Behavioral Health Workforce Curriculum Infusion Package -
This 5-part Curriculum Infusion Package (CIP) on Compassion Fatigue and the Behavioral Health Workforce was developed in 2020 by the Pacific Southwest Addiction Technology Transfer Center (PSATTC). Part 1 provides a brief overview of the behavioral health workforce and associated shortages, and introduces the demands on the workforce. Part 2 focuses on compassion fatigue and secondary traumatic stress. Part 3 provides a brief overview of how organizations can help individuals avoid experiencing burnout. Part 4 focuses on actions that behavioral health professionals can take to prevent compassion fatigue. And Part 5 focuses on self-care as an ethical duty in order to manage compassion fatigue.

Upcoming Webinars

Click here to view a full list of our MHTTC Training and Events Calendar and to Register

Educator Wellness Webinars- (The Educator Wellness Webinar Series is part of The Well-Being Series - Connections During COVID-19: Mental Wellness Webinars for Families and Educator) -
Hosted by Northwest MHTTC

Sign Up for the SAMHSA Mental Health Technology Transfer Center Network Pathways Newsletter

Knowledge Informing Transformation

National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit

GET THE TOOLKIT HERE
Mental Health in a Pandemic: Q&A with Thomasine Heitkamp and Dennis Mohatt, Co-Project Directors of the Mountain Plains Mental Health Technology Transfer Center (MHTTC)

Depression, Alcohol and Farm Stress: Addressing Co-Occurring Disorders in Rural America, a guide for screening alcohol and depression in farming populations

Rural Healthcare Surge Readiness: Behavioral Health

Sign Up to Receive the Rural Monitor Newsletter

Mental Health & Wellness Guide for Public Service Professionals

Being able to make a positive impact is what makes working in a public service field so special. From the school social worker keeping a group of at-risk teens on track to graduate, to the rookie cop protecting the neighborhood she grew up in, to the critical care nurse pulling a double shift during a healthcare crisis, public service professionals represent the best in all of us. Yet this same capacity and desire to do good often comes at the cost of mental health and wellness. Being overworked, dealing with life-and-death situations, and concerns over funding are just a few of the triggers that can lead to serious issues like compassion fatigue, burnout, and traumatic stress. And when symptoms do arise, it can be hard to ask for help when you’re the one who usually provides it.

This guide explores mental health issues that public service professionals are most at risk for, the common stressors that cause them, and solutions and resources to get well. While this guide is not meant to (and should not) replace professional medical advice, it can help serve as a starting point for understanding and dealing with the mental health challenges of being in a helping career.

Access the Guide HERE
NIMH Funding Opportunity Announcement

Implementing and Sustaining Evidence-Based Mental Health Practices in Low-Resource Settings to Achieve Equity in Outcomes (R34 Clinical Trial Required) – RFA-MH-20-401

Application Due Date: August 25, 2020, 5:00 p.m. Local Time of Applying Entity

This Funding Opportunity Announcement (FOA) supports pilot work for subsequent studies testing the effectiveness of strategies to deliver evidence-based mental health services, treatment interventions, and/or preventive interventions (EBPs) in low-resource mental health specialty and non-specialty settings within the United States. The FOA targets settings where EBPs are not currently delivered or delivered with fidelity, such that there are disparities in mental health and related functional outcomes (e.g., employment, educational attainment, stable housing, integration in the community, treatment of comorbid substance use disorders, etc.) for the population(s) served. Implementation strategies should identify and use innovative approaches to remediate barriers to provision, receipt, and/or benefit from EBPs and generate new information about factors integral to achieving equity in mental health outcomes for underserved populations. Research generating new information about factors causing/reducing disparities is strongly encouraged, including due consideration for the needs of individuals across the life span. Applications proposing definitive tests of an implementation strategy should respond to the companion R01 announcement RFA-MH-20-400.

This initiative supports pilot work in support of subsequent studies testing the effectiveness of strategies to deliver EBPs in low-resource settings in the United States, in order to reduce disparities in mental health and related functional outcomes (e.g., employment, educational attainment, stable housing, integration in the community, treatment of co-morbid substance use disorders, etc.) for the population(s) served. Of interest are settings where a significant number of children, youth, adults, or older adults with or at risk for mental illnesses can be found and evidence-based mental health treatments or services are not currently delivered. Applications focused on developmental work that would enhance the probability of success in subsequent larger scale projects are also encouraged.

Developmental work might include: refining details of the implementation approach; examining the feasibility of novel approaches and technologies; examining the feasibility of data collection including administration of instruments, obtaining administrative or other types of data, etc.; enhancing the protocol for the comparison group and randomization procedures (if appropriate); examining the feasibility of recruiting and retaining participants into the study condition(s); and developing and testing supportive materials such as training curricula. Therefore, collection of preliminary data regarding feasibility, acceptability and engagement of intervention targets is appropriate. However, given the intended pilot nature of the R34 activity code, conducting fully powered tests of outcomes or attempting to obtain an estimate of an effect size may not be feasible.

The goal of this FOA is to conduct pilot work in support of subsequent studies that develop and test the effectiveness of scalable implementation strategies to achieve delivery of EBPs with high fidelity in low-resource settings and significantly improve clinical and functional outcomes toward greater equity with outcomes documented in general population studies.

Eligibility

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 NIH 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 with and without 501(c)(3) IRS Status (Other than Institutions of Higher Education)

Small Businesses For-Profit Organizations Other Than Small Businesses

State Governments County Governments City or Township Governments Special District Governments

Indian/Native American Tribal Governments (Federally Recognized & Other than Federally Recognized)

U.S. Territories or Possessions Independent School Districts Public Housing Authorities Indian Housing Authorities

Native American Tribal Organizations (other than Federally recognized tribal governments)

Faith-Based or Community-Based Organizations Regional Organizations

**NOT Eligible to Apply:** Non-domestic (non-U.S.) Entities (Foreign Institutions) . Non-domestic (non-U.S.) components of U.S. Organizations. Foreign components, as defined in the NIH Grants Policy Statement.
NOW RECRUITING

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

Combining the strongest components of OnTrack and the evidence-based Individual Resilience Training (IRT) of NAVIGATE, C4 Innovations is offering a new training in coordinated specialty care.

This is an ideal opportunity for teams to receive new or refresher training in CSC. The tool will offer scalable, efficient professional development for CSC teams.

Now recruiting both new and already-established CSC teams interested in participating in a research study. Our goal is to test our 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?

- Comprehensive, role-specific training for all team members, including peers, offered at no charge to teams
- Courses, consultation calls, and a community of practice led by experts in the field. See reverse for full list of expert trainers.
- Opportunity for refresher training for existing teams and teams with new members.
- Teams will be randomized into two groups:
  o Group 1 teams will receive training on June 24 – June 26
  o Group 2 will receive training between July 8 – July 24
- Opportunity to provide critical feedback on a new CSC training tool

HOW CAN MY AGENCY TAKE PART?

Call our Research Coordinator, Effy: 347-762-9086
Or email: cscstudy@center4si.com
**OUR CSC ONDEMAND TRAINERS**

**Iruma Bello, PhD | Clinical Training Director, OnTrackNY**
Dr. Bello is an Assistant Professor of Clinical Psychology in Psychiatry. She is also the Clinical Training Director of OnTrackNY at the Center for Practice Innovations within the Division of Behavioral Health Services and Policy Research at Columbia University. She graduated with her PhD in Clinical Psychology from the University of Hawaii- Honolulu.

**Abaigael Duke | Recovery Specialist and Trainer, OnTrackNY**
A NYS certified peer specialist, Abaigael currently serves as a Recovery Specialist and Trainer for OnTrack NY. She has worked as a peer specialist in a variety of settings through the NYS Office of Mental Health, including clinics and as a member of an ACT team. She was based in the OMH NYC field office as an Advocacy Specialist in the Children's Services division.

**Susan Gingerich, MSW | Training Coordinator, NAVIGATE**
Susan Gingerich has been closely involved with the NAVIGATE First Episode of Psychosis program since 2009, helping to develop all the manuals and providing consultation calls for the directors of 17 NAVIGATE programs during the research phase of The Recovery After An Initial Schizophrenia Episode (RAISE) initiative. She is currently the training coordinator for the NAVIGATE Program.

**Thomas Jewell, PhD | Project Manager, Center for Practice Innovations (CPI) Division of Behavioral Health Services and Policy Research**
Tom Jewell, PhD is on the staff of the CPI, Columbia University, New York State Psychiatric Institute and the Department of Psychiatry at the University of Rochester, School of Medicine and Dentistry. His specialty has been in evaluation and research into evidenced-based practices. He is a family intervention trainer with OnTrackNY, which deals with first episode psychosis.

**Nev Jones, PhD | Assistant Professor, University of South Florida | Department of Mental Health Law & Policy | Louis de la Parte Florida Mental Health Institute**
Dr. Jones received her Ph.D. from DePaul University, followed by a postdoctoral fellowship at Stanford University in medical anthropology and psychiatry. Dr. Jones has worked in leadership positions in both state government and nonprofit community mental health. Her research covers social, cultural and structural determinants of disability and recovery, youth and young adult behavioral health services, and peer and family support.

**Piper Meyer-Kalos, PhD, LP | Director of Research and Evaluation, Minnesota Center for Chemical and Mental Health**
Piper Meyer-Kalos, PhD, HCP-P, holds her doctoral degree in Clinical Rehabilitation Psychology from Indiana University – Purdue University, Indianapolis and specializes in psychiatric rehabilitation and treatment for FEP with interests in recovery, positive psychology, and psychosocial treatment for people with severe mental illness. Since 2009, Dr. Meyer-Kalos has been part of the psychosocial development team of RAISE project and has co-led the individual therapy component (IRT).

**Iliana Nossel, MD | Medical Director, OnTrackNY | Assistant Professor, Columbia University Medical Center**
Dr. Nossel practices general adult psychiatry, including consultation, psychotherapy and medication management. She currently serves as the Medical Director of OnTrack NY. She previously worked as Associate Director of the PI Residents Clinic and completed a pilot study adapting Critical Time Intervention (CTI) for frequent users of the psychiatric emergency room.

**Gary Scannevin, Jr., M.P.S., CPRP | IPS Trainer Center for Practice Innovations (CPI) Division of Behavioral Health Services and Policy Research, New York State Psychiatric Institute**
Gary has worked in the mental health sector of healthcare for 29 years. He is currently an IPS Trainer at the CPI at Columbia University Psychiatry, where his primary mission is training Supported Education and Employment Specialists (SEES) in both OnTrackNY and OnTrackUSA.

**Delbert Robinson, MD | Associate Professor, The Center for Psychiatric Neuroscience, Feinstein Institutes for Medical Research**
Dr. Robinson has led NIMH-funded studies focused upon first episode schizophrenia, tools to enhance antipsychotic medication adherence, and obsessive-compulsive disorder. For the RAISE-ETP study, he chaired the Psychopharmacological Treatment Committee. He was the primary developer of the Medications manual for RAISE-ETP and has provided training and consultation for NAVIGATE prescribers since 2009.
Leaders from countries around the world came together in Rotterdam, the Netherlands in September 2018 for Zero Suicide International 4. As a result, the 2018 International Declaration was produced with a video complement, The Zero Suicide Healthcare Call to Action.

Over the last few months, RI International, the Zero Suicide Alliance and SAVE have continued to monitor the coronavirus (COVID-19). It has taken a great toll around the globe and become an ever present issue in our daily lives. Travel limitations continue to be recommended by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) as well as other guidelines for gatherings to minimize the spread and risk.

After much deliberation and with the safety of our Zero Suicide 5 participants as our priority, the Zero Suicide 5 International Summit to be held in Liverpool, UK has been postponed to the summer of 2021. If you have already registered, your place is guaranteed for our new date.

Please stay tuned for further updates and if you have any questions or concerns, please contact Karen.Jones@riinternational.com.

Crisis Now 2 Summit International Declaration Released August 4

Participants in the International Initiative for Mental Health Leadership (IIMHL) Crisis Now meeting in Washington DC in September 2019 crafted the beginnings of an international declaration for better crisis care. Tremendous thanks to Sue Murray and all those who did such amazing work in taking these ideas and creating the final product that we’ll promote starting next Tuesday, August 4. Please keep an eye for the hashtags #CrisisNow and #International Declaration and outreach Karen Jones if you’d like to help further in spreading the word.

Please also check out the video we published last week to promote the idea of crisis care for anyone, anytime, anywhere in the United States, The Promise of 988.

With the one year delay of the IIMHL exchange in Christchurch, New Zealand from 2021 to 2022, we’re continuing to plan in partnership with Gold Coast Health to hold Crisis Now 3 in Australia in conjunction with the rescheduled IIMHL activities (now slated for February 28 – March 1, 2022).

Team Hope 1 Summit

In addition to the crisis convening, we had previously planned our first hope and recovery event to also occur in conjunction with IIMHL this coming spring in New Zealand. But, given that we had not yet detailed any specifics we’re back to the drawing board for both date and location. Stay tuned.

In the interim, please check out our website https://hopeinc.com/ and you can view all the videos on YouTube playlist. Please subscribe for a new spotlight every week.

The MHDD-NTC is a collaboration between the University Centers for Excellence in Developmental Disabilities at the University of Kentucky, University of Alaska Anchorage, and Utah State University.

Established in 2018 through funding provided by the Administration for Community Living, the training center aims to improve mental health services and supports for people with developmental disabilities. By serving not only as a training center, but also as a national clearinghouse, the training center helps provide access to the most current evidence-based, trauma-informed, culturally responsive practices that address the mental health needs of individuals with developmental disabilities.

Please visit their website at https://mhddcenter.org/
The National Center of Excellence for Eating Disorders (NCEED) was created to serve as the centralized hub dedicated to eating disorders education and training for both healthcare providers and the general public. NCEED is partnering with the 3C Institute to develop and launch an interactive, web-based, educational, training platform to ensure that high-quality trainings are provided to health professionals across multiple disciplines.

Visit NCEED's Website at https://www.nceedus.org/

NCEED is the nation’s first center of excellence dedicated to eating disorders. It was founded in 2018 by the Substance Abuse and Mental Health Services Administration (SAMHSA), with the mission to advance education and training of healthcare providers and to promote public awareness of eating disorders and eating disorder treatment. Based at the University of North Carolina at Chapel Hill, NCEED includes clinicians, researchers, and advocates who specialize in eating disorders care and are committed to providing up-to-date, reliable, and evidence-based information.

The goal of NCEED is to ensure that all individuals with eating disorders are identified, treated, and supported in recovery. Though eating disorders are serious conditions, they can be identified and treated effectively—particularly when providers and the public have the knowledge and skills necessary to make a difference.

Information, Training, and Technical Assistance

The NCEED website (https://www.nceedus.org/) is designed to be user-friendly and easy to navigate for all users. The center’s web platform is divided into four content areas based on the user’s role. These content areas tailor the user’s experience in searching for up-to-date, evidence-based trainings and resources.

Get information on mental health services and resources near you, searchable by state or zip code: www.samhsa.gov/find-help
NCAPPS assists states, tribes, and territories to transform their long-term care service and support systems to implement U.S. Department of Health and Human Services policy on person-centered thinking, planning, and practices. It supports a range of person-centered thinking, planning, and practices, regardless of funding source. Activities include providing technical assistance to states, tribes, and territories; establishing communities of practice to promote best practices; hosting educational webinars; and creating a national clearinghouse of resources to support person-centered practice. Visit the new NCAPPS website for more information.

Each month, NCAPPS will host monthly informational webinars on a range of topics that relate to person-centered thinking, planning, and practice. NCAPPS webinars are open to the public, and are geared toward human services administrators, providers, and people who use long-term services and supports. Webinars will be recorded and archived on the NCAPPS website. All webinars will include a panelist who represents the perspective of service users, including our Person-Centered Advisory and Leadership Group members, self-advocates, or other stakeholders with lived experience with the topic.

<table>
<thead>
<tr>
<th>August 2020</th>
<th>Myths and Misperceptions about Financing Peer Support in Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2020</td>
<td>Electronic Health Records in Person-Centered Care Planning: Pitfalls and Promises</td>
</tr>
<tr>
<td>October 2020</td>
<td>Best Practice in Incorporating Supported Decision-Making and Person-Centered Thinking, Planning, and Practice</td>
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<tr>
<td>November 2020</td>
<td>Person, Family, Clan, Community: Understanding Person-Centered Thinking, Planning, and Practice in Tribal Nations</td>
</tr>
<tr>
<td>December 2020</td>
<td>Toward Person-Centered Transitions: Applying Person-Centered Thinking, Planning, and Practice for Youth with Disabilities in Transition</td>
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</tbody>
</table>

NCAPPS has posted on its website a **Health Care Person-Centered Profile** to assist people with disabilities, older adults, and others to communicate their needs and preferences with hospital and other health care staff. Depending on state and hospital policy, people with communication, comprehension, and behavioral challenges may face the possibility of a hospital visit without significant others or usual supporters present. To address the heightened challenges this poses, a group of experts in person-centered planning developed a tool that people and their families and caregivers can fill out and share with medical staff upon hospital intake or care site transfer.

The tool has two pages: a Health Care Information sheet for capturing brief and vital information about the person’s health status and a Health Care Person-Centered Profile for describing who the person is, what is most important to the person, and how best to provide support—vital information that can help medical staff provide more tailored and person-centered care.

The Health Care Information Sheet also has a section for detailed contact information to help medical staff reach a person’s emergency contact or legal representative. It contains a section for indicating whether advance directives are in place and where those documents can be found.

The Profile, instructions, and sample profiles are available at: [https://ncapps.acl.gov/covid-19-resources.html](https://ncapps.acl.gov/covid-19-resources.html)
Tips for Telehealth Billing During the COVID-19 Pandemic

Plan to get reimbursed for services you would typically provide in the office? Then use this primer to identify the various types of telehealth visits and associated billing codes.

Keep in mind that guidelines change often during the COVID-19 crisis. Please reference the links below for the most current details.

1. **TELEHEALTH VISITS THAT REPLACE OFFICE VISITS**

   This is a real-time video visit and is the most common type of mental health digital visit.

   It has the same standards as an in-person visit and should be paid at the same rate. However, it is a good idea to review the settings on your billing software to make sure it is accurate.

   You can use the same CPT codes you already use with the addition of a modifier – modifier 95 in most cases – that tells the payer that the visit was a telehealth visit and a place of service code (POS) that tells the payer the location of the clinician. Coverage policies may vary across payers, especially during the public health emergency. Before you bill, make sure to check and confirm that you can provide and bill the service by telehealth.

   *Information listed in italics are those services that can also be temporarily provided by telephone during the COVID-19 crisis.*

   **Initial Psychiatric Evaluation**
   
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90792+95</td>
<td>30 (16-37*) minutes - E/M code [Audio only - use the appropriate 99441-99443 code] and 90833+95</td>
</tr>
<tr>
<td>90792+95</td>
<td>45 (38-52*) minutes - E/M code [Audio only – use the appropriate 99441-99443 code] and 90836+95</td>
</tr>
<tr>
<td>90792+95</td>
<td>60 (53+*) minutes - E/M code [Audio only – use the appropriate 99441-99443 code] and 90838+95</td>
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</table>

   **Evaluation and Management Outpatient**
   
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>99204+95</td>
<td>Patient not present</td>
</tr>
<tr>
<td>99213+95</td>
<td>Patient present</td>
</tr>
<tr>
<td>99215+95</td>
<td>Group</td>
</tr>
</tbody>
</table>

   **Psychotherapy Alone**
   
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>90832+95</td>
<td>30 (16-37*) minutes</td>
</tr>
<tr>
<td>90834+95</td>
<td>45 (38-52*) minutes</td>
</tr>
<tr>
<td>90837+95</td>
<td>60 (53+*) minutes</td>
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</table>

   **Family Therapy**
   
<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>90846+95</td>
<td>Patient not present</td>
</tr>
<tr>
<td>90847+95</td>
<td>Patient present</td>
</tr>
<tr>
<td>90849+95</td>
<td>Group</td>
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</table>

   **Group Therapy**
   
<table>
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<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>90853+95</td>
<td>(Added temporarily to the Medicare Telehealth list for the period of the COVID-19 crisis)</td>
</tr>
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</table>

2. **TELEPHONE VISITS**

   There are CPT codes that describe care provided via telephone alone. They are for medical discussions or assessment and management of a new (allowed during COVID-19 crisis) or established patient.

   For physicians and others who can bill for E/M services:
   
   - 99441: 5-10 minutes
   - 99442: 11-20 minutes

   For psychologists, social workers, and others who can bill for E/M services:
   
   - 98966: 5-10 minutes
   - 98967: 11-20 minutes
   - 98968: 21-30 minutes
Tips for Telehealth Billing During the COVID-19 Pandemic

3 VIRTUAL CHECK-IN (G2012)
Physicians and others who can bill E/M services can bill for time spent talking to a new or established patient on the telephone or via telephone and video. Generally, the physician is responding to a contact made by the patient. This code should not be billed if the patient has been seen in the 7 days prior to the call or within 24 hours or the soonest available appointment after the brief check-in. The goal of this visit is to see if a patient needs to be seen for further evaluation or if the problem can be resolved through this call.

4 E-VISIT
This type of visit is not real time or face-to-face. It is a digital communication that a patient must initiate. Often it is done through a portal or email. This visit requires a clinical decision that typically you would provide in an office. Time is cumulative during a 7-day period. You can use CPT codes for these visits based on time.

<table>
<thead>
<tr>
<th>Those that bill evaluation and management services should use:</th>
<th>Those that cannot bill evaluation and management services should use:</th>
</tr>
</thead>
<tbody>
<tr>
<td>99421 5-10 minutes</td>
<td>G2061 5-10 minutes</td>
</tr>
<tr>
<td>99422 11-20 minutes</td>
<td>G2062 11-20 minutes</td>
</tr>
<tr>
<td>99423 21-30 minutes</td>
<td>G2063 21-30 minutes</td>
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</table>

REMOTE PATIENT MONITORING
This involves the collection and interpretation of data that is digitally stored and transmitted by a patient to a clinician. An example is sleep tracking data from a wearable device. There are no specific billing codes in mental health for this type of visit.

STAY CURRENT
Guidelines for telehealth visits change fast. For up-to-date details on telehealth, you can use these resources.

- SMI Adviser
- American Psychiatric Association
- Center for Connected Health Policy
- Centers for Medicare and Medicaid Services
- Federation of State Medical Boards
SMI, Psychotropics, and Sexuality  
**Thursday, August 20, 3:00 p.m. to 4:00 p.m. E.T.**

Sex and sexuality are very sensitive and private issues for most people, and even more so for those with mental illnesses. Sexuality is often overlooked in the SMI population and many medications used to treat these disorders impact sexual performance and satisfaction. This presentation will discuss the effects of specific medications in this area and potential solutions, both pharmacological and non-pharmacological.

**Presenter:** Satarria Dilks, DNP, APRN, McNeese State University

[Register HERE](#)

SMI Adviser Coronavirus Resources

**Recorded Webinars**

- Managing the Mental Health Effects of COVID-19
- Telepsychiatry in the Era of COVID-19

**Physician Continuing Medical Education (CME) Credit**
The American Psychiatric Association (APA) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The APA designates this enduring activity for a maximum of 12.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

**Psychologist Continuing Education (CE) Credit**
The American Psychiatric Association is approved by the American Psychological Association to sponsor continuing education for psychologists. American Psychiatric Association maintains responsibility for this program and its content.

**Nursing Continuing Professional Development (NCPD, formerly CNE) Credit**
The American Psychiatric Nurses Association is accredited with distinction as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

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**Grant Statement**
Funding for this initiative was made possible (in part) by Grant No. 1H79SM080818 01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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**2020 Annual Conference on Advancing School Mental Health October 29 to 31**
The Annual Conference on Advancing School Mental Health brings together a diverse group including educators, providers, researchers, administrators, advocates, youth, caregivers, and national/state/local leaders to share the latest research and best practices. The 2020 conference will take place Oct. 29-31 in Baltimore.

[Register On-Site](#)

**For Additional Information, Contact Christina Walker, 443-790-4066**
SAMHSA’s 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

Social Marketing Assistance Available

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

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

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

Tip Sheets and Workbooks

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

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

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

Engaging Stakeholders
- Involving Families in Social Marketing
- Social Marketing in Rural and Frontier Communities
- The Power of Partners
- Involving Youth in Social Marketing: Tips for System of Care Communities
- The Power of Telling Your Story
Visit the Resources at NASMHPD's
Early Intervention in Psychosis (EIP) Virtual Resource Center

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

**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 Guides**

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)
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NASMHPD Links of Interest

LETTER TO THE EDITOR: DIFFERENTIATING DOMAINS OF INVOLUNTARY CONTAINMENT FOR PERSONS WITH SEVERE PSYCHIATRIC IMPAIRMENT AND COVID-19, Carmen Black Parker, M.D., et al., Psychosomatics, June 18

“It Cost Me Everything”: In Texas, COVID-19 Takes a Devastating Toll on Hispanic Residents, Perla Trevizo, ProPublica, & Mike Hixenbaugh, NBC News, July 30

INTERIM REPORT OF COSTS INCURRED BY STATE AND LOCAL RECIPIENTS [OF CORONAVIRUS RELIEF FUNDS] THROUGH JUNE 30, Department of the Treasury Office of Inspector General (OIG), July 23

AGE-RELATED DIFFERENCES IN NASOPHARYNGEAL SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-CoV-2) LEVELS IN PATIENTS WITH MILD TO MODERATE CORONAVIRUS DISEASE 2019 (COVID-19), Heald-Sargent T., MD, PhD., et al., JAMA Pediatrics, July 30

VIEWPOINT: HOW A PANDEMIC COULD ADVANCE THE SCIENCE OF EARLY ADVERSITY, Danielle Roubinov, Ph.D., Nicole R. Bush, Ph.D. & W. Thomas Boyce, M.D., JAMA Pediatrics, July 27

INTERSECTION OF COMMUNITY DEVELOPMENT AND MENTAL HEALTH: FACT SHEETS, Build Healthy Places Network & Neighbor Works America, July 23

RACIAL EQUITY IMPACT ASSESSMENT, Center for Racial Justice Innovation


NOBODY ACCURATELY TRACKS HEALTH CARE WORKERS LOST TO COVID-19. SO SHE STAYS UP AT NIGHT CATALOGING THE DEAD, Nina Martin, ProPublica, August 2