CMS Issues Urgent Call for Action to Address Drop in Children’s Health Care; March to May Medicaid, CHIP Data Shows 44 Percent Fewer Outpatient Mental Health Visits than in 2019

In an early evening stakeholder call on September 23, CMS Administrator Seema Verma called “on states, pediatric providers, families, and schools to ensure children catch-up on overdue medical, behavioral health and dental appointments as well as childhood immunizations.”

The call for action was issued as CMS released preliminary data collected in the Medicaid and Children’s Health Insurance Programs (CHIP) through May 2020 showing that, during the COVID-19 pandemic public health emergency (PHE), rates for vaccinations, primary, and preventive services have steeply declined. Because preventative and routine healthcare is crucial to ensuring that children stay healthy, CMS released the preliminary data to raise awareness of the vital services Medicaid and CHIP provides, and to urge stakeholders to take action to make services more readily available in order to begin closing the gap in care for children.

The CMS Administrator noted that, with many schools remaining closed for in-person instruction, many of the key services children receive—such as child screens and vaccinations routinely received prior to the start of the school year and in-school services such as speech therapy, physical therapy, and occupational therapy—are likely being delayed.

During the March to May 2020 timeframe, the data reveals 22 percent fewer (1.7 million) vaccinations received by Medicaid and CHIP beneficiaries age 2 and younger, 44 percent fewer (3.2 million) child screening services that assess physical and cognitive development and can provide early detection of autism and developmental delay, and 69 percent fewer (7.6 million) dental services received. The drop occurred even after accounting for the significant increased use of telehealth.

The delivery to children of any services via telehealth increased by over 2,500 percent from February to April 2020, but the preliminary data appears to show that mental health services delivered to children through telehealth declined in May, spiking significantly in some states before falling, while only increasing slightly in April in others. Although CMS cautions the data is only preliminary, Connecticut, Maryland, Minnesota, Nebraska, and New Hampshire appear to have had the highest rates of mental health services delivered through telehealth as of May 2020, while Arizona, Florida, Pennsylvania, Rhode Island, and the Virgin Islands seem to have had the lowest rates of mental health services delivered through telehealth.

Outpatient mental health service rates among children dropped from nearly 138 services per 1,000 beneficiaries in January 2020 to about 58 services per 1,000 beneficiaries in May 2020, including telehealth visits. There were 44 percent (6.9 million) fewer outpatient mental health services delivered between March and May 2020, compared to March through May 2019, even accounting for telehealth visits. Montana, New Jersey, Ohio, Oklahoma, and Vermont had the highest outpatient mental health service rates as of May 2020, while Colorado, Hawaii, Puerto Rico, Rhode Island, and the Virgin Islands had the lowest outpatient mental health service rates.

Vaccination rates among beneficiaries age 2 and younger dropped from nearly 700 vaccinations per 1,000 beneficiaries in January 2020 to about 460 vaccinations per 1,000 beneficiaries in May 2020. Screening rates among children dropped from nearly 68 screens per 1,000 beneficiaries to a low of 28 screens per 1,000 beneficiaries in April, rising back up to 35 screens per 1,000 beneficiaries in May. While child screening rates started to rise in May, they were still below January levels in nearly all states. Alabama, Georgia, Idaho, North Carolina, and Texas had the highest screening rates as of May 2020, while California, the District of Columbia, Hawaii, the Virgin Islands, and Wisconsin had the lowest.

There were 69 percent (7.6 million) fewer dental services delivered between March through May 2020 than in March through May 2019.

Noting the natural lag between when a service is delivered and when CMS receives data on that service, CMS says the decline in services occurring in the early months of the pandemic are a particular cause for concern. While the agency says national data show that vaccination rates are increasing, the number of vaccines that have been administered so far this year have yet to make up for the large decline earlier in the year. To ensure that children catch up on their missed vaccines, CMS says vaccination rates must not only approach those of 2019, but be much higher in order to mitigate the dip during the early part of the COVID-19 PHE.

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Continued on Next Page
The third annual Crisis Residential Conference is taking place virtually October 14 & 15. Hosted by the Crisis Residential Association, this conference brings together the best ideas in residential alternatives to psychiatric hospitalization. Boasting a spectacular lineup of nationally recognized speakers and thought leaders, attendees will learn about innovations and best practices in the field of behavioral health crisis care.

You can see our agenda of keynotes, breakout sessions, TED Talks, and networking opportunities along with information and registration for the conference at [https://www.crisisresidentialassociation.org/conference.html](https://www.crisisresidentialassociation.org/conference.html)

Early Bird Rate available until September 18:
$175 for members  $245 for non-members
$225 for non-members to attend conference AND become a member of CRA.

Regular Rates after September 18:
$225 for members  $295 for non-members
$275 for non-members to attend conference AND become a member of CRA.

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Fall Back-to-School FREE CME/CEs Recorded Webinar Collections

Thanks to our partners, at SAMHSA and at the California Tobacco Control Program, SCLC is able to offer FREE CME/CE credit to all eligible healthcare providers. **Please use the discount code SAMHSA23, and for California providers use the discount code CADPH23, to waive the $65 fee.**

**Collection A:** This Collection of recorded webinars from SCLC includes six webinars, for a total of 7.0 CE credits. Topics include veterans and tobacco, cessation efforts in public housing and community health centers, systems change for tobacco cessation, vaping and e-cigarettes in the behavioral health population, FDA regulations in tobacco products and non-daily smokers.

For more information and to register for this collection, [click here](#).

**Collection B:** This Collection of recorded webinars from SCLC includes 10 webinars, for a total of 11.0 CE credits. Topics include update on cessation from the OSH, CDC, cessation for the Medicaid population, opioids and tobacco use, tobacco-free behavioral health settings, smoke-free public housing project, nicotine cessation across disciplines, improving cessation efforts by using data, race & structural racism in tobacco, using quitlines to reduce disparities among tobacco on American Indian, Alaska Native, and Asian populations, and the health effects of nicotine.

For more information and to register for this collection, [click here](#).
#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.

![CrisisNow.com](https://www.crisisnow.com)

**THIS WEEK:** ANGELA KIMBALL OF THE NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI) ON THE IMPORTANCE OF FAMILY IN CRISIS AND RECOVERY

Three years ago, Angela Kimball, the national director of advocacy and public policy at the National Alliance on Mental Illness (NAMI), witnessed her thirty year old son experience a psychotic break. He’d struggled with bipolar disorder since childhood, but this was new. When Alex began living on his own, says Kimball, he eventually tapered off of his medication. He felt a loss of control and didn’t want to be dependent on something that changed his brain chemistry. There was a common blunting effect among all of the medications he was on, which Alex felt constricted by—not only personally but also professionally as an artist. When experiencing an upward curve in mood, early in a manic phase, he felt pretty darn fantastic. He would have so much energy and creativity. His artwork was phenomenal. Then there would be a shift, and Kimball could see the signs that her son was headed toward a crisis. It was in Alex’s voice as his mood transformed from high energy to angry and tense. Soon, he’d be unable to sleep. That’s when, says Kimball, she knew the crash was coming, followed by periods of depression.

What was different in 2017 is that these changes in mood also came with new symptoms: paranoia and delusion. I’d never seen anything like it. The crisis wasn’t out of the blue. Kimball knew Alex wasn’t doing well, but, as a parent of an adult, she says it’s hard to separate your reaction to what someone says or does from what you know intellectually might be going on. “…”

Sometimes, says Kimball, the crisis experience is so paradoxical and rapid fire that a loved one just doesn’t have the standard mechanisms to identify danger.

**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.

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 www.vibrant.org 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.thefactionalliance.org www.edc.org 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 www.mentalhealthfirstaid.org www.twitter.com/NationalCouncil

R.I. 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 www.zerosuicide.org www.twitter.com/RILInternational
NAMI Utah Initiates New Online Suicide Prevention Education Programs, including Free Workshops, Suicide Prevention Training for Suicide Prevention Month

The National Alliance on Mental Illness (NAMI) takes National Suicide Prevention Awareness Month in September very seriously – especially in Utah where the number of deaths by suicide is consistently above the national average. In recognition of the need to educate and support the community in efforts to decrease suicide, NAMI Utah is launching new, free online programs.

Starting this month, the public in Utah can attend free one-hour seminars where they will hear stories from Utahns who share their mental health stories of how they have successfully navigated their mental illness. These online workshops, called “In Our Own Voice,” are offered the first and third Thursdays of the month.

Also beginning in September are free online QPR suicide prevention trainings that teach how to effectively communicate with someone is suicidal and how to get them help. QPR trainings will be held the fourth Thursday of the month.

Wayne Connors, chapter president for NAMI Utah Southwest, told St. George News earlier this month that QPR stands for “Question, Persuade, Refer.” He said the trainings and technique offer a “very beginning to expose the deep dark secret the suicidal person thinks they are holding and brings it out in the open.” He said it is not easy to confront people close to you about suicide or the anticipation of it.

“It is a short 1 to 1/2-hour program to give friends and relatives a way to try to save someone in deep depression, not wanting to go on and who thinks life is not worth living,” Connors told the News. “It is not easy to confront people close to you about suicide or the anticipation of it. QPR classes give a way to do that confrontation in a loving, meaningful way. This is another proven way to confront mental illness with meaningful results.

Additionally, NAMI Utah offers a host of online classes and support groups for anyone with a mental health condition and family members of loved ones with mental health conditions. All NAMI meetings, podcasts and online support are open to all and free, Connors said.

One of the most popular online programs is Connection, a support group for adults with mental health conditions. Participants are given a safe, confidential, virtual space to share their experiences with one another, receiving support and resources from their peers. Led by NAMI-certified facilitators who have mental health conditions themselves, these groups have increased in popularity since the start of the COVID-19 pandemic.

Ammon Robinson, NAMI Utah’s support group facilitator of the year in 2019, teaches NAMI’s online Peer-to-Peer class, an eight-week course for adults with mental health conditions. The class teaches basic mental health education, treatment options, safety planning, recovery, self-help strategies, communication tips, deep breathing, and goal setting. Robinson told the News the class helped him take personal responsibility for his own mental health.

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**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.

**ENROLL HERE**
An Urban Institute study funded by the Robert Wood Johnson Foundation and published September 18 has found that 3.3 million non-elderly adults have lost their employer-sponsored health insurance (ESI) coverage from April through mid-July and nearly 2 million became uninsured during that time period, as the impact of the coronavirus pandemic grew in the U.S.

However, the analysis of the U.S. Census’ Household Pulse Survey found that 2.2 million people gained public health coverage under Medicaid and other programs during that same time.

The number of adults ages 18 to 39 with ESI fell by 2.2 million. Among these adults, the percentage of those uninsured increased by 1.5 percentage points, but public and private non-group coverage changed little. Being uninsured did not significantly increase for adults ages 40 to 64, who experienced a 1.8 percentage point increase in public coverage.

Nearly all ESI losses observed in the survey (90 percent) occurred among men, 3.0 million of whom lost ESI. Approximately 2.3 million men became uninsured during this period, their rate of being uninsured increasing by 2.4 percentage points.

About 2.1 million adults with a high school degree or less education lost ESI, a 2.8 percentage-point decline for the group. Public coverage among this group climbed by 2.5 percentage points, and the percentage of those uninsured increased by 1.6 percentage points, equal to 1.2 million more adults without coverage.

Medicare-Fee-for-Service Enrolees May Have to Pay for COVID Vaccines

The Wall Street Journal reported September 21 that Trump administration officials have concluded that Medicare’s exclusion of emergency-use drug costs could leave millions of Medicare Fee-for-Service enrollees paying out-of-pocket for COVID-19 vaccines the government intends to make free to everyone else.

About 44 million people, two thirds of Medicare enrollees and about 15 percent of the U.S. population, are covered by Medicare Fee-for-Service.

Congress in March passed the Coronavirus Aid, Relief, and Economic Security Act, or CARES Act, which ensures free coronavirus vaccine coverage, including no out-of-pocket costs for people on Medicare. But Medicare doesn’t cover costs for drugs approved under emergency-use designations. The Food and Drug Administration authorizes certain drugs for emergency use to provide speedy access to treatments for serious diseases during a health crisis. Standards for emergency-use authorization aren’t as high as they are for its typical drug approvals.

The White House and HHS may press Congress to change the language in the CARES Act so that it includes Medicare-Fee-for-Service coverage for a vaccine approved under an emergency-use authorization. But WSJ reports that Administration officials worry that the changes might not be made in time for a possible October vaccine rollout. The Administration has concluded that the problem can’t be fixed with an executive order.

CDC Advisory Committee Delays Vote on How to Distribute a COVID Vaccine

The Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices (ACIP) on September 22 delayed a vote on how to prioritize distribution of any coronavirus vaccine until the FDA gives emergency authorization or approval for a vaccine. Instead, an ACIP workgroup will conduct a review of data from late-stage vaccine trials with an eye toward presenting recommendations to the full ACIP.

Once FDA decides to proceed with one of the coronavirus vaccines now in development, ACIP will hold an emergency meeting—its next regularly scheduled meeting is not until next month—with a public comment session and vote on recommendations for how to use the vaccine, including which populations should have access to it.

The National Academies of Sciences, Engineering, and Medicine (NASEM) released draft recommendations earlier this month that front-Health care workers in high-risk settings, first responders, people with underlying medical conditions and older adults in overcrowded living conditions be among the first to receive prospective coronavirus vaccinations. Under the NASEM draft, other essential workers, teachers, people in homeless shelters or group homes and people in prisons and jails, and the staffs who work such settings would be second in line. The first two stages are expected to cover roughly half of the population.

The third phase would include young adults, children, and workers in essential industries, after which 85 to 95 percent of the population would have a shot. The fourth phase would cover everyone else.

But the immune systems of elderly individuals may be less responsive than those of other populations, and no vaccine trials have yet included children as test subjects.
As House of Representatives Extends Funding for the Money Follows the Person (MFP) Demonstration Program, CMS Announces Availability of $165 Million in Supplemental Funding

One day after the House of Representatives passed a Continuing Resolution for Fiscal Year 2021 that extends funding for the Money Follows the Person (MFP) Medicaid demonstration program, the Centers for Medicare and Medicaid Services (CMS) on September 23 announced it would be making as much as $165 million available to states for MFP supplemental funding.

The MFP program, created by Congress in 2005, helps state Medicaid programs transition individuals with disabilities and older adults from institutions and nursing facilities to home and community-based settings they choose.

According to a report released by CMS at the same time as the funding announcement, MFP-participating states have transitioned 101,540 Medicaid beneficiaries from institutional care to home-based and community services (HCBS) since the program was implemented in 2007. However, last year, with Congressional funding in question, state participation in the program had dropped from a high of 44 states and the District of Columbia, and only 4,173 Medicaid beneficiaries were transitioned under the program – a 46 percent drop from 2018.

To be eligible, participants must be Medicaid beneficiaries residing in an inpatient facility (such as a hospital, nursing facility, or intermediate care facility for people with intellectual disability) for 90 days or more. Participating Medicaid enrollees must move to a qualified residence in the community, which includes homes owned or leased by the participant or a family member, apartments, or small group homes. After transitioning to a qualified residence, participants are eligible for MFP services for 365 days.

Each of the 33 states still participating in the program will be eligible to receive as much as $5 million for planning and capacity building activities to accelerate long-term care system transformation design and implementation, and to expand HCBS capacity. CMS says the supplemental moneys can be used for:

- assessing HCBS system capacity and determining the extent that additional providers and/or services are needed;
- assessing institutional capacity and determining the extent to which the state could reduce this capacity and transition impacted individuals to more integrated settings;
- recruiting, educating, training, and providing technical assistance to providers and direct service workers, and quality improvement activities, including training people with disabilities to become direct service workers;
- caregiver training and education;
- assessing and implementing changes to reimbursement rates and payment methodologies to expand HCBS provider capacity and/or improve HCBS and/or institutional service quality;
- building Medicaid-housing partnerships to facilitate access to affordable and accessible housing for Medicaid beneficiaries with disabilities and older adults; and
- implementing diversion strategies to prevent nursing facility admission.

In addition, the agency says states can use the funding to support HCBS planning and capacity building activities put in place in direct response to the COVID-19 public health emergency, such as in planning and implementing the use of telehealth for nursing facility transition activities that would normally be conducted in-person or redesigning service delivery to reduce the risk of COVID infection.


“The tragic devastation wrought by the coronavirus on nursing home residents exposes America’s over-reliance on institutional long-term care facilities,” said Administrator Seema Verma. “Residential care will always be an essential part of the care continuum, but our goal must always be to give residents options that help keep our loved ones in their own homes and communities for as long as possible.”

“Home and community-based care is not only frequently more cost effective, but is preferred by seniors and adults with disabilities seeking to maintain the dignity of independent living. This new federal investment will help states get our loved ones back home.”

Supplemental budget requests under this funding opportunity will be accepted on a rolling basis through June 30, 2021. CMS will provide all eligible grantee states that currently operate an MFP-funded transition program, with additional information on this funding opportunity.

- Additional information is also available at: https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html.

CMS Issues Urgent Call for Action to Address Drop in Children’s Health Care; March to May Medicaid, CHIP Data Shows 44 Percent Fewer Outpatient Mental Health Visits than in 2019

(Continued from page 1) CMS says the increased risk of transmission of infectious vaccine-preventable illnesses, such as measles, mumps, and influenza due to decreased vaccinations is real, and can result in decreased school attendance, decreased learning, and increased childhood illness in general.

CMS says although the start of the school season will be different for many children as they begin their education in a virtual manner, it is important for schools and families to catch up on well-child visits and ensure that children are up-to-date on their immunizations.

The agency says there is a critical need for children to receive preventative and routine healthcare visits.

Department of Labor Revises Temporary Final Rule Limiting When Families First Coronavirus Response Act (FFCRA) Public Health Emergency Leave Must be Paid For

In revised final temporary regulations published September 16, the Department of Labor (DOL) revises the circumstances governing when Families First Coronavirus Response Act (FFCRA) Public Health Emergency leave must be paid for by an employer and clarifies which health care providers employers may exclude from receiving the paid leave.

FFCRA requires paid leave when an employee:

- is subject to a government quarantine/isolation order related to COVID-19;
- has been advised by a healthcare provider to self-quarantine due to COVID-19 concerns;
- is experiencing symptoms of COVID-19 and seeking a diagnosis;
- is caring for an individual who is subject to a government quarantine/isolation order or who has been advised by a healthcare provider to self-quarantine;
- is caring for their child whose school or childcare facility has been closed or whose childcare provider is unavailable due to COVID-19 precautions; or
- is experiencing a substantially similar condition as specified by the Department of Health and Human Services.

The rule revision, effective on the published date through December 31, is in response to an August 3 decision by the U.S. District Court for the Southern District of New York striking down certain provisions of the temporary rule originally published on April 1. The District Court struck the original temporary rule’s mandate that employees were not entitled to paid leave (in three of the six qualifying scenarios cited by DOL) unless their employers had work for them to do at the time they sought leave.

In the revised rule, DOL stands by its “work availability” scenarios, maintaining that there is no statutory basis for treating some FFCRA reasons differently than others, but provides more detailed reasoning, saying:

- FFCRA requires paid leave when employees are unable to work or telework “due to” or “because of” a qualifying reason—that is, they would not miss work but for their FFCRA reason.
- Consistent with the FMLA’s use of the term “leave,” if an employer has no work for an employee to do, the employee is not taking “leave” under the FFCRA.
- One of the FFCRA’s purposes is to discourage employees who might have COVID-19 from going to work and infecting others. Eliminating the work-availability requirement does not serve this goal.

However, DOL reminds employers in the revision that they cannot make work unavailable in an effort to deny or avoid providing FFCRA (paid) leave benefits.

DOL also reaffirms the original final temporary rule’s statement that employees cannot take intermittent FFCRA leave without their employer’s consent. While acknowledging that Congress did not address intermittent leave in the language of FFCRA, DOL argues it was granted broad regulatory authority to ensure that application of FFCRA is consistent with application of the Family and Medical Leave Act (FMLA). It says the FMLA principle of avoiding undue disruption to business operations that exists with respect to the use of intermittent leave similarly applies to the use of intermittent leave under FFCRA.

Similarly, the final temporary rule’s employer-consent requirement is akin to the FMLA’s employer-consent requirement for non-medical leave (for example to care for a newborn or adopted child). Under the revised temporary rule, intermittent FFCRA leave is not allowed except to care for children whose school or childcare closed, unless the employee is permitted to telework. However, taking FFCRA leave on specific days to align with a mixed in-person/virtual schooling of the employee’s child or children is not taking “intermittent” leave, and so does not require employer consent.

The original final temporary rule required employees to submit supporting documentation prior to taking leave, which the District Court deemed inconsistent with FFCRA. In the revised final temporary rule, DOL eliminates the advance documentation mandate. Instead, employees can be required to provide documentation “as soon as practicable.”

Clarifying the Definition of Excluded “Health Care Provider”

The FFCRA gives employers the option of denying paid leave to “health care providers,” which the original final temporary rule defined to encompass anyone in health care. The District Court struck down that definition. In the revised rule, DOL modifies the definition to cover:

- Employees who meet the definition of health care provider under the FMLA, i.e., physicians and others who make medical diagnoses; and
- Employees who are employed to provide diagnostic, preventative, or treatment services, or to provide “other services that are integrated with and necessary to the provision of patient care which, if not provided, would adversely impact patient care”—like bathing, dressing, hand feeding, taking vital signs, setting up medical equipment, and transporting patients and samples.

Examples in the second category include nurses, nurse assistants, medical technicians, and any others who directly provide diagnostic, preventative, treatment, or integrated and necessary services. It also includes those who provide such services under the supervision of (or in assistance to) FMLA-defined health care providers or nurses, nurse assistants, medical technicians, and other direct-providers. Finally, this category includes employees such as lab technicians who may not interact with patients or report to providers, but whose services are integrated with and necessary to the provision of patient care. IT professionals, maintenance staff, and food service workers are not covered by the definition and cannot be excluded from the paid leave requirements.

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<thead>
<tr>
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<th>2019 Civilian Population Age 18+</th>
<th>2019 Civilian Population Age 18+ with SMI (5.4%)</th>
<th>Lower Limit of Estimate (3.7%)</th>
<th>Upper Limit of Estimate (7.1%)</th>
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Source: Center for Behavioral Health Statistics and Quality (CBHSQ)
### Number of Children with a Serious Emotional Disturbance (SED), age 9 to 17, by State, 2019

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<tr>
<th>State</th>
<th>2019 Civilian Population of Youth Aged 9 to 17</th>
<th>Age 5 - 17 Percent in Poverty</th>
<th>State Tier for % in Poverty</th>
<th>Level of Functioning (LOF) Score&lt;=50</th>
<th>Level of Functioning (LOF) Score&lt;=60</th>
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<td>Upper Limit</td>
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Source: Center for Behavioral Health Statistics and Quality (CBHSQ)
As many people in the United States begin to plan for fall and winter holiday celebrations, CDC offers the following considerations to help protect individuals, their families, friends, and communities from COVID-19. These considerations are meant to supplement—not replace—any state, local, territorial, or tribal health and safety laws, rules, and regulations with which holiday gatherings must comply. When planning to host a holiday celebration, you should assess current COVID-19 levels in your community to determine whether to postpone, cancel, or limit the number of attendees.

Virus spread risk at holiday celebrations

Celebrating virtually or with members of your own household pose low risk for spread. In-person gatherings pose varying levels of risk. Event organizers and attendees should consider the risk of virus spread based on event size and use of mitigation strategies, as outlined in the Considerations for Events and Gatherings. There are several factors that contribute to the risk of getting infected or infecting others with the virus that causes COVID-19 at a holiday celebration. In combination, these factors will create various amounts of risk, so it is important to consider them individually and together:

- **Community levels of COVID-19** – Higher levels of COVID-19 cases and community spread in the gathering location, as well as where attendees are coming from, increase the risk of infection and spread among attendees. Family and friends should consider the number and rate of COVID-19 cases in their community and in the community where they plan to celebrate when considering whether to host or attend a holiday celebration. Information on the number of cases in an area can be found on the area’s health department website.

- **The location of the gathering** – Indoor gatherings generally pose more risk than outdoor gatherings. Indoor gatherings with poor ventilation pose more risk than those with good ventilation, such as those with open windows or doors.

- **The duration of the gathering** – Gatherings that last longer pose more risk than shorter gatherings.

- **The number of people at the gathering** – Gatherings with more people pose more risk than gatherings with fewer people. CDC does not have a limit or recommend a specific number of attendees for gatherings. The size of a holiday gathering should be determined based on the ability to reduce or limit contact between attendees, the risk of spread between attendees, and state, local, territorial, or tribal health and safety laws, rules, and regulations.

- **The locations attendees are traveling from** – Gatherings with attendees who are traveling from different places pose a higher risk than gatherings with attendees who live in the same area. Higher levels of COVID-19 cases and community spread in the gathering location, or where attendees are coming from, increase the risk of infection and spread among attendees.

- **The behaviors of attendees prior to the gathering** – Gatherings with attendees who are not adhering to social distancing (staying at least 6 feet apart), mask wearing, hand washing, and other prevention behaviors pose more risk than gatherings with attendees who are engaging in these preventive behaviors.

- **The behaviors of attendees during the gathering** – Gatherings with more preventive measures, such as mask wearing, social distancing, and hand washing, in place pose less risk than gatherings where fewer or no preventive measures are being implemented.

People who should not attend in-person holiday celebrations

**People with or exposed to COVID-19**

Do not host or participate in any in-person festivities, if you or anyone in your household

- Has been diagnosed with COVID-19 and has not met the criteria for when it is safe to be around others
- Has symptoms of COVID-19
- Is waiting for COVID-19 viral test results
- May have been exposed to someone with COVID-19 in the last 14 days
- Is at increased risk of severe illness from COVID-19

**People at increased risk for severe illness**

If you are at increased risk of severe illness from COVID-19, or live or work with someone at increased risk of severe illness, you should

- Avoid in-person gatherings with people who do not live in your household.
- Avoid larger gatherings and consider attending activities that pose lower risk (as described throughout this page) if you decide to attend an in-person gathering with people who do not live in your household.
Workshop Themes and Tracks:

- Tackling Mental Health Disparities for Children of Color
- Mental Health, Substance Use, & Family and Peer Virtual Support Services that Work

Each workshop time period will feature workshops addressing the conference themes as well as topics such as peer support, family/youth leadership, co-occurring mental health/substance use disorders, trauma-informed services, etc

See the Schedule - The Full Agenda is Coming Soon!

Registration Fees:

- $50 per person
- $45 per person for groups of 10 or more

Register Here!

More information about workshops, presenters, sponsors, and more will be posted in the coming weeks. We look forward to seeing you in November.

Additional NASMHPD Links of Interest


**Majority of Americans Expect to Not Pay for COVID-19 Vaccine**, *Ipsos* Poll, September 22

**CDC Director Says over 90% of Americans Have Not Yet Been Exposed to Coronavirus**, Marisa Fernandez, *Axios*, September 23

**Supply Shortages Continue to Plague COVID-19 Testing**, Caitlin Owens, *Axios*, September 22

**Endocrine-Disrupting Chemical Exposure in Teens Associated With ADHD-Like Behaviors**, Psychiatry and Behavioral Health Learning Network, September 21 & **Association of Exposure to Endocrine-Disrupting Chemicals During Adolescence With Attention-Deficit/Hyperactivity Disorder-Related Behaviors**, Shoaff J.R., Ph.D., *et al.*, *JAMA Network Open*, August 28


The 61ST Annual Conference (1st Virtual Conference)

Implementing Behavioral Health Crisis Response at State and Local Levels: New Paradigms, Partnerships, and Innovative Approaches

One (1) Session, Six (6) Consecutive Weeks  
Each Thursday, September 17 to October 22, 2:00 p.m. to 4:30 p.m. E.T.

This year, the National Dialogues on Behavioral Health conference that is usually convened in New Orleans was going to focus on cutting edge and innovative approaches to behavioral health crisis response at both state and local levels. But then, another crisis came along almost to underline the importance and significance of the topic that we had selected.

The behavioral health world, including its crisis response systems, has been scrambling to adapt and adjust to the new realities of the COVID-19 Pandemic. We thought it was critical that we take these new realities into account, both in terms of conference content and conference format, to dialogue on this important topic. Join us for 6 consecutive weeks as we address the emerging issues and innovations related to behavioral health crisis response in this new environment.

CONFERENCE RATE: ONLY $100.00 FOR ALL SIX SESSIONS OR ONLY $25.00 FOR EACH INDIVIDUAL SESSION.

FOR MORE INFORMATION AND TO REGISTER FOR THE CONFERENCE, GO TO OUR WEBSITE:  
WWW.NATIONALDIALOGUESBH.ORG

CONTINUING EDUCATION CREDITS APPLIED FOR AND PENDING FOR SOCIAL WORKERS


The IPS Employment Center offers several self-paced online courses, which include reading material, videos, homework assignments based on routine work responsibilities, and interactive feedback with instructors. The 12-week online IPS Practitioners course (available in English and Spanish) focuses on the evidence-practice of supported employment and supported education. The 10-week online IPS supervisors course helps supervisors to develop skills to improve program performance and outcomes. The 5-week Vocational Rehabilitation course teaches Vocational Rehabilitation counselors about IPS and their role partnering with IPS programs.

For more information, https://ipsworks.org/index.php/training-courses/
Let’s Move Forward in Our Journey

We are excited to present our first Virtual Fall 2020 CSAVR Conference integrating live and recorded sessions led by highly respected leaders in our field and some amazing special guests.

**SCHEDULE**

**CSAVR Leadership Forum**
- Monday, November 2, 1:00 p.m. to 4:00 p.m. E.T.
- Wednesday, November 4, 1:00 p.m. to 4:00 p.m. E.T.

**Directors Forum**
- Thursday November 5, 1:00 p.m. to 4:00 p.m. E.T.

**2020 Fall Virtual Conference**
- Monday, November 9, 1:00 p.m. to 4:15 p.m. E.T.
- Tuesday, November 10, 1:00 p.m. to 4:00 p.m. E.T.
- Wednesday, November 11, 1:00 p.m. to 4:00 p.m. E.T.
- Thursday November 12, 1:00 p.m. to 4:00 p.m. E.T.
- Friday November 13, 1:00 p.m. to 4:30 p.m. E.T.

[Download Full Agenda (PDF)](#)

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**CSAVR FALL 2020 CONFERENCE**

November 2 through 13

Celebrating 100 Years of Investing in America

Register HERE

Cindy L. Otis, Vice President, Analysis, Alethea Group
Join Us for This Virtual Event

The Ohio State University Wexner Medical Center
Department of Psychiatry and Behavioral Health Presents

2020 Suicide Prevention Conference
Innovations, Interventions and Specialized Populations

Tuesday, Sept. 29
8 a.m. – 4 p.m.

Join us for this virtual event where we will explore innovations, examine intervention models and discuss care for specialized populations for suicide prevention. This one-day virtual conference will also offer CCME, OPA-MCE and CPE credits.

This panel of experts will examine health care utilization before suicide; share research and knowledge about implementation strategies, measures and outcomes to the Zero Suicide Model; identify key assumptions of emergence and pathways to suicidal behavior; and discuss tools, resources and strategies needed for suicide prevention.

The Suicide Prevention Conference 2020 is proud to welcome these distinguished presenters:

Brian Ahmedani, PhD
David Brent, MD
Craig Bryan, PsyD, ABPP
Brian Mustanski, PhD
Kamesha Spates, PhD

Don't miss these local experts in the panel discussion:
Mark Hurst, MD
K. Luan Phan, MD

To learn more and register, visit wexnermedical.osu.edu/SPC2020

*The Ohio State University Center for Continuing Medical Education (CCME) designates this live activity for a maximum of 6 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The Ohio State University Department of Psychiatry OPA-MCE (Ohio Psychological Association-Mandatory Continuing Education) Approved Provider #3160229886

The Ohio State University Department of Psychiatry is an approved provider of continuing professional education (CPE) for Counselors and Social Workers for the Ohio Counselor, Social Worker and Marriage and Family Therapist Board. Approved Provider #RCS090902

It is recommended to check with your respective boards on eligibility to use AMA PRA Category 1 Credit™ toward recertification.

THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER
Leadership (and Partnership) Starts with You

Register Now for the 2020 UnSummit!

Special Team Pricing:
$75 off per person for 3 or more attendees
For every 5 registrations, get one free

Registration Rates:
CBHL Member: $175
Non-Member: $250
8.5 CEU/CMEs: $75-$100

Curious how we can 'move the needle' for improved health when working in diverse communities with different cultures, agendas and expectations for leadership? Want to explore your role as a leader? When to step up and when to step back while building authentic community partnerships?

Leadership within a partnership differs from leadership in a traditional, hierarchical organization. Join us for a dynamic, interactive and flexible 9-week UnSummit where together we will explore best practices for partnering with communities to improve health outcomes.

The 2020 Un-Summit: A Leadership Forum
Weekly Live, Interactive & On Demand Content
September 24 – November 19, 2020

Why join yet another virtual event?
• Unique learning package delivered over 9 weeks
• Flexible with live, interactive and on demand content
• Up to 8.5 CEUs available for physicians, psychologists & social workers
• A robust interactive event app
• Dynamic keynote speakers
• Engaging panel presentations paired with interactive follow up discussions
• Opportunities to network and build resilience with colleagues
• On demand case study presentations to share innovative partnerships
• Opportunities to connect with thought leaders from around the country!

Visit Us On-Line
The Technology, Mind and Society Showcase is coming soon—are you registered?

Join thousands of your peers virtually this fall as APA brings together scientists, applied practitioners, IT executives, students, policymakers and industry leaders for great new content, in a safe, convenient and more compact format. TMS 2020 will examine how psychological science can inform the development and adaptive use of new technologies that affect people’s lives. Registration is FREE.

We are honored to announce the following keynote speakers for this premier interdisciplinary showcase for emerging research and innovation:

- Jeremy Bailenson, Stanford University
- Lisa Feldman Barrett, Northeastern University
- Maja Matarić, University of Southern California
- Rosalind Picard, Massachusetts Institute of Technology

REGISTER FOR FREE

- Get the latest research and cutting-edge practices in this rapidly evolving field
- Hear thought-provoking discussions with globally recognized experts
- Engage with vendors through virtual exhibits
- Submit your questions during live access and open dialogue

Reserve your place now and discover the role psychological science plays in human and technology interaction.

In cooperation with
Areas of interest include, but are not limited to:

Potential applicants seeking to develop technologies for remote monitoring or treatment delivery should have performed sufficient due applications that address more long-standing barriers to SUD treatments or tackle issues with predominately in-person clinical trials research. This NOSI will also prioritize applications that have an impact beyond the circumstances created by the COVID-19 pandemic, for example, SUD treatment/research programs, including racial/ethnic minorities, socioeconomically disadvantaged individuals, and rural populations.

This NOSI encourages research among subgroups that have been disproportionately impacted by COVID-19 or have difficulty accessing patients, including efforts to bring access to difficult to reach populations, and to conduct clinical trials remotely. The purpose of this NOSI is to stimulate research to evaluate the safety and efficacy of telemedicine or remotely provided treatments for SUD, and to develop tools for remote collection of data in clinical trials of treatments for SUD.

Background

Most mainstream treatments for SUD currently rely on in-person clinical visits as an essential setting for treatment delivery and outcomes monitoring. The advent of the COVID-19 pandemic has substantially disrupted in-person treatment delivery, demonstrating the limitations of relying on in-person approaches. Further, even during normal circumstances, in-person treatment delivery results in additional travel-related demands and schedule conflicts (e.g., work, childcare) that can be burdensome to patients. These issues may be addressed via remote treatment delivery and patient outcomes monitoring as exemplified by telemedicine. Few studies have demonstrated that remote delivery of SUD treatment is feasible, safe, and efficacious. These remote delivery methods are generally still in the early stages of development, and existing studies generally lack the scope required to inform dissemination into clinical practice. Therefore, there is a need to develop new remotely-delivered SUD treatments and expand the dissemination of those already evaluated.

Similarly, clinical trials of SUD interventions generally require frequent in-person contact to monitor tolerability, adherence, and efficacy outcomes. The COVID-19 pandemic halted most SUD clinical research, which is evidence that methods for conducting clinical trials remotely are needed to overcome these challenges when participants cannot attend in-person clinic visits. Thus, there is an urgent need of research to develop tools to reduce the frequency of in-person visits in SUD clinical trials.

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.
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/SUIDs
- 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/SUIDs 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 lgargan@ffcmh.org.
Notice of Upcoming Targeted PCORI Funding Announcement
Suicide Prevention: Brief Interventions for Youth -- Cycle 3 2020

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

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.
BE INFORMED

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 LIVE 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

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.

Questions? Please email DBHDDLearning@dbhdd.ga.gov

Get information on mental health services and resources near you, searchable by state or zip code: www.samhsa.gov/find-help

SAMHSA
HHS.gov
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, visit our website.

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Virtual Native Talking Circle: Staying Connected in Challenging Times

**Bi-Weekly, Mondays, 12:30 p.m. C.T.**

Talking circles are based on the tradition of sharing circles. Please join us together for our virtual talking circle. This event is held bi-weekly. This group will be facilitated by a Native guest and will focus on concerns about yourself, your family, your work, and/or your tribal community that you may be experiencing during these uncertain times. There is no fee or expectation to participate in this event. This is a respectful meeting space. Come share your concerns, offer support, and respect the group’s privacy.

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Register HERE
Registration is Now Open!

Research shows that spirituality positively impacts health and wellness – including for individuals living with mental illness, and for their families. Understanding the critical intersections of spirituality and mental health can increase the overall effectiveness and quality of treatment across an individual’s continuum of care.

Faith leaders and mental health practitioners are working together, developing strong and successful examples of what can be replicated around the nation. This webinar series seeks to share:

- **Research** demonstrating the outcomes possible when considering spirituality and mental health together, rather than as separate areas of study.
- **Testimonies** of personal and lived experiences, highlighting what can be achieved, and engaging diverse communities.
- **Examples** of spirituality and mental health being addressed together to improve the health and wellness outcomes for clients and their families.

**REGISTER FOR THE ENTIRE SERIES**

**WEBINAR SCHEDULE:**

1. **Sept. 29, 12:00 pm** — **Spirituality in Treatment:** Systemic Treatment Models Bridging Faith and Mental Health Professionals
2. **Oct. 13, 12:00 pm** — **Spirituality and Post-Traumatic Growth:** Spirituality as Catalyst for Resilience
3. **Oct. 27, 12:00 pm** — **Spirituality and Severe Mental Illness:** Questions of Recovery versus Purposeful Renewal
4. **Nov. 10, 12:00 pm** — **Spirituality and the Life-time Course of Mental Illness:** Support for Patients, Caregivers, and Family by the Faith Community
5. **Nov. 19, 12:00 pm** — **Spirituality and Treatment:** Contributions to Faith and Forgiveness in Recovery
6. **Dec. 8, 12:00 pm** — **Spirituality and Community-wide Crisis:** Building Systems to Support Connection and Recovery

If you have any questions about this new series, please email us at partnerships@hhs.gov.

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**5 Action Steps for Helping Someone in Emotional Pain**

1. **Ask**
   - “Are you thinking about killing yourself?”
2. **Keep Them Safe**
   - Reduce access to lethal items or places.
3. **Be There**
   - Listen carefully and acknowledge their feelings.
4. **Help Them Connect**
   - Save the National Suicide Prevention Lifeline number 1-800-273-8255.
5. **Stay Connected**
   - Follow up and stay in touch after a crisis.

[www.nimh.nih.gov/suicideprevention](http://www.nimh.nih.gov/suicideprevention)
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.
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 announcements 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, amy.goldstein@nih.gov.

The Georgia COVID-19 Emotional Support Line provides free and confidential assistance to callers needing emotional support or resources information as a result of the COVID-19 pandemic. The Emotional Support Line is staffed by volunteers, including mental health professionals and others who have received training in crisis counseling. Hours of operation: 8 am - 11 pm. Call 866.399.8938

Georgia Emotional Support Resources
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
Fund 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
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 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.

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 to 31 in Baltimore.

Register On-Site

For Additional Information, Contact Christina Walker, 443-790-4066

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,

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**

<table>
<thead>
<tr>
<th>TTC</th>
<th>Resource Type</th>
<th>Title</th>
<th>Link</th>
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</table>

The MHDD-NTC is a collaboration between the University Centers 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/](https://mhddcenter.org/)
Rural Health Information Hub

**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**

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### 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](#)

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**IIMHL and IIDL Leadership Exchange**

Valuing Inclusion, Resilience and Growth.

Kaingākautia te whakawhāiti tāngata, te ngākau manawaroa, te puāwaitanga o te tangata.

**SAVE THE DATE**

28 Feb to 4 Mar, 2022

Christchurch, New Zealand

Te Pou o te Whakaaro Nui
NCEED has gathered information to help support the community as the COVID-19 crises evolve. Resources were created to provide guidance on how to support yourself, your loved ones and your patients:

https://www.nceedus.org/covid/

- Eating Disorders and COVID-19: What Healthcare Providers Need to Know -

- Eating Disorders and COVID-19: What Individuals and Families/Caregivers Need to Know -

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

GET THE TOOLKIT HERE
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>September 2020</th>
<th>Electronic Health Records in Person-Centered Care Planning: Pitfalls and Promises</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2020</td>
<td>Best Practice in Incorporating Supported Decision-Making and Person-Centered Thinking, Planning, and Practice</td>
</tr>
<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>
</tr>
</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
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.

**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**
- 90791+95
- 90792+95

**Evaluation and Management Outpatient**
- 99204+95
- 99213+95
- 99215+95

**Evaluation and Management Plus Psychotherapy**
- 30 (16-37*) minutes - E/M code [Audio only – use the appropriate 99441-99443 code] and 99832+95
- 45 (38-52*) minutes - E/M code [Audio only – use the appropriate 99441-99443 code] and 99835+95
- 60 (53*) minutes - E/M code [Audio only – use the appropriate 99441-99443 code] and 99838+95

**Psychotherapy Alone**
- 90832+95
- 90834+95
- 90837+95
- 30 (16-37*) minutes
- 45 (38-52*) minutes
- 60 (53*) minutes

**Group Therapy**
- 90853+95 *(Added temporarily to the Medicare Telehealth list for the period of the COVID-19 crisis)*

**Family Therapy**
- 90846+95
- 90847+95
- 90849+95
- Patient not present
- Patient present
- Group

**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
Cultivating Trauma-Informed Organizations and Services for People Living with Disabling Mental Health Conditions  
**Friday, September 25, Noon to 1:00 p.m. E.T.**

Research has uncovered trauma as a core public health concern facing our nation, linking experiences of trauma to mental health conditions, substance use concerns, chronic physical health problems, housing instability, and shortened life expectancy. Additionally, experiencing trauma and victimization increases the risk for developing serious mental health conditions, which in turn increases risk for experiencing additional forms of trauma, including institutional trauma. For marginalized communities, including people of color, LGBTQ individuals, and people impacted by poverty, this can be further complicated by experiences of structural violence as well as collective forms of trauma.

This webinar will introduce participants to the various forms and effects of trauma, recognizing the effects of trauma in both people accessing care as well as staff and systems, while cultivating multi-dimensional responses to address trauma and prevent re-traumatization. It will also highlight evidence-based interventions for the treatment of trauma within the context of co-occurring disabling psychiatric conditions.

**Presenter:** Gabriela Zapata-Alma, LCSW, CADC, Director of Policy and Practice for Domestic Violence and Substance Use at National Center on Domestic Violence, Trauma & Mental Health

Register [HERE](#)

Self-Directed Care for Individuals with Serious Mental Illness  
**Friday, October 9, Noon to 1:00 p.m. E.T.**

Underlying the goal of recovery for people with SMI, is the concept of self-determination. This is a process of taking back control of lives which have been overwhelmed by the debilitating nature of SMI and the loss of control resulting from reliance on a system that fosters dependence. Self-determination encompasses concepts such as free will, civil and human rights, freedom of choice, independence, self-direction, and individual responsibility. The challenge to the mental health system was to develop a philosophy that places the individual at the center of the system, and specific programs that deliver on it. Self-directed Care provides this, and enables individuals to assess their own needs, determine how and by whom these needs are met, and manage the funds to purchase the services. A support broker can help the individual develop their budget using their plan and a fiscal entity handles the payments. This webinar will take a comprehensive look at Self-Directed Care and its benefits for individuals with SMI.

**Presenters:** Patrick Hendry, Mental Health America  
David Sarchet & Megan Cobb, Florida Self-Directed Care (SDC)

Register [HERE](#)

**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.

**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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REGISTER FOR THE ONLINE CONFERENCE

*Dissemination and implementation science in a dynamic, diverse, and interconnected world: meeting the urgent challenges of our time.*

As the global health workforce continues to respond to the COVID-19 pandemic, the dissemination and implementation (D&I) science community can respond by bridging the gap between research, practice, and policy.

Attend the AcademyHealth-sponsored virtual *Science of D&I Conference* in December and join a growing, vibrant community using evidence to inform decisions that will improve the health of individuals and communities – setting the field up for a strong future.

**Join us Online to:**

- Learn about the latest innovations in the science of D&I;
- Explore new research findings and contribute to the next set of research priorities;
- Identify and understand challenges facing D&I research; and
- Engage in unique virtual networking opportunities with leading experts in the field.

**SMI Adviser Coronavirus Resources**

**Recorded Webinars**

- Managing the Mental Health Effects of COVID-19
- Telepsychiatry in the Era of COVID-19
- Serious Mental Illness and COVID-19: Tailoring ACT Teams, Group Homes, and Supportive Housing
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

**SARS-CoV-2 Reference Panel Comparative Data**, Food and Drug Administration, September 15

**Face Masks and Surgical Masks for COVID-19: Manufacturing, Purchasing, Importing, and Donating Masks During the Public Health Emergency**, Food and Drug Administration, September 3

**4 Ways to Handle COVID Fatigue**, Elizabeth Su, TalkSpace, September 11

**Why Am I Being So Petty During the Pandemic?**, Ashley Laderer, TalkSpace, September 14

**Adjunctive Lumateperone Shows Efficacy for Bipolar Depression**, Jolynne Tumolo, Psychiatry and Behavioral Health Learning Network, September 14

**The Pandemic Proves We All Should Know ‘Psychological First Aid: Here Are the Basics’**, Stacey Colino, Washington Post, September 22

**Does Wearing Glasses Protect You From Coronavirus?**, Tara Parker-Pope, New York Times, September 16 on-line and September 22 in print

**Is Coronavirus Affecting the Hearts of College Athletes?**, Gretchen Reynolds, New York Times, September 16 on-line and September 22 in print


**Majority of Americans Expect to Not Get First-Generation COVID-19 Vaccine**, Axios Ipsos Poll, September 22

**Boost for Global Response to COVID-19 as Economies Worldwide Formally Sign Up to COVAX Facility**, World Health Organization, September 21