

FINISHED TRANSCRIPT

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
OCTOBER 21, 2015
WELCOME TO PBHCI!
GRANTEE KICKOFF WEBINAR

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>> The broadcast is now starting with all attendees in listen-only mode.

>> PRESENTER: Good afternoon welcome to the first of the five part webinar series introducing PBHCI. We are excited to have you join us today on the learning collaborative with fellow grantees.

I am the deputy director for SAMHSA-PBHCI and the regional portion with Anna Green the technical coordinator.

As you may show, SAMHSA promotes behavioral health services to better address the needs of individuals with mental health and substance abuse conditions, whether it is specialty or primary care settings.

The health providers integrate care and the Center continuously posts practical tools and resources to the website, providing direct phone consultation to providers and stakeholder groups, directly working with SAMHSA behavioral healthcare facilities.

You will have the opportunity to hear about how this can be helpful to you with regard to PBHCI. Today's webinar is being recorded and all participants will be kept in listen-only mode. You can find the call-in number on the right-hand side of the screen.

Questions may be submitted throughout the webinar by typing them into the dialogue box to the right of the screen and sending it to the organizer.

We will do everything we can to get to all the questions today. But if not, we will follow up to support you after today's webinar.

If you experience technical difficulties at any point, please call 888-259-8414. The slides are currently posted at integration.SAMHSA.gov

And then lastly, provide your feedback via the survey at the end of the webinar to improve our processes. Today we are fortunate to have speakers from the substance abuse and mental health area providing grant requirements, discuss management aspects and data collection.

Also we will hear from the director who will discuss resources and support available to you over the next four years or so and Monday.

Cynthia is the branch chief at SAMHSA for community support programs.

She will talk about the project team and the role of the grant project officer.

I will turn it over to her to get us started.

>> PRESENTER: Hi, this is Cindy. Thank you, Bree.

First I introduce the government project officers we have in the room today. First is Tenly Biggs. Next is Marian Sheinholtz and Joy Mobley and Roxanne Castaneda and Kate Schlotter. Kate is new, as you can tell.

I also want to introduce our grant management specialist, Sal Ortiz who you will hear more from later on. Also, staff from our training and technical assistance center are here today. You will be hearing from them about their roles a bit later in the presentation.

Let me talk now about the role of the GPO. Next slide, please. The GPO is the federal representative, the primary point of contact for the grant award and is responsible for the overall grant monitoring and grant compliance of the requirements of the grant award.

It is the GPO's responsibility to approve all program changes, including budget, project scope and director and key personnel.

You must submit a GPO request prior to making a change, like before you hire somebody new or change your scope, please submit that request to the GPO.

Your GPO will review and discuss your quarterly reports with you, and review

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and discuss data collection.

They are also responsible for field training and any technical assistance requests, and most importantly to support you to achieve your program goals.

So it is important to know your GPO and develop a relationship with them. That is a brief and quick overview of the GPO's role. Thank you, everyone.

>> On the next slide we will talk about the CIHS support team which you will also hear about later.

The grantees are organized into regions, which you will see on the map, and each has a regional liaison and a regional coordinator.

You will be introduced to them more formally later in the week. The liaison provides technical assistance and training too, but really for the needs of the grantees.

This can include wellness, data collection, evaluation, registry, using data in a meaningful way. We really try to organize topics and support that really meets the needs of the grantees.

Also there is a regional coordinator as part of the support team who works closely with the liaison and grantees to coordinate technical assistance and support.

We are always in communication with SAMHSA, so it is a unique support team. Next will be a map of how the grantees are organized, all the active PBHCI grantees.

I will note that you can probably identify where you are in the regional display. Then as we move on with the presentation, you will learn more about your liaisons and coordinators.

At this time I would like to introduce Joy Mobley, grant process officer for Region 1. She will talk a bit about Region 1.

>> PRESENTER: I am the grant project officer for Region 1, a fantastic region.

And a little bit about myself, I am a clinical psychologist and I came to SAMHSA earlier in the year from an integrated military health system.

I feel I have a lot to offer you all with regard to experience and working hand in hand with primary care providers.

Other interests I have lie in trauma and working with military service members. I look to working with you all. Thank you.

Oh, sorry. Also in the region your CHIS liaison is Aaron Williams and your coordinator is Emma Green. You will be hearing more from them later.

>> PRESENTER: I am Tenly Biggs from Region 2, New York and Pennsylvania -- sorry, New York and New Jersey. Region 3 is the other map you will hear from next.

My background is in clinical social work. I have been with the program for the past three years. For Region 2, right now you are going to be supported by Tony Salerno for your liaison, but there will be somebody new.

The coordinator is Emma Green. I'll turn it over to Marian now, she is the GPO for regions 3 and 4.

I will just quickly cover this. For region 4, she is the GPO. You can see the highlighted states here, 20 grantees. CHIS is Kathy Dettling and the CHIS coordinator is Rose Felipe.

>> PRESENTER: I am Roxanne Castaneda, grants office project officer for the Midwest. I have three regions and 47 grantees in the project so you will hear me saying that all the time about all my regions.

I am an occupational therapist, been with SAMHSA about five years, as well as this project from the start. It has been lovely to watch it grow from the tiny group of 13 we started with, to now up to about 121 folks.

What makes the project unique, we have a very strong partnership with our technical assistance center. We operate as a team, and that is something I am

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very proud to be a part of, and I think will you find it very helpful in your life as a grantee.

In the midwest CHIS liaison is Jeff and the CHIS coordinator is Rose.

>> PRESENTER: This is Joy again. I recently stole Region 7 from Roxanne and we will be working together.

Roxanne is the grant project officer for Region 8. And we also share in this region our CHIS liaisons Linda and coordinator Hannah Mason.

Next slide, please. It's me again, the best region of the United States, Region 10 and Region 9 which includes the unique territories of Hawaii and Alaska.

I am the project manager for this group and my CHIS liaison is Aaron William and coordinator is Hannah Mason.

Next slide, please. Now back to Joy with an overview of the PBHCI requirements.

>> PRESENTER: Hi everybody. We will go over general program requirements.

The purpose is establishing projects for provisions of coordinated integrated care services to collocation of primary care and specialty care services in a community-based mental health setting.

The goal is to improve the physical health status of adults who are living with serious mental illness who have or are at risk for co-occurring primary care conditions and chronic diseases.

The objective is supporting the triple aim of supporting those with serious mental illness and enhancing consumer care experiences and reducing the per capita cost of care.

One major requirements is to establish a PBHCI coordination team to meet quarterly, at a minimum that includes the following staff: Chief executive officer, chief financial officer, chief medical director, primary care lead PBHCI director and consumer and the consumer must comprise at least half of this body.

It is also a requirement to have an integration treatment team which at a minimum includes the primary care provider, nurse care coordinator, integrated care manager, peer wellness coach, substance abuse counselor, and pharmacists, dentists, nutritionist.

You get the idea. We just want everybody talking to each other. Next slide, please. Some core requirements for the program, we would like you to provide by primary care professional onsite primary care services, probably one of the biggest aims provided by specialty care individuals with a medical necessarily referral.

You must have three memorandums of understanding and letters of commitment with distinct primary care providers to the applicant service population.

The memorandum of understanding must address how you are going to share data, connection with care coordination activities, relation to the integrated team and associated planning, including the providers operations.

So we want you all not only to have the relationships, but to see the plan involved in actually working with these folks.

I think the real idea behind having three, making sure if any of the agreements fall through, that you have a backup.

Next slide, please. Some other requirements areas: We expect the program will operate as health home services, including care coordination, health promotion, comprehensive transitional care from inpatient to other settings, including appropriate follow-ups.

Also individual and family support which includes authorized representatives, referral to community and social support service, including appropriate follow-up.

We also would like you to have the engage the with health and information technology, including submitting at least 40% of your prescriptions electronically, as lab results and continuity of care of records between providers, and participate in regional extension center programs.

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A few other things regarding electronic health records. The use of the electronic health record is to generate condition-specific reports to use for continuous quality improvement, reduction of disparity and research and outreach.

These are the things we would like you to collect with the use of your electronic health record. Also you must target specific interventions to appropriate populations and choose protocols for sharing data across primary care health and behavioral health systems.

Finally the grant is the support of the Million Hearts initiative supporting cardiovascular disease prevention with the goal of preventing a million heart attacks and strokes by 2017.

So we will be asking you all to use one of the Million Hearts Campaign for a protocol listed on the next slide.

Here are the four recommended protocols for the Hill I don't know Hearts. At this point I will turn it over to Roxanne.

Let's talk about the needs assessment for the cohort which should begin 60 days and annually thereafter, so 60 days after the start date in 2015.

But the capacity assessment should be conducted, and the integrated practice assessment tool should be used to help you.

At a minimum have basic collaboration onsite with the goal of full collaboration in a transformed, merged integrated practice by the fourth year of the grant program.

This is something your technical assistance specialists will be very helpful to you, teaching you how to do this.

Start-up. Service delivery should begin by the fourth month of the project at the latest. Primary care services must be available five days per week by Year 2.

CIHS will provide grantees TA on the two areas I mentioned. Sustainability. Grantees must submit a sustainability plan in beginning of Year 2 detailing how expanded medical eligibility and available CMS third party billing and other strategies will be used to sustain services post-grant.

On the CHIS, they have an outline they can offer to you if you don't have a tool you use yourself. With regard to wellness, had present tobacco cessation and health education and literacy self-help management programs which should incorporate recovery principles and peer leadership and support and must be included in the integrated person's enter center care plan.

You are encouraged to set annual targets in the reduction. In the past 30 days, self-reported tobacco use and trying to have a smoke-free workplace.

In addition, also wellness consultation and education and other things previously mentioned.

You must choose at least -- next slide, please.

You must choose at least one evidence based practice from each of the following, tobacco, formerly peer to peer tobacco dependence, learning about healthy living, tobacco prevention for people with serious mental illness.

Nutrition and e ice, a number of them, the New R, the Dart, weight watchers in-shape, stoplight diet and Achieve.

Self-management and the CDC protocols you were shown earlier as well. There are information and links to all of what I just read which CHIS will provide to you upon request.

Next slide, please. You will be expected to screen and assess consumers for the presence of co-occurring mental and substance use disorders, incorporate recovery principles and peer leadership and support, and consider the unique needs of running veterans and families in developing their proposed project, and consider prioritizing this population for services where appropriate.

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Next slide, please. Language of recovery. Grantees are expected to incorporate SAMHSA's working definition of recovery as an underlying theme for all PBHCI efforts.

A process of change through which individuals improve health and wellness, live a self-directed life and strive to reach their full potential.

Next slide, please. Notice of award, terms and conditions.

>> PRESENTER: As you have all received this, you will notice in this NOW the mention of the disparity impact statements.

By November 30th you must submit electronic copy of that NOW to your GPO and grant management specialist, Sal Ortiz.

You must include three components. First, the proposed number of individuals to be served by subpopulations in the grant implementation area, provided in a table covering the entire grant period.

In other words, we should see a chart to list Year 1 and 2 and 3 and 4, telling me who you are serving, what groups they come from.

Again, you can from the examples that are listed in the link. The disparity population should be described in a narrative, so not just numbers; tell me why the population is targeted and what is their disparity compared to the overall group.

Secondly, quality improvement plan for how you will use the program and outcomes to manage outcomes by race, ethnicity and LGBT status when possible, and to also include adjustments to reduce disparity for the unidentified subpopulation.

Next slide, please. The third condition, the quality improvement plan should include methods to development of implementation of policies and procedures to ensure linguistic appropriate services and provision of effective care and services in response to diverse cultural health practices, preferred language and other communication needs of all subpopulations within the proposed geographic region.

For Conditions 2 and 3 basically in the quality improve the plan you want to be able to enhance and explain how you will target that specific population, what types of processes will you have in place to either do outreach to make sure the services are culturally appropriate and competence.

You can actually look at all 15 class standards to really generate for processes from that. Because again, when you work with your primary care partner -- most of the time they aren't actually implementing the class, but on the behavioral health side, we haven't greatly promoted it.

So collaboration before both pieces, really important. So submitting a statement saying you adhered to the class, really not enough.

Some grantees say oh we are serving a Russian implementation program and we have sign language in Russian, which is really important.

We have guarantees saying the integrated treatment plans and prescriptions are translated into Spanish, which is very important and effective for our group.

Next slide, please. We are doing this because health and human services secretary made this a priority.

It is in her action plan to reduce racial and ethnic health disparity, stating grantees will submit data as part of the grant application.

So we've been doing this since 2012. Next slide, please. How are we defining disparity? SAMHSA uses the Healthy People 2020 definition, which I won't read and you have seen as part of the RSA package.

Go to Appendix G for more information of the RFA for more key definitions and breakout terms, but I will highlight the subpopulation must be from a racial or migration minority group or sexual population.

And the targeted subpopulation should already be in your application. If you

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have questions, please email your GPO.

But again, there should be a consistency in what you propose in your application, as well as in the disparity impact statement.

I know some folks will argue that our specific population is a disparity group compared to the overall U.S. population, but that isn't the intent of the Secretary's plan.

Again, the focus is on access using outcomes. So when you identify the subgroup, what is the access, the services used, are they staying in or dropping out of services?

And of course what are the impacts on the outcomes and how you plan to address all of those issues. The racial disparity will be tracked by A says, number enrolled in the program

You have to report on the race, ethnicity LGBT populations which you will see in the data tracking form and screening.

Also use and number of services used and the outcome to the African-American subpopulation doing better in terms of blood pressure versus the overall group because maybe you notice higher rates much blood pressure or at risk for diabetes e when compared to Caucasian or Asian American.

Next slide, please. The impact statement is due to your grant management specialist and GPO by November 30th.

The BHICA will be sent to CHIS also due November 30th, IPAT to November 30th. Service delivery, meaning when you actually start to enroll a client, it should begin no later than February 1st of 2016.

Select protocol for blood pressure and report it in your quarterly report due January 31st. We will send you a template so that you can see the questions and what kind of information we expect you to collect throughout the grant.

Of course the sustainability plan will not be due until October 31st of went six fine, to Year 2. Next slide, please.

Now I will turn to over to Sal Ortiz, your grants management specialist.

>> PRESENTER: Assume the grants management specialist for the entire PBHCI program. I look forward to working with you all.

Today I will go over a brief overview of grants management. Next slide, please. Here are some topics I will be discussing.

We will talk about the different partners you will be working with, the different roles of each of the staff you will be working with.

I will go over some actions that generally require prior SAMHSA approval, as well as discussing the prior approval process for those items.

I will review some reporting requirements and explaining the annual budget constraints for each of the budget years.

I will provide information on how to apply for the next 12 months after the first year has ended, and I am providing link to our SAMHSA grant manager website that provides further information on the topics I will be going over today.

Important in terms of helping us manage your grant and providing assistance to you, when you submit correspondence or letters, always include your grant number when you contact SAMHSA in emails Oregon on the phone to better assist you.

Also always include your contact information in SAMHSA communications. Next slide, please. Here are some partners you will work with, in addition to the support provided by the technical assistance center.

Here are some federal partners you will work with, the government party officer. Next person is myself, grants management specialist.

You will also be working with another office, payment management services next slide, please. Here is a brief overview of your government project officer's responsibility.

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Cindy previously mentioned some of it, but here is another brief overview. GPO is responsible for program attic and technical grant aspects, working in partnership with the division of grants management throughout the remaining grant cycle.

Next slide, please. As I stated earlier, the GPO works in partnership with the division of grants management.

My office is responsible for president business and financial management matters of this grant. We are responsible for any award negotiations.

We provide the official approval for any requirement that generally requires prior SAMHSA approval.

We obligate federal funds and assist with client issues and with closeout of the grant.

Another office you will work with, the payment management services. They are the ones who actually monitor or assist you with any cash transactions you will draw down from your premium management account.

If you haven't established that account yet, on the bottom of the NOW on Page 2, there is information to contact this team to help you get your account setup.

If you want to know who your account representative is, click on "contact us" and it will be broken down by entity or nonprofit, state government, travel governments.

So please look for your respective entity, and your contact will be listed there. Next slide, please.

Here you see the most common items that generally require prior SAMHSA approval. One main thing is a key staff change.

That requires prior approval and the notice of award, in that we listed the positions considered key staff, which is generally the program director.

If this position is replaced, provide that to your government officer and myself for prior approval. Another item requiring prior approval is if you will be doing significant rebudgeting of 25% of your annual period.

I will use this example of 400 thousand dollars for the year, you can rebudget up to 100,000 without prior SAMHSA approval.

But because it is a cooperative agreement, please keep your GPO informed of any important changes that occur because of this rebudgeting leeway so we remain aware of what is going on in the program.

Another item generally requiring prior approval from San is a, if there will be transfer of substantive program attic work to a contractor.

Right now you won't have to worry about this, but after your first year has ended, if you have any unspent funds you will have the option to carry over those funds into either the second year or a subsequent year of the grant project.

Carrying over funds requires prior approval from SAMHSA. We can go over the detail when the time period gets closer.

Another item requiring prior approval, changes in scope. If you will deviate or change your proposed goals reflected in your application that maybe considered a change in scope.

So please contact your GPO and myself if you believe a change in scope is necessary. Another item requiring prior SAMHSA approval, a no-cost extension.

Once you reach the end of the grant project if you have unmet goals or need additional time for early phase-out of the grant, we can allow up to 12 months after the four year period to assist you finalize anyone met goals or additional time.

Right now it doesn't apply, but you will have that option when the project nears its end. I provided a link on this slide that takes you to the grant manager website that provides additional detail for each of the items I just went over right now.

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Next slide, please. Here you will see the process for requesting prior approval. I just mentioned that a request should be submitted via email to both your GPO and myself.

Please address the request to the both of us, mentioning your grant until and provide program justification as applicable.

It should be signed by both program director and busy fix. Once a request is submitted to us, it will be jointly reviewed by the GPO and myself, and after it is finalized, my office will issue a revised notice of award reflecting the approval.

Next slide, please. Here are some reporting requirements that are submitted to both the GPO and the division of grants management.

You are all responsible to submit a quarterly progress report to the website on the slide, and please also contact your project officer.

We listed the due dates in the notice of award be in the reporting requirements section. Another item not mentioned in the notice of award you will be required to submit quarterly cash transaction reports.

These will be given to the system account manager quarterly through your online payment management account.

I provided a link there which shows you the breakout of the due date for the quarterly federal cash transaction reports.

Another report that is due to us, the annual federal financial report. This report will capture your total annual expenditures, and it will validate the availability of anyone obligated funds that were remaining at the end of Year 1 budget period, and you will have the option to request, to carry over the remaining balance as needed into a subsequent year.

That will be due before you can carry any funds.

Next slide, please.

Here are the annual budget constraints. This is a four-year grant project. As you can see the first budget period started September 30 of 2015, going through September 29th of 2016.

You can see the remainder of the budget years of this grant. As I said earlier, once the first budget period has ended, if you have remaining unspent funds, you have the option to carry them over to either Year 2 or a subsequent year if needed.

Next slide, please.

Here I provided some brief information on how to apply for the next 12 months. There are two types of grantees in this program.

The majority of you are annually-funded recipients. Will you be required to submit a noncompeting continuation application via grants.gov.

My office will give information about how to support the continuing application, and it will be electronically mailed to the designated Biggs official you identified in the HHS checklist form submitted with your application.

That official is responsible to forward communication from the division of grants management to any other interested parties within your organization.

Once we finalize the instructions, we will email them to the busy figures, and we will also post the instructions on the SAMHSA website which I provided a link to.

The other type of recipients in the program, those labeled a multiyear recipient. That information would be under the remarks on Page 3 to see the categorization of the multi--year.

For those categorized as multiyear recipients, refer to the multiyear condition of the award, as you will need to support an application to us, but not via grants.gov and you can refer to your special conditions for more details about those requirements and carrying them out.

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I am providing a link to the main SAMHSA grants management website name goes into the item I just mentioned in more detail, as well as other regulations and policies and procedures that you should adhere to.

So this is a very type of useful information with regard to post-award requirements. Familiarize yourself with that, and it will help you out a lot. Next slide, please. You.

I emphasize, please include your grant until and contact information whenever you contact SAMHSA via email or on the telephone.

Next slide, please. If there are any questions, feel free to contact me. The contact information was on a slide, as well as on the last page of your notices of award.

My address and phone numbers are there, so feel free to contact me, and we can arrange a time to have a phone call if necessary.

>> PRESENTER: Now data collection and monitoring.

>> PRESENTER: All contact information will be on one final slide at the very end of the presentation.

For data collection and monitoring, in the application we are asking everyone to look at the number of consumers enrolled.

Again, the definition is the sensitive individuals, the number of adults with mental illness, targeted by geographic area.

Minimum by Year 1, there should be more than 10% enrolled, and so on up through the years of the grant. So we will look at each person's application to determine the number of people served.

As mentioned, if you want to change the actual number, for instance you realize that you proposed a thousand by the end of Year 4, and in Year 2 you realize a thousand was a bit ambitious.

We have folks go through Superstorm Sandy, and they had to stop providing services and rebuild their in a still these.

So various things happen, but let your GPO and Sal know, and we can discuss descopeing your program. But it all depends on the circumstance, and that was an extreme example.

Required normal data. You have to submit quarterly reports to the GPO at the email address Sal mentioned.

The data is the national outcome measures, including the infrastructure prevention and promotion indicators and the Section H health indicators.

All of this will be inputted into the government data collection and monitoring system. Right now we're going through a change and when we have more updates about what the system will look like, we will give you that information.

In the meantime, grantees are expected to collect and report on the following health outcomes, also known as Section H indicators at baseline, discharge and at six-month intervals.

This is blood pressure twice a year, as well as height and weight, body index twice a year, and the list goes on. Be there will be training on all these areas, as well as annual budget information and nonclient measures for the PBHCI program for services, and train structure treatment and mental health promotion indicators and a technical assistance survey.

Next slide, for the on wall goals and budget information, program directors will enter performance goals and budget information for the year.

The goals and budget information are directly entered into the system, based on existing plans. We the GPOs approve the goals and budget information, and the data will be used for performance measurement and oversight.

And the project directors can make the annual updates every year. Next slide, please. For the other client measures, the service activity data collected via

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client measurement services tools.

This is basically a screening form clients fill out during intake.

Once you have all that information filled out and you enter it into your EHR or your registry, they would be counted as being enrolled into the PBHCI program.

You really should have the data for your own agency, but on the SAMHSA end, until you put it into your collection and monitoring system, we don't know that person is now enrolled.

So you basically need to have that information in two different places on the particular date when it will be collected for all consumers receiving services.

So any person receiving services paid for with our grant funds, they have to be enrolled and have Section H indicators collected.

The IPP, they collect information on program activities, impact on infrastructure development, impact on prevention and mental health promotion.

You report these measures for your program, and the data down the line can be viewed and downloaded and the performance report should match your goals.

Examples of IPP indicators would be any policy development changes, organizational changes, any screenings and referral that were completed.

We like to again kind of get a sense of how you are using the funds to promote mental health or primary care in this case, and then get that information back to us.

Technical assistance survey is usually put out when the monitoring system is up and running for more information about providing technical assistance, but I won't read the slide now

This is an example of a Section H indicator report. Again, we are transitioning so I'm not sure if the same report will be generated with the same look; it may look slightly different.

But the information you see here, that is what we expected to you collect, the blood pressure BMI, and all the other things listed the here.

Next slide, please. The PBHCI, this particular evaluation, as mentioned we said if it were funded it is expected all grantees would participate in the cost-set evaluation.

We were able to get the evaluation funded and it began the same time the grant started for this year. I will kind of go over some evaluation basics, next slide, please.

The history of our program, previous cohorts that had evaluation completed by Rand Corporation, the findings showed some improvement in specific health indicators but not all.

Various models were being used with the conclusion being we need more extensive evaluation of the PBHCI programs to report effectiveness to SAMHSA and Congress.

It is important that SAMHSA have a sense that things are working. We need the data to show it, and we're now at a point we feel pretty strongly that an evaluator contractor can come in, look at what we're all doing and basically share the integration to make sure it is all working.

For the goals, there are four overarching questions. What services do consumers receive? How does integration improve health and physical outcomes? What are the active ingredients of integration? And what challenges and solutions do grantees encounter?

Who is conducting the evaluation? Mathematica and Rand Corporation are working on the equation together. It lend in 2020.

Data collection begins as soon as a start enrolling consumers for the PBHCI program. What is required of guarantees?

Basically you are doing the same thing you need to do for our program, collecting data at enrollment and baseline at every six months.

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Of course there are some limited variables from registries that will be asked for more information with regard to, participate in a brief staff survey then sample a small group of grantees for telephone interviews and site visits.

Technical assistance available? Yes, Mathematica and Rand will provide assistance to help grantees with monitoring the completeness of the NOMs and data submissions and extract data from registries, troubleshoot other challenges as needed.

The TA is intended to minimize data collection burdens and facilitate your own evaluations. Staff will be available via phone and email and drop-in sessions and website, et cetera.

In terms of the eval, you will receive a separate inn say takes for a brief evaluation orientation to provide more details on data submission requirements, the timing of the submissions, evaluation-related technical assistance, answered contact information for staff.

Next slide, please. Right now I will turn it back to Laura.

>> PRESENTER: Thank you to everyone from SAMHSA for the overview of PBHCI requirements.

Now to Laura, the director of the center for integration health solutions.

>> PRESENTER: Hello everyone. Great to be with you today.

I want to introduce you to the center, who we are and what we will be doing with you to support the success of your programs.

As a technical assistance center, we have the big pictures and goals. We want to help make integrated care the national standard of practice so that no matter where you go, be it a service in the community your whole health and wellness is addressed.

We are dedicated to operating a world class technical assistance center with the consultation and tools and supports you need for project success, focusing on SAMHSA program.

Then focus on the broader audience for folks like yourselves who may be just starting or expanding, taking what you learn with regard to integrated care, how do we take that to the broader behavioral health field?

For a sense of our audience of who we work with, certainly the PBHCI grantees is a core audience for us in terms of technical assistance.

We are also supporting SAMHSA grantees who received funding minority AIDS initiatives with substance use and primary care.

As you know we are funded by HRSA. As part of it we provide technical assistance to health centers to expand behavioral health capacities.

For those partnering with HQAC to embed a practice, we are here as a resource to your partner, like a really nice add-on.

It is like our primary care partner is also here to help you be successful in what you are trying to achieve, feel free to reach out to support them, and then lastly, national audience.

We thought we would give a nice visual showing the relationship. As I alluded to, the center for integrated health solutions at the bottom of the screen going up, it is run by the National Council for Behavioral Health.

This is a national association you may be very familiar with. All the CHC staff are housed at the national council, receiving funding support through SAMHSA and HRSA to run the technical assistance center.

As you can see, SAMHSA fund you directly, not coming through the center, but the technical assistance is.

The end result is certainly all the consumers and individuals you are serving. Next slide, please. This is a slide on workforce.

As you are working now to put your teams together, we have a lot of great

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resources that will help support you around workforce.

This is everything from sample job descriptions for your project directors to core competencies you can embed in staff training, recruitment materials; and then obviously trainings that you can use in-house and otherwise to make sure your entire staff across the organization is well-prepared.

Related this is we compared some resources in a handout you may have seen in the handout section next slide, please.

The learning community. We have structured our technical assistance to really focus on organizing people in groups of shared commitment, and that you communicate regularly about your experience and that you can really learn from one another.

Then in terms of the consulting and can coaching, that you have a real specific team that can provided guidance and to support you as part of your integration efforts.

We think it is important because we want to build on the collective knowledge and real world experience of the grantees, and really help facilitate some of that networking across grantee organizations, a high priority for us.

Bree will talk been the ways we will be doing that. We want to be sufficient and support the work you do, and how do we pull the resources together in a way that makes sense and gives you easy access to technical assistance you need.

Verbally we will identify themes across all the grantees. So as you complete but BHICA and IPAT assessments, we will be coming to look for commonalities of where we can provide some technical assistance.

Lastly before I turn it over to Bree, how we're organized. In the beginning you saw a map of how the current grantees through the six regions are organized, and that you really do have a team approach.

This is your government project officer, a liaison, and a coordinator. And that we're really going to work with the core team you identify as part of the technical assistance.

With that, next slide, please. Bree will talk about some specific activities about the learning community and the technical assistance that you can expect.

>> PRESENTER: I will take the opportunity to highlight some support mechanisms for grantees. These are really again geared to facilitating the learning community across grantees and helping support them in achieving success with PBHCI.

We have regional meetings, two of them per year region-specific.

According to the map we showed earlier, you will kind of be clustered with the regional states. These meetings will happen between January and March, to right around the corner.

And then again, August to October, so will you be receiving a lot of communication from your teams in terms of coordination around these regional meetings.

We really draft agendas specific to the grantees to help us put agendas together and invite topic-specific speakers for the needs of the grantees.

The opportunity is unique because then, it brings together the learning communities. You will have an opportunity to meet with other grantees and share best practices, challenges, and really to learn from some of the previous cohorts and grantees who have had experience with the implementation of PBHCI.

It is a great opportunity.

We really do build time in for having those meaningful discussions with grantees around implementation.

Also we will have a select number of slight visits. Your slowly a son and possibly a coordinator and another field expert depending on the needs of the visit, you will be visited at your organization.

This is geared to taking a closer look at your implementation, talking about

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your goals and maybe some of your challenges.

And really just to support you and where you are at in terms of implementation. Also we have various phone-based communication.

This week will you be hearing from your liaison and your coaching people. The calls are at least three a year, to provide coaching and individualized grantee support.

You will check in about your BHICA and IPAT goals. The first call will happen in early December, as you will have already established goals around BHICA goals and IPAT integrations.

We also provide individual technical assistance, so the support can be through a phone or video consultation.

It is really geared toward expertise that is really tailored around what issues you are experiencing.

This is supported by the grantees, and also grant project officers. When we have a series of group calls, the calls are meant to bring together different providers within your project who are working on a specific area or topic, and to draft the agenda based on the needs of the group

Again the agenda is draft in a way that is where we receive input from the groups, and then we facilitate meaningful information with regard to the specific providers.

Project director, or community groups calls or we inn wellness coordinators, nurses, CEOs. These calls will be talking with the fellow project directors or other providers in areas specific to your role.

We also have web-based communication. You have probably all be on the PBHCI list serve. If you aren't, email Emma Green to be added to the list service.

The purpose is providing a grantee venue for grantees to share tips or resources, or maybe you developed a consumer handout you feel is really effective and that other grantees would benefit from having it.

We all encourage you to access the list serve to communicate between regional meetings and continuously around progress and successes and challenges.

And also you will see important SAMHSA announcements listed there to. We will have a series of webinars which will occur monthly.

Typically the third Friday of the month, of course if we have holidays or something, we will probably move that around.

But we will communicate that via the list serve. And we really to try to align these topics to what is happening in the field.

For example one of our first webinars coming up in November will likely be on the BHICA and IPAT because we know the requirement has to be complete within the first couple months of the grant.

So we want to provide guidance around the completion of those two reports. Other areas can be tobacco cessation or age indicators, things that ally well with you and your implementation.

You will also see PBHCI updates here, as well as new resources. And then of course our website, which you probably have all had the opportunity to peruse, with archived webinars and lots of resources.

Then of course in you do find yourself looking for a resource and you don't find it on our website or you really want more information, you can always email any of us or your GPOs.

This is an example of topic-specific resources and what is available. I again want to emphasize we're all looking to help our grantees be successful in your grants.

If you aren't successful or you don't find what you need through the learning communities, reach out to us and we will do the best we can to help you out with

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whatever you need.

I want to highlight the dates of the webinars. This is the first one, so the next one will be November 4th on project management and workforce communication.

November 18th, implementing evidence based practices, talking about the Million Hearts campaign and tobacco cessation practices, the wellness programs.

December 2nd, understanding and using data to inform outcomes. We have a data collection guru on our team who will provide a data collection webinar.

December 16th will be a webinar on strategies and workloads for consumer engagement and retention, so really talking about engagement and motivational interviewing to keep your consumers engaged in PBHCI I.

Then is 30 minute presentation portion for Q&A so that you have an opportunity to hear from each other, in addition to hearing from us.

As a reminder, I think all of this was touched upon. CHS will be available for BHICA and IPAT guidance, due to SAMHSA by December 1st.

You are always able to reach out to us, and we are happy to help with the assessments.

There is the November webinar around the BHICA and IPAT and their completion and also setting goals, which should help you as you continue through completing those assessments.

Also during December we will give health disparity impact statement guidance. You will hear more about examples of the health disparity impact statements and any coaching or guidance you may need in order to help you complete those.

They are meaningful and we want to make sure that you have what you need in order to build a meaningful statement.

The coaching calls I mentioned, you will be hearing about those from your coordinators. There will be email communication about upcoming regional meetings from January to March.

This is a great opportunity to meet other guarantees and regional teams. The newsletter, you should be receiving these.

If you need to be added to the list, email myself or Emma Green. We also receive bus-ride updates and list serve news, and then the PBHCI webinars every third Friday of the month when possible.

At this point I just wanted to call attention to our website. You can also email integration at the national council.org.

At this point we will open it up for questions. We will unmute the lines for a question and answer session.

I'm looking to see if we already have some questions in the queue to start with. There are some questions.

First question: Are there recommendations for use of consent forms? What if people refuse to respond to the survey?

>> PRESENTER: In terms of consent forms for services, the TA center actually has several examples. Emma, don't know if you wanted to comment about how they can access that, or if they should just email you, or if you want to point them to the right place on the website.

>> PRESENTER: What was the question?

>> PRESENTER: Maybe I misunderstand it.

>> PRESENTER: A consent form for services or the survey? And what survey are they referring to?

>> PRESENTER: I think the question was around the NOMs or initial intake survey.

The question, do they have a do a consent form beforehand? And at any point if the consumer declines to answer a question, is that okay or do you have tips about how to handle that?

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>> On the form you can put "refused to answer" no problem.

There is no form we ask you to provide, but the assumption is that us a prepare consumers or clients to be enrolled, that they had go through your regular agency consent form packet and the policies that go along with that, et cetera.

>> PRESENTER: Thank you. Another data collection question. Should we use the NOM or GTI when we start enrolling clients?

>> PRESENTER: It's a good question. I hesitate because there will be new guidance coming out really, really soon, and I want to say hopefully in the next couple weeks with regard to which form grantees should be using.

Whoever asked the question, I think it is smart to think through the areas that should really be considered when you put the program together.

But if you will be plan to already enroll clients, I highly recommend getting in touch with your GPO so we are all on the same page.

Because right now, this is a grace period for you to think through your startup. Strategic planning-wise absolutely you want to know the list of questions and how to ask them and what data needs to be collected.

You can you look at the NOM tool that was under the tracking system, because that is the historical tool we've been using.

The DCI does have new questions added, but again I don't want to have you guys start off on the wrong foot because we have been receiving changing guidance for the past year.

So I ask you to be a little more patient, but based on the web that are you saw, definitely Section H indicators are areas you really need to be able to capture as you move forward.

>> PRESENTER: Thank you. Since we're on the topic of data, there are a couple more questions. Next question: Are we reporting to SAMHSA individual-level data with identifying information? Are there recommendations for IRB approval?

>> PRESENTER: YOU are not reporting any unique identifiable information to us, you are not doing that.

When the data collection system is up and running, you will need to create a unique number identifier for that particular client, and everything else will be tracked to that specific identifier

We eventually aggregate the reports and say everything in summary. IRB approval, if you were to do it, it should be mentioned in your application, but our program does not do that.

>> PRESENTER: We do not. We are not research; we are services. This is Roxanne. And we clearly make that distinction to not add any extra burden on the grantee to do this.

And we don't want people to be rendered ineligible because they have to go through a RB process.

>> PRESENTER: I know other grantees use universities as research, but that needs to be explored separately as it is not part of our grant program.

>> PRESENTER: Next question has to do with services, primary care services. Licensing of primary care in California is estimated to take one year to complete.

Since the February 1st deadline requires initiation of primary care on that date, if so would we be allowed to purchase primary care services in the interim for the third party such as an XQAP as the application for primary care is pending.

>> PRESENTER: This is the GPO for California, Roxanne. I know from the existing grantees that this has been an issue.

But you are required to start on the start-date, and you have to have a Plan B. One agency in Los Angeles actually started enrolling from within their agency.

The site of the program was out in the community somewhere, and they were struggling with county approval. It took almost as long as you guys said, but

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so they wouldn't drop in enrollment be, they started enrolling from within their mother-agency and also looked at contracting a third party.

I have another grantee in the west in Oregon who found and used a mobile FQ unit to motor over to the mother site and start providing services on the date of, which is something we can discuss in more detail.

Email me and we can talk about it more. We can schedule time and then have a call.

>> PRESENTER: Thank you, Roxanne. Next question has to do with the implementation team.

The coordination teams, half the team is required to be PBHCI consumers. Basically if there at a minimum five professional individuals, does that mean at least five consumers? That is the question.

>> PRESENTER: The team can be a minimum of those positions, but I think it should be -- isn't it up to twelve?

I haven't looked at my RFA in a while, and please remember the purpose of the coordination team is to advise the PBHCI program.

So you have all the top leadership involved to meet together, and then have you at least one PBHCI consumer on that team.

But the other consumers can come from other parts, and they are just part of that coordination coming together to review the various policies and procedures in place for the program itself.

>> PRESENTER: Great. Thank you. The next question has to do with the subject of -- actually, never mind. We're still trying to figure that question out.

Are regional meetings required? And who is expected to attend from each site?

>> PRESENTER: Per the RFA, the regional meetings are encouraged for attendance. Let me be really honest that given the current government limitation, we have not been able to have an annual meeting, a national annual meeting.

So the national annual meeting takes place once a year, listed as a requirement. Regional meetings are twice a year.

On the years without an annual meeting, we recommend you select one to go. Again who should come is the project director, primary care provider and other folks you can have like the nurse care manager.

Because at the regional meeting, the idea is that it is closer to where you are located, to the expense shouldn't be as high, per se, as the annual meeting because it is national.

And people always keep voting for Puerto Rico or Hawaii but that probably won't happen. We try to be respectful, having it take place in various regions.

We encourage attendance because the face-to-face time is very wonderful and virtual meetings are being encouraged more and more.

The more people tell us how valuable it is to have this every year, the more leverage I will have to say let's keep doing this.

We will give more information down the line about who should come, but bringing a peer to the meeting is also very valuable.

Anybody have anything else to add?

>> PRESENTER: It also gives you a chance to meet and work with the SAMHSA regional administrator. That person basically represents SAMHSA in your region and has all sorts of resources.

They have brought speakers in. They have just allowed for unbelievable networking per region. Most in not all our regional people are invested in the PBHCI program and they are a great source of the support.

And by virtue of the federal planning required by the federal government, they usually host us at a federal site.

It is a meeting to have grown to have a lot of meaning to the participants.

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Adding to her point, our administrators know all your state folks. When you want to bring your CMS person for the state of Michigan or the behavioral health person or substance abuse director, in Maine for instance, you want the RA to help you with that.

They meet all the time and our HRSA counterparts work very closely with SAMHSA as well. Those regional meetings are really, really key.

Next question?

>> PRESENTER: My budget question from before. He what is the answered turnaround time for request for prior approval on budget modifications?

Sal is on the line and can probably tackle that one.

>> PRESENTER: With regard to any budget modifications, you don't need to come in for everything in terms of rebudgeting.

But depending on what it is we will generally to try to get back to you within 30 days or sooner, depending how busy we are and what the issue is, we try to get back to you within that time period.

>> PRESENTER: Next question. The presentation says statement due November 30th but guidance call is December 1st. Can you please clarify?

>> PRESENTER: As noted in the notice of award, it will be November 30th. That is when you have to submit it to your GPO and to Sal. Make sure you send that to us.

>> PRESENTER: Another data question. Do clinical staff have to go through a formal training to conduct NOM assessments? If so, what does a training look like?

>> PRESENTER: That is a really good question. Again, every grantee does it differently in terms of who is actually implementing the NOM survey.

Coming from the behavioral health side of things, I feel that we are much more in tune with sensitive questions because you never know, coming in through the door, where the person is at.

So depending on which tool you are looking at, because the new tool and I don't know which tool we will be using, but we will find out soon.

The new tool includes specific questions regarding trauma, suicidal ideation and prevention. Again we don't know what can trigger someone.

When it comes to that person administering the NOMS you want the right support.

We have had peer specialists or navigators do the actual implementation of the screening, as well as licensed clinical social workers and nurses and medical assistance.

So it all depends on what makes sense, but again, it is about having the right processes and procedures in place, should something require a more clinical level of supervision.

Are you more than welcome to reach out to the folks on the list serve for ideas, as I am sure people have things in place they can recommend, and I think that would be a better resource.

>> PRESENTER: Next question: When can we start hiring for the project team? Can you share with us the financial process of being reimbursed?

>> PRESENTER: You should be able to draw down. Sal, are you still on the line? They should able to draw-down and begin hiring now, correct?

>> PRESENTER: Correct. The official start-date was September 30th to this program, so you can start throwing funds down anytime.

The first sufficient date, as I said on and is stated on notice of award was September 30th, so it can be started immediately.

The only other thing I would add, in the application some you have listed a project director name with their resume.

Because the assumption saw obviously got approved and funded, so the person

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named on the application is still the project director.

However, we know that things change and if that person is no longer the project direct earn or you did not have one identified but you are identifying one now, you need to submit their CV or resume to your GPO before you actually hire them on to the project.

All other applications can you put out for hire and recruiting, but with regard to the PD, you have to give us a chance to look at who you are bringing on.

It is important to send a letter accompanying the CV that has to be signed by the CEO of the organization discussing why there has been a change and why there is a recommendation or desire to hire the person identified.

Because for Sal and the GPO having to approve that, the person can be in "acting" status, but only after you have made official contact. That is a very crucial detail.

>> PRESENTER: Accompanying the letter is a checklist Sal can also provide. That person should be listed in the notice of award.

>> PRESENTER: Great point. Everyone received a notice of award and there should be project director listed there.

And if not, it will either say to be hired or to be determined. If that is the case, submit a request to your GPO or myself for our review and approval.

>> PRESENTER: Thank you so much, Sal. We are out of time for the webinar, but we will be following up with you to answer your remaining questions.

You will be getting an email later this week, so feel free to ask your coordinator and/or GPO, and also we will have the integration email I referenced earlier to answer any remaining questions.

I take this opportunity to thanks everybody for joining us, we are glad to have you as part of the learning community.

Also I thank the presenters from SAMHSA, as it was a wonderful opportunity to engage with you in our first web and-a-half.

Please take a few moments to complete the short survey that will now be generated. We look forward to working with you in the coming months.

Thanks everybody. Have a great day and thanks again for joining us for this webinar.

(Concluded at exactly 30 minutes after the hour)

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