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>> Mindy: Hello everyone, welcome to the SAMHSA-HRSA Center for Integrated Health Solutions webcast. Title is "From Jail to Community Behavioral Health: Ensuring Continuity of Care." Today's webinar will be featuring innovative partnerships between local criminal justice agencies and community mental health providers. Our presenters will be sharing key elements of successful programming. Also, digging into strategies for enhancing communication and information sharing across the system. My name is Mindy Klowden, and I'm the Director of Training and Technical Assistance for CIHS and the SAMHSA-HRSA. I work with providers across the country offering consultation around integrated care. Also, I and our team lead on issues like sustainability and working through policy issues. I am happy to be with you all today. I also am joined behind the scenes by my colleagues, Roara Michael, who I am very glad is here with me. She will be working the magic to make sure everything works perfectly in the system. Thank you, Roara.

A little bit for those of you who may not be familiar with the SAMHSA-HRSA Center for Integrated Health solutions. We come up with the development for integrated primary care and behavioral health to better address the needs of individuals with mental health and substance abuse disorders. Whether those are specialty behavior healthcare settings or primary care provider settings. In addition to these kinds of national webinars which are designed to help providers gain resources and learn more about integrated care. We are also continually posting practical tools and resources to the website. We provide direct phone consultation to providers in groups and also state. We work directly with SAMHSA-HRSA primary and behavioral healthcare

integration grantees and safety net providers from qualified health centers.

Just a few housekeeping remarks before we begin. One thing to notice if you do want to download the presentation slides, please click the drop-down menu labeled "Event Resources" on the bottom left of your screen. The slides are also going to be available on the CIHS website. During today's presentation, your slides will automatically be synchronized with the audio. You will not need to flip any slides to follow along. You will listen to audio through your computer speakers so please ensure that they are on and the volume is up. At any point during the session, you can submit questions to the speakers by typing the question into the "Ask a Question" box in the lower left portion of your player. At the end of everyone's presentation we will be having some discussion and addressing the questions that you type in. Don't feel like you need to wait until then to type the question if you don't want to forget what it was.

Finally, if you need technical assistance, please click on the question mark button in the upper right corner of your player to see a list of frequently asked questions and contact information for the technical support if that's needed.

I would like to welcome all of today's presenters. We are joined today by Dan Abreu who is the Senior Project Associate with SAMHSA Center for Behavioral Health and Justice Transformation. The Center is another TA Center so CIHS is very pleased to be partnering with GAINS Center today. We will also be joined today by Abigail Tucker who is the Clinical Director at the Community Reach Center in Adams County, Colorado. As well, we will be joined by Abigail Fallen the Senior Program Manager on Health Information Exchange and Data Security with the Camden Coalition of Healthcare Providers. Laura Buckley, the Senior Program Manager at the Coalition of Healthcare Providers. Thank you all so much for joining us today.

Now before we dive in, just a quick disclaimer. The view, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), or any of the other agencies listed here. I will now turn over the presentation to Dan Abreu, thank you Dan.

>> Dan: Thank you Mindy, I want to thank the HRSA Center for hosting this webinar. It is to spark discussion and innovation to promote one central concept. Jails are healthcare institutions and community healthcare initiatives should include jail officials and their healthcare providers. My background is, I have been with policy research in the GAINS center, since 2005 and before coming to the GAINS center I worked for the New York State office of mental health and forensic services providing mental health services in New York State prisons. Much of that time focus on overseeing the reentry for people with mental health services returning back to their communities. Over the past several years, there's been a significant change in healthcare delivery. Advancements in integrative healthcare, development of how homes, system mergers expansion of managed care, health information exchanges and the Affordable Care Act. While altering the healthcare landscape. This webinar is not long enough to address the confusion over HIPAA which is not nearly what many people think. Most communities, however jails are not included in funding or implication of these various initiatives. Resulting in constantly having to elect or fit access to healthcare through the justice and general population. First, the numbers. There's almost 2 million individuals incarcerated in the nation's jails and prisons. For those of you who might not know the U.S. has the highest incarceration rate in the world. There is an additional 4 million individuals under probation or parole supervision. Jails incarcerate pretrial individuals from those not yet convicted of any crime and individuals sentenced to one year or less. In prisons,

incarcerated individuals, incarcerated over one year. On any given day there are twice the number of individuals incarcerated in prisons than in jails. However, this is a staggering number, there are almost 12 million people a year admitted to jails, many for the length of stay less than 30 days. Just long enough to disrupt access to healthcare benefits, housing, employment and other social supports. That justice filed individuals as significant. The recent Bureau of Justice administration survey found high prevalence of these following health conditions in state prisons. An increased prevalence of high blood pressure and diabetes. Three times the prevalence of heart related disease. 4 ½ times the prevalence of infectious disease. 10 times the prevalence of hepatitis, over six times prevalence of tuberculosis. 3 ½ times the prevalence of HIV. Prevalence of melanoma is also high. Rates of serious mental illness in jail is four times higher than in the general population and 75 percent of the individuals with serious mental illness with a recurring disorder. In addition, there is 68 percent prevalence with individuals with substance abuse disorders in jails and prisons. Further challenging character of this population is a prevalence of trauma. This is derived from individuals with mental illness who participate in 1 of 17 SAMHSA jail programs. As you can see, there is no gender difference. Among the individuals who have participated in this program. The lifetime prevalence for women is about 96 percent, men is 89 percent. What surprised us when we looked at this data, a little more in depth was the amount of current trauma people participating in the jail program had experienced. The trauma was defined as having to have a traumatic episode one year prior to the arrest which brought them to the diversion program. For women, the prevalence rate was 74 percent, and for men 86 percent. The kinds of trauma exposure was different with women more often being relational, violence as a result of relationships that they were in. Men were more often victims of crime violence and environmental violence. Other characteristics of justice involved individuals who also show that they are more likely to

be homeless, more likely to have co-occurring disorders. That they are more likely to have problems while they are incarcerated and disciplinary problems. More likely to be unemployed. With more psychological impairment. While jail stays are generally short for most, justice about individuals with mental illness have a longer length of stay. Generally due to inability to make bail, being homeless, perceived risk and preferential and paternal custody practices. There is a subgroup of individuals in this data that comes from New York City. Actually, I am going to skip this slide. There is a subgroup of individuals who are high utilizers, in this data it comes from New York City but individuals who are high utilize not as much as we would find in the healthcare systems. From our experience these patterns of high utilizations exist often in unity. You can see that there were 473 people who were admitted to jail 18 times or more. Charged generally with misdemeanors. 21 percent of that group had serious mental illness. Almost all had substance abuse disorders. That's 473 people with 10,000 admissions. You can see that this data shows the utility not addressing the underlying means which is often substance abuse and mental health needs that result in repeated incarcerations. Now not all jails provide healthcare in the same way. It's important to understand that jails healthcare treatment battles if you are going to be successful in providing integrated care and continuity of care. One model is that the jail, the sheriff department itself will employ healthcare staff. The second model would be that the county funds health services and provides in jail services. In this instance, the county health department is the employer. Another model is that jail contracts with the national correctional healthcare vendor. We see this as a pretty frequent model of general healthcare services. The fourth model is that the jail contracts with the local private or public provider. Of these models, jails contracting with local providers or the county health or where the county health provider is providing the services, these hold the most promise for community and jail healthcare practices

because of the proximity, geographic proximity of the providers and also they share responsibility for providing care to the target population. Models where there is an out-of-state contractor to come in to provide services tend to focus more just on the basic needs. So providing collaborations with the community care system can be more problematic. Doctor Tucker later in this webinar will discuss how or her community used the sequential intercept model to guide criminal justice and behavioral health collaboration. But let me give you a brief overview of the sequential model now. This model is developed back in 2006 by Doctor Patty Griffin and Doctor Mark Vinuz with the assistance of the GAINS center. What it does is provides a planning paradigm for communities to either prevent and treat the justice system, minimize penetration into the justice system to facilitate healthcare access upon reentry. If you look at the intercept zero and one, this is where you try to prevent entrance in the healthcare system. By collaborating with the police department. Looking at integrating police, the work that the police do with crisis care systems is an important thing to look at. Police very often in many communities are the first responders to a crisis. In suicide calls and without the collaborations, people sometimes because of a lack of resources or a lack of understanding the systems can end up incarcerated. So, we are seeing across the country now, much more collaboration between mobile crisis teams and police where the crisis is done conjointly. Also, accessing services in a crisis and communities are beginning to look at integrating moving further into the intercept where there's been an arrest and court appearance. Steps two and three. The concerns over the kind of treatment people are getting in jail. The kinds of collaborations that we're seeing is improvement and screening in jails to better identify people with serious mental illness and a use of screening tools, we are seeing more and more sharing of electronic health records with the jail and the community providers. They will share the same electronic health record or the community will provide and participate in a health

information exchange. We are also seeing more efforts so that the jail formulary is matched to the formulary of providers in the community. This is going to be a significant disruption to treatment in jails where people will have been on medication for a period of time. To make them stable, when they go into the jail and can get access to the same medication. Very often, their treatment will be compromised as a result of that.

Looking at samples and opportunities for integration around reentry and intercept for, there is, we look at medications upon release. Many jails will provide only a prescription for continuing medication and whatnot. But then it ends up being a gap because people can't get that prescription filled because they lack healthcare benefits or they can't get the appointment with the community provider. Communities are looking at providing on-demand access upon reentry for the medication. Promptly enrolling people and medicating upon release. In reaching engagement, the best practices about reaching engagement when talking about hospitals is discharges from hospitals or jail or prison is that the person, especially for somebody with a serious mental illness, that the person actually meets the provider and case manager prior to the release. Peers can also be very valuable, resources when you're looking at reentry. Intercept five where we are talking about parole and probation supervision, we are seeing in terms of integrating both supervision and treatments strategies at co-located services providing a visit to the probation officer on a weekly basis to provide care or assessment in that setting. Or vice versa. The probation officer will visit the behavioral health provider on a regular basis to make reporting to probation more easier for the person. We are also seeing better integration of both supervision practices by parole. In probation and treatment practices by the mental health providers. A resource for those interested in learning more about integrating healthcare initiatives with jail initiatives is the community correctional healthcare website. This is, they have done a review of best practices around the country. They have done an

analysis of their practices, this is a graphic of Multnomah County, Oregon and how they shared electronic health records to improve services and healthcare outcomes. Federal grants also provide opportunities to improve care integration. The certified community behavioral healthcare clinics are a vehicle for expanding access to intensive community-based services for individuals. With untreated mental illness and addiction. There are currently 67 certified community behavioral health clinics operating in eight states. They address the multiple needs of service access issues of justice in populations. This is from CCBHC survey and the results of the program improvements. That's probably pretty difficult to read, but what that shows is that 42 percent of the CCBHC reviews the expanded and enhanced services that this clinic provides to improve access to care for justice and vulnerable individuals. Some of the improvements that CCBHC is other healthcare that focuses on and even federally qualified health clinics that focus on improving access for justice of vulnerable individuals. Some of their enhancements include bridge medication funding. Reach in services, connections to people prior to release. Connectivity with justice agencies. The HIPAA concerns are addressed proactively so we don't become a barrier to access. Date of release access, tied to the services. So it is not a weight to get critical services at a critical time. Also, quality measures, looking in the healthcare system having reductions in justice involvements and healthcare measures. This way health providers are held accountable for addressing not only the health needs but reducing the social determinants of health which can result from repeated incarcerations. At this point, I am going to turn the presentation over to Doctor Tucker to discuss her fabulous work.

>> Abigail Tucker: Thank you very much, this is Abigail Tucker. Good morning to those of you who are on the western side of the United States with me and good afternoon to those of you on the East Coast. I am very fortunate to be on this presentation and

thank you to HRSA and SAMHSA and the national Council for hosting this webinar. Part of my background includes working in a community mental health center that is north of Denver, Colorado. What I appreciate about the center that I work at is that we are not only always looking forward to a work organization which prepares our culture well for tackling challenging problems. Moreover I also work in a community that is not afraid of tackling challenging problems. Certainly I go through this a bit more in my presentation, but in Adams County, Colorado which is again north of Denver I've been very fortunate to have the partnership of our criminal justice agencies, jails, behavioral health and our physical health providers and that has allowed us to do a lot of the innovative work that I'm happy to show here today. Setting the stage just for the state of Colorado, those who are not familiar, Colorado like most states in the nation in being faced with a challenge of individuals whose primary etiology for jail stay is behavioral health. In response to that, there has been several collaboration. To name just a few, Colorado has a criminal and juvenile justice known as the CCJJ and they have several taskforces. I'm very fortunate to sit on one of those task forces which is focused on individuals in jail with behavioral health needs. The expectation on a taskforce is to come up with innovative solutions when you're sitting at the table with law enforcement, jails, courts, behavioral health, physical health and brainstorm innovative solutions. At times, this can take be taken all the way up to the legislation. In the past several years, task force from Colorado criminal and juvenile justice has moved forward ending the use of jails and holding facilities for individuals on involuntary commitment for behavioral health. Most recently, put forward to Senate bills that are going to hopefully restructure diversion in the state. If you download the presentation, those are hyperlinks and it can take you directly to those taskforces as well as the recent legislation. But for example, one of them is introducing a model that would have a behavioral health provider who works both with the jail

and the County Court to help not only identify but assess individuals with low level criminal genic charges and high or potentially low level mental health and get them diverted out of the system. Hopefully for free diversion model. That's one example. The other thing that Colorado has certainly done his supported inmates, the office of behavioral health supports jail based services in both direct and indirect ways. In regards to the presentation you heard earlier it's a great way in which they are bringing together both jail and behavioral health and physical health providers through funding. In other words, if they don't just find a jail behavioral health service, but require the entities in the community and the jail work together in contract in order to receive the funds. There's a couple of other initiatives of the partnerships which are certainly welcome and I encourage folks if you download the presentation to click on those hyperlinks. By including a course corrections document from Equitas. The governor's office also has released a strategy specific to provision of the criminal justice system and there is a Colorado Consortium which is focused on the opioid epidemic we are experiencing here in Colorado. The reason I wanted to highlight a statewide initiative is because one of the benefits that we have found in our local communities is making sure that our voice both including behavioral health, physical health and jails and criminal justice is making sure that our voices heard at the state level in making sure that we are listening at the state level for funding opportunities and legislative opportunities. One of our recommendations at the local levels to make sure you're staying engaged with the state and national level is that you won't miss an opportunity. We would love to just do a quick poll so that in a larger way, we can gather some different presentations, sorry different perspectives. My first question is how many of you listening have used the sequential intercept model in your community? I understand you should be receiving a survey. I am also going to review but certainly heard it earlier today as well.

>> Mindy: I will give everyone a few seconds to answer the survey and we will share the results.

We have had a few folks respond. It looks like about 28 percent say yes and about 72 percent say no.

>> Abigail Tucker: That is great to hear, that's more options to make that happen. On the second question, do you have a community task force so at your local level that addresses mental health, behavioral health and the criminal justice system? As the poll is heading out your way to get a response again, looking for if there is for example I highlighted this statewide CCJJ that Colorado has and you have anything similar to that that is bringing both behavioral health and the criminal justice together for a task force focus?

>> Mindy: It looks like on those who have responded, about 78 percent say yes or it's shifted a bit. 40 percent say no. 60 percent say yes.

>> Abigail Tucker: The last polling question and again I appreciate your time as the surveys come forward, it helps me ensure that the presentation I put forward for the remainder of my time is focused on what folks are hearing or needing. The second one is really a second part question, if yes, if you're involved in a community stakeholder meeting specific of criminal justice and behavioral health, which of the following types of organizations are participating?

>> Mindy: Great, we've had everyone respond here. 50 percent is community mental health center. 28 percent are substance use disorder treatment provider. 10 percent primary care provider such as SQHC or rural health center. 19 percent or 20 percent is public health agency. Eight percent is hospital systems. 25 percent is human service agencies. We had about 14 percent say other.

>> Abigail Tucker: Great. Thank you all so much for participating. In those poll questions. To bring it down from the state level to our local level here in Adams County, Colorado we do have a local task force so ours is the Adams County Justice Coordinating Council known as the Adams County CCJC. Again if you download the presentation, that hyperlink will take you to our landing page and you can learn a bit more about our coordinating Council. The agencies involved include the Adams County Sheriff's office and our county, the Sheriff's office is also the jail detention facility or the provider for jail services. Community reach center is the community health center which is both behavioral health and substance abuse treatment provider. Thornton Police Department, we actually have nine different municipalities in Adams County and we have memberships from, membership and feedback from all of our local law enforcement. The Thornton Police Department is the agency in which we did a specific pilot list that I will share with you in a bit. Certainly, the county in general. We will talk here in a bit that while every agency involved was participating both in time and commitment. That our county also helps support us with legal counsel as well as information technology support. We felt it was important and I certainly would encourage if you are already participating in a stakeholder meeting or if you are creating one, to make sure that you have a shared framework and a shared language. By a shared framework, specifically what I mean is that you are creating goals and objectives that all parties are agreeing on. When we first created our criminal justice coordinating Council we surveyed all of our members and almost unanimously came up with three objectives that people wanted to work on. Behavioral health, alternative sanctions and information sharing. To date, if you do I'm just going to click back, if you go back to the hyperlink here for the Adams County criminal justice coordinating Council, you will see that there are three committees and those are the three committees from our objectives when we originally surveyed, behavioral health,

alternative sanctions and information sharing. In addition, after we created our framework we wanted to have a shared language. For the behavioral health committee, we used SAMHSA GAINS Center model. In 2015 we sat down with all of our criminal justice partners and our treatment providers and we mapped out our community. It took us almost about six months because it takes a long time. I would highly encourage using this model if your community has not already done so. It is a great way to create a shared understanding as well as a shared language. I was very impressed to hear how many different criminal justice agencies learn something about somebody on a different intercept. For example, our probation department learning about details in the court system. The shared learning created better engagement and buy-in. If you're familiar with this model and in addition to mapping out each intercept, the goal then is to knock out what are your behavioral health options and to use data to assess it if there are gaps in your community. In order to gain or gather a commitment, after we did the SAMHSA subsequential intercept model mapping, we engaged colors to create a vision. Our vision is that our local criminal justice system that mitigates risk and helps the underlying behavioral health needs of the individual is interaction with the justice system are driven by unmet needs. I'm going to pause because it looks like we are getting a couple of great questions. I want to remind folks that they can email us after if we don't get all of our questions answered. Please do continue to just put those great questions. We will make sure we have time for questions and if you email them in, we will also make sure we follow up. After we pulled together again the shared vision, shared language with sequential intercept model and exchange our goals we wanted to move it from concept to reality. Go ahead. Mindy, was that you? I apologize. Sorry. Moving from commitment towards data informed decision-making with our agreements. The concept of wanting to share behavioral health information and criminal justice information led us to put together a type of illegal agreement.

A project charter which outlines both for our fund sources as well as our own eye as department technically helped with the project. The business associate agreement which helped protect us on HIPAA and certainly would agree with what was stated earlier, is that HIPAA does not need to be the challenge that sometimes it can feel like. They getting together in the same room creating business on the agreements is one way to help break down those myths and fears. Management control agreement which are used between criminal justice agencies. One of the recommendations that I frequently make to criminal justice agencies and physical health agencies is to really get to know behavioral health providers and their boundaries. Often times I experience that the concerns with HIPAA and 42 CFR are more concerned because of a lack of understanding. Not necessarily concerns that can be met with a solution. In this process when we created our legal agreements, but then moved into our data sharing dashboard, we were really lucky to be a recipient of a 2016 Laura and John Arnold foundation to the Open Justice Broker Consortium. They helped us in the work that I'm about to outline. Our dashboard, again brings information from behavioral health and the justice system. We are focusing at this time or our community focus this time on intercept to which if you recall is jail. It brings together an anonymous way jail custody data and behavioral health diagnostic information. It's built on open source which means the technology and process can be shared. It has ad hoc analytics tools which means we can run additional analysis beyond the dashboard that we will demo today. It uses national justice information community sharing standards which for us, to help gain the trust of our criminal justice agencies and how we were going to use the information. It has access control features which also helps gain the trust not only of our criminal justice agencies but also of our own behavioral health. As one example of those axis of controls is that I as a employee of community research Center have my own access control in order to be an employee here. I can't access our electronic health records for example if I am not an

employee. We built the access control to the dashboard on everybody's individual employment so if for example, I no longer work with the community resource center that would limit my control to the dashboard because it works through your employer's access control. As a visual, I know that it's not the best slide but I'm just going to walk through for a moment. As the data architectural overview, the jail management system or the jail custody data gets sent over to an intermediate host and I highlighted earlier that the county provides or one weight they provided force is by physically hosting those servers. They send the information over to community re-center and we in our own network create a unique identifier so that the protected health information can be dropped. With a unique identifier specific to the diagnostic data and the jail custody data can move forward into a staging area that creates the dashboard as well as the analytics tool. I will first demo the dashboard, the other demo is really just the analytics tool of the dashboard. I understand that folks should be able to possibly see the dashboard here.

>> Mindy: Abigail, let me jump in here for a second. For those in the audience you should be able to see a tab titled the demo jail booking dashboard. If you click on that tab, you can access the link. If you click on the link it will pop up in a separate tab for you to view. Abigail will go through it as you are also on the website. They may not be able to access the generator. The second tab that is there. I just want to give everyone a head's up on that. It looks like there's an error in that link. We can still see the demo jail booking dashboard.

>> Abigail Tucker: Thank you for that. For folks who are already able to go to the demo dashboard, it would say OJBC demo jurisdiction at the top. If not, I will go through briefly and hopefully when you get an opportunity to download the presentation you can check it out yourself. But it has a dashboard that at the top has different toggles. One is your

pace status, this is things like sentence to pretrial. One is illnesses and disorders so this is your diagnosis. Charge type whether it is traffic, misdemeanor, felony, bond type. Work-release status. Then the next two are some of our things we wanted to make sure we were also targeting. The utilization as I stated earlier, Adams County has multiple municipalities, all using the same jail. It was important to again have stakeholder bias that all of the different municipalities could see their jail count meeting their individual utilization. Then the charge disposition as well. One thing that I guess I would want folks to really walk away from is that everything you see on here is not only the work of a lot of individuals at the Sheriff's office, County, OJCC, community resource center but what it's built upon consensus. We've had standing monthly meetings that we would get together and decide what are the important pieces of information that we want to be able to look at and intercept to which is again jail custody data to help us make decisions about what behavioral health and physical health interventions we needed. And most specifically to be able to then measure impact. At the top of the dashboard you will see there is a button that says metric and it says population count. It also has length of stay and rebooking. That metric was very specifically designed because we knew that we wanted to soon be intervention that intercepts to using again the intercept model. We wanted to see how we were having an impact. As I question earlier that folks were asking about mobile crisis and co-responder models. We wanted a way to say if we went live with that, let's say October 1, 2018. We wanted to be able to look back and perhaps three months or a year and see if it impacted the length of stay or the rebooking rate. Another way to find rebooking rates could be looking at the rate back to the jail to see if that specific intervention had any type of impact on those metrics. We could then break it down by jurisdiction which again are a different municipality. Then the agency as well. One last thing I wanted to explain about the dashboard for those of you who are on it and able to see it and hopefully

for those of you who are not you can see it at a later date and time is that we have a population. We define our general population as anybody who is in the jail at the time that the data is being pulled. Or our target population is an individual who is in the county jail who has a mental health diagnosis. That is how we identified and I apologize, our behavioral health diagnosis because that includes substance abuse disorders. That is the target population and again, our goal is to redirect individuals from the criminal justice system to the behavioral health system. Hopefully that is a helpful dashboard for those of you who are able to see it and if not, hopefully you can return to it. Then just discussing where we are at right now with our coordinating Council is that now that we have built the dashboard for intercept two and we have a dashboard also for intercept one, that is law enforcement focus. We are now moving from data to implementation. Again, we grounded ourselves in collaboration and vision and we used a substantial intercept model to share framework and language and map out our system. Then we wanted to make sure that we had data at every intercept so that when we got to this phase which is implementation, we would have a way to a cross criminal justice and behavioral health measure the impact that it would have. Upon implementation strategy that we are looking at right now is a diversion not only targeting intercept two. If you recall, it's actually our hope is that we are in line with the states model which is posted direct prefiled diversion and hopefully that is just a length of time for us where we are listening to the state and supplying feedback to the state. To have time to ourselves really well with the dashboard to be able to implement the statewide intervention but locally be able to see it having an impact on the target population. Again our target population is individuals with behavioral health disorders who we believe that their disorder has contributed or created the circumstances for low level criminal behavior. Our goal is we talk to see REST advising or getting rebooked into the jail to the length of stay in the jail and whether or not they are engaging in treatment.

We have been having stakeholder meetings that are hoping to begin that as a pilot this fall. As one other example of an implementation for intervention on intercept one, again that is law enforcement. If post 9-1-1 and law enforcement dispatch. Certainly for those of you familiar with the sequential intercept model has a zero and we are redefining the difference in the community that once it's a 9-1-1 call that we have been moved into intercept one. Our population of individuals with behavioral health disorders are very similar and you'll notice a theme that we believe is the behavioral health disorder has contributed or created circumstances into why law enforcement are being dispatch. In that dashboard, we will be looking not only at jail bookings and jail length of stay because we know that all of these intercepts intertwine and therefore so should their outcomes. But we will also be assessing officer time and return calls to 9-1-1 meaning that if we have a call, if it comes in 2,911 and is pulled up on our dashboard and that information is sent to community re-center and we do a positive outreach to them, whether that is a co-responder or an intake or a crisis center intervention. Our goal is that that individual does not call back into 911 for a primary behavioral health disorder need. Certainly we want folks to access 9-1-1 if needed but if we have a statewide crisis system we have to have mobile response and we are hopeful that this invention will start to redirect individuals from behavioral health to the crisis system that's been set up. Again, we are hoping to start that pilot at the end of this summer, early fall and we are excited that we want to have a dashboard at a local level assessing the direct impact. Our next phase for where we are moving is how to better integrate justice and health. And certainly in Colorado we have a lot of frontier land so that is the next one here, we want to bring right partners who are committee and talk about data sharing. Personally, the community research Center which includes anybody who is justice involved we have a no wrong door approach to referrals. We have a care navigator and a connection with Salud who is a local

FQHC. We have groups and integrative behavioral health treatment programs. One of our other things we have is a dental clinic and we have already initially found that often times that can be a bridge way for individuals with substance abuse disorders is that when we can partner with our local FQHC dental healthcare it's an avenue to open a discussion in a less stigmatizing way to address substance abuse disorders. Currently we have a dashboard for intercept one and two so the future direction is to create dashboard and analytic tools for intercepts 3, 4 and 5. As I stated earlier, we also want to increase our integration with physical health and sharing with other communities. As I stated earlier, this was developed as open source technology and our hope is that we create a framework that can be shared both in the state and nationwide. Thank you all again, are there questions?

>> Mindy: A few questions, we are going to go ahead and continue with the presenters. Then we will attempt to answer as many questions as we can with the time we have allowed. But we will also respond to people's questions as they are typing them in and we have most folks along with the questions we have their email. We will be able to get you answers and just bear with us as we continue through the presentation. I would like to turn it over to Laura Buckley and Abigail Fallen from Camden, New Jersey.

>> Abigail Fallen: Thank you, good afternoon to those on the East Coast and morning to those on the West Coast. This is Abigail Fallen from the coalition. I'll introduce my colleague, Laura in a brief moment. We are very excited to be participating in this today and want to thank the presenters before us as we feel like those are some very stimulating transition happening here. Thank you. A little bit about who we are, the Camden Coalition of healthcare providers, we have a mission in our organization that sparks a field and movement that unites community of caregivers in Camden, New Jersey as

well as across the nation to improve the well-being of individuals with complex health and social needs. Our mission at the coalition is for a transformed healthcare system that will ensure every individual receives whole-person care, rooted in authentic healing relationships. The Camden Coalition began as a small breakfast club of providers and these individuals shared patient stories that identified services with the goal of providing better care. Those that were involved in the healthcare process were willing to meet and began to understand that the issues were primarily related around silo data and not being resolved. The initial birth of our health information exchange was designed to respond to the silo health information. Here in the coalition I serve as senior manager with information system and technology. One of the arms of the coalition that I oversee is our health information exchange. We are a regional model that has existed now for roughly 8 years. We have gone through a few technology changes over time to better meet both our needs internally with the work that we do but also, for our external partners as well. Camden, New Jersey for those that are not familiar with it is a relatively small city. It is about nine square miles in size. It is directly across the bridge from Philadelphia, Pennsylvania. Despite its small size, it has roughly 70,000 that live in the city that are at or below the poverty line. Prior to the affordable care act most were uninsured or underinsured. Now most fall into the Medicaid population. Within that nine square miles, we actually have three health systems that all have placement here so within one mile, I can actually physically walk to three different health systems. Which also! The potential for the silos that we mention. Our evaluation as it relates to utilization of patients has shown that for whatever reason there may be, that as utilization of one person increases, the loyalty to one particular institution begins to increase. This really helped drive the need for this health information exchange and this creation. In 2015 we upgraded to a more sophisticated platform. We are now using what is called care evolution as our health

information exchange. Our health information exchange over time has really begun to serve more of our data backbone for a lot of different programs. As we have identified more needs in our community as well as at the national level, our health information exchange continues to come in and support those initiatives. Our health information exchange is a platform that allows for a long-term use of data from any data contributor as well as providing reports and analytics to identify patients that potentially fit management services. Our system is unique in the sense that we feel strongly about how it's been created which is built on trust and strong relationships with organizations. Both in and around the city of Camden. Whether you are a hospital, primary care provider, FQHC or another agency of any kind you share a common theme when you participate in our HIE. And that's very much a need for data and trusting relationships. The health exchange was not initially designed for what we thought would be the most beneficial. But rather in response to the issues and problems that providers were facing within their own systems. We continue to grow and expand our HIE in ways that would still exist in other technologies that cannot currently be resolved. Our participants are connected to us through legal agreements, participation agreements and business associated agreements. We also have a very strong government model that consists of policy, procedures that every individual is using our system must abide by. It's a consolidated database of EMR but rather focuses on those social and community-based connections. That we feel are sometimes overlooked in a healthcare setting. The foundation of the Camden Coalition really recognizes the social and community-based needs. As well as most of our partners. Using this philosophy we have created various use cases for other work within the health information exchange. Some of those examples include housing first, prevention and now RESET which Laura will be introducing momentarily. Our tool has expanded beyond the treatment platform and sets when the right partners at the table. The RESET projects would not be entirely possible

without our partners at both the County and the jail itself to be included in our system. As of today, we do have the clinical participation from the county jail in our health information exchange to provide that data. Just a little bit more before I transfer this over. As a nonprofit we have a board we must report to and that has a subcommittee called the HIE oversight community. This group provides guidance on sustainability, cases of data, just to name a few. As the needs continue to identify themselves through our patient engagement or from identifying gaps in existing healthcare platforms, we continuously attempt to use the HIE as the backbone of the programs. Our system is capable of creating customized reports, for learning purposes as well as providing insight to the health of an individual. We can examine both that an individual level as well as a positive level so we feel that's important. Legal barriers are issues we are presented upon whether it's a particular use case of our health information exchange or participating in our use case. Our philosophy is really to take our time and get to know our partners and get to make them comfortable. I believe Abigail Tucker spoke on this earlier, but many times we find that this is new territory for folks and they are just not sure how to respond to it. There is confusion amongst HIPAA as well as CF R2 and our goal is to work closely with other health information exchanges through the state to learn about their areas of success. But also to really sit down with other organizations to find out where their other issues of anxiety are as a relates to data sharing or where they feel some level of discomfort to try to work through those things and develop a common understanding. With that, I'm going to turn it over to Laura Buckley.

>> Laura: Thanks Abby.

Hello everyone. As mentioned earlier, I am a Senior Program Manager here at the Camden Coalition. I work on our community-based outreach. I am a provider for training and when I was

hired four years ago, I was hired to do direct patient care coordination. As well as oversee staff and programs to better serve individuals who frequent the local healthcare system who have necessities and social vulnerabilities. To identify those folks as I mentioned through our health information exchange. In doing this work here at Camden for the last four years, the contingency that I have I witnessed firsthand has also been the highlighted earlier by Dan and Abigail is that people with complex social needs face a variety of issues all at the same time. Poverty, homelessness, addiction, chronic medical conditions and mental illness. Many, also have the experience earlier like trauma and as a result, individuals often interact with multiple human service systems like healthcare, criminal justice and housing. But because of the systems often sideload the root cause behind the utilization of the services can or are really addressed and coordinated in an efficient way. From a Camden specific perspective our ongoing care management of care patients over the last many years revealed that patients involved with the criminal justice system were more difficult to make contact with from a community outreach perspective. They had more extensive legal entanglements, experience greater social instability than our average patient with perhaps who did not have criminal justice involvement. As Abby highlighted earlier, we understand that constant jail can impede access to mental health treatments or mental health substance disorders and can increase the likelihood of future jail time for individuals with mental illness. As we continue here in Camden to highlight and scale up the established complex care models, an area that's growing innovation across cross sector collaboration particularly with the criminal justice systems. Here in Camden we started Camden ARISE which stands for administrative records integration for service excellence which creates this multidimensional picture for citywide challenges. In a broad sense, as she explained the coalition has worked to bring information across systems and places for the last 10 years or so. But Camden ARISE allowed us to push integrated

data beyond just as healthcare data sets. In 2014 when we launched ARISE, there is a link of information from including the criminal justice system and healthcare, how to better understand about the allocation of resources and address these root causes of the reoccurring public issues. The project first phase integrated data from the Camden County Police Department with information from the original hospitals to shed light on these overlapping issues. If you look at the slide what we found is the big yellow circle it's more than 93,000 people with a hospital claim. The smaller blue circle is more than 18,000 people who have also had police encounters. About 12,500 people who have overlapping hospital claims and police encounters. That's that section there between the yellow and the blue. The smaller green. Is about 12,500 is the set identified with 226 people with dual sector high utilization, people who are familiar with frequent both the Camden County jail here in Camden and local hospitals. This is Abe, he is an example of one of the 226 individuals. I know there is a lot on this slide so I will break it down. The X axis which is the gray bar cutting across the middle of the screen is the timeframe. From the left with starting from January 2010 scrolling all the way to the right to December 2014. Looking at the data set through those four years. The top half of the slide is healthcare data. The bottom half of the slide is criminal justice data. That small section between the gray bars is the housing data. On the police side which is the bottom half, you will notice a story highlights the clear escalation of severity and charges. Starting with public nuisance for instance, all the way to related ultimately to the right side with violence which resulted not surprisingly in longer jail stays. The hospital side which is again the top half of the slide is not as much of an escalation as the criminal justice side but it does show accidents and an increase in untreated infections. If you will notice on the lower right corner there's a purple doctor for heroin overdose on the police and counterattacks which was on on street overdose according to police data but we didn't see any

hospital data for that encounter. There are a lot of, a key takeaway for us as an agency from the data as it follows up as an outreach team is that there are a lot of potential for intervention that we could have worked with Abe earlier along the way before things potentially progress. That is for us to really look at Abe and people like a with this holistic picture and to use the dead and more regularly in order to do that. With the support from the Laura and John on roads foundation the announcement of this data set allowed us to design and find a care management program to serve these individuals who frequent both the healthcare and criminal justice system in Camden. There is one jail in Camden County, the Camden County correctional facility and we have named this small pilot program Camden RESET which is reentering society with effective tools and we name that in conjunction with the Camden advisory Council. Ultimately the role was Camden RESET is to help patients obtain the skills they need to avoid arrest and preventable hospital readmissions and ultimately improve their well-being. This is a pilot program, we officially launched in December. It's slightly longer than we anticipated for us to gain access into Camden County jail to see individuals but we know it was really important for us as a pilot as stated earlier by Dan and Abigail is that we could see people inside of the facility as well as when they get released. We launched in December through the grant we were asked to serve a small number of individuals with a number of 15 folks. We determined the process was to identify individuals is we receive the jail records that we have through our relationship with the jail. Then we prioritize from that data sent in on individuals with three or more jail commitments within a year. We then reviewed the health information exchange so we reviewed the healthcare data side to rule out non-Camden city individuals and we do that for a couple of reasons one is we are not reaching Camden-based city and we are from just an efficiency standpoint but with a smaller team that can be hard to run all over South Jersey. Camden city can be more efficient and some of our sustainable

County care organizations want to maintain residence in Camden city and we to focus on Camden city. Of course these are health information records and to look at the utilization pattern from local hospital. We landed on two or more patient admissions. Within that same., The same 12 month period of the jail sentence or for or more ED visits all within the same year. What do we do, our care team as I referenced earlier we first engage patients at the Camden County jail. We offer them the opportunity to consent and enroll in our program. A team of, we are staffed by nurses, social workers, community health workers who help identify their needs and begin the sustained relationship that addresses both the medical and social barriers to wellness including of course mental health and substance use concerns. The team visits participants inside the jail as well as in the community to customize a care plan centered around their goals. We accompany two appointments including primary care, specialty care, mental health, substance use, housing, or social services, Social Security. Really wherever the patient needs to go in order to continue the care plan. We connect them to all of those agencies, housing, mental health, substance abuse and of course the court and legal services. We are a time-limited intervention and consider ourselves linker so to speak so we do not take the place of mental health treatment fully, we do not replace substance use treatment in the city. We work to empower our patients towards graduation where they, the patient and/or identify a person in their life or a program that can manage without us. If we've identified a few successful strategies to ensure this continuity of care with folks who are returning home from jail. As Abigail mentioned, the HIE is a big piece of that. The HIE allows us to create beacon reports. We get alerted in real time when folks are visiting any of our local hospitals. We can choose either email alerts that are daily. For me, I get them at 8:00 a.m. so my other key members get real time. It's common if somebody gets the ED notice at 2:05 PM and we get the email notice at 2:06 PM saying the person is at the local ED. We get this on a few

occasions where we make sure we are staying on top of a person's care and there's been a few folks who were homeless when they were released although we had a quick rapport and relationship established inside, and so it was hard to be outside for them. But when they got an alert that they were at a hospital, we could immediately go to the hospital and meet them on that side. Generally our clients usually have the initial surprise of how did you find me, how did you know I was here. But they are also grateful that we both found them and we visited. We follow them, we showed up and which is a really strength of how we roll our report and relationship with clients. Usually what we hear is I lost my phone or I would have called you. But I couldn't get you. Thanks for showing up here. The HIE has also integrated the medical and mental health provider inside of the Camden County jail here in Camden County. The medical and healthcare provider as part of the network which is in that integration works bidirectionally. The providers inside of the jail can view the health information exchange so when people are visiting them inside they can look at their health history and use in the city. As well as they are now putting basic information inside or in the health information exchange so we can review these basic reports from the outside. This was particularly helpful recently when an individual was released from the jail and we shortly coordinated there after meeting the individual with a mental health crisis. We coordinated through the individual to go to the local mental health crisis unit for final thoughts and we printed out the discharge paperwork from the HIE that was from the inside facility. Then we made sure that the hospital staff had access to that and had the most recent med list. Another key strategy that we use is to coordinate directly with jail and admin staff, beacon reports and the data are incredibly helpful. The reality that nothing replaces coordinated care, coordinated care like building relationships directly with the staff in the various systems. For here I have to give a huge shadow to the Camden County correctional facility for setting up boards quarterly committee

meetings and I know Abigail earlier mentioned about the importance of the task forces. In here at Camden County we have one which is really been incredibly helpful. We also have, the folks who are there are relevant across the spectrum including mental health substance abuse and other providers in the city. We also have biweekly meetings directly with the service providers inside the Camden County jail where my team and I meet with the director of nursing. To get involved in the services with the lieutenant who reaches the outreach efforts as well and who is a liaison officer who's been a real commitment that Camden County has made to doing coordinator reentry reform. The staff there allows our nurse and social workers to touch base in person to ensure coordination of care and management which is really helpful when somebody is coming up on release. We can make sure they are released. Which happened the other week which is amazing but we can meet the individual when they are released at a facility in good morning to ensure safety connections instead of folks getting released soon as the day begins just to say 12:00 a.m. midnight until 4:00 a.m. coordinating with both the client and the staff to make sure the release happens in the morning so our team can meet them literally there at the facility to make sure they can get connected to housing, connected to insurance, health insurance and connected to care and access medication to ensure they have quick transportation to necessary transportation and of course coordinating with their family or a loved one if they would like us to. Similarly we get to immediately connect to the PCP as well. That is part of this big group of providers. Relatedly coordinating directly with the community providers is key. A lot of time is spent correlating with the community providers for mental health, substance abuse, housing, social coordination. The patient consents and we share the medical and health with folks from the jail directly from the community providers to ensure the continuity. It's the best strategy to consistent with the meetings. We have one every week with the local addiction medicine provider here in Camden. Although it's

only 30 minutes it takes a lot of time and energy emailing back and forth to make sure we are all on the same page and working together towards the patient's goals. It helps clear the little things that can get lost but we know are not that little notably transportation to and from facilities. It's needed between the patient and the Medicaid nonemergency medical transportation provider and or us or another provider making sure that somebody knows who is covering transportation how, and when. We also have open monthly meetings for community providers to network and learn from one another which is another great place to make sure that I know personally and we know as a team the providers name so when we get a call asking for an appointment or are wondering what happened when somebody got kicked out of a program or we are told it was too complex for that abuse treatment it's not like I'm some anonymous person calling to advocate. They know me and know the relationship goals and between providers which helps with patient advocacy. Of course, the relationship with primary care doctors are there as well with a lot of time and energy into it. What are we seeing on the panel right now, although as I highlighted we are not specifically triaging for mental health or substance issues. We have found that individuals going back and forth between Camden's hospitals and jails have both mental health and substance abuse diagnoses which is similar to what Dan mentioned earlier from the broad overview of criminal justice involve population nationally, it's here in Camden city. I made about 75 percent have a mental health diagnosis as well as a co-occurrence of substance abuse and 94 have a substance abuse diagnosis. Highlighting the only thing initially as people who are going back and forth between the systems. Part of that is the learning, is to confirm who are these folks that are going in and out. Which again, highlights the intense level of need and coordination to ensure that the behavioral health provider inside of the jail is coordinating with the providers on the outside. In addition to having the HIE facilitator having a goal between us that when we are inside the jail and in the

community, what is needed is the outreach models that we are modeled outdoors. We can really flex into all spaces. The HIE helps us with the data infrastructure to support it. Finally, I wanted to highlight the national Center for complex health and social needs which is an initiative of the community coalition. The center will have the third conference in December in Chicago which is a great place to learn more about this growing field of complex care. Network with peers, advocate for patients and learning more. We would love for everyone to check that out, at complex care to get involved. We can't do this alone. The take away from all of this, for me is that it takes a village.

>> Mindy: Thank you so much to all of our amazing presenters. You can hear there is some important work going on and we have quite a few questions in the questions box. I'm going to try to group some of them. We have gotten quite a few questions about the legal agreements that you all have in place, how you have worked to secure the VA A's and how you managed particularly in terms of the health information exchange. This is a question for all of our presenters. What guidance you have for other communities around managing consent.

If anyone wants to jump in first, go ahead.

>> Abigail Tucker: This is Abigail Tucker from Adams County, Colorado. One specific thing to help out is for our dashboard, because they are anonymous and aggregate, we don't seek individual consent. The dashboard and the analytics tool do not provide unique client information. The protections that we put in in the project charter and our business associate agreement is to ensure that the anonymous aggregate level of the data is protected. In other words the businesses were business associate agreement for us extends our requirements under HIPAA to the other agencies that we are working with. It extends their own obligation essentially helping educate them about what it is to be a covered entity and ensures that they again as

written in the agreement understand that that has to be protected by them as well as us. But again since it's not an individual client data, we do not get individual client consent.

>> Mindy: Thank you. Can we ask Camden as well?

>> Abigail Fallen: Yes, participation in the State of New Jersey is an opt out model as it relates to data flowing into our health information exchange. Particularly with our work at Camden Coalition, we do have care coordination consents that we obtained from the patient primarily as a bedside if we can get them at that point, if not we certainly in the very next follow-up. Where we are listing out the areas of sensitive data that may also be included. Other health information exchange partners right now that are covered entities pursuant to HIPAA are able to use their privacy practices as the gatekeeper so to speak to then view the data with the health information exchange. We are starting to navigate the part to information and are certainly heavier eyes are on the most recent provision to that as well so that we can become compliant but still maintain instability for our users of the system.

>> Mindy: Staying with the topic of information exchange, what have you all experienced in terms of what you criminal justice agencies need to be educated around or what challenges if any do you see that they are having in terms of being able to share information back to the behavioral health and primary care providers?

>> Abigail Fallen: This is Abigail Fallen again. It is very unique in the sense that the county itself was very adamant about having a strong relationship and involving the self in the exchange in the beginning. In fact when they put together the RFP for the healthcare facility to serve the population at the jail, one of those requirements is that they have to connect to our system. We were incredibly blessed with that. The part of

the RFP to navigate some of that. What I found was interesting is when we started the actual work for integration, was how much data lived in the jail that didn't connect with one another. For example, we found out almost immediately that the healthcare services data did not integrate with the jails data as it related to individuals coming and going. Today is Monday; I am the nurse in the healthcare clinic at the jail. One of my patients wouldn't show up for medications. What I would find out is that somewhere between midnight Sunday and 2:00 p.m. today, that individual was released. There was no transition of care that could happen. That is part of what RESET also serves to provide is a more efficient process to release the individuals back into the community where they should be by creating a more stable environment for them. So it's been very interesting to sort of navigate some of these barriers that we didn't necessarily anticipate in the beginning. Just by having conversations about what they currently have and what they currently have problems with.

>> Dan: This is Dan, I think the other thing has to deal with the model of healthcare that the jail uses. When these local providers whether it's the county provider, the county contractor with a local provider, I think those some of the barriers around collaboration and integration are lower when the outside providers are coming and unless it is made clear at the point of developing the RFP for the services. It's just not going to happen, providers don't feel any special need for community. They are focused on the custody issues. The other point I would like to make is for people who want to understand more about how jail management systems interact with their medical systems which interact with community systems, just point you to community correctional health services website. They do a really good analysis of some of the challenges, but also some successes in integrating the various systems.

>> Mindy: Great, thank you all. Another area where several people asked a question around is what guidance you have, this is particularly for Abigail Tucker, what guidance do you have for less progressive states or less progressive communities in terms of getting some of these initiatives going and bringing convening folks that may initially be resistant to coming together and where there might not be state led initiatives.

>> Abigail Tucker: Sure, great question. It certainly can be a challenge in any state. My two specific recommendations as number one, to find out what are the goals that that agency has that would align with a goal that you might have. A common goal that folks might align on even if they have differences on healthcare, provisions, behavioral health disorders, is cost. Is there a cost metric that can be an agreed-upon goal between the behavioral health and criminal justice on why task force or collaboration should occur. The other common way in which people might have a shared goal is around community safety. There is a fair amount of research out there that the provision of healthcare to include behavioral healthcare creates safer communities. Often times we have a reverse stigma against that. But doing some of that research sharing some of that research as well as sharing some of the top saving data that is being experienced in other pilots such as some of the ones you heard today. Again, the goal is to find something that can be agreed on. I think about it much like motivational interviewing or any type of complications to focus what you can agree on and instead of focusing on what the differences are. The other example I think Abigail from Camden mentioned, the same thing. As much as possible, even if it means driving to lunches or working to get people in the same room. It's a lot easier to build commitment and to work through differences when you're in the same room then if you are across email or phone. Finding ways where you can have consistent meetings where people experience that they are getting value out of it but are also able to get through differences. I often found that it was in those in person

meetings where one of the number-one ways in which I think we supported innovation is by doing a lot of education around our community mental health system including behavioral health. There was a lot of misunderstandings about what we could and could not do that was resulting in our criminal justice agencies having erroneous assumption that we might not be able to partner on something. I know that most of those strategies are easier said than done but that would be my recommendation to find what you can agree on and work on a goal. Get in person together with the expectation that challenges will happen but it's getting through them, not stopping at them.

>> Mindy: Great, thank you. For Camden folks, one of the questions from participants asking about how you are funded, how your incorporated and what role members play.

>> I'm sorry, what was the last part of that? How are --?

>> Mindy: What role members play in terms of having to find your work?

>> Abigail Fallen: As a nonprofit, we have a mixed method of funding so we do have some grounds, both federal and other grants. We have some financial participation from other partners in and around the city of Camden that believe in income missions and projects that they participate in. A lot of it is grant funding for sure. Our membership, the government that depends upon which thing you are referring to. The board has one set of responsibilities, overseeing all of our work and particularly our CEO. The HIE oversight committee that I mentioned earlier has a strong participation for sustainability and where we want to put our focus. The quality initiative is another one to name. As well as some vendor neutrality, we are a sandbox. I talked about the nine square miles and three hospital systems. All three of those hospital systems participate at the coalition on a variety of projects and

initiatives. They believe in those projects. In a competition or dealings that they have with each other don't come into our office which we highly appreciate and respect that level so it helps us move those common themes and missions forward as well.

The Camden pilot specifically is funded from the Laura and John Arnold foundation. Our community outreach team, we do not bill Medicaid.

>> Mindy: Great, thank you. Unfortunately that's all we have time for today. I do want to remind people that are recording and transcription on this webinar will be available on the CIHS website which is on the screen before you on the slide before you. I also want to point out that if you have a need for more in-depth technical assistance around integrated care or any of the pieces that you heard today, you can contact us and we provide free consultation via telephone. I also want to give Dan a minute here to share anything that you think is worth sharing about the GAINS Center in PA.

>> Dan: Sure, we are funded by SAMHSA. To provide certainly phone TA and we certainly have a number of resources on our website. Related to the topics that we discussed today. I will give some of the communities a head's up most likely in September when we get our new contracts, we will be offering free sequential intercept mapping workshops that communities can apply for by application. They don't take six months, it's about a day and ½ workshop that the communities can apply for. Feel free to visit our webpage or contact me or our number four additional systems.

>> Mindy: Great, thank you so much Dan. Thank you to Abigail Tucker, Laura Buckley and Abigail Fallen. I really appreciate you sharing your expertise with all of us today. Folks, please know that once you exit the webinar you will be asked to complete a short survey. We appreciate your feedback on today's

webinar. Your input is important to us in forms of development of future CIHS work. Again, thank you everyone. Have a great afternoon. Bye.

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