

**OLDER AMERICANS BEHAVIORAL HEALTH  
TECHNICAL ASSISTANCE CENTER WEBINAR  
TOPIC: FINANCING AND SUSTAINING BEHAVIORAL HEALTH INTERVENTIONS**

Marianne Schienholtz: Hi. Most of you know me. This is Marianne Scheinholtz. I want to welcome you to the webinar Financing and Sustaining Behavioral Health Interventions. I'm going to pick up my phone and speak directly into it because I think the sound will be better.

I am the project officer for the capacity expansion grants and the current grant for older adult behavioral services and one of the technical officers for and as well as Jennifer Solomon and today's webinar is specifically prepared to question concerns that you have and we want to welcome any of the project directors and any others that joined from your organization.

Let me introduce the speakers. Alixe McNeill will provide an overview and moderate the questions. The first presenter is Danielle Nelson and aging specialist with the U.S. Administration on Aging in the administration for community living. After Daniel Joe Hyde, the expert technical expert lead at JBS International will speak. As you know -- following Joe's presentation we will hear from Stephen Ferrante the Aging Director at Florida Atlantic University as well as principal of the Group Victory LLC. They are the primary presenters today and after their

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presentations there will be a few brief comments made by Jennifer Solomon and by Kim Dash. Jennifer will talk about the center for substance abuse prevention and some of the possible ways that you might apply there for funding or get assistance and Kim will talk a bit about the Science to Service Initiative in the Center for Application of Prevention Technologies. Let me turn it over now to Alixe.

Alixé McNeil: Hello everyone. Welcome speakers and participants. This afternoon as Marian mentioned we wanted to focus on specifically how to finance the services that the TCE grantees are conducting under their new grant, so we're looking at behavioral health services including some depression care services. We have Danielle Nelson who will speak to us in detail about the Older Americans Act and many parts of title three that are applicable to behavioral health issues and look at prescription drug and alcohol misuse and prevention and particularly financing, screening, brief intervention and referral to treatment, the expert model, and then we will learn from Florida how people who had grants specifically to do this with older people in Florida and that program called "Florida BRITE" And many sustained after the SAMHSA grant ended and we're

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going to learn how they have been financing and sustaining those services and looking at suicide prevention efforts. We will then learn from SAMHSA's Service to Science resources, a resource that we think might be interesting to you. We would like you to know about it. You might consider pursuing it. The speaker Kim Dash is going to address this issue will address it very briefly this afternoon but is available for further contact if that is of interest to you. We will identify steps to assess potential of financing sources. We hope that you will ask clarifying questions, so that we can make sure what we're hearing today you can see the direct applicability to your organization and any kind of question is absolutely in line. Where there are answers I think the speakers have the answers. Where there are no answers we will look at pursuing that separately. And at the end we will determine whether or not any of the TCE grantees are interested in follow-up technical assistance calls. I will be asking which grantees and which speakers we might put further calls together with.

During the time of question and answer we ask that you send the questions in through the chat box that you see on the

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website. If there are any question about that please let me know now, but you just simply drop down the green tag at the top of the screen, and it shows you the chat box. Just type that question in. We plan to open all the mics at the time of questions and answers so if you have an additional one you can address it then. We will have Q and A after each of the speakers, and at the point we will move on with timing and move on and set up additional calls if needed, so now I would like to turn to our first speaker Danielle Nelson.

Danielle Nelson: Hello and thank you. I am glad to be here today talking about the Older Americans Act and what specific parts could be used for funding. So looking at the first slide the act was passed in 1965 and due to concern from policy makers about service for older adults. Mental health appears 29 times in this act and during the last authorization that occurred in 2006 and added 20 of those 29 times. You are currently aware the act is up for reauthorization.

Let's go to the next slide and get to the specific funding for behavioral health services, so within the Older Americans Act title three. This is known as core program.

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There are three distinct parts all of which can support behavioral health and include Title 3B, supportive services and services are eligible for funding. This includes for mental health screening, outreach, education and counseling and referral to services for treatment. This includes support for case management in which some behavioral interventions are embedded. So the next title within title three is part D and so this is the disease prevention health promotion part. As of this year, 2012, due to a change in appropriation language from Congress these funds are required to be used for specific programs and AOA has come up with our definition and it's a three tiered definition of what we consider evidence based.

Very similar to SAMHSA and we have a minimal criteria that is basic and some of these programs are listed here, so the last title I will speak about is Title 3E and the National Family Caregivers Support Program and could be used for these activities and specifically counseling services. States are required to ensure that all services are available in the states and counseling, education and training and support groups. Other services related to behavioral health under this section, Title 3E, can include

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information to caregivers about available behavioral health services, assistance to caregivers in gaining access to behavioral health services and individual counseling. It could include organization of support groups and caregiver training to assist caregivers in the area of behavioral health.

Next slide please. If you're unsure about the behavioral health activities being implemented within your community a great place is to start with a state plan known as -- state aging -- sorry, state plan on aging or known as the state plan, and/or the local agency of aging and known as the area plan so state or area plans are two, three, four year periods and annual adjustments made as needed. It's the state time frame that is for both of these. In order to be approved by the state agency must develop this plan for the designated service area, so the wording from the Older Americans Act states that each plan shall provide the area of aging in coordination with the state agency and the state agency responsible for mental health services, increased public awareness of disorders, remove barriers to treatment and coordinate health services including health screening provided from funds on agencies on aging and

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community centers and other public agencies and nonprofit private organizations so this actually completes my formal presentation. I will like to take any questions that you might have around this Older Americans Act for this.

Alix McNeill: We have not received any questions online yet, but do any of the callers or participants have one? I think the phones are all unmuted. If anyone has a question please speak up. Does anyone have a question about the Older Americans Act?

Chris Kerr: No. Not at this time. Thank you very much.

Alix McNeill: Thank you Chris. Okay. Then let's go on -- thank you Danielle. We appreciate the detail, and 29 times is quite a few times. It is clearly part of the Older Americans Act. We all know -- we always hope there is more funding for the act but the money that is there is certainly can be used, and we know of many organizations across the country that have successfully used it and just yesterday I was counting up how many ideas have started healthy ideas and referrals and looks like 114 organizations across the country. Not all of them use the money but a number of them do, so it's an important

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contribution to this area of work. Now we turn to Joe Hyde the technical expert lead at JBS International that works closely with SAMSHA with financing of experts after SAMHSA grants.

Joe Hyde: Good afternoon everybody. Yeah I am Joe Hyde, and I am the technical expert lead on the expert initiative, and myself and the staff provide technical support to all of the state agencies that have a state expert grant as well as to the medical residency training programs that are also developing in training physicians and piloting different expert models and various settings. As well a little bit of background as program director of mental health center close to 20 years and six or seven years working in FQHC. I have worked in a number of the kinds of settings that you folks are currently working in, so next slide.

So as I understand what are your tasks as grantees that you're looked to provide a range of preventive services around your grant and prescription and medication misuse, alcohol misuse and abuse and activities related going on related to screening and intervention and sounds like there is interest in terms of SBIRT and the plans and patients plans each state submits and talks about the menu of

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services. SBIRT figures prominently in all of the patients in the medical plans coming out in states and certainly recognized and picking up and the funding have not gotten to where the planning efforts are.

Next slide. Some things that we want to talk about. We want to talk about financing and other strategies looking at feasibility in terms of SBIRT within your practice setting. We will talk about the major third party payers and that being commercial insurance, Medicare, and Medicaid and also talk a little bit about other kinds of funding for sustainability kinds of strategies whether local grants or talking with your single state authority regarding your access and state resources, or monies that the state maybe putting forward that have - and block grant dollars tied to it.

Next. Okay. By our most recent look at it, and there are states right now that have fully activated, and are used their SBIRT codes in Medicaid and five other states where it is pending and I think with the upholding of the ACA recently it will continue and I think you will see many more states now moving forward in terms of the amendments that they need to make to their Medicaid plans.

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Interestingly and one of the reasons pay attention to Medicaid and beyond the fact it's the historic payer for mental health services for persons with disabilities -- Medicaid also tends to be, if you will, the trends that are in particular areas for private insurance as well. In terms of you folks in California have their SBIRT code pending and Colorado and Texas don't have codes at this time. To the best of our knowledge Kansas and Michigan have not yet activated their codes. Although we do know there are pilots going right now going on in Michigan regarding SBIRT and not only involved in the state but some of the private payers initiatives, particularly Meridian and one of the larger entities and Kaiser nationally are doing pilots and looking and integrating the intervention within their systems.

Next. Okay. Now, in terms of -- what I want to talk about a bit is that as a program administrator, as a financial manager, as a senior leadership, I think we can probably all agree that screening and briefing intervention is a pretty good idea. There has been ample evidence based on more than 200 research studies that it does good things. That it yields positive outcomes not only in terms of

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substance abuse but other areas. There was a recent study done, or a recent report where 1.5 million folks funded via SAMSHA their outcomes were looked at and what was reinforcing the outcomes in terms of that broad science to service initiative were nearly identical from what came from the earlier research studies and I think it did demonstrate that the model is of successfully transferable from carefully controlled research studies done in research hospitals and research settings, to the oftentimes more messier clinics and hospitals that we work in and we need to look at this business case. A couple of core issues that people need to look at and do you have a sufficient work force to do this process? Secondly, is their policy environment within the organization and state at a minimum would be neutral to this kind of intervention and hopefully supportive. At the broader state level the kind of policy environments that get in the way are things like - has more to do with hospitals and the UPPL laws. I will struggle with what that stands for, but basically means if you come into the hospital secondary to an injury and alcohol plays a role in it, the insurance companies are within their rights not to -- actually they will pay for

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the care you receive, and then they will bill you, and so it's set in place in a number of states where that exists. A sort of a "don't ask, don't tell policy" And more difficult to do that and some are tricky and the state policies that exist in some places where you can't bill more than one service at a time in a given day and that can create barriers for folks. Internal policies may have to do with either access to patients or doing universal kind of screenings, those things. Supportive infrastructures. There are really two that we think about and people should pay attention to. I mean in terms of the SBIRT model what distinguishes it from other brief interventions is there is universal screening involved because brief intervention based on case finding has been around for quite a while. It's sort of what employ assistance programs are made out of, but what distinguishes SBIRT is that there is universal screening, and not only does it happen once but periodically and whether every six months or year or two years everybody is screened, and what we have learned sort of the hard way is particularly if you have a good size clinic, it's difficult to do that without some kind of electronics, some data system and whether electronic record

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or health IT and that information can be flagged. In the clinic that I came out of in Massachusetts and we saw about a thousand patients a week, and no way could we track all of that if we didn't have electronic system to keep track of all the patients coming through the doors, so that kind of infrastructure is important. The other infrastructure that is important is training and coaching and mentoring for staff in terms of the delivery of the intervention because one of the things that has been sort of demonstrated time and again, and I will encourage you to read Steve Martino's work on this and you will get fidelity drift and people will go back to what is easy and comfortable and get eroding of this evidence base practice and that is true of any evidence base practice.

Next slide please. Okay. And then the other -- the key question are there sufficient resources? And practically put if there is not a way to receive compensation for doing that service -- if the codes are not turned on in your state, clearly investigate the who and the what is involved in this, and then if because of politics or dire situations it's not going to happen there are alternative mechanisms in terms of ways that people might seek third party payment

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for that, or other kinds of payments for that, and that in terms of activating codes -- particularly if you're looking at Medicaid codes or those that have to do with the states, although I think there is more impetus with ACA moving forward activating Medicaid codes takes a while. I think the experience in Colorado with pretty active organized mobilized efforts it was close to three years from beginning to end, and it's just within the last year that the codes have become fully operational so it takes time and those entities are slow moving and plus there are activities they must do with federal CMS authority in terms of plan amendments and despite the fact that the federal government does recognize those codes, so recognize that these change processes take effort and they require time, and they take time. And the blunt practical reality is if at the end of the day you come to the opinion that you just don't have the resources, or the resource aren't sufficient, implementation is going to be challenging, and I am probably not saying something that you don't already know, but what I hope to present to you is a fairly coherent model other places have used in terms of at least framing some of the questions, and how to figure out

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whether that financial picture does make sense in your practice setting.

Next slide. There we go. A couple of things we also want to talk about. There are a lot of things that we know what works with SBIRT and SAMHSA has been funding initiatives now for a decade and 20 plus states and pilots within colleges and federally qualified health centers and different populations with good quality cross site evaluation and state evaluation and we know if something is going to work there needs to be adequate staff and leadership in place and need leadership support and you hear the term -- it's not trivial, but it kinds of gets trivialized at times. You need a champion on site and it's true and you need someone to say yes this is a good thing and not only it's good but we need to commit resources whether it's staff time or change in practice or other resources to make this thing happen. The other thing that we know is that sort of who delivers the intervention and how it gets done really is influenced significantly by the unique context of your organization, and the people need to do a practical and thoughtful analysis of the work flow within your system, and then really develop an

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implementation model that makes sense in terms of your site, and that ultimately what you want with something like SBIRT is a universal process within your organization. If you really wanted just to be invisible in so far as it's just something that you do just as you might in a more of a mental health clinic. Everybody does some sort of a mental status exam. There is some sort of universal screening around that and alcohol or if you're at a primary care practice everybody gets their blood pressure checked every time they walk in the door and those are things part of the territory and that sustains things as well. If they're embedded as part of the fabric the likelihood the continue beyond funding is greatly enhanced and if it's built into your electronic health record that you are prompted to ask those kind of universal screening questions also further builds the likelihood it will sustain. In terms of practice models the commonly used model across systems is a collaborative model. The early SBIRT designs if you have followed the research in the 80's and 90's out of BU and Larry Gentillo's place and Yale and had the physician pretty much doing it all, so the clinician doing it all and that was fine. In terms of the practical world it doesn't

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make great sense, and what you see now is most places have some kind of a teaming approach, and I will talk more about what those look like, but most places use some kind of a teaming approach with delivery of SBIRT.

Next please. Okay. Just by way of an example. This actually comes out of a health center, but a simple teaming approach here. This health center is one actually I did some work with and they're up in Oregon and early on they were doctors of patients home medical model and when the person checks in at the desk that person answers a simple - - eight or nine question wellness survey to the person at the desk and embedded and "did you get a flu shot this year? Do you wear a seat belt when you drive your car? Do you eat green vegetables?" And also the screens around alcohol and use of substances. That gets filled out by the patient and the Allied Health member picks up and quickly scores it and easily scored things and then it's passed on to the clinician who carries out whatever intervention might make sense and one of the lessons that they learned and every place has learned that you want to streamline the screening process to make it as quick and easy as possible, and again you can do it with as few as three simple

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questions, which I will review with you a little bit later on. One of the things that we have learned is stand alone screening doesn't work well. A case study -- we did technical assistance with a clinic in Tennessee earlier this year and they contacted asking for support. They were getting only like a three, three and a half percent positive screen and we went through and did some work flow and they created this nice pretty looking, well formatted screen that had across the top in 22 point font "substance abuse screen for all patients" And they were pulling people out of the waiting room and we are doing your screen now. And people are "I don't know what you're talking about" And what we suggested embed into a broader screen. They did that. They piloted that and low and behold the positive screening rates went from three and a half percent up to 14% because stigma exists and people are mistrustful, particularly if you're a Medicaid recipient and knowing what happened in some of the states in terms of the approaches taken by certain state officials around potential substance abusers and people were just leery of that but embedded into broader surveys always works better.

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Next please. The two brief screen questions that we suggest people use, and there are other ones out there so don't get me wrong, but the two that we suggest on the front end for pre-screen is what is called the NI triple A screen and one developed by the National Institute on Alcohol Abuse and Alcoholism (NIAA), and the other is called the single question drug screen and what we know about both of those screens is that when you do them about 75 to 80% of people will screen negative which means that they are responding negatively to those, and in terms of pre-screening you're pretty much done, but you will then have 20-25% -- in terms of national averages that will screen in, and that's the population and you move on to a full screen, and doing a quick pre-screen takes seconds to do.

Next please. Here is what a full pre-screen looks like in terms of alcohol at any rate. The first question -- this is again embedded into another survey, but pulling the questions out. "Do you sometimes drink? Yes or no?" And if no you're done and if yes, you move on to the next screen and is it has pretty decent sensitivity for a single question, and if you're unfamiliar with the term

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sensitivity and specificity and sensitivity means 82% of the time a yes means a yes and the specificity is about 80% of the time. A no means no. These screeners are never perfect but the folks at NIAA felt that the value in terms of adaptability with the setting of a single screen far outweighed the fact that more developed and in-depth screeners which take more time are things that busy clinics are most likely not going to do, but people are more willing to pick up the single screeners and embed them in.

Next slide please. And the single drug screen is similar. What is interesting if there is a "yes" People are always moved on in terms of a full screen, and if it's a "no." In terms of specificity there's some people who fly through, but again the belief is that the value in a screen like this is that practices are more willing to adopt it, and it's better to use something that people are willing to use that's pretty good as opposed to trying to adopt something that is really robust that clinics have a harder time sustaining.

Next. Hopefully you will get copies of these slides. What I laid out here and it's a useful exercise if you haven't done it. If I am preaching to the choir on this suffer

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through it with me but it's a useful exercise in the clinic setting to this kind of work flow and look at how you can streamline -- from a patient perspective because people hate to go through a rigmarole and in terms of your perspective. What is the most efficient way that can you do this? And this is an example that comes directly from a clinic in terms of doing a screening process, and really there are just - in there are straightforward steps and there are basically two decision points in the whole screening process, so it's pretty simple. The more you can just have a step by step process -- one, it's easier for staff to learn, and it becomes part of their routine. The more decision points you build into these processes the more confusing it is for folks and interestingly the harder it is to train folks around these things.

Next please. Okay. I want to talk about two models. I will primarily talk about the integrated health model and my understanding of who are on the phone and in terms of this there are two models. One is primarily a medical model where you might have a doctor, nurse, medical assistant. In some places created this new hybrid of worker called health educator which oftentimes is a new bachelor's prepared

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social worker time person working in the clinics, so that is one model. The other model is more of an integrated behavioral health model that is more - if you will, consistent with what the changes in health care are talking about. It's a little more difficult of a model to get started, but I think it does offer some greater possibilities a little further down the line, and people have interest in terms of integrated behavioral health there are some very good things out there these days in terms of that, so but you want to look at what your staffing options are in terms of that, and kinds of who will be doing what, and how will you be using these positions?

Next slide please. In terms of the integrated health model I think what is its strength, particularly integrated within the health center or primary care setting, you then do have the opportunity for integrating care, and I imagine if not - I imagine that most of you are thinking about what is going to be your roles within patient center, medical homes or medical organizations, and because that's an important part of what the future is holding for us all, so I think what this does present for you that does provide

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integrated care and the behavioral health model and more responsive model where you can do real life and warm hand offs and closer and collaborative work. You bring a broader range of skills in terms of the services being done. There are more financial options open to you that the position can be revenue generating, and it's certainly consistent with the Affordable Care Act. Bachelors and cost more than this - there are modifications that need to take place in billing procedures. If you're within a health care system or a hospital that parent entity will have to make some amendments to the joint accreditation and occasionally people get sort of confused or there are some questions -- well, I think the concern is greater than the question truthfully but between HIPPA and 42 part two and the confidentiality laws and those are some of the limitations.

Next. I am going to talk about financing and reimbursement and what I want to present to you is a very simple straightforward financing model that you might want to take a look at in terms of then saying to yourself "does this make sense and is it sustainable within an organization?" And? Ways that you can answer those types of questions.

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Next. Okay. It is really building a mathematical model and we say it shouldn't be a stand-alone budget and financing and stand alone budget and it's a menu of services and it needs to be looked at in terms of that.

Next. So if you're looking at a finance model -- I mean the three things you need to look at is "what are the real costs?" What is the revenue? And are there other benefits as well that might not be financial but nevertheless benefits and whether to the organization or the patient. Costs and there are costs and whatever staffing profile you come up and that is useful to do that so you can more accurately do your staff loading who is doing what, what their time might look like, and you need to figure in the other operating expenses and work with the business office with that and that can tell me what it costs to deliver this thing, and then you need to look at your possible revenues, whether it's reimbursement, health insurance, or insurance, or support from city, state, county, united way, or foundations, whoever. Those are all things that you need to look at. Then you need to look at the other benefits too. One in terms of improved outcomes in terms of patients, but there are -- one of the reasons hospitals

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have adopted it and picked it up out of internal resources is around risk management because they know that people who are drinking at unsafe levels or engaged in drug taking behavior are at risk. People go in for surgery they get fluky with anesthesia and you're not supposed to wake up and they did, so the risk issues of a concern. Also if a person is involved in a mental health clinic practice and they're on medications to manage the symptoms of mental health illness and drinking imposes risk issues and there maybe other benefits to the organization for doing it. Perhaps giving you a seat at the table and negotiate with these patients.

Next please. If you're unfamiliar with them I'm going to do a quick run through. I'm not going to go into depth on each of these, but right now these are the prevailing codes used by most states in terms of billing, and one of the things that you need to do either directly or if you have or are engaged with a trade association in your state, and truthfully if you have a trade association I would use them because that's what they're paid to do and really understanding and have them or have somebody who is paying for what right now at the state level? And so these are

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your basic sort of SBIRT, commercial code, Medicare and Medicaid codes for SBIRT.

Next slide. These are your traditional mental health codes that get used sometimes for SBIRT it. They are sure you're all familiar with.

Next slide. Okay. And the thing I want to tell you beyond the codes one of the things, particularly if you're looking at the specific SBIRT code, it's important for you to get or to understand the language about who can bill for what, when and under what circumstances because some states -- I am just thinking -- the state of New York for instance, they have painted the waterfront as long as you had a certain amount of training all sorts of people can deliver SBIRT and other places have been very restrictive who can deliver it and when and under what circumstances, so finding some of those things out at your local state level is an important thing to do, so what I want to present to you in terms of then beginning to build this sort of financial model is you need to be able to forecast what your revenue is going to look like. Okay. And this one I arbitrarily -- if I was actually doing it again I would put it lower and forecast 20% of patients will be screened, but

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just for our purposes here and okay you have 20-25% of people who are going to screen positive based on the pre-screen. Generally people do not get paid for the pre-screen. Most insurance companies don't pay for that. And that's part of why they embed it in something else, but what is reimbursable the complete audit on somebody and you delivered the audit and can provide that is billable. If they screened at elevated risk you can do a more formal one with them at whatever level, and depending on where they are at their level of risk if they fall below a threshold or a willing think to seek treatment you can definitely do a follow up with them which is billable code or treatment referral which is the second layer of codes there and such, so that there are three different points in there where you can bill for your services, and using that as a model you can begin then to generate some sense about what's the work going to look like because you should have data already - how many patients are we seeing a year? And if you're saying about 20% of the people are going to screen in, then you know about 20% of these people you will be doing an audit or DAST with and maybe 25% require intervention about the use of unsafe alcohol and you can

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factor that equation to what the dollars and cents are going to look like.

Next. This is a bit more -- I'm going to show you three different models. They're all basically doing the same thing. The three models really represent three different staffing profiles. Model one is a fairly traditional medical model where you got physician, or physician's assistant and you might have a medical assistant doing things, so that is a traditional medical model. Model number two -- next please -- is a bit more complex of a model where then -- again you might have the screening that goes on, and then depending how things shake out there are three different ways the interventions could go, and those are sort of what would be typically associated procedure codes with those, and the next model, and this one is probably most akin to the organizations that you work in where you have the BHC stands for behavioral health clinician. It's just too words for the box. Where you have the behavioral health clinician delivering the interventions, and so you can see there then what kinds of billing or coding can be generated from the interventions that you deliver, and depending how you work those out then

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you can begin to make some cost estimates. That's the purpose of doing all of this is so that you can begin to look at what can this generate for me? And what's it going to cost to deliver these services?

Next slide. And ultimately after you have gone through these exercises where you're going to be looking at how you are going to staff this thing and what's that going to cost, what kind of revenue you're going to generate, can you do a straightforward feasibility equation. When people talk about feasibility studies sometimes there is a level of mystery that is shrouded in them and it's paying attention to detail and being realistic and conservative and tenth grade math and does this thing make financial sense in my estimation?

Next slide. So I guess a way to summarize business model. There are a number of ways of essentials in terms of practice models and you need to base the model on to base the work model on the work flow of the clinic and there is strategy going on and health clinic and whether primary provider and staff and mental health service agency and might be clinician and support staff. We all need to look at issues of reimbursement and that's the world that we

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live in. I didn't go to graduate school to think about this stuff but quickly as I became a clinic supervisor and program director and in Massachusetts and everybody needs working knowledge of this stuff whether you're a clinician or a program director. It's important for all of our survivals. I think in terms of thinking about it and planning for it and look at integrated service and not a stand-alone service and you need to look at what are the elements of a financial model in terms of looking at revenues and other benefits and costs, so that you can make an informed decision about does this make sense for your organization?

Next. I made reference to this already. There is no such thing as a Medicaid plan. There really are 54 of them. Every state and territory has a different plan for Medicaid. There are some commonalities and broad structures and requirements that are passed down by CMS but the way Medicaid is designed it is a state and federal partnership, and so your state has its own interpretation of some of those things and one of the places I mentioned or alluded to is where provider associations can play a real important role for you is around interpretation and

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audience and advocacy and the largest is -- well, the state affiliate and the state association. There is also in 47 of the 54 states and territories there is a state association for substance abuse providers. Sometimes they are one in the same with behavioral health. Actually more of the states they're stand alone and different, and the third is your state group that was the old family service America. It's now called the alliance for children and families and those are all three very sophisticated organizations and they have dealt with state advocacy issues and federal issues and if you have those concerns I really encourage you to work with those organizations to be your spokesperson because there is strength in numbers. From what we know about insurances and you probably know this as well as I do, Medicare is the most restrictive of them all but it's slowly changing. The thing that has people most aggravated is who can deliver services really has not changed much in decades and that it tends to be physicians, nurse practitioners and psychologists and social workers, and I think PA's can deliver services now, but despite the fact for 20 years license, marriage and family therapists and others have been recognized

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nationally Medicare hasn't caught up to them and restructuring efforts are going on in Medicare and there is a certain limitation and what the federal folk can do. The greatest advocacy comes from the professional folks in terms of doing this. Another thing to be mindful of even though codes might want be active in your state you can still deliver the practice. I think universal screening, and I think the intent around all of this and universal screening around alcohol and other substances should be a standard of care. It's not something that people have to mention and make a decision about. Much like you don't make a decision every time you get your blood pressure don at the doctor's office and should be a standard of care across all behavioral health, and that doesn't require money. That requires sort of recognition and choice on the part of organizations, and that in the health clinic I worked in as a behavioral health specialists we were doing SBIRT pre-dating the state turning on the codes and we worked things out and billing 9804's when it would work, so there are work around in terms of doing these things as well.

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Alix McNeill: Joe, thank you very much for your detailed presentation. We appreciate it. We have not received any written questions, but if somebody has one question we could entertain that now. Otherwise we will ask you later if any of the grantees would like to speak directly to Joe at a later time. Are there any questions? Well, I know the grantees sent us questions ahead of time and Joe answered many of them during his talk, so I'm not hearing any others. You're unmuted. I'm not hearing any others. We will move directly to Steve Ferrante and thank you very much Joe.

Joe Hyde: You're very welcome.

Alix McNeill: Stephen.

Stephen Ferrante: Good afternoon. I'm going to speak to you specifically about an implementation of SBIRT in the state of Florida as well as what happened since that implementation in terms of sustainability for the project. In the Florida BRITE project is the name of the project I'm speaking of. It is a state wide older adult initiative around behavioral health initiatives much the BRITE stands for brief intervention and treatment for elders. I had the

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opportunity of working state wide and locally in my community to both in fact, develop and implement the BRITE project so I have information from a systems wide standpoint and the service provider's standpoint. What I would like to do since you just heard extensive information about the SBIRT models and BRITE is modeled after that and with these things, so I would like to talk to you a little bit about the inception what happened with the BRITE project. I do want to say though that the BRITE project from the standpoint of being effective and efficient program was just in fact just that. It was successful in identifying elders across the state and with substance issues and related problems and in particular in the state of Florida there was a focus on depression in older adults. And the other thing to talk about is when the state initiated the BRITE project they standardized protocol and training for all sites which really assisted the project in moving forward.

Next slide please. The BRITE project started out with actually state general revenue funding from the Florida office of substance abuse and mental health programming. There were four in fact pilot sites. Two years into the

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program and the project started in 2004 and awarded a SAMHSA grant and for the state and expand it towards the older adult population, so the SAMHSA funding, five year funding increased to 21 total provider sites. Just to give you a sense BRITE services were given in traditional settings, primary settings, emergency medical rooms and hospital sites.

Next slide please. Part of the initiation and implementation of the project this was done around 2011 and the time the project was winding up in terms of federal funding and 19 agencies responded to the survey talking about what if anything they had doesn't or they had been successful with thus far in terms of continuing the project. From answering questions from the funding standpoint 14 of those 19 agencies had indicated that they are not yet got it and were unsure. 17 of the agencies said they identified other funding to sustain the project. One specifically indicated they will be using county funding to support their project of the agencies also talked about one specifically investigating Medicaid funding and another looking at insurance coverage and one particular site indicated they were going to look at the potential to bill older adults

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for the intervention services and use private pay as a way to do their project. In terms of the sustainability survey on the program side of the project you can see there was a far more positive response in terms of continuation at least at some level. 16 of the 19 agencies indicated at a minimum they would be continuing the pre-screening function and that could be either internally or with their collaborative partners externally or both and they would embed that into the practices and 17 of the agencies indicated they will continue brief intervention as a service. 19 of the organizations - all of the ones who responded indicated that they indicated they would be doing that and recognition of the experience of looking at those issues in the older adult population, and almost all 19 agencies -- 18 of them indicated they would make external referrals to substance abuse treatment when there was a risk involved. A little over half of the agencies said they were offer ongoing training and staff development. That seemed to be a plus to the organizations in terms of developing their organizations, and eight indicated they would be embedding the project in their existing project

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despite funding and seven in the primary care setting and for the project.

Next slide please. So following up with all of the sites, the 21 sites, in June of 2012 to see what actually happened with sustainability. Five of the 21 sites were sustained fully, and in terms of both funding and programming, and the types of funding that those five sites were using to sustain themselves, four of the agencies were using state funding, which is the block grant money that the state receives. One agency as indicated in their sustainable survey was in fact using county funding, and then one of our agencies also indicated that besides the state funding they were supplementing their efforts with other grants, donations and private money and a number of the sites indicated in order to maintain the infrastructure and capacity they were using graduate interns to help support the program as a form of sustainability.

Next slide please. So now looking at actual sustainability on the program side of things those five agencies that remain fully funded also adhere to the program and its full fidelity as well so they were operating the program how it was implemented through the pilot sites as well as the

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SAMHSA funded sites. In addition to that for other sites that were identified as unfunded sites, in addition to the five, we had an agency indicating they in fact continued the pre-screening and their partners were involved with pre-screening even though they were not adhering to the full fidelity or fully funded. Another agency indicated they continued the depression screening and in a hospital setting and another the education component of the BRITE project and one agency indicated they were currently in the process of hiring an RN in the hopes of reviving their BRITE project and investigating insurance Billings since they were bringing on an RN.

Next slide please. Okay. So just some other considerations as well in terms of the Florida BRITE experience, and the first one being in terms of practiced integration. Some of the sites indicated they embedded the practice into their existing agency services, both at the time that they were surveyed for sustainability plans as well as those sites that remained operating some form, if not the full form of BRITE services, and again we saw some practice integration not just with the agencies themselves, but with their external partners so that is certainly an

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important aspect of sustainability. The next thing worth mentioning is the role of the partners and as Joe described this is certainly a collaborative practice model and there was a lot of collaboration that occurred to implement the Florida BRITE project, so a question would remain what happened to all of that collaboration after the funding was gone? And perhaps part of sustainability is not just for the funded agencies but the whole network and all collaborative partners. Tapped in with the funding and Older Americans Act money and the Medicaid waiver program in the state of Florida and these are still perhaps opportunities for Florida as for other parts of the country, and the last point to make is planning and prior to implementing the program and that's really when it should start and you know you will move forward with the initiative and perhaps this was a lesson learned in the state of Florida and there was more sustainability and planning going on we saw sites remain funded and retain their full fidelity and sustainability planning could include some outcome measurement and clearly there were quality of life outcomes as a result of BRITE as well as community outcomes and even some cost benefit outcomes, and

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so really measuring that value and quantifying that value would be important for sustainability and business planning and certainly to market and promote the program not only the collaborative standpoint but a funding standpoint .

Alix McNeill: Next slide please. Any questions related to the Florida BRITE experience? >> We don't have any written questions but does anyone have a question for Stephen? I guess not. Thank you for your very comprehensive presentation and the information from Florida and it's most helpful to us. >> My pleasure. >> Now Jennifer Solomon and Kim Dash will speak briefly and go ahead Jennifer.

Jennifer Solomon: Good afternoon. Can we go to the next slide please? SAMHSA's Abuse Prevention Treatment Block Grant goes to fund states and have plans based on identified needs and these are identified data needs. What we wanted to point out to you states may consider the needs across a life span. An example of this is New Jersey and prevention plan and this addressed the needs of older adults. Most states address the needs of younger people first and the grant talking about underage drinking but I want you to be aware states are looking at the substance abuse and mental health needs of older adults in terms of the block grant.

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Alixé McNeill: Thank you Jennifer.

Jennifer Solomon: Sure.

Alixé McNeill: And now Kim Dash is going to talk about a resource that maybe of interest to the grantees. Go ahead Kim.

Kim Dash: Sure. Thanks. Good day everyone. So I'm going to take about five minutes to provide a quick overview of the Service to Science Initiative. This is a national initiative to enhance the evaluation capacity of innovative programs and practices that address critical substance abuse prevention and related behavioral health needs in states, tribes and jurisdictions and communities. As noted earlier it's a project from SAMHSA center for the application of technologies and some ways represents the flip side of technology transfer and it's really about moving programs from practice to research, and thus its purpose first is to help innovative integrated prevention and demonstrate and proof documents of their effectiveness, and second it's designed to increase the pool and diversity of effective prevention intervention. It is my understanding that some of you receiving these grants have

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implemented innovative programs or made adaptations to these programs in addition to doing these interventions so Service to Science participation maybe something you want to consider, and here what you see is a flow chart that depicts the trajectory of program participants among the three phases of service to access, service selection, and academies and financial selections and each year a network representatives nominate substance abuse programs for participation. Programs then choose to apply. Capped and review applications and based on the bottoms and eligibility and availability and selects about 50 programs for participation. For the next cohort of participants are due August first. That's pretty soon. It's around the corner. If you're not ready to have a nomination this year you could do it next year about this same time and August 2013. Now selected programs are matched with a pair of subject matter and evaluation method experts with whom they meet at initial two-day on site consultation and sometimes a academy and tailored to the needs of the participants so the technical assistance is really designed to meet programs where they're at. Following the academy CAPT provides each program up to 30 hours of intensive and

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customized TA and guided by the action plan and developed by CAPT and TA providers and after follow up TA participants become eligible to compete for CAPT administered subcontracts and evaluation capacity and may total up to \$30,000 for one year and pending availability of funds. We sometimes refer to them as mini contracts. Okay.

Next slide please. Over time we have learned there are multiple benefits to programs participating in service to science. Programs and organizations have additional access to outside evidence experts who in some cases are the only evaluators available to them, but in other cases we work alongside and internal and external program evaluators or teams. Participants demonstrate improved evaluation capacity. For example, demonstrating program outcomes using more rigorous research methods. Participants have developed more refined programmatic approaches and submitted materials to evidence base registry programs such as SAMSHA in rep. They have leveraged work from service to access to obtain evidence and other funding sources.

Next slide. So if you're interested in participating in service to science you should contact the lead in your CAPT service

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area. The key on the bottom is the one you would use to determine your CAPT service area, so for example Jewish Family Services of Los Angeles, California, you would want to speak with Eric Olson in the west and grantees in Kansas and Texas and Kathy Gary in the southwest and family services in Michigan are listed here and you should free to contact me directly if you have interest or questions about the initiative or your eligibility.

Next slide. We can also forward to you a copy of our brochure. We have an electronic version of that. We can share with you descriptions of past service to science participants that have developed, implemented and have programs for older adult's population. There have been seven such programs. Other resources you might want to look at and available on the CAPT website and the links are available here, our starter guide, our call for nominations and general announcements and explains the eligibility criteria for participating in service to science and seeking nominations and finally for those that wish to speak directly to the state representative who are responsible for program nomination for Service to Science this last link takes you to that information, and as I mentioned

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earlier programs participating need to be nominated by their state national prevention network representation or single state agency, and again those nominations are due August 1, so does anyone have any questions for me?

Alixé McNeill: Are there any questions for Jennifer or Kim? Hearing none we will just keep moving along.

The next slide we were very interested in learning from SAMSHA's suicide prevention team what they found around the country about financing services around suicide prevention, so we spoke with Ms. Blogier and gave us these ideas. She encouraged anyone among the TCE grantees who are concerned about this issue if you're not already in communication with your suicide prevention coalition in your state if there is one that you do that. They are oftentimes very on top of funding in this area. Seems like most states have these coalitions at this point. She also suggested that grantees periodically check the SAMHSA website to look at new grant opportunities. She suggested that since it's the local hot lines that SAMHSA has been supporting that you be in contact with the hot line to see if there is any collaboration that might occur where you could support -- where you together might seek funding. ROZ suggested that

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the grantees sign up for suicide prevention resource center weekly E-newsletter and we have the source right there. This is a link to a home page that you will see. It tracks a number of different funding sources from government foundations and other sources related to suicide prevention, so if you might take a note of that now and you will also be receiving the slides and that these are listed here. She also said that grantees might consider the Administration on Aging, both looking at their national AOA website for opportunities, but then reflecting back on what Danielle shared with us earlier in terms of Older Americans Act fund that supports counseling, case management, suicide prevention. Questions can be embedded in case management and then follow up counseling or depression care can be supported by Older Americans Act funding. So now I would like to ask if there are any questions on any of the subjects that we have heard today. Although Joe is no longer with us, he had to go to a meeting, but if there are questions for others we are happy to entertain them now. I think the lines are unmuted. TCE grantees or the federal partners or others who are on the call? As most of you know this particular webinar was focused directly to the

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TCE grantees. We will be something somewhat similar in October, but we will cast it for many more people in the country and look at how to present it there and be looking for your advice on that. Are there any of you that would like us to organize technical assistance calls directly with any of the speakers from today where you would like to off line have a conversation with one of them? And you can think about that and during your next call with Marian Scheinhotlz we will touch on asking for your feedback on this webinar and whether or not you would like to have follow-up TA calls. You will receive the recording from the webinar today, and we will also be posting it on the AOA website as well as NCOA and our partners and when SAMHSA posts these webinars they will have them as well. If there is nothing else I think we will sign off and give you an extra four minutes before your next activity. Thank you very much for participating today. We appreciate your making time in this busy summer season.

>> Thank you.

>> Bye.

>> Thank you.