Advancing Behavioral Health Equity in Primary Care

Frequently Asked Questions

August 4, 2021

General Program Information	
Question	**Answer**
When does this program start? How long does it last?	The learning collaborative will run for 20 months, from September 27, 2021, to May 31, 2023.
How many grantees will be accepted?	We are targeting 15 Community Health Centers with up to 45 sites.
What can the grant dollars be used for?	Grant dollars can be used to offset staff time, travel costs, and other program-associated costs.
Can you elaborate on the request to identify a priority sub-population?	Participants will be asked to select one or more priority subpopulations on which to focus efforts to improve behavioral health integration and equity. Priority subpopulations include Black, Latinx, Asian American / Native Hawaiian and Pacific Islander, American Indian and Alaskan Native, LGBTQ, those who are seriously and persistently mentally ill, and adolescents and transition-age youth.
Many barriers to behavioral health equity & integration are external to us (i.e., managed care/payors, county, BH fragmentation, etc.). Will this learning	While the scope of this program will focus on changes and improvements community health centers can make *directly*, one of the key drivers of this program is Community Partnerships so teams will work to develop and improve these partnerships in service of integration, alignment of care, and equity (e.g.,

collaborative address a clinic's role in local system transformation?	including establishing agreements for specialty care / social services, referrals, and communications, and sharing data/ systems).

Eligibility	
Question	**Answer**
How do you define community clinics? Do these clinics need to provide primary care?	Yes, clinics applying need to provide primary care to be eligible. Organizations in California that provide comprehensive primary care services to historically underinvested populations are eligible to apply. Applicants must be nonprofit and tax-exempt under 501(c)(3) of the Internal Revenue Service Code or a governmental, tribal, or public entity. Eligible organizations include: • Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes. • Community clinics, rural health clinics, and free clinics. • Ambulatory care clinics owned and operated by county health systems or public hospitals. • Indian Health Services Clinics.
Is a consortium of community health clinics eligible to apply?	For this program, CCI will consider applications from FQHCs and other community health clinics (see eligibility above) who deliver primary care directly.
Are FQHCs who are also CCBHCs eligible?	Yes!

What level of behavioral health integration is expected within a community health center at the point of application?	Teams are expected to have a foundation of co-location or integrated care, where behavioral health, primary care, and other health care providers: • work in the same facility or office space (this might look different at the time of COVID-19), • communicate regularly about shared patients (by phone, email, or in-person), • collaborate, driven by a need for each other's services and more reliable referral, need for consultation and coordinated plans for patients, or as colleagues on the same care team, • meet to discuss cases (occasionally or regularly), • feel part of a larger team (formally or informally).
We provide sexual and reproductive primary care, but we do not provide comprehensive primary care. Are we eligible to apply?	Clinics that provide comprehensive primary care services to people of all genders, are eligible.
Are we required to provide substance use treatment in-house or can it be outsourced?	The goal of this program is to support health centers to work toward providing fully integrated treatment for mental health, substance use disorders, and social needs. The patient experience and the operational integration is what matters. If the patient experiences integration, and it meets the definition of integration described above, then it is acceptable for the substance abuse or behavioral health services to be provided by a contracted entity.

Program Deliverables and Participant Expectations	
Question	**Answer**
Are there specific deliverables that will be required for this program?	Participants will be required to submit: - A completed capabilities assessment (3 times: baseline, midpoint, and end of program) - Universal data submission (2 times, with baseline if available) - Quarterly progress reports - Final storyboard (which will be developed throughout the program)
What infrastructural requirements is this program looking for (e.g., EHR, registries, etc.)?	• Applicants should have the ability to identify populations and subpopulations via a registry, electronic health record, or population management software. • Applicants must also have the capability to report data at the population level for common behavioral health measures such as number of patients screened, number of patients with behavioral health conditions, and number of completed referrals (e.g., to social services, specialty care)
What data will clinics be asked to report? How frequently?	Clinics will be asked to report on a universal measure set at two points throughout the program. While the measure set is still being finalized (see *Table A1* in the RFA), it is our goal to include measures on which clinics are already reporting, and those that are most helpful in telling the story of this program's impact on health equity and behavioral health outcomes. Program participants will have input into the measure set before it is finalized.
What coaching support will you provide?	The program will provide monthly coaching sessions to enable teams to apply program resources and learnings to their own projects. Coaches will help

	participants identify (1) what they are trying to accomplish, (2) what changes they will test/implement, and (3) how they are using data to measure their success. Coaches will jointly problem solve challenges and connect teams to resources to advance their goals. (Coaching will start in October 2021 with the first session dedicated to reviewing and refining the baseline capability assessment.)
Who should be on the core team?	The core team should consist of 4 to 6 individuals in the following roles that include both primary care and behavioral health representatives: i. A project lead who is responsible for day-to-day activities and can coordinate the work of the team, ii. A behavioral health care provider and leader to champion changes in their clinic and influence change across the organization, iii. A physical health care provider and leader to champion changes in their clinic and influence change across the organization, iv. At least one frontline staff member (e.g., medical assistant, care manager, care coordinator, call center representative) who will co-develop, test, and implement changes, v. Other team members could include those with expertise in data, systems management/electronic health record, etc.
Who is required to attend the convenings and coaching calls?	We expect "core team" members to attend the four learning sessions, four webinars, and monthly coaching calls. We recognize that the whole team will not be able to attend every meeting, but since success is driven by a strong team (including a physician champion), we expect that they participate regularly, especially in the coaching calls.
Who should be on the extended team, and what are the attendance requirements?	Teams will be asked to have 1-2 extended team members. This person (people) will serve as an executive sponsor and be able to make decisions that help in removing barriers and setting the core team up for success. We are hoping that this team member(s) will participate in the following ways:

	i. Join a coaching call in Year 1 focused on how to support the team's action plan. ii. Attend a virtual or in-person session by the end of Year 1 where the team shares work-to-date or a pitch for upcoming efforts (expected fall 2022, date TBD). iii. Meet with the team in Year 2 to discuss spreading and sustaining the progress and accomplishments of program participants to date.