Learning Objectives:

• Be informed of interim findings of the Behavioral Health Home services evaluation.

• Share experiences, challenges, and solutions in the provision of BHH services, with specific attention to making and tracking referrals.

• Develop/enhance relationships with fellow BHH services providers.
1:00   Welcome and Overview
1:10   Introductions and Getting acquainted
1:20   BHH services interim evaluation findings
1:55   Facilitated small group discussions: evaluation results, now what?
2:45   Break
3:00   BHH services providers panel: Referral tracking
4:00   Q&A, discussion with panel
4:15   DHS updates, wrap-up
Getting Acquainted

Introduce yourself at your tables:

• Name
• Role
• Organization
• Share a success or success story
BHH services interim evaluation findings
Wilder Research
Behavioral Health Home Services
Preliminary Evaluation Findings

April 9, 2019
Agenda

- Key evaluation findings
  - Consumer interview themes
  - Implementation checklist
  - Staff interview results
  - Referral tracking
- Next steps
- Using evaluation data
- Discussion
Interviews with Individuals Receiving BHH Services
Background: Interviews with people receiving BHH services

What: NAMI-MN and Wilder interviewed 81 adults and 12 caregivers who received BHH services from 18 sites

When: July through August 2018

Why: To learn about their experiences with the BHH services model
Assisting in setting goals

- Nearly all respondents identified health goals they were working on, including:
  - Managing anxiety and staying calm
  - Increasing physical activity
  - Improving social skills

89% said staff helped them come up with goals

94% said staff helped create a plan to address goals
94% said the plan and/or staff helped them reach their goals

- Most common improvements included:
  - Physical health
  - Mental health
  - Socialization skills
  - Stable housing
  - Independence in daily living
## Supporting appointments

<table>
<thead>
<tr>
<th>Does the BHH services team...</th>
<th>Most of the times or always</th>
<th>Sometimes</th>
<th>Never</th>
<th>Not needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help you make the appointments you need?</td>
<td>47%</td>
<td>29%</td>
<td>6%</td>
<td>19%</td>
</tr>
<tr>
<td>Remind you about the appointments?</td>
<td>51%</td>
<td>20%</td>
<td>4%</td>
<td>25%</td>
</tr>
<tr>
<td>Provide assistance to help you get to the appointments?</td>
<td>26%</td>
<td>21%</td>
<td>10%</td>
<td>43%</td>
</tr>
<tr>
<td>Follow up with you about the appointments?</td>
<td>62%</td>
<td>25%</td>
<td>3%</td>
<td>10%</td>
</tr>
</tbody>
</table>
Providing resources

- Learned about their health condition: 67%
- Received ANY referral: 93%
- Transportation referral: 85%
- Mental health services referral: 78%
- Physical health services referral: 77%
- Housing referral: 76%
- Food support referral: 75%
Building satisfaction

When asked what was most helpful, respondents said:

- Great staff
  - Reliable
  - Dependable
  - Responsive
  - Caring
  - Accommodating
  - Flexible
Building satisfaction

When asked what was most helpful, respondents said:

- **Great staff**
- **Emotional support**
  - Encouragement
  - Having someone to talk to
  - Comfort
Building satisfaction

When asked what was most helpful, respondents said:

- Great staff
- Emotional support
- Useful information
  - Answering questions
  - Problem solving
  - Finding resources
  - Helping to manage day-to-day living
Building satisfaction

When asked what was most helpful, respondents said:

- Great staff
- Emotional support
- Useful information
- Help with appointments
  - Making appointments
  - Managing appointments
  - Providing reminders
Building satisfaction

When asked what was most helpful, respondents said:

- Great staff
- Emotional support
- Useful information
- Help with appointments
- Check-ins
  - Follow-up calls
  - Maintaining accountability
  - Celebrating successes
Creating positive change

- Individuals served reported **improvements** in:
  - Mental health
  - Physical health
  - Self esteem
  - Hopefulness
  - Socialization
  - Self-awareness
  - Knowledge about health condition
  - Coping skills
  - Confidence
  - Independence in daily living
Improving services

- Overall, respondents did not have suggestions, but those who did wanted:

  **Greater staff capacity**
  - Greater staff availability
  - More consistent check-ins or follow-ups
  - Better staff retention
  - Increased staff training

  **Additional resources**
  - Transportation assistance
  - Opportunities for more social interaction
  - Housing support
Implementation Checklist
Background: Implementation checklist

**What:** 19 sites completed self-report implementation checklist

**When:** April 2018

**Why:** To document the extent to which they were implementing key elements of the behavioral health home services model at that time
Most common BHH services elements implemented

- Use of electronic health records (100%)
- Access to referral and contact information (100%)
- Evidence-based practices (100%)
- Accessible care and appointment support (100%)
- Person-centered health action planning (100%)
- Tracking cultural and personal preferences and needs (100%)
- Culture to support the BHH model (90-100%)
BHH services elements with greatest room for improvement

- Use of Provider Partner Portal for population management (63%)
- Support for transitions in care (74-79%)
- Health coaching (79%) and wellness education (74%)
- Use of patient registry to inform population management (79%)
- Access to medications (74%) and lab results (84%)
- Systematic follow-up with screenings (84%)
- Capacity to administer or refer for SUD screening (84%)
- Use of Mental Health Information System (84%)
Staff Interviews
Background: Interviews with BHH services staff

**What:** Wilder interviewed 74 staff from 19 sites

**When:** April through May 2018

**Why:** To ask about the progress in implementing the BHH services model, additional supports needed, and changes seen in people receiving BHH services
Observing positive change

- Staff observed the people they served improving in:
  - Independence in managing health conditions
  - Independence in daily living
  - Advocating for themselves
  - Engagement in healthcare
  - Knowledge about health condition
  - Understanding the health system
  - Treatment for untreated conditions
  - Preventative healthcare
  - More stable housing
Observing positive change

- Staff observed the people they served improving in:
  - Independence in managing health conditions
  - Independence in daily living
  - Advocating for themselves
  - Engagement in healthcare
  - Knowledge about health condition
  - Understanding the health system
  - Treatment for untreated conditions
  - Preventative healthcare
  - More stable housing
Implementation challenges

- Staff identified challenges in implementing BHH services:
  - BHH services not well known or understood
  - Slow referrals
  - Difficulty accessing records from outside providers
  - Diagnosis assessment requirement
  - High staff turnover
  - Billing or receiving payment
  - Cumbersome patient registry
  - Insufficient reimbursement rates
  - High caseload ratios
Needed supports for people served

- BHH services providers identified they need access to more:
  
  **Affordable housing**

  **Transportation**

- Those receiving services asked for more of these supports too
Needed supports for BHH services implementation

BHH services providers asked DHS to help:

**Improve reimbursement**
- Advocate for funding for administrative supports
- Negotiate for higher rates
- Make claims processing faster

**Create efficiencies**
- Allow greater flexibility on requirements
- Ensure the Partner Portal is updated

**Build capacity**
- Advertise and educate providers/community about BHH services
- Offer additional training
- Facilitate more regular check-ins
- Provide more opportunities to connect and share lessons learned
Referral Tracking
Background: Referral tracking

**What:** Collected data on all referrals made by BHH services providers

**When:** Three quarters (April 1 – June 30; July 1 – August 31; September 1 – Dec 31)

**Why:** To identify patterns in the number and types of referrals offered and received
Overall referrals made and followed-up on

BHH services providers made about **4,000** referrals in 9 months.

**62%** were followed-up on by the person receiving the referral.

Sites made between **34** and **870** referrals (Avg = **174**)

Sites had a follow-up rate between **23%** and **98%** (Avg = **63%**).
## Most common types of referrals

<table>
<thead>
<tr>
<th>Referral type</th>
<th>Number of referrals</th>
<th>Percent of total referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health care</td>
<td>959</td>
<td>24%</td>
</tr>
<tr>
<td>Physical health care</td>
<td>820</td>
<td>21%</td>
</tr>
<tr>
<td>Housing</td>
<td>588</td>
<td>15%</td>
</tr>
<tr>
<td>Transportation</td>
<td>227</td>
<td>6%</td>
</tr>
<tr>
<td>Disability services</td>
<td>173</td>
<td>4%</td>
</tr>
<tr>
<td>Recreational, social, or cultural</td>
<td>154</td>
<td>4%</td>
</tr>
<tr>
<td>SNAP/Food support</td>
<td>153</td>
<td>4%</td>
</tr>
<tr>
<td>Dental care</td>
<td>143</td>
<td>4%</td>
</tr>
</tbody>
</table>
Most followed-up on referrals

<table>
<thead>
<tr>
<th>Referral type</th>
<th>Percent of referrals followed-up on</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA/Insurance/MnSure</td>
<td>77%</td>
</tr>
<tr>
<td>Disability services</td>
<td>71%</td>
</tr>
<tr>
<td>MFIP/Financial assistance</td>
<td>70%</td>
</tr>
<tr>
<td>SNAP/Food support</td>
<td>70%</td>
</tr>
<tr>
<td>Transportation</td>
<td>67%</td>
</tr>
<tr>
<td>Housing</td>
<td>63%</td>
</tr>
<tr>
<td>Physical health care</td>
<td>63%</td>
</tr>
<tr>
<td>Education</td>
<td>63%</td>
</tr>
</tbody>
</table>
Next Steps
Upcoming deliverables

- Comprehensive report due to DHS in June
- Series of summaries in August, likely including:
  - Urban sites
  - Rural sites
  - Primary care sites
  - Mental health sites
  - Certified Community Behavioral Health Clinics (CCBHC) sites
- Full implementation evaluation in the future
Using Evaluation Results
Tips for using your evaluation results

Know your audience – Who are the most important stakeholders for your results? What are they most interested in knowing?

Consider what information will impact and what might overwhelm your audience.

Determine if each audience is more interested in ‘hard facts’ or anecdotal narrative.

Practice cultural sensitivity in sharing results.
Using your evaluation results to improve programming

**Develop an action plan for what needs to be done, by whom, and by when**

- Find ways to enhance the activities that:
  - Participants like the most
  - Are closely related to positive outcomes
- Identify opportunities to strengthen other activities
- Look whether participants received the amount and type of services intended
  - If not, find ways to reduce barriers
- Prioritize key strategies most relevant to goals
Using your evaluation results more broadly

**Influencing decision makers**
- Make your point quickly
- Use personal stories with data
- Understand your audience may hold different opinions, values, backgrounds
- Show your passion
- Understand what different decision makers consider credible

**Marketing and fundraising**
- Promote outcomes AND satisfaction
- Use relatable comparisons to show the size of impact
- Use your findings to identify what grants to pursue
- Include findings in grants to give you a competitive edge
- Share data in multiple ways
Discussion

- At your table:
  - Identify a note taker and a presenter
  - Discuss the following (15 min):

  *How can evaluation results be used to support BHH service providers?*

- We will come back and report to the group (15 min)
Facilitated small group discussions: evaluation results, now what?

Break Time!
BHH services providers panel: Referral tracking Western Mental Health Center, Northern Pines Mental Health Center, Fairview Health Services, Vail Place
“My integrated care team has made my life whole again. I finally have a group that is helping me stand up for myself.”

~WMHC Client

Sarah Ackerman, Executive Director
E-mail: Sackerman@wmhcinc.org
Phone: 507-337-4926
### Tracking Tool – pg. 1

<table>
<thead>
<tr>
<th>Date of referral</th>
<th>Organization or service referral was to</th>
<th>Type of referral</th>
<th>Did client follow up on the referral?</th>
<th>Notes</th>
<th>Staff initials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physical health care</td>
<td>☐ Physical health care</td>
<td>☐ Legal assistance</td>
<td>☐ Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Mental health care</td>
<td>☐ Mental health care</td>
<td>☐ Child care</td>
<td>☐ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Dental care</td>
<td>☐ Dental care</td>
<td>☐ Education</td>
<td>☐ Unsure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Chemical health care</td>
<td>☐ Chemical health care</td>
<td>☐ Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Housing</td>
<td>☐ Housing</td>
<td>☐ Transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Disability services</td>
<td>☐ Disability services</td>
<td>☐ SNAP/Food Support</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ MA/Insurance/MnSure</td>
<td>☐ MA/Insurance/MnSure</td>
<td>☐ MFIP/Financial Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Other, specify:</td>
<td>☐ Other, specify:</td>
<td>☐ Recreational, social, or cultural</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Other basic needs, specify:</td>
<td>☐ Other basic needs, specify:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>____________________</td>
<td>____________________</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>|                  | Physical health care                   | ☐ Physical health care | ☐ Legal assistance                    | ☐ Yes |               |
|                  | ☐ Mental health care                   | ☐ Mental health care | ☐ Child care                           | ☐ No  |               |
|                  | ☐ Dental care                          | ☐ Dental care      | ☐ Education                           | ☐ Unsure |               |
|                  | ☐ Chemical health care                 | ☐ Chemical health care | ☐ Employment                          |       |               |
|                  | ☐ Housing                              | ☐ Housing          | ☐ Transportation                       |       |               |
|                  | ☐ Disability services                  | ☐ Disability services | ☐ SNAP/Food Support                    |       |               |
|                  | ☐ MA/Insurance/MnSure                  | ☐ MA/Insurance/MnSure | ☐ MFIP/Financial Assistance          |       |               |
|                  | ☐ Other, specify:                      | ☐ Other, specify: | ☐ Recreational, social, or cultural   |       |               |
|                  | ☐ Other basic needs, specify:          | ☐ Other basic needs, specify: |       |       |               |
|                  | ____________________                   | ____________________ |                                         |       |               |</p>
<table>
<thead>
<tr>
<th>Date of referral</th>
<th>Organization or service referral was to</th>
<th>Type of referral</th>
<th>Did client follow up on the referral?</th>
<th>Notes</th>
<th>Staff initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health care</td>
<td>Child care</td>
<td>Legal assistance</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health care</td>
<td>Education</td>
<td>Education</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental care</td>
<td>Employment</td>
<td>Employment</td>
<td>Unsure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical health care</td>
<td>Transportation</td>
<td>Transportation</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability services</td>
<td>SNAP/Food Support</td>
<td>SNAP/Food Support</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MA/Insurance/Transaction</td>
<td>MFIP/Financial Assistance</td>
<td>MFIP/Financial Assistance</td>
<td>Unsure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td>Recreational, social, or cultural</td>
<td>Recreational, social, or cultural</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other basic needs, specify:</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of referral</th>
<th>Organization or service referral was to</th>
<th>Type of referral</th>
<th>Did client follow up on the referral?</th>
<th>Notes</th>
<th>Staff initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health care</td>
<td>Child care</td>
<td>Legal assistance</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health care</td>
<td>Education</td>
<td>Education</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental care</td>
<td>Employment</td>
<td>Employment</td>
<td>Unsure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical health care</td>
<td>Transportation</td>
<td>Transportation</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability services</td>
<td>SNAP/Food Support</td>
<td>SNAP/Food Support</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MA/Insurance/Transaction</td>
<td>MFIP/Financial Assistance</td>
<td>MFIP/Financial Assistance</td>
<td>Unsure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td>Recreational, social, or cultural</td>
<td>Recreational, social, or cultural</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other basic needs, specify:</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of referral</th>
<th>Organization or service referral was to</th>
<th>Type of referral</th>
<th>Did client follow up on the referral?</th>
<th>Notes</th>
<th>Staff initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health care</td>
<td>Child care</td>
<td>Legal assistance</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health care</td>
<td>Education</td>
<td>Education</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental care</td>
<td>Employment</td>
<td>Employment</td>
<td>Unsure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical health care</td>
<td>Transportation</td>
<td>Transportation</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability services</td>
<td>SNAP/Food Support</td>
<td>SNAP/Food Support</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MA/Insurance/Transaction</td>
<td>MFIP/Financial Assistance</td>
<td>MFIP/Financial Assistance</td>
<td>Unsure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, specify:</td>
<td>Recreational, social, or cultural</td>
<td>Recreational, social, or cultural</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other basic needs, specify:</td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Referral Tracking Process

• Inside Referrals
  – Follow up using ECR and Patient Registry

• Outside Referrals
  – Followed Up: Yes, No, Unsure
    • Document date that referral went out
    • Date of appointment
    • Call to follow up on appt. findings
      – Additional referral/services needed
      – Reschedule if needed

• Responsible Party & Timeframe
  – Integration Specialist
  – Weekly Team Review & Up-date Patient Registry
Challenges

• Identifying specialty local resources
• Education on BHH services vs TCM services
• Lack of Discretionary/Emergency Funds
• Lack of Client Follow Through
Success

- Increased Accountability for the follow up process with referrals
  - Consistent reminders
  - Better quality care
  - Client involved in process

- Removing Access to Barriers
- Whole Health Approach
Northern Pines
BHH services Program
What we will cover

- Results
- What we learned from others
- What worked
- Improvements to be made
Our Referral Tracking Results

- Our caseload compared to other sites
- Improvements between quarters
What we learned from others

• Team Huddles
• Referral examples
What Worked?

• Connecting each week
• Embracing our mistakes
What can we improve in the future?

- Be intentional during meetings
- Changing EMR
- Better utilization of the registry
- Inclusivity in documentation - Give yourself credit for the work you do
Thank You!

Teamwork makes the dream work!

Contact Information for NPMH BHH services:

• 218-454-3832 (Office)
• 218-851-6326 (Chris Abelt)
• cabelt@npmh.org
Behavioral Health Home (BHH) Services Providers
Spring Learning Workshop

Leah Rosen, BSW, BHH SW CC
Judy Karels, BSW, BHH SW CC
Referral Tracking Process

• Overview of Referral Tracking System
  - Process of tracking referrals
  - Time needed to complete referral tracking process
Challenges and Solutions with Referral Tracking Process

• **Challenges**
  - Time Consuming
  - Missing Data

• **Solutions**
  - Set aside dedicated time to complete systematic chart reviews
  - Review BHC and PCP orders
  - Standardized process for documenting referrals (was already in place)
Recommendations

• Recommendations to improve referral tracking process:
  - Build in electronic tracking system to include date/time/type of referral
  - Track how many outreaches until referral was used
  - Track date referral was used or discontinued
Success Stories

- **Success Stories**

  - Resources provided
  - Number of patient contacts before referral was discontinued
  - Positive impact of referrals
Vail Care
Referral Tracking Process
Vail Care Approach to Referral Tracking

• Initial questions and thoughts by our team:
  • “Let’s not work harder than we have to!”
  • “How can our existing technology support us with referral tracking without EXTRA work?”

• We created a modifiable log template in our EMR – Credible.
  • Log allows us to enter/track up to 10 separate referrals in a single service entry.
  • The “type of referral” includes the recommended DHS list of referrals.
Process for Tracking Referrals

• Staff start the service to document a referral being made;
• Select the appropriate box for type of referral, add the date and add any relevant notes;
• If multiple referrals (up to 10) are made, all can be tracked in a single service;
• This service won’t “lock” in Credible – it remains open as a reminder it’s still in progress.
Closing the Loop

• Monthly, a Credible Report is pulled to identify which services still need to be completed.

• Staff open the service and fill in any remaining fields to document the outcome of the referral.

• This serves as a reminder to follow up with individuals to see if they need additional support in relation to the referral.

• Quarterly, a report is again pulled to identify any “open” notes. Information is gathered to fill in the necessary fields so the note can be completed (locked) indicating the service and referral loop is closed.
### Claim Delay Reason:
- Approved: False
- Approved By / On:  
- Diagnosis: (F20.0)
- Episode ID: 12450
- Billing Matrix: BHHR-Referrals
- Status: COMPLETED
- Authorized ID:  
- Signed: 2/25/19 3:47 PM
- Merged:  
- Billing Group: Val Place
- Additional Fields:  
- non_release: False

### BHH-Vail Care Progress
#### Notes
- **Goal Progress**

#### Referrals
<table>
<thead>
<tr>
<th>Date of Referral</th>
<th>Organization or service referral was to</th>
<th>Type of referral</th>
<th>Did participant follow-up on the referral?</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/18/2019</td>
<td>Best Living Assisted Living Program</td>
<td>Housing</td>
<td>Yes</td>
</tr>
<tr>
<td>02/25/2019</td>
<td>Housing</td>
<td>Housing</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Notes:**
- Thumper toured the program but didn't like the location. He will continue to look.
- Date of Referral: 02/25/2019
- Type of referral: Housing
- Did participant follow-up on the referral?: Yes
- Notes:
  - Thumper set up a tour of Valley View Assisted Living for March 3rd.
Any challenges?

• Vail Place had used a similar process for another program so the general process was in place.

• Initial planning meetings were held with our Data and Evaluation Coordinator (our EHR expert) to discuss required elements and process, reports and QA.

• Implementation was fairly smooth.

• It’s important to pull reports to watch for services left “open”.

• This process allows for built in quality monitoring. It helps insure we didn’t miss following up on a referral.
Vail Care Team

- Kristina Swanberg, Lead System Navigator kswanberg@vailplace.org
- Julie Plante, RN, Integration Specialist jplante@vailplace.org

Questions?
Behavioral health home (BHH) services Updates
Providers & people served

- **28 BHH services providers**
- **Over 3000 people served**
- **Residing in 65+ counties**
- **See website for providers**

Minnesota Department of Human Services | mn.gov/dhs
**Upcoming Learning Events**

**May 15, 2019 in Marshall**

Leadership and Organizing in Action Workshop
Learn how to exercise leadership to engage others in population health and quality improvement. Participants will also understand how to organize and mobilize partners and stakeholders who have an interest in defining a shared vision and action plan to strengthen collaboration and create health together.

**June 4, 2019 in Duluth**

**July 2019**

Position Paper: Racism and Its Harmful Effects on Nondominant Racial & Ethnic Youth and Youth-Serving Providers: A Call to Action for Organizational Change
Creating Inclusive Programs

**August 2019**

Addressing tobacco uses and dependence in individuals with mental illness and motivational interviewing.

**TBD**

Sharing final evaluation results, discussion on use of results and sharing of resources

Minnesota Department of Human Services | mn.gov/dhs
Thank You

Thank you!

Questions?

For more information visit: mn.gov/dhs/mhcp/bhh-services