Ohio | Department of Medicaid

Ohio Mental Health & Addiction Services

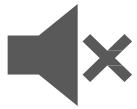
OhioRISE | Resilience through Integrated Systems and Excellence

OhioRISE Psychiatric Residential Treatment Facility (PRTF) Workgroup

June 2, 2021

9:00 AM-11:00 AM

Housekeeping



All participants can mute and unmute their own lines, **so please be sure to mute your line when you're not talking. If you are muted during the meeting and called in, you must press *6 to unmute.**

Please introduce yourself by entering your name, title, and organization in the chat feature.

We hope to have robust oral discussion among workgroup members. All other attendees may enter comments or questions using the **chat** feature in Teams.

The slides from this meeting will be available following the meeting on the OhioRISE Website.

Agenda

1. Welcome and Introductions
2. PRTF Overview
   - ❖ CFR Recap
   - ❖ QRTP vs. PRTF
3. PRTF Concepts
4. Small Group Discussions and Large Group Report-out
5. Next Steps

PRTF Workgroup

Psychiatric Residential Treatment Facility (PRTF) Workgroup **Role**

- Contribute personal experience from providing / participating in use of residential and psychiatric residential treatment
- Provide expert clinical and programmatic feedback on development of serving children and youth in these settings
- Review and provide feedback on regulatory concepts and rules
- Provide critical feedback regarding PRTF implementation

PRTF WORKGROUP MEMBERS:

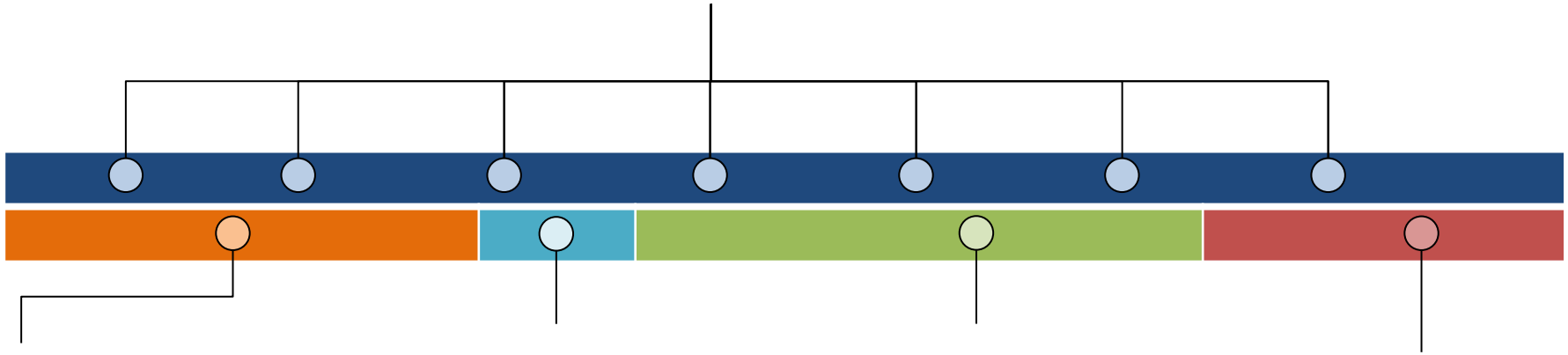
OhioRISE Advisory Council members and others they suggested for workgroup participation

- Diverse range of expertise and experience
- Local system partners
- Associations and providers of services
- Youth and Families with lived experience
- Ohio's geography

OhioRISE PRTF Timeline

January 2021 - TBD 2022

OhioRISE Advisory Council Meetings



March-Fall 2021

PRTF Workgroups

Fall 2021

Initial Rule Filings

Spring 2022

Implementation and Operations Workgroup

Summer 2022

Final Rule Filings
PRTF Go-Live 7/1/22

PRTF - CFR Recap

42 CFR Part 441, Subpart D Review: General Requirements - 441.151

Inpatient psychiatric services for individuals under age 21 must be:

- Provided under the direction of a physician
- Provided by:
  - A psychiatric hospital; or
  - A psychiatric facility that is not a hospital that:
    - Is accredited by The Joint Commission, CARF, COA, or any other state-approved accrediting organization; and
    - Meets requirements in 42 CFR 441.151 to 441.184, and 483.350 to 483.376
- Provided before the individual reaches age 21, or if receiving the services upon turning age 21, until the earlier of:
  - Discharge; or
  - reaches age 22
- Certified in writing to be necessary in the setting in which the services are provided

42 CFR Part 441, Subpart D Review: Certification of Need for Services

441.152 - A team must certify:

- Ambulatory care resources available in the community do not meet the treatment plan needs of the recipient
- Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician; and
- The services can reasonably be expected to improve the recipient's condition to prevent further regression so that the services will no longer be needed.

441.153 – Certification of the need for services must be made by an independent team that:

- Includes a physician;
- Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry; and
- Has knowledge of the individual's situation

42 CFR Part 441, Subpart D Review: Active Treatment and Individual Plan of Care

441.154 – Active Treatment – Requires a professionally developed and supervised individual plan of care that is:

- Developed and implemented no later than 14 days after admission and designed to achieve the beneficiary's discharge from inpatient status at the earliest possible time

441.155 – Individual Plan of Care – A written plan developed for each beneficiary in accordance with regulations, to improve the patient's condition to the extent that inpatient care is no longer necessary

- The plan of care must:
  - Be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the beneficiary's situation and reflects the need for inpatient psychiatric care;
  - Be developed by a team of professionals specified under §441.156 in consultation with the beneficiary; and parents, legal guardians, or others in whose care the youth will be released after discharge;
  - State treatment objectives;
  - Prescribe an integrated program of therapies, activities, and experiences designed to meet the objectives; and
  - Include, at an appropriate time, post-discharge plans and coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care with the beneficiary's family, school, and community upon discharge.
- The plan must be reviewed every 30 days by the interdisciplinary teams to:
  - Determine that services being provided are or were required on an inpatient basis, and
  - Recommend changes in the plan as indicated by the recipient's overall adjustment as an inpatient.

42 CFR Part 441, Subpart D Review: Interdisciplinary Team Requirements - 441.156

The individual plan of care must be developed by an interdisciplinary team of physicians and other personnel who are employed by, or provide services to patients in, the facility

Based on education and experience, preferably including competence in child psychiatry, the team must be capable of:

- Assessing the beneficiary's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities;
- Assessing the potential resources of the beneficiary's family;
- Setting treatment objectives; and
- Prescribing therapeutic modalities to achieve the plan's objectives.

The team must include at a minimum, either:

- A board-eligible or board-certified psychiatrist;
- A clinical psychologist who has a doctoral degree and or a physician licensed to practice medicine or osteopathy; or
- A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases, a psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association

- The team must also include one of the following:
  - A psychiatric social worker;
  - A registered nurse with specialized training (in mental health) or one year's experience in treating mentally ill individuals;
  - An occupational therapist who is licensed, if required by the state, and who has specialized training or one year of experience in treating mentally ill individuals; or
  - A psychologist who has a master's degree in clinical psychology or who has been certified by the state or by the state psychological association.

42 CFR Part 441, Subpart D Review: Emergency Preparedness - 441.184

PRTF must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years, that must:

- Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
- Include strategies for addressing emergency events identified by the risk assessment.
- Address resident population, including, but not limited to, persons at-risk; the type of services the PRTF has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
- Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.

The emergency preparedness plan must include:

- Implementation of emergency preparedness policies and procedures re: substinence needs; a system to track the location of staff and residents; safe evacuation from the PRTF; a means to shelter in place; a system of medical documentation the preserves and protects the confidentiality of resident information; emergency staffing strategies; arrangements with other providers to receive residents; and the role of the PRTF in the provision of care and treatment at an alternate care site; and
- Development and maintenance of a communication plan; and
- Development and maintenance of an emergency preparedness training program

42 CFR Part 443, Subpart G Review: Protection of Residents - 483.356

Restraint or seclusion must only be used for the protection of residents in an emergency safety situation

- Each resident has the right to be free from restraint or seclusion of any form used as a means of coercion, discipline, convenience, or retaliation
- An order for restraint or seclusion must not be written as a standing order or on an as-needed basis
- Restraint or seclusion must not result in harm or injury to the resident and must be used only:
  - To ensure the safety of the resident or others during an emergency safety situation (unanticipated resident behavior that places the resident or others at serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention); and
  - Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired
- Restraint and seclusion must not be used simultaneously
- An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, the resident's chronological and developmental age; size; gender; physical, medical and psychiatric condition; and personal history (including any history of physical or sexual abuse)

PRTF Regulations – 42 CFR Part 443 Subpart G - Restraint and Seclusion

Restraint or seclusion must only be used in an emergency safety situation:

- If resident's treatment team physician is available only, he/she can order restraint or seclusion
- Physician must order least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.
- The physician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention
- Each order for restraint or seclusion must:
  - » Be limited to no longer than the duration of the emergency situation
  - » Under no circumstances exceed 4 hours for residents 18-21, 2 hours for residents 9-17, or 1 hour for residents under 9
  - » Be documented in the resident's record by the end of the shift in which the intervention occurred
- Face to face assessment must be completed by a physician or licensed practitioner within 1 hour of initiation
- Notification, reporting and staff training requirements
- Postintervention debriefings within 24 hours
- The facility must notify the parent or legal guardian of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention

QRTP vs. PRTF

BBI Comparison of Federal Requirements – QRTP vs. PRTF

Component	QRTP	PRTF
System	Children involved with the child welfare system (Title IV-E agency which can be state or Tribal).	Children with behavioral health needs, including children involved with child welfare.
Funding	Title IV-E funds can reimburse “maintenance” costs, which include room and board, supervision, case management and allocated indirect costs for children who are eligible. Title IV-E will not reimburse the cost of any treatment services received by any child regardless of the child’s IV-E eligibility.	Medicaid (Title XIX) can reimburse the entire cost of care and clinical services through the "Psych under 21" option, subject to requirements at 42 CFR 441 Subpart D. Medicaid reimbursements cover not only treatment services but also “maintenance” costs such as “room and board” that are incorporated into the provider rate.
Service Definition	A QRTP is a newly-defined level of care for placement in a child care institution created under The Family First Act. The QRTP is one of the four reimbursable non-foster family placement settings (licensed as child care institutions) that the Title IV-E agency can seek federal reimbursement for under Title IV-E for a child who is removed from their family and goes into foster care. Family First defines access to continued reimbursement for the QRTP level of care.	PRTF may be provided by the listed entities below if they have a provider agreement with a State Medicaid Agency to provide the inpatient psychiatric services to individuals under the age of 21 who are Medicaid-eligible • A **psychiatric facility** that is not a hospital but is appropriately accredited.

https://familyfirstact.org/resources/comparison-federal-requirements-qualified-residential-treatment-programs-qrtp-psychiatric

Comparison of Federal Requirements – QRTP vs. PRTF

Component	QRTP	PRTF
Population Served	Children up to age 18 who are in out-of-home care for whom an assessment, completed by a qualified individual, determines that the child's needs cannot be met in a less restrictive, family-based setting because of their serious emotional or behavioral disorders or disturbances	Individuals under age 21 who are diagnosed with a psychiatric condition and demonstrate the need for PRTF service.
Treatment Model	QRTPs must have a trauma-informed treatment model that is designed to address the needs, including clinical needs as appropriate, of children with serious emotional or behavioral disorders or disturbances and be able to implement the necessary treatment identified in the child's assessment	PRTF programs are designed to offer a short term, intense, focused mental health treatment program to promote a successful return of the youth to the community. Specific outcomes of the mental health services include the youth returning to the family or to another less restrictive community living situation as soon as clinically possible and when treatment in a PRTF is no longer medically necessary.
Staffing	QRTPs must have registered or licensed nursing and other clinical staff who provide care within the scope of their practice as defined by state law, are onsite consistent with the QRTP trauma-informed treatment model and are available 24/7. These staff do not have to be directly employed by the QRTP.	PRTFs are not required to have a specific number of nursing staff at each facility or unit. However, the PRTF must ensure there is sufficient RN coverage to perform RN duties, such as nursing assessment during emergency safety interventions, and treatment for injuries.

https://familyfirstact.org/resources/comparison-federal-requirements-qualified-residential-treatment-programs-qrtp-psychiatric

Comparison of Federal Requirements – QRTP vs. PRTF

Component	QRTP	PRTF
Family	QRTPs must to the extent appropriate, and in accordance with the child's best interests: • Facilitate participation of family members in the child's treatment • program; • Facilitate outreach to the family members of the child, including siblings, document how the outreach is made (including contact information), and maintain contact information for any known biological family and fictive kin of the child; • Document how family members are integrated into the treatment process for the child, including post-discharge, and how sibling connections are maintained.	The PRTF is expected to work actively with the family, other agencies, and the community to offer strengths-based, culturally competent, medically appropriate treatment designed to meet the individual needs of the youth. PRTFs must: • Develop a plan of care with the parents/legal guardians of minors and those individuals who have legal guardians. • Notify parents/legal guardians after serious occurrence(s). • Give parents/legal guardians the opportunity to participate in debriefings of emergency safety interventions.
Discharge Planning	The QRTP is required to do discharge planning.	The PRTF in the individual plan of care must include discharge plans and aftercare resources such as community services to ensure continuity of care with the child/youth's family, school, and community upon discharge.
Aftercare	QRTPs are required to provide family-based aftercare supports for at least 6 months post-discharge.	PRTFs are required to identify in the individual plan of care, aftercare resources such as community services to ensure continuity of care with the child/youth's family, school, and community upon discharge.

https://familyfirstact.org/resources/comparison-federal-requirements-qualified-residential-treatment-programs-qrtp-psychiatric

Comparison of Federal Requirements – QRTP vs. PRTF

Component	QRTP	PRTF
Licensing and Accreditation	QRTPs must be licensed as child caring institutions by the state entity responsible for this in accordance with section 471(a) (10) of the Social Security Act. QRTP's must be accredited by The Joint Commission, The Commission on Accreditation of Rehabilitation Facilities (CARF), The Council on Accreditation of Services for Families and Children (COA), or another independent not-for-profit accrediting organization HHS approves.	PRTFs are licensed or certified in each state based on the state specific requirements for this service, specified by the state Medicaid program. PRTFs must be accredited by The Joint Commission, The Commission on Accreditation of Rehabilitation Facilities (CARF), The Council on Accreditation of Services for Families and Children (COA), or any other accrediting organization with comparable standards recognized by the State.
Cultural Competence	Not specifically stated in Family First, but there might be in the licensing requirements and or contract requirements of the Title IV-E agency.	Recommended to meet CLAS standards.
Qualified Individual	A trained professional or licensed clinician who is not an employee of the State/Tribal Child Welfare Agency and who is not connected to, or affiliated with, any placement setting in which children are placed by the State/Tribal Child Welfare Agency.	The practitioners required for the treatment team would be considered qualified individuals. All PRTF treatment is under the direction of the physician.

https://familyfirstact.org/resources/comparison-federal-requirements-qualified-residential-treatment-programs-qrtp-psychiatric

Comparison of Federal Requirements – QRTP vs. PRTF

Component	QRTP	PRTF
Assessment / Reassessment	This is to be done by a qualified individual (QI) and must be completed within 30 days of placement. The QI shall: • Work in conjunction with the family of, and permanency team for, the child while conducting and making the assessment. • Use an age-appropriate, evidence-based, validated, and functional • assessment tool (HHS is to provide guidance) to assess the child's • strengths and needs. • Determine if family members or another appropriate placement can meet the child's needs, consistent with the child's short- and long-term goals, in the least restrictive setting consistent with the child's permanency plan. • Document why having the child/youth live with a foster family or one of the other acceptable non-family foster home settings cannot meet their needs & why a QRTP is the most effective and appropriate level of care for the child/youth (lack of sufficient foster families is not an allowable reason). • Document the family and permanency team's placement preference that acknowledges the importance of keeping siblings together and if their preference is different from that of the assessor's, the reason why the preferences of the child and the team are not recommended. • Develop a list of child-specific short- and long-term mental and behavioral health goals. Evidence must be submitted at each status review and permanency hearing that the placement in the residential facility continues to be necessary and is meeting the child's needs.	The assessment must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual's situation and reflects the need for inpatient psychiatric care. The treatment team completes the PRTF certification of need for services. The team must include at a minimum: a board certified or board eligible psychiatrist or a psychologist and a physician. The team must also include one of the following: • A psychiatric social worker. • A registered nurse with specialized training or one year's experience in treating mentally ill individuals. • An occupational therapist who is licensed, if required by the State, and who has specialized training or one year of experience in treating mentally ill individuals. • A psychologist who has a master's degree in clinical psychology or who has been certified by the State or by the State psychological association. The team must certify that: • Ambulatory care resources available in the community do not meet the treatment needs of the individual; • Proper treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician; and • The services can reasonably be expected to improve the beneficiary's condition or prevent further regression so that the services will no longer be needed. The treatment plan must be reviewed and updated at least every 30 days by the treatment team.

https://familyfirstact.org/resources/comparison-federal-requirements-qualified-residential-treatment-programs-qrtp-psychiatric

Comparison of Federal Requirements – QRTP vs. PRTF

Component	QRTP	PRTF
Approval Process for Placement/ Continued Placement Approval	The Court must consider the assessment, the determination and the documentation made by the QI and determine if the needs of the child can be met in a foster family home and if not, whether placement in a QRTP provides the most effective and appropriate level of care in the least restrictive environment, and whether that placement is consistent with the child's short- and long-term goals as specified in the permanency plan. • The court must make the determination within 60 days of the placement as long as a child remains placed in a QRTP, the State agency shall submit evidence at each status review and each permanency hearing for the child: A) demonstrating that ongoing assessment of the strengths and needs of the child continues to support the determination that the needs of the child cannot be met through placement in a foster family home, that the placement in a QRTP provides the most effective and appropriate level of care for the child in the least restrictive environment, and that the placement is consistent with the short- and long-term goals for the child, as specified in the permanency plan for the child, B) documenting the specific treatment or service needs that will be met for the child in the placement and the length of time the child is expected to need the treatment or services; and C) documenting the efforts made by the State agency to prepare the child to return home or to be placed with a fit and willing relative, a legal guardian, or an adoptive parent, or in a foster family home. Any length of stay in a QRTP of a child longer than 12 consecutive months or 18 nonconsecutive months (or, in the case of a child who has not attained age 13, for more than 6 consecutive or nonconsecutive months) must be reviewed by and written approval provided by the head of the State/Tribal Child Welfare Agency for the child to continue in the QRTP.	Continued stay is determined by medical necessity documented by the treatment team.

https://familyfirstact.org/resources/comparison-federal-requirements-qualified-residential-treatment-programs-qrtp-psychiatric

PRTF Concepts

PRTF Guiding Principles

- PRTF is one service on a continuum of care for youth with complex needs
- Trauma-focused, culturally and linguistically competent care
- Individualized, collaborative, and intensive interdisciplinary treatment
- Strength based and evidence-based treatment
- Quickly stabilize youth behaviors and address symptoms to allow return to community in as short of a time-frame as possible.
- Non-coercive care environment
- Youth and family engagement is key component
- Shared decision-making between youth, family and treatment TEAM
- Strengthen and expand the youth and family's community connections and natural supports
- Develop and retain competent PRTF workforce
- Data collection and analysis to demonstrate outcomes and identify any areas for improvement

OMHAS

- Licensure/Certification Standards
- Seclusion and Restraint

ODM

- Eligible providers
- Coverage and Limitations
- Cost Report

OhioRISE Plan

- Selective Contracts
- Medical Necessity Criteria

PRTF Rule Framework Topics

- Characteristics of Youth
- PRTF Model
- Treatment Team
- Staff Qualifications and Training
- Admission Criteria, Certification of Need, Admissions and Discharges

Today

- Treatment, Transition Planning, and Continuity of Care
- Required Services
- Treatment Environment
- Family Engagement
- Data, Outcomes and Performance Improvement

Next Meeting

PRTF Characteristics of Youth

- PRTF programs treat complex youth with mental illness or co-occurring diagnoses and significant behavioral challenges. Many of these youth typically have one or more of the following needs and system experiences:
  - » Severe mental health symptoms
  - » Past hospitalizations
  - » Aggressive or highly aggressive behaviors
  - » Fire setting
  - » Sexualized behaviors
  - » Chronic self-harm/severe self-harm/suicide attempts
  - » Intellectual Disability
  - » Autism Spectrum Disorder
  - » Eating disorders
  - » Multiple past placements
  - » Co-occurring significant substance and mental health issues

PRTF General Service Description

Psychiatric Residential Treatment Facility (PRTF) is an inpatient level, intensive multi-disciplinary residential treatment provided in a non-acute setting for youth with complex needs.

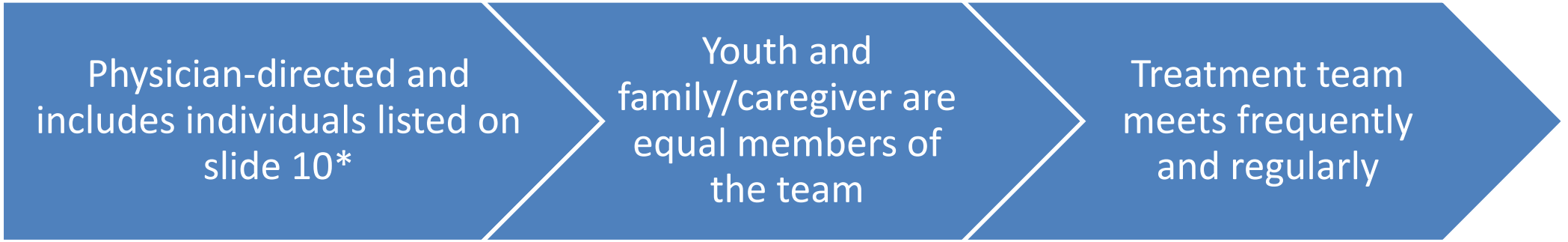
A PRTF delivers individualized services to youth in order to:

- Stabilize behaviors ***in as short as possible timeframe***, and
- Help youth and their family or other caregivers to develop the knowledge and skills needed to safely manage their needs in the community, so that the youth can succeed in all aspects of community living, e.g., home and family, school, employment, etc.

PRTF Model

- Provides active treatment under the direction of a physician seven days a week to children and youth under 21 years of age with complex behavioral health conditions, including but not limited to, severe aggression and functional impairment.
  - » More intensive than other residential services
  - » Able to address the intensive treatment, supervision, and safety needs of the children and youth referred and possess the capacity and expertise to provide targeted treatment services to address the variety of needs of these youth
  - » Expected to adjust programming and treatment based on the needs of the population, the culture of the milieu and the clinical needs presented by the children at the time of treatment.
  - » Evidence-based services
  - » Strength-based
- Time limited, short lengths of stay with treatment focused on the objectives that are most important for the youth to address to achieve a successful transition to their community.
- Offer appropriate educational services
- Available to family post discharge
- Utilize PI processes to monitor performance, address problem areas and troubleshoot, assure increased use of best practices and adjust service delivery when warranted.

Treatment Team



*Note: ODM and MHAS do not intend to permit an Occupational Therapist to be the only required member other than psychiatrist/physician/psychologist

PRTF Staff

- Physician medical director
- Psychiatrist (if the medical director is not one)
- Administrative Director
  - » Bachelor degree in human services field + 4 years prior human services program supervisory experience or master's degree in human services field + 2 years prior human services supervisory experience.
- Clinical Director with two years clinical experience in mental health setting that serves children or adolescents with emotional problems
- Clinical staff to meet each resident's treatment needs who are appropriately credentialed, including to provide substance use disorder services if the PRTF's admission criteria includes youth with SUD
- 24/7 Nursing

Staff Training

- Focus on the talent of the staff in order to achieve positive outcomes
- New hire and on-going staff training (not limited to clinical and direct care staff), including:
  - » Trauma
  - » Evidence-Based Practices
  - » De-escalation techniques
- Culturally and linguistically competent
- Mental Health First Aid for Youth

Admissions, Certification of Need and Discharges

- A PRTF will develop its admission criteria and assure that it has the staff and resources available to meet the needs of referred youth who fit its admission criteria:
  - » Age
  - » Sex
  - » Behaviors it will treat, including aggressive children
  - » Exclusionary behaviors
- Admit youth if confirmed need for PRTF and the youth meets the PRTF's written admission criteria
- Capability to rapidly accept referrals
- Discharge upon successful completion of treatment or with prior department approval, i.e. "no eject policy"
- If admitted to acute inpatient, PRTF must accept the individual back if discharged from the acute unit within a certain number of days

Discussion Topics for Breakout Session

- From your perspective, what are the differences between a PRTF and a QRTP/residential facility?
- What are the best clinical and programmatic methods to facilitate shorter lengths of stay, incorporating transition planning, so youth can discharge directly from PRTFs to safely return to, and remain in, the community?
- Which youth would be best served by PRTFs? What admission criteria would help target these youth?
- What staff training topics are you currently using? Who is receiving training? Who delivers the training?

Breakout Room Discussions

Breakout Rooms

- Break out into smaller groups to discuss rule concepts
- Choose one person per room to take notes and be prepared to report out
  - » This person can also facilitate the discussion or choose someone else to facilitate
  - » The facilitator should help guide the discussion in the room
  - » The facilitator should share their screen and bring up the slide deck
- Typing in the chat box will save your notes for ODM to review later

*Note: If you called in for audio and used another device for video, you will have to manually leave the breakout room you were assigned to get back to the main room to participate with your audio feed.

Next Steps

Next Steps

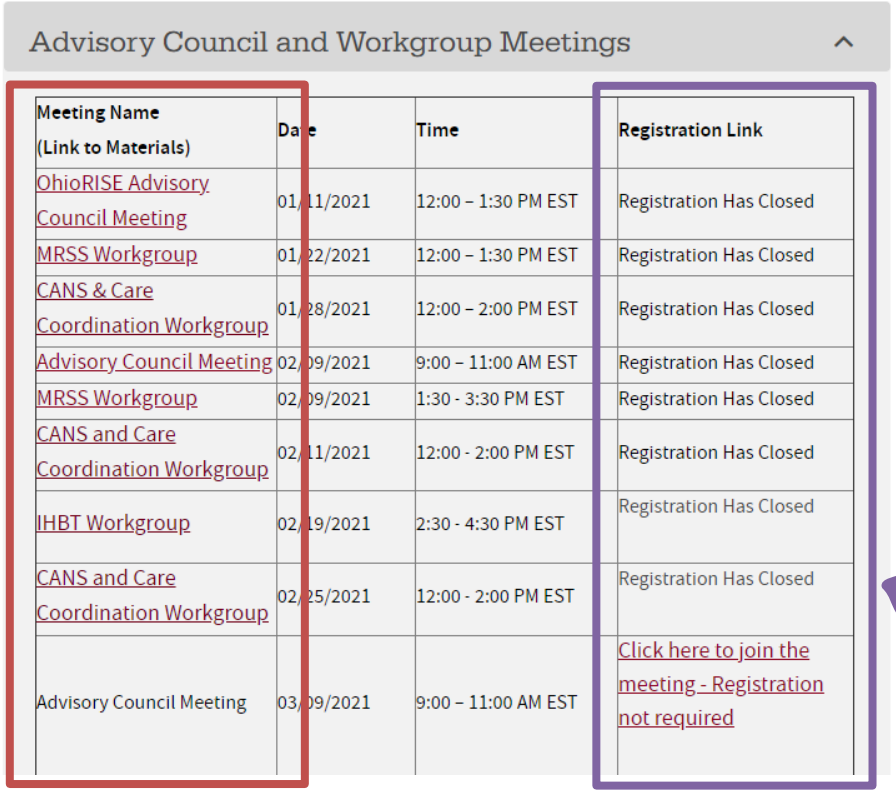
- Next Meeting June 18
  - » Discuss draft rule concepts
  - » Breakout rooms

- Consider breakout room feedback
- Share draft rule for stakeholder comments

OhioRISE Website

On the **OhioRISE website** we post the dates and times of future meetings, links to join the meetings, and presentation materials.

Select **'Advisory Council and Workgroup Meetings'** dropdown tab



Meeting Name (Link to Materials)	Date	Time	Registration Link
OhioRISE Advisory Council Meeting	01/11/2021	12:00 – 1:30 PM EST	Registration Has Closed
MRSS Workgroup	01/22/2021	12:00 – 1:30 PM EST	Registration Has Closed
CANS & Care Coordination Workgroup	01/28/2021	12:00 – 2:00 PM EST	Registration Has Closed
Advisory Council Meeting	02/09/2021	9:00 – 11:00 AM EST	Registration Has Closed
MRSS Workgroup	02/09/2021	1:30 - 3:30 PM EST	Registration Has Closed
CANS and Care Coordination Workgroup	02/11/2021	12:00 - 2:00 PM EST	Registration Has Closed
IHBT Workgroup	02/19/2021	2:30 - 4:30 PM EST	Registration Has Closed
CANS and Care Coordination Workgroup	02/25/2021	12:00 - 2:00 PM EST	Registration Has Closed
Advisory Council Meeting	03/09/2021	9:00 – 11:00 AM EST	Click here to join the meeting - Registration not required

Access meeting presentations by clicking on the **'Meeting Name (Link to Materials)'**

Join meetings by clicking on the meeting links in the **'Registration Link'**

Thank you for participating!