INSTRUCTIONS

This guideline outlines the process for applying for a training with the Health Care Agency, Behavioral Health Training Services (BHTS) department.

All information is needed in order to submit a complete application and to coordinate the training development and implementation.

GENERAL TRAINING REQUEST PROCEDURES

Checklist for Requester

- ☐ Contact BHTS@ochca.com to request assistance with a new training
- ☐ Meet with assigned Training Coordinator to discuss what type of training is needed
- ☐ Develop plan and timeline for the new training
- ☐ Review requirements for advertising, CE process, and information required to support the training implementation

CE PROCEDURES

Checklist for CE Application Portion

Please NOTE: *Continuing Education (CE) credits should* ***not*** *be advertised until after they have been approved through the CE process.*

- ☐ Work with your assigned contact at BHTS to gather and complete required information for the CE application, which must be submitted at least 60 days prior to the training.
- ☐ Submit curriculum vita/resume for each presenter(s).
- ☐ Submit a brief bio for each presenter(s).
- ☐ Submit timed agenda for presentation.
- ☐ Submit the presentation (e.g., PowerPoint).
- ☐ Submit promotional material for learning activity (such as a flyer, email, brochure, etc.)
- ☐ Submit the Financial Interest Disclosure Forms (if applying for CME credit(s)).

SUBMISSION

Submit the completed application and all required information as indicated above to your assigned training coordinator at BHTS.

REQUESTOR INFORMATION

Name of Person Requesting the Training ______ Job Title ______

Phone Number ______ Organization and Department ______ Pony Address ______

Street Address ______ City ______ State ______ Zip code ______

ACTIVITY INFORMATION

Credits Being Requested

☐ MD CME Cat I ☐ Psychologist (APA) ☐ RN (CEP 15109)

☐ LMFT/LCSW (CAMFT 62340) ☐ AOD & CADAAC ☐ Not Applicable

Date Application Submitted ______ Name of Training Coordinator ______ Total Training Hours Requested ______

Training/Conference Title (Full Name) ______

Training Date(s) *(For trainings with single dates, list the date once. For multiple training dates, list each date separately.)*

Training/Conference Date(s)	Start Time(s)	End Time(s)

Lunch Time & Break Description (Specify) ______

Type of Training/Conference (Select One)

☐ In-Person (enter address): ______

☐ Virtual training (select which platform)

☐ Zoom Meeting ☐ Zoom Webinar ☐ Web Ex ☐ Microsoft Teams ☐ Other (specify): ______

☐ E-learning: on-demand, self-paced, asynchronous
(enduring material): Submit a copy of the post-test along with scoring guide which includes the correct answers and the passing score.

☐ Blended Live/Virtual (instructor and/or audience members can be virtual or in-person)

Instructor(s) Information *(To include additional instructors, it can be submitted with the application on a separate sheet.)*

Name	***Title***	***Organization/Institution***	***Commercial Product to be Discussed (if any)***

Training Information

Brief Training/Conference Description

Measurable Training/Conference Objectives

(Describe MEASURABLE behaviors or desirable attributes the attendee will demonstrate / achieve upon completion of the program, OR what change in patient outcomes is expected. Use words like "identify," "describe," "list," "demonstrate." – [Criterion 5 & 6] **A minimum of 3 Learning Objectives are required and 1 per hour is recommended.**

Educational Component Addressing Cultural and Linguistic Competency

(Are cultural/ethnic or linguistic information or data used to establish therapeutic relationships, diagnosis/treatment, enhance process of clinical care?) California Assembly Bill (AB) 1195 http://www.meded.uci.edu/CME/pdfs/AB1195-compliance.pdf

Educational Component Addressing Implicit Bias

(How does the training provide examples of how implicit bias affects perceptions and treatment decisions of physicians or strategies to address how unintended biases in decision making may contribute to health care disparities?) California Assembly Bill (AB) 241 https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB241

Target Audience

(Must indicate why this material is appropriate for the training level and scope of practice of the licensed practitioners indicated? If this activity is for CME, a significant portion of attendees must be physicians) – [Criterion 4]

No. Attendees:	____ County Employees	____ Contractor/Community	____ Interns/Volunteers	____ Total Attendees
If Applicable:	____ % Physicians	____ % Allied Health Professional		____ % Other

Needs Assessment (select all that apply)
(Identify gaps in current practice / outcomes and desired practice / outcomes) – [Criterion 2]

☐ Specific QI data ☐ Committee Studies of Care ☐ County Data
☐ National Trends from National Data ☐ Professional Literature Review ☐ US Health Data

Describe how the needs for this training were assessed and how it will meet those needs.

Teaching Methods (select all that apply)
(Consider the setting, objectives, and desired results of the activity.)

☐ Lecture ☐ Skills Training ☐ PowerPoint Slides
☐ Audio-Visual Segment(s) ☐ Interactive Discussion ☐ Role-play
☐ Other (please specify): ____

References for Content Covered
(At least three (3) current (within the past 10 years), relevant (aligned with learning objectives and content), supporting (e.g., peer-review journal articles for assessment/ intervention or topics related to psychological practice, education or research), and complete references (in APA format) must be provided as evidence that program content is intended to maintain, develop, and increase conceptual and applied competencies that are relevant to psychological practice, education, and science.)

Method of Evaluation
How will HCA measure subsequent outcomes – [Criterion 3]

☐ HCA BHTS Evaluation Form is used
☐ Other: Please describe in box below what evaluation method is being suggested

How will presenter convey to attendees the absence or possibility of conflict of interest *Submit attestation that conflict of interest discloser was conveyed – [Criterion 7]*	
☐ In writing prior to presentation	☐ Verbally prior to presentation

Proof of Attendance
☐ Sign-in/out sheets with participant name, license type, and license number ☐ User report from virtual platform with participant name, time completion, license type, and license number

Office Use Only:	
Date ESM reviewed for Culturally Development training: ________________	**Date flyer approved by HCA Communications:** ________________
Date CE/CME Application was approved: __________________	**Number of CE/CME credits approved:** _______________

Training Subject(s) (Select all that apply)	☐ Children & Tay	☐ Clinical Supervision	☐ Clinical Updates
	☐ Consumer Benefits	☐ Cultural Competence	☐ Deaf & Hard of Hearing
	☐ Evidence Based Practice	☐ Patient's Rights	☐ Peer Support Personnel
	☐ Public Health	☐ School Focused Training	☐ Screening & Assessment
	☐ Signs / Symptoms of BH	☐ Trauma-Informed Care	☐ DMC/SUD

MHSA Categories (select one)	**MHSA Sub-Categories (select one)**
☐ Workforce Staffing Support	☐ Workforce Education & Training Consultation ☐ Benefits Consultations and Employment Resources for Consumers
☐ Training and Technical Assistance	☐ Training on Evidence-Based Practices ☐ Training for Consumers/Family Members of BHS ☐ Culturally Competent Trainings for Staff and Community ☐ Mental health Training for Law Enforcement and First Responders (CIT)

For MHRS trainings only	
Select an option below for Eureka outgoing confirmation email (select one)	
☐ Zoom Registration Required	Thank you for pre-registering for [**enter name of training**] scheduled on [**enter day, date and time of training**] **Step 2:** To be completed by [**enter date and time**]. Please complete the **Zoom Registration** by clicking on the following link: [enter Zoom registration link]. Once registration is completed, you will receive a confirmation email with your *unique* Zoom link. *Please do not share your unique Zoom link.*
☐ Zoom Link Attached	Thank you for pre-registering for [**enter name of training**] scheduled on [**enter day, date and time of training**]. Please use following link to access this training: [enter Zoom registration link] *Please do not share your unique Zoom link*
☐ Zoom Link from BHTS email	Thank you for pre-registering for [**enter name of training**] scheduled on [**enter day, date and time of training**]. You will receive a confirmation email from BHTS about a week before the training with your Zoom link. Please use that link to access the training.
☐ Check this box if MS Forms link is needed	
Other platform (please identify)	
Date to be released in Eureka:	

Unit Number(s) of attendess allowed (for Eureka purpose):	
Registration Deadline:	

Cost for training (*if applicable*)
☐ HCA Program (specify department/program you're working with) Dept: _________________ Program: ____________________ ☐ Joint Providership (specify outside Agency you're working with) ____
Unit Number: ______________ Job Number: ______________ Enter Amount: $ ____________ Enter date approved by department rep/manager (if applicable): __________________ Date Contract Executed: _________ Justification (for RQL):

Select the appropriate training evaluation template:

☐ PEI Funded Community and Staff (Live)
☐ PEI Funded Community and Staff (Recorded)
☐ PEI Funded Community School-Based (Live)
☐ PEI Funded Community School-Based (Recorded)
☐ WET Funded Community and Staff (Live)
☐ WET Funded Community and Staff (Recorded)