Prevention and Behavioral Health Promotion Program Guide

Health and Human Services Commission
December 2021

TEXAS
Health and Human Services

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INTRODUCTION

The Health and Human Services Commission (HHSC) developed this guide for Prevention and Behavioral Health Promotion[1] contractors funded by HHSC.

Throughout the Program Guide, the Health and Human Services Commission and Prevention and Behavioral Health Promotion unit is referred to as "HHSC," in lieu of the term "System Agency," and each provider agency is referred to as "Provider," in lieu of the term "Grantee." Providers include agencies to which HHSC allocates funding for Prevention Grant Program Services.

This guide applies to contractors implementing the following programs:

- Youth Prevention (YP) programs, which include:
  - Universal (YPU),
  - Selective (YPS), and
  - Indicated (YPI);
- Community Coalition Partnerships (CCPs);
- Community Coalition Partnerships – COVID-19 (CCP-COV); and
- Prevention Resource Centers (PRCs).

Section One applies to all programs and provides general guidance, including priority areas, relevant theoretical models, performance measures definitions/guidance, guidance on purchases, and policy/procedural guidance. Section Two provides additional guidance for each specific program type.

[1] HHSC defines the term *behavioral health promotion* to mean "the advancement of mental health, resilience, and well-being of individuals, families, and communities."

SECTION ONE: GENERAL GUIDANCE

1. Priority Areas

CCPs, PRCs, and YP programs will seek to promote behavioral health and reduce use or misuse of substances, prioritizing the following: underage alcohol use, marijuana and cannabinoid use, tobacco and other nicotine product use, and prescription drug misuse. Strategies should address underlying factors that lead to substance use and misuse, including adverse childhood experiences; Social Determinants of Health (SDoH); or other youth, family, and community risk and protective factors.

2. Core Concepts

Preventing substance misuse effectively requires an intentional focus on the core concepts defined in this section. Providers must use these concepts when planning and implementing services.

2.1 Social Determinants of Health

The federal government's Healthy People 2030 initiative[2] defines SDoH as "the conditions in the environments where people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." SDoH can be grouped into five domains:

- Domain 1: Economic Stability – help people earn steady incomes that allow them to meet their health needs
- Domain 2: Education Access and Quality – increase educational opportunities and help children and adolescents do well in school
- Domain 3: Healthcare Access and Quality – increase access to comprehensive, high-quality health care services
- Domain 4: Neighborhood and Built Environment – create neighborhoods and environments that promote health and safety

[2] Healthy People 2030, U.S. Department of Health and Human Services, Offices of Diseases Prevention and Health Promotion. Retrieved June 1, 2021, from U.S. Department of Health and Human Services.

- Domain 5: Social and Community Context – increase social and community support

SDoH affect behavioral health as well as physical health, in individual and combined ways. Exposure to adverse SDoH factors can increase the level of stress experienced by people, which can raise the risk of experiencing mental health issues and substance use problems. SDoH have a major impact on people's health, well-being, and quality of life. Examples of SDOH:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, violence, adverse childhood experiences
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water, weather, and climate
- Language and literacy skills

2.2 Adverse Childhood Experiences

The Centers for Disease Control and Prevention define adverse childhood experiences (ACEs) as "potentially traumatic events that occur in childhood (0-17 years)."[3] Examples include:

- Experiencing violence, abuse, or neglect;
- Witnessing violence in the home or community;
- Having a family member attempt or die by suicide; and
- Aspects of the child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with substance misuse, mental health problems, and instability due to parental separation or household members being in jail or prison.

ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood. ACEs can also negatively impact education and job opportunities; however, ACEs can be prevented. Preventing ACEs requires addressing factors at all

[3] Centers for Disease Control and Prevention (2019). Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from the Center for Disease Control.

levels—the individual, relational, community, and societal levels from the Socio-Ecological Model. Examples of strategies to prevent ACEs include:

- Strengthening economic supports to families;
- Promoting social norms that protect against violence and adversity;
- Ensuring a strong start for children;
- Teaching social and emotional learning, safe dating and healthy relationships skill programs, and parenting skills and family relationship approaches;
- Connecting youth to caring adults and activities (e.g., through mentoring programs and after-school programs); and
- Intervening to lessen immediate and long-term harms.

2.3 Behavioral Health Equity

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "behavioral health equity is the right to access quality health care for all populations regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location. This includes access to prevention, treatment, and recovery services for mental and substance use disorders."[4]

Advancing health equity involves ensuring everyone has a fair and just opportunity to be as healthy as possible. In conjunction with quality services, this involves addressing SDoH. Focusing attention and resources on primary prevention could significantly reduce inequities. Incorporating SDoH and addressing health disparities will help close the gap in health and safety outcomes.

The following resources can be used to help address issues of health equity and SDoH within underserved communities:

- SAMHSA Behavioral Health Equity Resources
- The Prevention Institute

3. Required Frameworks/Models

Providers delivering prevention and behavioral health promotion services must follow SAMHSA's Strategic Prevention Framework and socio-ecological model. Services must be centered on the Center for Substance Abuse Prevention (CSAP)

[4] SAMHSA Behavioral Health Equity

Strategies at the level of effort indicated in the program-specific sections of this guidance document.

3.1 Strategic Prevention Framework (SPF)

The SPF assists communities in understanding and addressing the complex issues of substance misuse and related behavioral health problems facing their communities. The model is widely used to identify prevention strategies and programs that will best meet local needs. The SPF has five steps, with two core guiding principles:

1. **Assessment** – Step one of the SPF helps prevention professionals identify important substance use and related problems and their contributing factors. It identifies relevant risk and protective factors from a variety of data sources. This step provides information to help prioritize specific substance use problems, identify factors related to the problems, and assess community resources and readiness to address them.
2. **Capacity Building** – Step two of the SPF helps prevention professionals identify resources and build readiness to address substance use and misuse. Work involves mobilizing both human and structural resources to build a prevention system that can effectively address local problems and assess the willingness and motivation of a community to address the identified problems. Key components of this step involve raising community awareness, engaging diverse stakeholders, strengthening community collaboration, and enhancing the prevention workforce through training and professional development.
3. **Planning** - Step three of the SPF involves developing a strategic plan to address the identified priority problems and prevention goals of a community. Key components of this step involve identifying and prioritizing the relevant risk and protective factors to be addressed, selecting effective, evidence-based environmental strategies to be implemented, and building a logic model that provides a clear rationale for selecting programs or processes.
4. **Implementation** - Step four of the SPF helps prevention professionals deliver evidence-based strategies/interventions. This step involves putting the strategic plan into action through a clear implementation plan that outlines the goals to accomplish, specific steps to achieve the goals, and persons/organizations responsible. It lays out expected timelines and external partners and identifies the organizational supports that are

necessary for successful implementation. Implementation plans should also include ways to monitor progress and fidelity of the implemented strategies; address preceding capacity-building steps; and factor in adaptations necessary to consider cultural diversity. The implementation plan can be referenced on the Community Anti-Drug Coalitions of America website.

5. **Evaluation** - The final step of the SPF involves systematic collection and analysis of information about program activities, characteristics, and outcomes to describe the challenges and successes of implemented strategies. Evaluation results are used to improve the effectiveness of a prevention program.

Each of the above five steps are guided by the following core principles:

1. **Sustainability** – defined as the process of achieving and maintaining long-term results.
2. **Cultural Competence** – defined as the ability to interact effectively with members of diverse populations.

3.2 Socio-Ecological Model

According to *A Guide to SAMHSA's Strategic Prevention Framework*,[5] the socio-ecological model is a multi-level framework that allows providers to consider the different contexts in which risk and protective factors exist.

The model considers the dynamic between individual, relationship, community, and societal factors. The four overlapping levels in the model illustrate how human development and behavior differ based on the person's influences and surrounding environment. To sustain prevention efforts over time and achieve population impact, it is necessary to address the multiple levels at the same time.

The four levels are:

1. **Individual.** The first level identifies factors specific to the individual, such as age, education, income, health, and psychosocial problems, which may correspond with substance use. Prevention strategies at this level promote attitudes, beliefs, and behaviors that prevent substance use and misuse.

Specific approaches may include conflict resolution and life skills training, social-emotional learning, and healthy relationship skill programs.

2. **Relationship.** The second level examines an individual's closest social circle—family members, peers, teachers, and other close relationships—that contribute to their range of experience and may influence their behavior. Prevention strategies at this level may include parenting or family-focused prevention programs and mentoring; and peer programs designed to strengthen parent-child communication, promote positive peer norms and problem-solving skills, and promote healthy relationships.
3. **Community.** The third level explores the settings in which social relationships occur, such as schools, workplaces, and neighborhoods. Prevention strategies at this level focus on improving the physical and social environment in these settings (e.g., by creating safe places where people live, learn, work, and play) and addressing other conditions that give rise to substance use and misuse in communities (e.g., neighborhood poverty; residential segregation and instability; high density of alcohol outlets).
4. **Society.** The fourth level looks at the broad societal factors, such as social and cultural norms, that create an atmosphere in which substance use and misuse is acceptable and encouraged. Other significant factors operating at this level include the health, economic, educational, and social policies that contribute to economic and social inequalities between groups in society.

Applying this model to prevention efforts likely will have a more effective and comprehensive impact on relevant risk factors that influence both people and populations.

3.3 Center for Substance Abuse Prevention Strategies Defined

Prevention and Behavioral Health Promotion Providers must implement the following strategies at the percentage of effort detailed in Section Two of the Program Guide. For additional information on the CSAP strategies, visit SAMHSA's Focus on Prevention.

1. **Prevention Education** is a two-way approach to teaching participants important social skills. This includes skills that assist in promoting behavioral health and wellness such as social emotional skills, coping skills, parenting skills, relationship building, and positive youth development. Unless otherwise approved, activities must be conducted using an HHSC-approved,

evidence-based curriculum proven to promote desired outcomes based on effective implementation strategies. When implementing the prevention education strategy, Providers must:

A. Conduct fidelity checks according to the curriculum developer and document each session in accordance with the Program Guide documentation requirements;

B. Conduct and document quarterly fidelity checks and quality assurance checks and maintain documentation on file; and

C. Administer HHSC-provided pre- and post-tests for all participants enrolled in prevention education.

2. **Information Dissemination** increases knowledge and changes attitudes through communications that are mainly one-way. Information dissemination may be conducted in the form of educational presentations related to the state's four prevention priorities, general substance use/misuse prevention, and behavioral health promotion; or through media awareness activities. Presentations must be a minimum of 30 minutes with the same audience.

   A. Providers must coordinate and collaborate with HHSC's Prevention Statewide Media Campaign (SMC) and other HHSC-funded Providers to develop and promote consistent statewide messaging. Examples of SMC activities include:

      a. Media interviews;

      b. Media campaigns (including social media);

      c. Public service announcements (PSAs);

      d. Billboards;

      e. Bus boards;

      f. Printed news articles;

      g. Printed editorials; and

      h. Aired or printed press releases.

   B. Presentations and SMC activities that focus on minors and tobacco and other nicotine products must include information on tobacco/nicotine cessation, Texas tobacco laws as they apply to minors, and health consequences associated with the use of tobacco and other nicotine products.

3. **Positive Alternatives** provide fun, challenging, and structured activities with supervision, so people have constructive and healthy ways to enjoy free time and learn skills. These alcohol- and drug-free activities are provided with the intent to help people, particularly young people, have positive experiences that promote behavioral health and wellness. Positive alternative activities must take place for at least 30 minutes with the same participants. Examples of positive alternatives include after-school sports, community service activities, neighborhood projects, and art/music/dance classes.
4. **Community-Based Processes** strengthen resources, such as community coalitions, to prevent substance use and misuse. Organizing, planning, and networking are included in this strategy to increase the community's ability to deliver effective prevention and treatment services; educate and mobilize the community toward prevention efforts; and offer the Provider opportunities to obtain meaningful community agreements with agencies, community sites, PRCs, and other stakeholders that enhance prevention efforts. Community-based processes may include:
    A. Improving systems and processes to increase the ease, access, ability, and opportunity to use those systems and services (e.g., assuring healthcare, childcare, transportation, housing, justice, education, safety, special needs, cultural and language sensitivity);
    B. Increasing or decreasing the probability of a specific behavior to reduce risk or enhance protection by altering the consequences for performing that behavior (e.g., increasing public recognition for deserved behavior, individual and business rewards, taxes, citations, fines, revocations/loss of privileges);
    C. Leading and participating in, and collaborating with, HHSC-funded coalitions to strengthen and promote prevention activities and promote behavioral health environmental strategies. If an HHSC-funded coalition is not located within the Provider's service area, the Provider must then collaborate with a non-HHSC-funded coalition; and
    D. Conducting and participating in community-based education and mobilization activities.
5. **Identification of Problems and Referral to Services** includes determining when the needs of a participant require additional education or intensive services and strategies outside the scope of the activities in this contract; and properly referring participants who present a need for individualized services outside the scope of prevention.

A. Prevention programs must not conduct screenings or assessments with the intent of diagnosing substance use disorders, assess the severity of substance use, or determine the appropriate level of substance use treatment under any prevention services contract. Examples of services to which participants and families might be referred include:

   a. Regional, HHSC-funded outreach, screening, assessment, and referral centers

   b. Food banks

   c. Resource assistance programs (rent, clothing, electricity, etc.)

   d. Academic enrichment programs (tutoring, etc.)

   e. Counseling services

   f. Clinics and other healthcare and mental health providers

6. **Environmental and Social Policies** are aimed at the settings and conditions in which people live, work, and socialize. These strategies work to change policies, social norms, environmental conditions, institutional practices, and behaviors to reduce risk factors and increase protective factors. As these changes are carried out at the community level, they can have a sweeping impact. Environmental strategies may be substance-specific or address underlying factors that lead to substance use and misuse including adverse childhood experiences; SDoH; and other youth, family, or community risk and protective factors. Environmental strategies may also focus on promoting behavioral health and wellness. Specific examples of environmental and social policy strategies include:

   A. Enhancing Physical Design – Changing the physical design or structure of the environment to reduce risk or enhance protection (e.g., parks, landscapes, signage, lighting, outlet density).

   B. Modifying/Changing Policies – Formal change in written procedures, by-laws, proclamations, rules, or laws with written documentation or voting procedures (e.g., workplace initiatives, law enforcement procedures and practices, public policy actions, systems change within government, communities, and organizations).

3.4 Alignment with Strategic Plans

To the extent applicable, Providers must offer services that help address gaps in accordance with the current Statewide Behavioral Health Strategic Plan and Substance Use Strategic Plan. These resources can be found on the HHSC website.

4. General Staff Training Requirements

The Prevention Program Director and all other prevention program staff, including temporary employees, must complete the general required trainings as specified in this section, in addition to the program-specific trainings detailed in individual program sections. For all staff hired during fiscal years 2020 and 2021, HHSC will consider September 1, 2021, as the "date of hire" in reference to all required trainings and certifications, although each agency has the latitude to adopt stricter training deadlines for their staff. Providers must maintain all training and certification documentation in employees' files for HHSC review, upon request.

4.1 Required Certifications

The Prevention Program Director, Coalition Coordinator, Data Coordinator, and any staff person providing key oversight must obtain a minimum of a Certified Prevention Specialist designation within 20 months of employment, unless otherwise approved by HHSC.

Prevention Specialists, and any individual providing direct services, must achieve a minimum of an Associate Prevention Specialist designation within 20 months of employment in this program, unless otherwise approved by HHSC.

Requirements for the Certified Prevention Specialist certification and the Associate Prevention Specialist designation may be obtained by visiting the Texas Certification Board website.

4.2 Required Training

HHSC contracts with a training provider to offer or coordinate most of the required trainings, excluding cardiopulmonary resuscitation. For more information on trainings, please visit Texas Prevention Training.

4.2.1 Prevention Skills Training

This is a one-time required training for all prevention program staff and directors. Providers must complete this required training through the HHSC-funded training entity within six months from the date of hire. This training includes a minimum of three hours in each of the following prevention-specific areas:

- Cultural competency;
- Risk and protective factors/building resiliency;

- Child development or adolescent development, as appropriate;
- Communication; and,
- Prevention across the lifespan.

4.2.2 Substance Abuse Prevention Skills Training

This is a one-time required training to be completed through the HHSC-funded training entity. Program directors and any staff providing key oversight of prevention services must have completed the Substance Abuse Prevention Skills Training upon the date of hire, unless otherwise approved by HHSC. Other prevention program staff must complete the training, after obtaining a minimum of 12 months of service delivery experience, no later than 20 months after the date of hire of employment for this program.

4.2.3 Prevention Continuing Education

A minimum of 15 hours of continuing education units, specifically related to prevention or job-related duties, must be completed each fiscal year. Continuing education must include annual training on cultural competence, prevention-related ethics, and the six Prevention Domains:

1. Planning and Evaluation;
2. Prevention Education and Service Delivery;
3. Communication;
4. Community Organization;
5. Public Policy and Environmental Change; and
6. Professional Growth and Responsibility.

Providers may obtain Prevention Continuing Education hours through the HHSC-funded training entity; annual Prevention Provider meeting; HHSC's annual The Institute; or other entities approved by the Texas Certification Board. Information on Texas Certification Board-approved continuing education providers may be found on the Texas Certification Board website.

4.2.4 Prevention Training for Volunteers/Interns

Volunteers and interns working more than 10 hours a week or providing any direct service delivery must complete Prevention Skills Training. Volunteers who are providing curriculum education must also complete curriculum education trainings

to ensure they can adhere to the requirements of this contract as required by HHSC. Direct service delivery includes curriculum education, on-going positive alternatives, and presentations. Providers must maintain documentation of the completion of this training for review by HHSC upon request. This documentation is required for all volunteers and interns providing ongoing assistance in prevention activities.

5. Statewide Media Campaign

The SMC is an ongoing public awareness campaign funded by HHSC that engages Texas youth, parents, and communities through multiple media platforms, including social media, PSAs on television and radio, and SMS (text messaging).

All HHSC-funded providers (YP programs, CCPs, and PRCs) must participate in the SMC by designating two staff members as media representatives. These media representatives attend monthly meetings about the SMC and maintain active accounts on HHSC's SMC SharePoint site. CCPs and PRCs must maintain active Facebook and Instagram pages. HHSC encourages a provider with more than one CCP or PRC to share one Facebook and one Instagram page across the organization, rather than having separate pages for each program.

CCPs and PRCs must also share all SMC social media messages and help distribute PSAs and other campaign materials to their communities using a specific budget detailed in the program-specific statements of work. YP programs must share SMC social media messaging and other campaign materials with their communities as well.

6. Adherence to Culturally and Linguistically Appropriate Services (CLAS) Standards

Providers must demonstrate adherence to the National Standards for CLAS in Health and Health Care[5] for the proposed target population and demonstrate good-faith efforts to conduct outreach to underserved populations. These include people:

- Of color;
- With low educational or socioeconomic status;
- With limited English proficiency;

[5] https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

- With disabilities;
- Of Native American Tribes;
- Holding military and veteran status and their families;
- Who live in Colonias; and
- Who identify as lesbian, gay, bisexual, transgender, and queer (and questioning).

The Provider will document how they are adhering to the CLAS Standards and maintain these efforts for review upon request of HHSC.

Resources for the CLAS Standards include:

- National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care
- Texas Cultural Competence Guidelines for Behavioral Health Organizations available under the "Guidelines and Handbooks" header.

7. The Implementation Plan

Providers must submit an Implementation Plan that includes information on how prevention services will be implemented during the fiscal year. The annual Implementation Plan must detail services for all program types described in the contract. Subsequent revisions to the plan cannot not change the overall scope of the project, as determined by HHSC. HHSC must approve the revised plan prior to implementation.

Providers must use HHSC's Prevention Activity Tracking Tool (PATT) to document the following prevention activities as they occur:

- Curriculum education
- Prevention and behavioral health promotion presentations
- Community-based education/mobilization activities
- Positive Alternatives
- Problem identification and referral to services and follow-up
- Program staffing
- CCP meetings
- Coalition presentations

- CCP environmental and social policy documentation efforts
- PRC collaboration and data-sharing efforts
- PRC community-based processes
- Tobacco retail compliance/initial contact form and follow-up
- Tobacco-related information dissemination (Tobacco Prevention Coordinators)
- Tobacco presentations (Tobacco Prevention Coordinators)

No login is required to make entries into the PATT. At least one senior staff member at each provider organization (e.g., executive director, program director, coalition coordinator) and all PRC data coordinators must have a Qualtrics account to access the Provider's PATT data. Entering new staff information into the PATT will notify HHSC to create Qualtrics accounts for any new executive staff or data coordinators. These staff are responsible for maintaining their accounts by keeping passwords current.

The Implementation Plan documents the specific approach the Provider will take to complete the grant requirements. The Implementation Plan is completed annually and must be reviewed and approved by HHSC prior to implementation. The Provider may request updates to the plan during the fiscal year through their Program Specialist and Contract Manager. Any requested changes must be approved and documented prior to implementation. Please contact your assigned Contract Manager or Program Specialist for the most current copy of the Implementation Plan form.

8. Allowable Purchases

Providers must develop and maintain policies and procedures to ensure compliance with all applicable allowable cost rules and regulations.

- Food or snacks may be purchased for participants of a Strengthening Families Program or a prevention activity/service occurring after-school or outside the school setting, in accordance with guidance provided by SAMHSA.
- T-shirts with an educational message relevant for substance use prevention or behavioral health promotion may be purchased.
- Incentives that promote engagement in or completion of prevention services may be purchased but must not exceed $30 per person per fiscal year. If incentives are used, the Provider must develop policies and procedures to

ensure consistent incentive distribution, such as defining the point in which incentives are made available to participants. Providers must document the recipient's name and incentive value at the time of distribution and make this documentation available to HHSC upon request.

- Materials used to educate about prevention and behavioral health promotion may be purchased but must not exceed five percent of the approved budget, unless otherwise approved by HHSC.
- The total cost of Positive Alternatives, conducted within each fiscal year, cannot exceed five percent of the approved budget, unless otherwise approved by HHSC.

9. Community Agreements

Providers must secure community agreements with public schools; community sites; and relevant agency, business, or community partners to ensure a streamlined continuum of care for people and their families. Partners should include entities that will host prevention education activities/services, support data collection efforts, meet individual and family needs beyond the scope of the prevention program, and potentially provide additional funding. A community agreement may be documented via a memorandum of understanding, letter of agreement, or memorandum of agreement.

Agreements must:

- Be established prior to service delivery;
- Be individualized as much as possible to address the needs of each participating school, community site, or partnering agency;
- Establish a detailed outline of the service delivery and implementation structure if applicable; and
- Establish responsibilities of entering parties based on guidelines from HHSC.

Providers may choose to use multi-year agreements to establish recurring partnerships. Additionally, Providers may deliver services prior to execution of a formal service agreement, when necessary.

10. Required HHSC Meetings and Communication

1. **Required Meetings:** Providers shall attend required meetings held by HHSC including:
   A. Annual Prevention Providers Meeting: Annual gathering open to all prevention program staff. Required attendance depends upon the program as outlined below, unless otherwise approved by HHSC:
      a. YP programs: Program Director and at least one Prevention Specialist per YP program type funded must attend;
      b. CCPs: Program Director and each Coalition Coordinator must attend;
      c. PRCs: All funded staff must attend.
   B. Annual Directors' Meeting: Program Directors for prevention programs are required to attend, unless otherwise approved by HHSC.
   C. Provider must also participate in technical assistance calls or program-specific meetings as requested by HHSC.
2. **HHSC Updates:** To ensure the Provider stays informed and continues receiving updated information, the Provider must assign one or more staff responsible for tracking policy updates posted on HHSC's identified platform and disseminating information within the Provider organization.
3. **Prevention and Behavioral Health Promotion Forums:** Providers shall ensure prevention program staff have access to each of the role-specific forums that apply. Providers must instruct any staff needing access to Prevention and Behavioral Health Promotion forums to contact their assigned Program Specialist. The forums include:

- YP Forum
- CCP Forum
- PRC SharePoint Hub and PRC Forum
- SMC SharePoint (all public relations coordinators and media representatives and other provider staff interested or involved in the SMC)
- Texas Prevention Training Forum (all YP program, CCP, PRC staff)

11. Performance Measure Definitions and Guidance

The table below provides guidance for any performance measures required for YP programs, CCPs, and PRCs. Within the table, there is a column indicating the applicable program for each measure.

Provider must report within Clinical Management for Behavioral Health Services (CMBHS) the performance measures required by their statement of work as detailed below. Required timelines for reporting measures may be found in the statement of work.

11.1 MEASURE AREA 1: PREVENTION EDUCATION

Measure	Description	Applies to YP?	Applies to CCP?	Applies to PRC?	Measure Guidance
1A	Number of unduplicated youth receiving prevention education/skills training per year	yes	no	no	Report the number of new youth receiving prevention education services. Each month, report **new** youth that attended their first prevention education session. If a youth received prevention education in a prior month, do not report in the current month.
1B	Number of unduplicated adults receiving prevention education/skills training per year	yes	no	no	Report the number of new adults receiving prevention education services.

11.2 MEASURE AREA 2: POSITIVE ALTERNATIVES

Measure	Description	Applies to YP?	Applies to CCP?	Applies to PRC?	Measure Guidance
2A	Number of Positive Alternatives conducted per month	yes	no	no	Report the number of Positive Alternatives conducted within the month. This measure captures the number of activities, not the number of participants.
2B	Number of youth in Positive Alternatives	yes	no	no	Report the number of youth involved in each Positive Alternative conducted within the month.
2C	Number of adults in Positive Alternatives	yes	no	no	Report the number of adults involved in each Positive Alternative conducted within the month.

11.3 MEASURE AREA 3: INFORMATION DISSEMINATION

Measure	Description	Applies to YP?	Applies to CCP?	Applies to PRC?	Measure Guidance
3A	Number of prevention/behavioral health promotion presentations	yes	no	no	Report the number of presentations made related to prevention and behavioral health promotion (formerly called ATOD presentations). This measure captures the number of presentations, not the number of people in attendance at the presentations.
3B	Number of youth attending prevention/behavioral health promotion presentations	yes	no	no	Report the number of youth that attended prevention and behavioral health promotion presentations (formerly called ATOD presentations) conducted within the month.
3C	Number of adults attending prevention/behavioral health promotion presentations	yes	no	no	Report the number of adults that attended prevention and behavioral health promotion presentations (formerly called ATOD presentation) conducted within the month.

Measure	Description	Applies to YP?	Applies to CCP?	Applies to PRC?	Measure Guidance
3D	Number of media awareness activities (not including social media) focused on prevention/behavioral health promotion	no	yes	yes	Report the number of prevention and behavioral health promotion messages or campaigns (including the statewide media campaign) delivered via traditional media (TV, radio, print media). Report only messages or campaigns that have been aired, broadcasted, or published. Each message or campaign may only be counted once. For example, if the same public service announcement is aired twenty times by the same station, it may only be counted as one media awareness activity.
3E	Number of social media messages focused on prevention and behavioral health promotion	yes	yes	yes	Report the number of messages delivered through social media related to the prevention priorities and the statewide media campaign. Each message may only be counted once. If you post the English and Spanish translations of a message as two (2) separate posts, count them as one message when reporting.
3F	Number of times local, county, or regional data is shared	no	no	no	Report the number of times that local, county, or regional data is shared. If posting to a website, count this once. If presenting to multiple organizations in one meeting, count this once. Data may be shared via in person presentations, mail, electronic distribution, etc.

11.4 MEASURE AREA 4: COMMUNITY-BASED PROCESSES

Measure	Description	Applies to YP?	Applies to CCP?	Applies to PRC?	Measure Guidance
4A	Number of community-based processes focused on prevention and behavioral health promotion	no	yes	no	Report the number of community-based processes focused on prevention and behavioral health promotion conducted within the month. This measure captures the number of presentations, coalition meetings, networking events and not the number of people in attendance.
4B	Number of youth attending community-based processes focused on prevention and behavioral health promotion	no	yes	no	Report the number of youth attending Community-Based Education and Mobilization Activities conducted within the month.
4C	Number of adults attending community-based processes focused on prevention and behavioral health promotion	no	yes	no	Report the number of adults attending Community-Based Education and Mobilization Activities conducted within the month.
4D	Number of prevention trainings coordinated and/or hosted in the region	no	no	yes	Report the number of trainings coordinated and/or hosted in the region within the month.
4E	Number of individuals attending trainings coordinated and/or hosted in the region	no	no	yes	Report the number of individuals attending trainings coordinated and/or hosted in the region within the month.
4F	Number of schools contacted to promote the Texas School Survey	no	no	yes	Report the number of schools contacted to promote the Texas School Survey. If the same school is contacted more than one time, only count it once.

11.5 MEASURE AREA 5: ENVIRONMENTAL AND SOCIAL POLICIES

Measure	Description	Applies to YP?	Applies to CCP?	Applies to PRC?	Measure Guidance
5A	Number of changed policies and social norms related to prevention and behavioral health promotion	no	yes	no	Report the number of changed policies and social norms related to prevention and behavioral health promotion.
5B	Number of compliance checks that are conducted on-site with tobacco retailers.	no	no	yes	Report the number of compliance checks, including follow-up visits for non-compliance, that are conducted on-site with tobacco retailers.

Guidance on the performance measures required as a part of receiving supplemental COVID-19 funds is located in Section 17.3 (Community Coalition Section) below.

12. Policy and Procedures Guidance

Providers must establish and follow policies and procedures outlined below and make them available for inspection by HHSC upon request:

- Establish and maintain policies and procedures as required by Texas Administrative Code, Part 15, Chapter 392, Subchapter F[6] relating to Contract Management for Substance Abuse Programs, and applicable laws.
- Develop and implement policies and age-appropriate procedures to protect the rights of children, families, and adults participating in a prevention program.
- Develop and maintain current written policies and procedures for employees, contracted labor, and volunteers who work directly or indirectly with participants. The written policies and procedures must address participant safety and ensure that all activities with participants are conducted in a respectful, non-threatening, non-judgmental, and confidential manner.
- Develop and implement written confidentiality policies and procedures if providing direct services to individual youth and families. This must include procedures to securely store and maintain privacy and confidentiality of information and records concerning participants and their family members and ensuring all employees and volunteers follow the agency's confidentiality policies, procedures, and requirements.
- Establish policies and processes to conduct continuous quality assurance of prevention strategies including but not limited to fidelity checks and ensuring accurate data collection and entry.
- Establish written policies and procedures outlining how the Provider will adhere to the National CLAS Standards.
- Develop and maintain current written policies and procedures addressing the requirements for criminal background checks as a condition for employment for applicants, contractors, interns, and volunteers who work directly with youth and their families. The written policies and procedures must require

[6] https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=392&sch=F&rl=Y

those same individuals (staff, contractors, interns, and volunteers) to notify the Provider of an arrest, conviction, investigation, or any other legal involvement.

SECTION TWO: GUIDANCE BY PROGRAM TYPE

13. Youth Prevention Program Guidance Participant Eligibility

The YP program has three populations of focus as defined in the section below. Providers must deliver services to the population as funded by HHSC and documented in the Implementation Plan.

13.1 Populations of Focus

YPU services focus on the general or broad population without consideration of individual differences in risk for substance use and misuse or other behavioral health issues.

YPS services focus on subgroups of the general population that are determined to be at risk for substance use and misuse or other behavioral health related issues.

YPI services focus on people in high-risk environments who have minimal, yet detectable, signs or symptoms foreshadowing a disorder; or biological markers indicating predispositions for a disorder but do not yet meet diagnostic criteria.

1. Eligible Participants:
    A. The primary population is youth pre-kindergarten to grade 12 who meet criteria from one of the priority/target populations: Universal, Selected, or Indicated, as described in the eligibility requirements.
    B. The secondary population may include parents, grandparents, guardians, and siblings of youth participants, and community members in the funded service area.
2. Special Populations:
    A. Providers should engage with populations that have been historically under-served and report the numbers served in CMBHS.
    B. These populations include:
        a. Populations with demonstrated health disparities including populations of color that have been historically marginalized

b. Individuals living in Colonias
c. Military/veteran families
d. Tribal communities
e. Individuals who are homeless
f. Rural communities
g. Lesbian, gay, bisexual, transgender, and queer (and questioning).

14. Youth Prevention Program Implementation Guidance

14.1 Youth Prevention Program Staff Training Requirements

YP program staff must receive training in the evidence-based curricula prior to implementing services. If the person responsible for delivering curriculum is unable to complete formal curriculum training through an HHSC-funded training entity prior to service delivery, the Provider must identify a qualified in-house curriculum trainer to provide the training. Provider staff completing in-house curriculum training must complete formal curriculum training through an HHSC-funded training entity no more than six months following original training due date (Please reference Section 1.6 for COVID-related timeline guidance).

In addition, YP programs must adhere to the following requirements:

- Cardiopulmonary Resuscitation (CPR) and First Aid Certifications – Providers must ensure that all prevention staff directly serving youth and families complete CPR and first aid certifications within 60 days of employment for this contract or have valid certifications upon hire. CPR/first aid training may be in-person or online as long as it is accredited through the American Red Cross, American Heart Association, or a similar accrediting body. Most accredited online CPR training opportunities will require a hands-on testing component.
- Suicide Prevention Training – The Provider's YP program staff must attend at least one suicide prevention training each year to build competence and encourage integration of mental health promotion strategies in their work. This training may be coordinated through an HHSC-funded training entity, regional PRCs, or other qualified sources.

- Mental Health First Aid Training – The Provider's YP program staff must attend at least one Mental Health First Aid training (youth or adult) to build competence and encourage integration of mental health promotion strategies in their work. This training may be coordinated through an HHSC-funded training entity, regional PRCs, or other qualified sources.

14.2 CSAP Strategy Percentage of Effort

YP programs must implement the CSAP strategies defined above with the following percentage of effort:

Strategy	Percentage of Effort
Prevention Education	70%
Information Dissemination	15%
Positive Alternatives	10%
Identification of problems and referral to services	5%

14.3 Prevention Education Curriculum Implementation and Information

1. YP programs must implement an evidence-based curriculum approved by HHSC as documented in the Implementation Plan. Providers must select from one of the following HHSC-approved curricula, unless otherwise approved by HHSC:
   A. All-Stars (YPU and YPS): A continuum of prevention programs, for grades 5-9, designed to delay the onset of risky behaviors with adolescents.
   B. Botvin Life Skills (YPU): A research-validated substance abuse prevention program proven to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors.
   C. Curriculum-Based Support Groups (YPS and YPI): An evidence-based preventive intervention for selective and indicated populations, designed

for males and females ages 6-17, whose high-risk situations, attitudes, and behaviors, place them at elevated risk for future behavioral and health problems including substance misuse, delinquency, and violence.

D. Project Towards No Drug Abuse (YPU, YPS, YPI): An effective drug abuse prevention program that targets high school-age youth through grade 12 using highly interactive classroom-based sessions.

E. Positive Action (YPU, YPS, YPI): A comprehensive, coherent program that has components for all parts of the school, family, and community, addressing all areas of the self (i.e., physical, intellectual, and social/emotional).

F. Strengthening Families Program (SFP): 7-session video curriculum (SFP 10-14) (YPU) that is a science-based family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems. SFP builds on protective factors by improving family relationships, parenting skills, and improving the youth's social and life skills.

G. Strengthening Families Program: 10-session video curriculum (SFP 7-17) (YPU, YPS, YPI)

H. Strengthening Families Program: 14-session curriculum (SFP 6-16) (YPU, YPS, YPI)

I. Too Good for Drugs (YPU): A comprehensive family of evidence-based substance use and violence prevention interventions designed to mitigate the risk factors linked to problem behaviors and build protection within the child to resist problem behaviors.

When implementing prevention education, Providers must implement the evidence-based curriculum with fidelity to the program model and implementation structure approved by HHSC. In addition, Providers must receive written approval from HHSC and the curriculum developer prior to implementing any adaptations or modifications to the curriculum implementation structure, unless otherwise waived by HHSC. Modification to the implementation structure of the curriculum may include the frequency of session delivery or modification to the length of each session but is not applicable to any modification of the grade range not expressly approved by HHSC.

Providers shall post or make available, in English and Spanish, the HHSC-developed prevention Participant Rights Form during the delivery of educational sessions. Additional languages, appropriate to the population

served, may be requested and will be developed by HHSC for use by the Provider. Postings must be conveyed in an appropriate manner to participants who have impairments of vision, hearing, or cognition. The Participant Rights Form must be used by the YP program in accordance with the contract requirements. The Participants Rights Form is located on the HHSC website.

2. Providers must document problem identification and referral in the PATT including the following information:
   A. Name of person making referral or identifying problem
   B. Participant Service Category – Youth or Adult
   C. Action Taken
3. Providers must report in CMBHS information related to the Curriculum Outcome Measures for each group cycle provided throughout the fiscal year. Outcome measures must be reported no later than 20 business days after the end date of the cycle. Curriculum Outcome Measures must include the following information:
   A. Group Number
   B. Cycle Begin and End Date
   C. Number of sessions (education classes) implemented during the group cycle
   D. Length (in minutes) of each curriculum session
   E. Number of youth and adults (if applicable) enrolled in the program
   F. Number of youth and adults (if applicable) completing the program
   G. Number of youth and adults (if applicable) completing pre and post tests
   H. Number of youth and adults (if applicable) completing the program successfully
4. Once the above information has been entered in CMBHS, the report will automatically calculate the following:
   A. Percentage of youth and adults (if applicable) completing the program
   B. Percentage of youth and adults (if applicable) completing the program successfully
   C. Overall success rate (based on the number of youth enrolled in the program)

The number of youth and adults successfully completing the program is determined from the number of youth (and adults where applicable) who completed the program and made a positive change between the pre- and post-test.

15. Community Coalition Partnerships Program Guide

HHSC funds 43 community coalitions throughout the State of Texas that encourage community mobilization to implement evidence-based strategies with a primary focus on changing policies and social norms in communities to prevent and reduce underage alcohol use, underage tobacco and nicotine products use, marijuana and other cannabinoids use, and prescription drug misuse.

15.1 Community Coalition Partnerships Program-Specific Staffing Requirements

CCP staff must complete coalition competency trainings within 90 days from date of hire, which may include the following:

- Strategic Prevention Framework Overview;
- Needs Assessment and Logic Models;
- Capacity Building;
- Sustainability Training; and
- Strategic Planning.

15.2 Community Coalition Program CSAP Strategy Implementation Guidance

CCPs must operate one or more community coalitions to implement the CSAP strategies defined above with the following percentage of effort:

Strategy	Percentage of Effort
Community-Based Processes	35%

Strategy	Percentage of Effort
Environmental and Social Policy	25%
Information Dissemination	20%
Positive Alternatives	20%

1. Coalition representation should strategically align with the CSAP strategies and engage stakeholders in appropriate ways. For example, strategies addressing environmental and social policy would likely require engagement of community leaders, local government officials, policy makers, businesses.
2. Coalition representation may include the following:
   A. Youth and young adults;
   B. Parents;
   C. Business sector;
   D. Media;
   E. Schools;
   F. Organizations that serve youth or young adults;
   G. Law enforcement agencies;
   H. Faith-based organizations;
   I. Civic and volunteer groups;
   J. Healthcare professionals; and
   K. State, local, or tribal government agencies with expertise in the field of substance misuse.

   Partner engagement should extend beyond coalition meetings to ensure the appropriate level of engagement. For example, business leaders or city council members may not attend every coalition meeting.
3. Media Awareness Activities
   A. Social and traditional media are core tools in a CCP's strategy to build community coalitions and promote prevention and behavioral health. A CCP's media strategy must include:

a. Developing messaging based on the priorities outlined under the number of social media messages section above and following guidelines in the SAMHSA toolkit, Focus on Prevention - Strategies and Programs to Prevention Substance Use.

b. Promoting consistent statewide messaging by participating in the HHSC SMC.

c. Maintaining organizational Facebook and Instagram accounts and any other social media platforms required by HHSC.

d. Sharing SMC social media messaging on these platforms. These social media platforms may also be used to post original content created by the Provider and to share relevant content posted by other organizations.

e. Ensuring that the organization's media representatives are registered with and have access to the SMC SharePoint site. Staff must request access using procedures outlined by HHSC.

f. Promoting prevention messages through media outlets including radio or television PSAs, media interviews, billboards, bus boards, editorials, or social media (if permitted by the Provider's organization policies) in the CSAP Definition Section.

4. Budget Requirements

A. Providers shall spend no more than 10 percent of the total CCP budget per fiscal year on media awareness activities (local regional media campaigns and support for the SMC.

B. Providers must dedicate a portion (but no more than half) of their media budget to promote the SMC.

C. Media expenditures in support of the SMC may include paid radio and television spots and paid boosting for social media content and other advertising approved by HHSC.

D. Allowable expenses on traditional paid media platforms include print media, radio, television, billboards, and other posted signage or paid advertising space and other advertising approved by HHSC.

E. Allowable expenditures on social media include:

a. Paid social media boosting or ads on Facebook, YouTube, Instagram, and Twitter.

b. Paid media boosting or ads on other social media platforms or apps require prior approval from HHSC.

5. Influencers should be used only in direct conjunction with a defined media campaign. Use of paid social media influencers as part of any media campaign must be approved by HHSC prior to implementation. Funds may not be used to create agency logos or other forms of agency branding.

15.3 COVID-19 Supplemental Funding Guidance

Coalitions who accept COVID-19 supplemental funding must:

1. Send at least two staff members to each community development training and technical assistance meeting required by HHSC.
2. Use data to pinpoint areas within the Provider's region that are most disproportionately impacted by COVID-19 and behavioral health disparities. Providers must use these data to develop and justify the proposed projects in their implementation plan. Possible data sources include:
   A. P-Chat data from HHSC
   B. The HOPE Initiative: Measures to Advance Health and Opportunity
   C. Regional Needs Assessment (found by visiting each individual PRC webpage)
   D. County Health Rankings
   E. Distressed Communities Index
   F. City Health Dashboard
   G. Esri's Racial Equity GIS Hub
3. Projects to be completed must address the negative impact COVID-19 has had on behavioral health and wellness and should focus on equity. This should include:
   A. Implementing stress-reduction/trauma-healing activities, particularly in areas most impacted. Examples of such projects include community yoga, mindfulness apps, craft distribution, and informal peer-to-peer support groups.
   B. Shifting physical design of the environment or enhancing systemic processes to promote behavioral health and wellness. Examples of such

projects include planting a community garden, renovating an outdoor space to host behavioral health/wellness activities, and providing transportation to/from community wellness activities including COVID-19 vaccinations. The Provider must work with HHSC to ensure that all proposed activities meet SAMHSA's Block Grant requirements. HHSC must approve all proposed activities documented in the Implementation Plan prior to implementation.

4. The Provider must use the Community Anti-Drug Coalitions of America's The Coalition Impact: Environmental Prevention Strategies to guide the development of their strategies for implementing this supplemental funding.
5. Report performance measures in CMBHS as follows:

Measure	Description	Applies to CCP-COV?	Measure Guidance
S1	Number of projects that change physical environment, build community resilience, or improve systemic processes to enhance behavioral health and wellness	yes	Report the number of projects that change physical environment, build community resilience, or improve systemic processes to enhance behavioral health and wellness.
S2	Number of youth attending stress reduction/trauma healing activities	yes	Report the number of youth attending community-wide activities that reduce stress or address trauma.
S3	Number of adults attending stress reduction/trauma healing activities	yes	Report the number of adults attending community-wide activities that reduce stress or address trauma.

16. Prevention Resource Center Program Guidance

16.1 Prevention Resource Center Specific Staff Training Requirements

PRC staff must complete PRC trainings within 90 days from date of hire, which may include the following:

- Epidemiology

- Strategic Prevention Framework
- Needs Assessment and Logic Models
- Capacity Building
- Information Dissemination
- Tobacco Law Training

16.2 Prevention Resource Center CSAP Implementation Guidance

PRCs must implement the CSAP strategies defined above with the following percentage of effort:

Strategy	Percentage of Effort
Information Dissemination	40%
Community-Based processes	40%
Environmental and Social Policy	20%

To effectively implement these CSAP strategies, the PRC programs have four core functions as described below.

16.3 Core Function One: Data Resource Coordination (Data Core)

A goal of each PRC is to maintain and serve as the primary resource for substance use and related behavioral health data for the region. In this capacity, PRCs must collaborate with the HHSC Data Specialist, other PRC Data Coordinators, other HHSC staff, and regional stakeholders to develop a comprehensive data infrastructure for the PRC region. Providers must:

1. Conduct and attend meetings with community stakeholders to raise awareness of substance use data needs and generate support to enhance data collection efforts within the region.

2. Promote school participation in the Texas School Survey of Drug and Alcohol Use and university/college participation in the Texas College Survey of Substance Use. Providers must coordinate with the Texas A&M Public Policy Research Institute on recruitment activities.
3. Support local and regional data collection strategies regarding substance use/misuse and related risk and protective factors.
4. Document collaborative efforts using HHSC-generated template.
5. Establish and maintain Community Agreements with community stakeholders that encourage networking and coordination to support the gatherings and distribution of data.
6. Develop and maintain a Regional Epidemiological Workgroup (REW) identifying substance use patterns focused on the State's four prevention priorities at the regional, county, and local level. The REW must also work to identify regional data sources, data partners, and relevant risk and protective factors to provide information relevant to identification of data gaps, analysis of community resources and readiness, collaboration on region-wide efforts, and recommendations or development of other forms of prevention infrastructure support. Providers must conduct/participate in a minimum of four (4) REW meetings and document using HHSC-generated template.
7. Develop a Regional Needs Assessment (RNA) to provide community organizations and stakeholders with region-specific substance use, behavioral health, and SDoH information. The RNA must include:
    A. Substance use consumption patterns;
    B. Consequence, incidence, and prevalence data;
    C. Community risk factors;
    D. Emotional and behavioral prevalence data;
    E. Population and culture-specific effects; and
    F. Data about assets that protect against substance use and misuse and promote emotional well-being.
8. Develop and facilitate at least one region-wide event based on RNA data findings to bring targeted communities and stakeholders together to educate and promote collaboration on substance use related issues.
9. Direct community stakeholders to resources regarding data collection strategies and evaluation activities.

16.4 Core Function Two: Training and Professional Development Coordination (Training Core)

The goal of the PRC Training Core is to build the prevention workforce capacity through technical support and coordination of prevention trainings. To achieve this goal, Providers must:

1. Work directly with an HHSC-funded training entity to identify training and learning needs as well as regularly promote trainings to all HHSC-funded providers in the region.
2. Assist an HHSC-funded training entity by hosting trainings and coordinating host training sites. This should include hosting and coordinating both virtual and in-person trainings. When hosting in-person trainings Providers shall provide training facilities and equipment, coordinate logistics, and receive and deliver training materials. When hosting a virtual training, Providers shall assist with identification of training and learning needs for their region, schedule and coordinate the delivery of the trainings, or provide a virtual platform to host the trainings.
3. Prioritize HHSC-funded trainings. Providers may host and coordinate trainings outside of those provided by an HHSC-funded training entity; however, Providers should ensure they use HHSC-funded training entity trainings to meet the training and learning needs of their region whenever possible. Although Providers may not use PRC funds to pay speaker fees, Providers may provide training facilities and equipment, coordinate logistics, and receive and deliver training materials. Providers should also keep the HHSC-funded training entity informed of any trainings that they are hosting in their region.
4. Distribute monthly updates to HHSC-funded prevention providers within the region about the availability of substance misuse prevention trainings and related trainings offered by an HHSC-funded training entity and other community-based organizations.
5. Ensure at least 25 percent of the annual number of adults trained are representatives from external community stakeholders. External community stakeholders are individuals who engage with HHSC-funded prevention providers (e.g., staff of youth serving organizations, community coalition members, other agency staff whose positions are not funded by HHSC).

16.5 Core Function Three: Media Awareness Activities Coordination (Media Core)

A goal of each PRC is to use social and traditional media to increase the community's understanding of substance use and misuse and to promote behavioral health. Within the PRC Media Core, Providers must:

1. Develop messaging based on one of the priorities outlined under the number of social media messages section above and following guidelines in the SAMHSA toolkit, Focus on Prevention- Strategies and Programs to Prevention Substance Use.
2. Promote consistent statewide messaging by participating in HHSC's SMC.
3. Maintain organizational Facebook and Instagram accounts and any other social media platforms required by HHSC. The SMC's social media messaging should be shared on these platforms. These social media platforms may also be used to post original content created by the Provider and to share relevant content posted by other organizations.
4. Ensure that the organization's public relations coordinator is registered with and has access to the SMC SharePoint site. Staff must request access using procedures outlined by HHSC.
5. Promote prevention messages through media outlets including radio or television PSAs, media interviews, billboards, bus boards, editorials, or social media (if permitted by the Provider's organization policies) in the CSAP Definition Section.

Budget Requirement for PRCs Media Awareness Activities

1. At least 10 percent of the total PRC fiscal year budget shall be spent on media awareness activities that include local and regional media campaigns and support for the SMC (for fiscal year 2022, each PRC may reduce their total spending to $2500).
    A. Providers must dedicate 25 percent to 50 percent of the media budget to support the SMC and related media expenditures as directed by HHSC.
    B. Expenditures for the SMC include paid radio, television spots, and boosting for social media content.
    C. Expenditures on other local or regional media campaigns include print media, radio, television, billboards, and other posted signage or paid advertising space.

D. Approved platforms for paid social media boosting or ads include Facebook, Instagram, YouTube, and Twitter. Paid media boosting or ads on any other social media platforms or apps requires prior approval from HHSC.

E. Influencers should be used directly in conjunction with a defined media campaign. Use of paid social media influencers as part of any media campaign must be approved by HHSC prior to implementation.

F. Funds may not be used to create agency logos or other forms of agency branding.

16.6 Core Function Four: Tobacco-Specific Prevention Activities Coordination (Tobacco Prevention Core)

A goal of the PRCs is to provide education and monitoring activities that address retailer compliance with state law and affect minors' access to tobacco and other nicotine products. Providers must conduct tobacco-specific prevention strategies within the PRC Tobacco Prevention Core to support the State's efforts to comply with the Federal Synar Amendment, 42 U.S.C. §300x-26[7], and assist retailers in the restriction of the sale of tobacco and other nicotine products to minors. States may have a retail violation rate of no more than 20 percent. For more information, visit the SAMHSA website. As part of the Tobacco Prevention Core, Providers must:

1. Conduct on-site, voluntary checks with tobacco retailers in the region to ensure retailers adhere to all protocols established by the Texas Comptroller's Office related to minor access to tobacco, permits, and required signage. Providers must report violations to local law enforcement or local comptroller offices and document this strategy using the agency required Tobacco Retailer Compliance-Initial and Follow-up Visit Contact Forms located in the PATT.

   A. In PRC regions with fewer than 2,000 licensed tobacco retailers, Providers shall determine the number of active tobacco retailers and visit 25 percent these retailers (unduplicated) each quarter. Providers must visit 100 percent of the active tobacco retailers each fiscal year.

   B. In PRC regions with 2,000 to 4,000 licensed tobacco retailers, Providers shall visit 2,000 of the active tobacco retailers in the region each fiscal

[7] Federal Synar Amendment

year. Providers must visit a minimum of 25 percent of this number (unduplicated) each quarter.

C. In PRC regions with more than 4,000 licensed tobacco retailers, Providers must visit a minimum of 225 unduplicated tobacco retailers per month of each fiscal year.

2. Provide education to tobacco retailers in the region that require additional information on the most current tobacco laws, especially as they pertain to minor access.
3. Conduct follow-up, voluntary compliance visits with all tobacco retailers who have been cited for tobacco-related violations and provide informational materials regarding Texas tobacco laws.