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BEGIN TRANSCRIPT:

LAURA GALBREATH: Good afternoon, and welcome to the SAMHSA-HRSA Center for Integrated Health Solutions National Webinar: Resources for the New Integrated Healthcare Workforce. My name is Laurie Galbreath; I serve as a director for the SAMHSA-HRSA Center for Integrated Health Solutions here at the National Council for Behavioral Health. Along with Rose Filipe, we will be moderating today's webinar.

As you may know, CIHS promotes the development of integrated primary and behavioral healthcare services to better address the needs of individuals with mental health and substance use conditions, whether they're seen in specialty behavioral health or primary care provider setting.

In addition to national webinars designed to help providers integrate care, the center is continuously posting practical resources and tools to the CIHS website, providing direct phone consultation to providers and stakeholder groups and directly working with SAMHSA's primary behavioral healthcare integration grantees and HRSA-funded safety net providers. [0:01:08]

It's a pleasure to bring you this webinar today as SAMHSA and HRSA have prioritized a workforce as a key strategy for the integration of primary care and behavioral health, so we're excited that this can be a focus and to bring you some expertise from the field.

With that, I want to let you know of, again, the purpose of today's webinar, which is to share the experience of one community health center, Cherry Street Health Services and the Heart of the City Health Center, which is in Grand Rapids, Michigan so you can hear from a health center, to discuss the newly-released set of core competencies for the integrated care workforce and to highlight some of the key workforce resources and trainings available to you on the CIHS website.

And just to note that most of the content today is directed to community health centers as part of our scope of work under the HRSA umbrella, but we'll certainly have applicability for behavioral health professionals and/or organizations as well.

Again, here are our presenters for today, and with that I'm going to turn to Rose to give us some housekeeping remarks. [0:02:21]

ROSE FILIPE: Thank you, Laura. Good afternoon, everyone. During today's presentation your slides will automatically be synchronized with the audio, so you will not need to flip any slides to follow along. You will listen to audio through your computer speakers, so please make sure they are on and the volume is up. To download the presentation slides, please click the dropdown menu labeled Event Resources on the bottom left of your screen. If you lose audio at any time, please feel free to refresh your player by clicking the double-click arrows located on your volume slider.

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Lastly, please take a moment to provide your feedback by completing the short survey at the end of the webinar. [At the] (ph) close of the webinar presentation, a recording will be available on the CIHS website shortly following today's webinar.

LAURA GALBREATH: Great. Thank you, Rose. We now welcome our first presenter, Kristin Spykerman who will share her organization's experience on important workforce issues related to behavioral health teams and integration.

KRISTIN SPYKERMAN: Thank you, Laura. It's a pleasure to be with you today. My name is Kristin Spykerman, and I'm the director of health home services at Cherry Street Health Services. And today I'm going to talk about and just give you a brief overview of Cherry Street Health Services, and then I'm going to tell you how we prepared for our integrated workforce. I'll give you a brief description of our Durham Clinic model, and our Durham Clinic is our fully integrated healthcare clinic that you'll hear about, and then I'll talk a little bit about the outcomes and some of the lessons we've learned. [0:04:20]

Cherry Street Health Services is a federally qualified health center, and we're based in Grand Rapids, Michigan. We were founded in 1998, and in 2011 we merged with two other organizations: Proaction Behavioral Health Alliance, which traditionally treated those with substance use disorders, and then Touchstone innovare. And Touchstone innovare was a case management agency that treated consumers who had a severe and persistent mental illness.

We're now the largest FQHC in Michigan. We have over 20 locations, and we're in four different counties with about 70,000 patients and 800 employees. Those sites include primary care sites, school-based programs, integrated health sites, medication-assisted treatment, employee assistance centers, residential programs, and targeted case management. [0:05:10]

So our preparation for the integrated workforce really started many years ago, and it was discussed for years by the three partner organizations. The three CEOs of those organizations

that I explained beforehand would get together often, and usually over lunch, and would talk about how they were all treating the same patients and that there had to be something different that we could do in order to get better outcomes and to help patients recover from their chronic illnesses.

So in 2009, what we did is we formed nine different workgroups, and those workgroups were made up from staff of all three of those partner organizations. And what we wanted to do was to try to move this integrated care team concept forward. Some of those workgroups included one for education, one for staff selection, one for practice management. [0:06:07]

And then in 2010 what we did is we formed what we call the integrated development team. We wanted to start small; we didn't want to just open up the doors and let a bunch of the patients in without having a prepared workforce.

So in 2010 we formed a small team, and that team was made up of staff from all three agencies. There was an internist, social worker, psychiatrist, medical assistant, RN, and they were all given four to six hours of release time per week. And what they did during those four to six hours of release time from their current positions was they did a whole lot of training. They learned how to work together as a team, and they started seeing a small number of patients.

As you can imagine, there was quite the learning curve when you get all of those providers from different disciplines together. When we started to break down those silos, we had a lot of terminology confusion. There were times when we would go for weeks and be talking about a concept and not realize that we were actually talking about different things. There was terminology confusion. As our social workers are talking about MI and we need to do more MI, the internist is wondering why we're trying to give somebody a heart attack. As we are talking the PCP, the internist thinks we're talking about him or her versus the [persons and their] (ph) plan. [0:07:25]

So there was a lot of terminology confusion, and that went on and on. So we spent a lot of time learning how to talk to each other. Staff felt overwhelmed by the complexity. In our previous siloed state, we were usually able to say, oh, okay, I'm treating you for your bipolar disorder, and I see that, you know, yup, you have diabetes. You should really go talk to your primary care physician about that. And vice versa, the primary care physician would say, yup, you seem like you're depressed, I'm going to give you a referral to counseling.

Once we started this integrated workforce, we told our staff they could no longer say "That's not my problem." It's now everybody's problem. Everybody's working on all the chronic health conditions, so there's a lot of complexity by this - with that.

There was lack of one uniform documentation system. When we started we had three different EMRs, so trying to merge that into one and figure out what we were going to use took a lot of effort.

There were old habits delivering care. This is not the 50-minute traditional outpatient session, it's not traditional targeted case management, and it's not traditional primary care, so we had to work on redeveloping new habits.

And we had to work on reframing existing views on patient behaviors. Stage of change was something that was very new to the staff at Cherry Street who had been working just in the primary care setting. And we were trying to move from talking about noncompliance to talking about stages of change. [0:08:51]

So what we did next is we did a whole lot of trainings with that development team, and you can see the list of trainings here that that team went through. There's a few that I want to highlight. The entire team was cross-trained, so when you see all of these trainings it means the entire team went through these trainings. So social workers were trained in asthma and diabetes and hypertension, and internists and RNs were trained in motivational interviewing. They were trained in substance use disorders and bipolar disorder and personality disorders. [0:09:27]

We did an introduction to integrated care because we wanted the team to know what it is we were trying to do, so we spent some time on that. We also spent quite a bit of time on characteristics of a high functioning team. We looked at decision-making methods, how are we going to make decisions as a team, what were our group norms going to be.

We also did some work on team dynamics, so all of the team members did the Myers-Briggs, and we talked about the strengths and weaknesses that each one of us had. We also did the 16PF Team Development Report, where we could look at our strengths as a team and where we were lacking as a team. And then we did some offsite team building, which was critical to us being able to work together. [0:10:08]

In 2011, the full team began providing integrated care, and that coincided with the opening of Heart of the City Health Center, so Heart of the City is one of Cherry Street's sites in Grand Rapids. This building was built by the three partner organizations all together, and it was built around the concept of the integrated workforce. So the way that the building is designed, it's designed for team-based care that involves multiple disciplines.

When we talk about integrated care in terms of what we're doing here at Cherry Street we knew we had to define what we were talking about. So we're talking about one location, and not just that we're collocated but we're all in the same space. We're not just in the same building, we're in the same pod. So social workers, psychiatrist, internist, physicians' assistants, everybody is in that one pod. [0:11:00]

All chronic conditions are treated together. So whether somebody has bipolar disorder and diabetes or hypertension and schizophrenia, those are treated together versus separately. There's a team approach to providing care, so the entire team is working on managing all of a person's chronic health conditions versus just the chronic health conditions that maybe their discipline was trained in. There's one treatment plan that all providers follow. There is one electronic medical record, so we've got one med list and everybody can see everything that's in there.

Then there's equal access to all providers, and this is one of the things that's a little different from the traditional patient-centered medical home model. Typically in the patient-centered medical home model, you may have a counselor in the setting, but you have to go through the physician in order to get a referral to that counselor.

In the Durham Clinic what we've done is we have allowed all our patients to have equal access to all providers. So if you are a patient of the clinic, you can see the psychiatrist or the social worker or the internist or the nurse without having to go through another provider. [0:12:08]

And then our interventions are tailored to stage of change, so we have a stage of change attached to each chronic health condition. So whether that's diabetes or asthma or depression or anxiety, there's a stage of change attached to it.

This is the staff that we currently have in our integrated health clinic. We've not internal medicine, psychiatry. We've got health coaches, nursing, physicians' assistant, medical assistants, a supports coordinator, peer support specialist, and then we have other services that are available in the building, other support services.

So what is a health coach? If you Google health coach you come up with a whole bunch of different definitions of what that might be, so this is the way we chose to define our health coaches. Health coaching; the roots are actually in substance abuse in the early 1990s, and it's based on motivational interviewing, really using the spirit of MI to effect behavior change. It's a holistic approach to treating chronic health conditions, and our health coach's primary role is to help individuals become informed and activated around their chronic health condition. So whatever those conditions might be, whether they're what we typically would consider a physical illness or a behavioral health issue, their job is to help people to become informed and activated. [0:13:30]

And then what we wanted is we wanted health coaches that were able to provide primary interventions when appropriate to the condition. So what I mean by that is that we wanted them to be able to do motivational interviewing if somebody was in pre-contemplation in order to move them towards an action stage of change. But then we also wanted them to be able to provide intervention such as cognitive behavioral therapy, dialectical behavior therapy, EMDR. So if we've got a patient that's afraid to see the internist, then we have health coaches that can actually do motivational interviewing and also do some cognitive behavioral therapy around looking at those fears. They're all fully licensed MSWs, and the primary reason for that is for billing. [0:14:13]

This is really where the core of our integrated health team happens. This is a picture of one of our huddles. Every morning, the whole team meets together and we go through all of the patients that are going to be seen that day. We're able to do this pretty quickly, but only because we practiced over and over and over again. I tell my staff that this is the most expensive meeting they will ever sit in and so we really need to make sure it's efficient and that it's worth it and it's helping people get better.

One of the things that's important to note about this meeting is there's no one person in charge. So in particular, the internist is not in charge. So there's a flat structure - and we'll hear that comment when visitors come in and watch our huddles - is that there's a very flat structure, and sometimes it's hard to even tell who is who because there's respects for all positions and everybody has a role and everybody's role is important. [0:15:14]

We decided that if we were going to create an integrated workforce and do integrated care we wanted to know whether or not it actually was helping. So what we did when we opened the clinic is we started a three-year IRB-approved evaluation. And these are some of the measures that we're looking at: We're looking at depression, anxiety, substance use, pain, BMI, blood pressure, lipid profiles, fasting blood sugars. And then we're also looking at what I think is one of the most important measures, which is patient activation. This is really one of the keys, because you can provide the best treatment out there, but if the patient isn't activated in terms of taking care of their own chronic health conditions, then that treatment is not going to do much of anything. We're looking at self-perceived health status, and then we're looking at cost and claims data. [0:16:02]

So in the first year in our integrated care model we saw statistically significant improvement in BMI, blood pressure, depression, anxiety, patient activation, health status, substance use, and we saw an 18 percent reduction in ER use just within the first year.

We also within the first year saw a significant reduction in psychiatric facility admissions and total days, so we saw a 41 percent reduction in the number of admissions and a 47 percent reduction in the number of total days, and this was for our patients who have a severe persistent mental illness. And we compared the year prior to coming into integrated care and then the year since receiving integrated care and those were the results that we saw.

Some of the lessons learned; learning about something is not learning to do it. I often give the example that you could teach me all about how to do heart surgery, but you probably would not want me to actually perform heart surgery on you. So what we needed to do is instead of just starting with concepts and sitting people down and teaching them a whole bunch of things, they needed to be able to put that in practice and actually learn to do it. So that practice transformation doesn't happen until after the first patient is seen. We realize that this workforce needed to apply what they've learned in order to engrain it. [0:17:30]

We also learned that, to break old habits, new behaviors need to be modeled and reinforced. My former CEO has told me that I should never leave the team alone. And what he meant by that is that those new behaviors need to be modeled and reinforced over and over and over again, because otherwise people will revert back to old behaviors and will be back in our silos.

Another lesson we learned was to anticipate resistance, and I don't think that we did quite enough of this. So there was resistance both inside the organization and outside of the organization. Practicing with an integrated workforce is a completely new way of practicing, and it is moving people out of those safe silos that they've been in for a very long time, so there's resistance to that. And like I said, that's not only coming from within the organization, but comes from outside of the organization. [0:18:24]

There was resistance in terms of attitudes. There was competition for patients. So we would get comments like "Why would I refer any patients to you when that's going to affect my own productivity?"

There was lack of understanding of integrated healthcare. We very seldom - we usually would get comments such as the Durham Clinics, that's the place that everybody with a mental illness goes, or that's the place where everybody with a substance use disorder goes, or that's the place where anybody who's no-showing can go. So there was a real lack of understanding.

And then changing policies; there was resistance to changing policies. When we first merged, the Cherry Street internal medicine policy was that if you no-showed twice to an appointment, you were discharged. We have changed that now, but that's something, just one of those things that needs to be looked at, when you're bringing silos together and trying to integrate a workforce. [0:19:18]

Another lesson we learned is that you have to get commitment from the top down. If we would not have had the commitment from those three CEOs of the partner organization, I think we would have been shut down a long time ago. There's a significant time commitment, a significant financial commitment, and a significant commitment to the organization changing the way they practice. So that commitment has to come from the top down; otherwise, it's not going to work.

Another lesson we learned is not to discount the learning curve. It takes time and practice to be able to learn a whole new stack of competencies. Social workers don't come out of graduate school knowing about diabetes and being able to coach somebody on it. And internists don't come out of medical school knowing about dialectical behavioral skills or motivational interviewing, so it takes time to learn those things. [0:20:12]

And we also learn not to discount communication barriers. As I said before, we experienced a lot of communication barriers, and we underestimated how much of that we would have. There are still times that we come across a barrier that we hadn't expected, because we're still learning new languages.

And then perhaps one of the most important lessons we learned is to choose the right staff. We knew we needed staff that had the self-confidence to work within the limits of their license and to act as equals with other healthcare providers. We didn't want staff who would just refer to the MD on every decision and stay silent. We wanted staff who were self-confident enough to speak up and to actually say to the MD, if they're a social worker, this is what I need you to do when you see those patients today. [0:21:05]

We needed staff who had humility; humility to know what they don't know and then to be eager to learn it. So when I was interviewing staff, if I had a staff say, "Oh, yeah, my grandmother has diabetes and I know all about that," that's a red flag to me. I need staff that know what they don't know and then they want to learn.

We needed staff who had a willingness to create and learn a new language. This is a completely new way of practicing, and not all staff are willing or able to put the time and effort in that it takes to learn something new.

We wanted staff who were curious. When we first started practicing, we had many patients that were diagnosed, for example, with schizoaffective disorder. And so we wanted staff that would look at that and say what's really going on here, let's look at all of the aspects of what's going on here. And we actually found out that most of these patients didn't have schizoaffective disorder, but when we were treating them in silos, that's all we knew. So we needed staff who were curious. And then we needed staff who were flexible, so that they could quickly change direction. If something is not working, we are going to change direction, and change direction fast. [0:22:16]

LAURA GALBREATH: Great. Thank you for that. That's really great tips and a high-level overview of what you've been able to do with your team, so we really appreciate it. We do have time, we're going to take two quick questions, and then we're going to go on to our other presenter. We will have plenty of time at the end for further discussion with all of our presenters.

One question that came in for you is just where do you find the time to do all the training? And did the training take away from patient care in terms of maybe some of your time that your clinicians would be with patients?

KRISTIN SPYKERMAN: Yes. The time was a significant issue. At that point in time we had three separate organizations, so each staff that was selected was given four to six hours of release time by their home organization. So if I'm an internist, then I was given four to six hours of release time from my normal work to be able to devote to this project. [0:23:10]

So there's a cost involved with that because it does take away from patient care. But that's the way we found the time to do the training and to do the team building. We really thought it was important that the training happened as a team versus individually.

LAURA GALBREATH: And of course, several questions have come in since about how did you fund the training, how did you pay for that training.

KRISTIN SPYKERMAN: So there's definitely a portion of that training that we ate the cost of, because we were eating the cost of the lost productivity of those providers during that four to six hours a week. But what we did is we tried to use internal resources for training as much as possible, and we found we were able to do that pretty successfully. So for example, we've got two trainers on staff who are - been (ph) certified in motivational interviewing and so we were able to use them to do the motivational interviewing. The internist on the team did a training for the entire team on diabetes. We had another internist come in and do a training on hypertension. [0:24:11]

And then the neat thing that we found is that the community was so excited about what we were doing that they offered their time. I think we actually only paid one trainer to come in and train the team. Everybody else came in and did it without charging us.

LAURA GALBREATH: That's great, and a nice example of community partnership. We have other questions that we will get to later in our webinar, but we want to go ahead and turn it over to Michael Hoge to talk with us about the new core competencies developed for integrated care.

MICHAEL HOGE: Can you hear me okay, Laura?

LAURA GALBREATH: Yes, we can.

MICHAEL HOGE: Great. Good afternoon, everybody. Thanks for joining us. I'm going to be presenting a brief overview of the core competencies for integrated behavioral health and primary care. These were developed under the auspices of the Center for Integrated Health Solutions, and they were released several weeks ago. They are available at the Center for Integrated Health Solutions' website. If you just click on the Workforce tab, you will be able to access them if you have not done so already. [0:25:23]

The concept of core competencies has really been sweeping healthcare for the last decade or so, and it emerged because of significant public concern about the qualifications of physicians and healthcare providers in general. There's a lot of stuff in the public press about individuals being harmed through the receipt of healthcare, and the Accreditation Council for Graduate Medical Education began a major reform initiative in introducing core competencies that are now applicable to all physicians. They introduced their big six requirement that all physicians develop competencies in patient care, in medical knowledge, practice-based learning and improvement, distance-based practice, professionalism, and interpersonal skills and communications. And we took - paid great attention to those competencies, those competency categories, in looking at the development of these integration competencies. Once again, the ACGME competencies pervade all of medical education at this point in time. [0:26:29]

The introduction of competencies really created a paradigm shift in educating our workforce. So historically, we wanted to train someone. We assigned an individual to sit down and develop a curriculum and they would think about what they wanted to include. And the notion of competencies is that we identify competencies in advance and then have our curricula based on those competencies and sort of lead, in turn, to the training. The idea here is that we create a foundation for competency and some consistency across the field so that we're training to the same types of things as we develop our national workforce. [0:27:09]

The notion of a core competency is the sense that these are common competencies that are shared or cross-cutting across different professions or across different disciplines. They exclude specialized competencies that are unique just to selected groups.

A few caveats: Not every single competency in every competency set, even a core competency set, applies to every provider. In general, we think of the majority of the competencies in the set applying to those disciplines or professions for which it's intended to be relevant. But the relevance varies by discipline, it varies by job or role that a person is in, and by the particular setting in which it is deployed.

And there are certainly additions to the basic competencies that are required to do one's job which are unique to a role, and those would be the specialized competencies are sometimes advanced competencies. [0:28:09]

In developing this set of competencies for integrated care, we drew on a review of the published literature. And what you'll find in the published literature is there are lots of descriptions about integrated care and the tasks involved in delivering that care, but not a lot of lists or identification of specific competencies. These are largely implied in the written literature and we did a lot of work to sort of extract them. There are a variety of manuals on integrated care similar to the published literature that we referenced. And probably the main source for developing these competencies involved a panel of key informants, and we had 50 people from across the nation who were identified in multiple ways. They had authored articles and other resources on the topic of integration and they were nominated by other experts or nominated by the SAMHSA-HRSA Center for Integrated Health Solutions, nominated by the leadership within HRSA and within HRSA-supported FQHCs or community behavioral health organizations that were grantees in the SAMHSA-sponsored primary and behavioral healthcare integration program. [0:29:25]

We made a strong effort to find a pool of experts that was very diverse in terms of their expertise, bringing their knowledge about integrated care for children, adults and older adults for urban and rural healthcare, for culturally - expertise on cultural competence, diversity and disparities, healthcare financing, and lastly, a lot of diversity with respect to disciplines and specialties, internal medicine and family medicine, public health, addictions, psychiatry, social work, nursing, and peer support and recovery. [0:30:01]

We also had two senior content experts that helped guide this process. Andrew Pomerantz was or is the national mental health director for Integrated Services in the Veterans Health Administration. He's a professor at Dartmouth and developed the White River model for primary care mental health integration, and he was joined by Tillman Farley, who is the medical services director of Salud Family Health Centers, which is a federally qualified community mental health center. He has a very strong interest in integrated primary care and health disparities, particularly as those apply to immigrant populations.

The entire project was managed by the Annapolis Coalition on the Behavioral Health Workforce that I represent, and working with me on this project was our director, John Morris, and an additional consultant, Michele Laraia, who's an advance practice nurse.

The guiding assumptions in putting together these core competencies were as follows: They focus on full or close collaboration, and CIHS has released a description of various models of integration, so you can find the descriptions of full or close collaboration on their website.

It was a struggle to find language that would be acceptable across the diverse groups that might be interested in the competencies. We chose to refer to those receiving care as healthcare consumers and made the assumption, the guiding assumption, that healthcare consumers and family members are key partners in the healthcare process. [0:31:37]

As you look at the competencies, you'll see that they're highly skill-oriented; they describe observable behaviors. They tend not to specify knowledge; these are implied. And you'll see some attitudes are either implied or specifically described as well.

There are a lot of evidence-based treatments and tools that are used in integrated care, and we described having a knowledge and skills regarding evidence-based treatments as essential but did not list all of those specific treatments and tools since these will evolve over time. [0:32:18]

Probably one of the most enlightening things for us is we set out trying to build two competency sets; one focused on behavioral health and one focused on primary healthcare. The sets in their first draft looked very similar although they had some differences. And we got very strong feedback from our senior advisors and the expert panel that those really needed to be merged because there was a feeling that creating separate sets of competencies actually fueled the differences in these areas as opposed to working just to cross those boundaries and those bridges and bring people together, and we believe that we were successfully able to achieve that integration. [0:33:05]

The first approach to understanding the competencies is to look at the categories, and there are nine of them. Interpersonal communication is the most basic, and this was emphasized over and over again by the key informants, particularly the ability to establish rapport quickly with lots of different individuals, healthcare consumers, family members, and other providers.

Collaboration and teamwork is the second category. Brief evidence-based and developmentally appropriate screening is the third. The development of integrated care plans and the exchange of information amongst consumers, family members, and providers came together under the umbrella of care planning and coordination for the fourth category. Under intervention, we emphasized brief focused prevention treatment and recovery services as well as some longer term treatment and support for consumers who have persistent illnesses. [0:34:10]

Category six is about the ability to provide services that are relevant to the culture of the consumer and family member. Number seven is about the ability to function effectively within the organizational and financial structure of the local system of healthcare. Eight is about the ability to assess and continually improve the services delivered both as an individual provider and as an inter-professional team. And the last category is about the ability to use information technology to support and improve integrated healthcare.

Each of the categories is made up of individual competencies, and there are 96 of those in total. The strength of these individual competencies lies in the fact that they really make explicit many of the things that we know about integrated care that are implicit. My estimate is that as we talk to each expert, that they would typically identify between eight and ten competencies for us but would struggle to go much deeper than that in laying out a full array of competencies necessary for integrated care. And I believe that the power of the set really comes from the fact that all of these experts working together were able to build this more comprehensive set and then respond to each other's ideas, give feedback to each other, and, over a sort of multistage process, work to this fairly crisp set that has been produced. [0:35:49]

The challenge for any expert or administrator as you're managing your organization or your team to just sit and identify all of these specific competencies, and so we believe that the competency set as a whole provides a resource for those that are trying to develop a workforce and manage integrated care services. The one example that I would give you which is listed here is collaboration and teamwork is a concept that we talk about and think about frequently. The competency set identifies 18 different elements of collaboration and teamwork and really takes this broader general notion of collaboration and teamwork and breaks it down into specific observables. [0:36:35]

So when any time a competency set is delivered, the next question is always so what can people do with it? And I want to offer you five simple strategies for using the core competencies. Many of these are going to seem very basic or simple, but the power really lies in using numbers of these strategies to infuse a focus on competencies throughout a team or throughout your organization. [0:37:04]

The first involves incorporating the competencies into the job descriptions, either creating new descriptions or updating the descriptions that you have, drawing on those from the competency set that are most relevant to your particular positions, integrating those with other job-related duties that are required of your staff, and using the competencies to increase role clarity and expectations in workforce positions that are in integrated care.

We've done some work on burnout and turnover in behavioral health, and one of the findings is that the lack of role clarity and clear expectations about responsibilities is a prime driver of the satisfaction within turnover in healthcare position. So the extent to which you can use the competencies to be explicit about job roles and expectations can help address this problem. [0:38:00]

The second is to use the competencies in employee recruitment. The competencies provide a list of things that you could call from and then use in terms of screening applications, looking for people who have the right qualifications.

One of the ways in which I like to use competency sets is in interviewing of job candidates, and I think this set offers some interesting probes around some of the competencies such as a fundamental belief in the value and effectiveness of brief interventions, or a potential candidate's ability to recognize, respect, and value the role and expertise of healthcare consumers, family members, and other professionals in healthcare delivery, or focus on health and wellness in addition to the traditional focus on illness and its treatment.

The other way in which you can use the competencies is in creating realistic job previews. These job previews can be written descriptions about what jobs are like. Some organizations create videos, giving a sense of what a job will be like. There's evidence in the literature that creating realistic job previews decreases the frequency with which people take jobs for which they're ill-suited or take the jobs and then quit shortly thereafter. [0:39:19]

The competencies can be used in the orientation process for new employees, conveying roles and responsibilities and expectations in their jobs. A key point here is the importance of educating

supervisors about the competencies and engaging supervisors in using the competencies as a basis for their ongoing supervision with their staff.

The fourth strategy involves using the competencies as a foundation for your ongoing staff training and continuing education. You can use it as a basis for conducting a brief organizational assessment to look at where your primary workforce development needs are. I've seen many organizations use competency sets as a foundation for their ongoing in-service training. Those competency sets have less than a dozen categories of competencies. And a very common strategy is for an organization to take one competency category each month and to build some in-service training around that category and to do that on an annual basis so that you're constantly revisiting the core competencies that are essential for your organization. [0:40:37]

It's very clear that new and inexperienced employees will learn or have much to learn from the initial education and continuing education. But one of the things that I've experienced over the years that has surprised me is how open seasoned employees are to reviewing and discussing competencies, even competencies that are very basic. It's an opportunity for them to sort of come back and revisit their assumptions about the way the work is done. If you mix junior and senior employees, it's an opportunity for them to share their perspective with the less experienced employees. [0:41:15]

And the final point I would make here is that you can use the competencies in and of themselves as the basis for group discussions with your team or within your organization about the practice and culture within the team or organization; really sort of as a stimulus to thinking about where are we as a group, how are we doing on these particular dimensions, where are we strong, and where do we have room to grow.

The final strategy relates to performance assessment. The competencies can add a lot of specificity in your process of assessing the competency and the performance of your staff. I always like to say there are two approaches to performance assessment; the most common one is the "Oh, shoot, I have to do the annual performance review." And usually the language is more flowery than "oh, shoot," but it's that sort of view of performance assessment as a paperwork task that has to be done that's just a burden. [0:42:15]

The alternative approach is one where the annual documentation of performance is really the documentation of what has been an ongoing discussion with the employee and a process that I like to refer to as collaborative competency building. You can use the competency set to work with an employee to do a self-assessment: Where do they think they're strong, where do they think their areas of growth are in terms of the competencies. You can identify areas where growth is needed and put together some brief skill-building plans: How are we going to strengthen your skills in this area, what kinds of experiences or additional training can we offer. You can use the competencies and translate them into 360-degree evaluation instruments, which means you use them to get feedback from people who see the employee working in lots of different ways or from different perspectives. So feedback from their peers, feedback from a range of their supervisors, feedback from consumers and families, for example. [0:43:14]

Competencies and the competency categories can be used as a basis for employees to do portfolio development. You educate them about the competencies, and they collect information about the trainings and experiences they have over time that build their skills in each of the competency areas. And then last but not least, you can obviously just sort of incorporate the competencies into your formal performance reviews.

So the logic on the logic model here is that if we identify the competencies and are clear about what people need to know, if we fold them into our job descriptions, if we use them for the basis of recruiting folks, if we orient the new employees around the competencies, we train them on an ongoing basis to the competencies, and we assess them on those competencies, that we will overall improve the performance of our teams and organizations. This is a basic concept that comes out of implementation science, which has taught us that it is not sufficient simply to train individuals; we have to align all of the processes within our organization so that they support these new skills that we would like individuals to acquire. [0:44:28]

So I want to just briefly mention the fact that we talk as professions a lot about the competencies of individuals, but there's also the notion of competencies of a team as a whole. Obviously, not every individual has to have all the competencies. There is a distribution of the labor or distribution of tasks that occurs. In general, we sort of think of the team needing to have the comprehensive set of competencies and the ability to sort make sure that all healthcare needs are met through the assembly of those skills. [0:45:05]

And so, again, you could use the competencies as a discussion within a team for a team to look at who is handling which competencies and which perhaps are uncovered or need more development from a team perspective.

The final comment that I will make is that we designed these with a focus on integrated care. But if you look through them, I think you will agree with me that many of the competencies are broadly relevant to contemporary practice in this era of healthcare reform. So they can be used with integrated care, but you can use them throughout your organization with staff in all different kinds of roles. Because I think the bottom line lesson that we took away from this is that the hallmarks of integrated care, the competencies that are essential for integrated care, are what we're increasingly thinking of as the competencies that all healthcare providers need to have to practice in our rapidly changing healthcare systems. [0:46:06]

LAURA GALBREATH: Great. Thank you, Michael. We do have time for just one or two questions before we move on to some of the resources that are available to folks as they move the competencies into practice.

One of the questions that came in was around one of the companies that talked about cultural competency and, you know, in terms of the ability to provide services based on the consumers' culture. Can you speak to maybe the informant interviews of the development of how things like trauma, informed care, phase-based approaches - how does that get developed into that? Is that kind of assumed as part of the culture? Is that something we just need to maybe help people, as they think about that question, kind of dive deeper?

MICHAEL HOGE: I think that the development of culturally competence (ph) approaches in all of healthcare has been an enormous challenge. Many of the experts in the field will say publicly that they feel our progress on that or our status on that is that it's still largely aspirational; that we're committed to it, that we know we have to sort of attend to these issues, but we struggle to make it real in practice. [0:47:19]

Our general approach is to assume there are so many differences between individuals, so many types of diversity, that the challenge for a provider and the challenge for an organization or a team is to, first and foremost, understand the individual consumer and their family member as individuals or families and their specific needs, their perspective on their needs, and their priorities, and to tailor services to that. And at the team and organizational level, there are obviously certain types of characteristics that may recur in the population that's being served and for that team organization to become more expert at understanding those typical needs and being able to tailor services to that. [0:48:07]

And I think some of the pieces that you've mentioned, sort of the role of a faith or spirituality or other forms of diversity, sort of all fall within there. And it's a very, very large challenge, a very high demand to be able to achieve that, but we're constantly I think striving as individual providers and teams to be responsive at that individual and family level.

LAURA GALBREATH: Great, thank you very much. We'll come back to some of the other questions after this next segment, which is a great segue, because some of the questions that folks had shared with us at the very end was where are those competencies, how can I get them, and are they available in the public domain? And so that question is yes, and you kind of dived deeper into accessing the competencies and other resources and lessons learned from, you know, clinicians and teams like Kristin's. [0:49:04]

I'm going to talk a little bit about some of the resources that you can find on the center's website. Just to give you some context about why is the Center for Integrated Health Solutions doing work in workforce. As I mentioned in the beginning, SAMHSA-HRSA have strongly communicated that workforce development is an essential element of sustainable health delivery change, so we're going to sustain and really make the integration of primary care and behavioral health the standard that workforce development is important.

For our efforts, we have been a technical assistant (ph) center around for four years now, and this has been a multi-year effort to support workforce development as it relates specifically to integration of primary and behavioral healthcare.

Some of our activities in the past have included guiding principles for workforce development, obviously the release of the core competencies, some curriculum development, which I'm going to highlight here in just a moment, as well as dissemination of practical tools and resources which you have a key part in helping us to do. [0:50:07]

Some of the resources that I'm going to highlight in terms of the curriculum is that we've been able, over the last couple of years, to support the development of curriculum in about eight different areas. And I'm not going to highlight all of these, but I did think it was important to

share those with you. And all of these are available on the website, and I will show you kind of where you'll be able to find that here shortly. But the website integration.samhsa.gov is where you've going to find links to all of these different curriculums that I'm highlighting here.

So the first one I wanted to share with you was development of psychiatric consulting curriculums. So how do we help prepare psychiatrists to consult primary care practices in the successful treatment of individuals with mental illness that may not want to access a specialty system, may be able to be successfully managed in their primary care environment, with the support of the psychiatrist in a consulting role. [0:51:10]

So this is really a workforce training for psychiatrists that have come out of the AIMS Center at the University of Washington and is available online for any psychiatrist to take advantage of that really looks at these different modules that you see here to support them in being successful in that consulting role in addition to any work that it may be doing in the more traditional setting or in a traditional manner. This has really been a very valuable curriculum that has been helping psychiatrists and I think we're really excited to see the growth and evolution of this. And I think for your team, you know, if you have a partnership and you're asking that your behavioral health - organization to contract with the psychiatrist to provide consultation, this is a great tool to say, you know, if you've identified somebody, is this something that they could take advantage of to kind of help understand what it means to consult the primary care, to be part of that team in a primary care environment, and to get them ready to be successful. [0:52:14]

Next, as you may have seen from Cherry Street and from others, more and more we're turning to the use of paraprofessionals to support patient-centered care, and so how this training that we have made available through the center is for mental health consumers. So for individuals who have had a limp (ph) experience with a mental illness or an addiction, how would we train them as health educators, coaches, really looking at working with individuals one-on-one to create a health goal, a wellness goal, that they feel confident that they can achieve, and, through individual and group support, work with them over a period of time on a weekly action plan for success. It's been really well used in the behavioral health community, and we're seeing it growing in terms of how it can be used as a workforce potential in primary care. [0:53:11]

Next, if you are exploring, you know, wow, we really have some serious issues around substance use, and while we may have embedded, you know, a social worker in our practice, we'd like to also think about expanding the workforce and bringing in some addiction professionals... If that's something you're considering, this curriculum is really good for introducing addiction professionals to the primary care environment. Again, it will be a different way of providing services and being part of an interdisciplinary team.

So this course, which is a five-hour self-paid course online, it's free and available to anyone. It's something that you can do to introduce addiction professionals, and I actually found that it's actually very helpful to any behavioral health professional who's thinking about the primary care environment. It's a great introduction course, and again, because it's self-paced and only five hours, it's great. And again, it's free. It is, like the other curriculums, available online for free. There is a small surcharge if somebody wants continuing education credit for it. [0:54:18]

Next, the large initiative that I think really speaks to both the current workforce but also the future workforce is the integrated healthcare curriculum for schools of social work. In the partnership with the Council on Social Work Education, two courses have been developed and tested in approximately ten universities across the country to train the next generation of clinical social workers to be prepared after they come out of their programs to work in more integrated settings, so we're really excited to see the development of this curriculum. The draft curriculum is available on the CSWE website, which is linked from CIHS, so you can take advantage of some of that material now, and as well as some development on the future to make it available as an online course for existing clinicians as well as hope that this becomes a standard curriculum for all schools of social work in the coming years. [0:55:18]

Care management in primary care; so if you're a community health center - and maybe you already have some behavioral health staff that are embedded into your team - but as you move towards the patients [and their] (ph) medical home, you recognize that there may be some additional needs for training around care management.

So how do we help the behavioral health folks become successful in that role as care managers, as part of the team with the nurses, your physicians, and other members, and so really looking at the care management? And this is a course that was developed, again, in partnership with the University of Massachusetts and the medical school, so we're really pleased with that. Again, a resource is available online and hyperlinked through the center's website. [0:56:07]

This is one under development for all of you that are in the behavioral health field that are trying to integrate primary care; this one is thinking about bidirectionally, so for those of you with primary care clinicians that are going to be going and working at an embedded clinic at a community mental health center. So maybe you've set up a primary care clinic at the mental health center and you are going to have staff there several days a week. Well, what is the introduction to integration look like for this need for this very kind of significant population in terms of their complex conditions and their complex needs?

So really, we're developing a curriculum that will hopefully be online in the near future so that a primary care clinician can feel prepared to work in those environments as well as we focus on bidirectional integration. [0:57:01]

Lastly in terms of curriculum, I wanted to highlight mental health first aid. While certainly not limited to the center, the center was able to really recognize the needs of rural communities. And that, you know, when you do a mental health first aid training, certainly when you go through some of the training modules and scenarios, it's very different if you're nearest mental health center for some of you who may need some immediate help is 200 miles away.

And so we were really able to work with some of the leading content experts around rural health from WICHE as well as leaders in the mental health first aid curriculum development in addressing some of that, modules. And you'll see here primary care as well as a Spanish adaptation.

And one of the things I think is really interesting is that we're seeing more and more primary care providers take advantage of mental health first aid for all their staff, from the front desk to your medical assistants to your community health workers. It's a wonderful introduction to what are kind of some of the recognized features of mental health and addictions, and how can I be helpful in my interaction with someone who may be in a waiting room, having a panic attack? How can you be helpful in that moment inside and outside of the clinic walls? And we're really pleased to have been able to support that for primary care on a rural community. [0:58:30]

So I'm going to jump here to our website. And what you can see is integration.samhsa.gov. Everything that I've spoken about is here as well as the competencies. If you click on the Workforce tab, on the right-hand side you'll see that all of the competencies are there and are publicly available. And what we've added in terms of resources is once you open the competencies, the individual ones, you'll find hyperlinks from additional resources. [0:59:00]

So under screening and assessment, you're going to be able to find a hyperlink to the other sections of the website that provide clinical tools, operational tools; like, for example, job descriptions, intervention resources like screening brief intervention referral to treatment, and so forth.

And under the workforce category we've organized all of the content in several different ways, addressing the needs of team members, both as an interdisciplinary team as well as individuals, from psychiatrists to social workers. And speaking of teams, I'll be sharing another resource for you related to that that's going to be coming out soon from the center. From recruitment and retention, you heard from both of our presenters around the needs for that language, for those resources to support the integration, and you have to be able to recruit the right people and have the right information to bring them onboard and orient them.

I've talked about some of the education and training that we have available on the website. Supervision is certainly a key area in need of support as you embed behavioral health staff in a primary care setting. I see some of you asked questions about partnerships. We have a lot on how do you manage that relationship between partnering primary care and behavioral health providers and certainly in the area of leadership, also a key element when it comes to integration. [1:00:28]

So just to give you a quick example, if you are a community health center and you've recruited a licensed clinical social worker to join your primary care team, there are several ways you might be able to find some resources. Under the Recruitment and Retention tab we have a few job descriptions that providers have been generous enough to share with us from their experiences. Under the Team tab we have the new paper that I'll be speaking to you on essential elements of effective integrated primary behavioral healthcare teams, thinking about how do you run those huddles. [1:01:00]

Under Teams, but if you're a social worker, maybe you're going to go directly to the Social Worker tab and find things like interventions in integrated healthcare, which will link to

resources on our clinical section highlighting brief intervention, motivational interviewing, shared decision-making; all tools to help the team in providing integrated services.

And lastly, resources under supervision; things like a shadowing tool kit so that you can help set up a program for shadowing staff and be able to identify what are some of the key elements that they were able to observe as part of that shadowing. So just a way to kind of walk you through how we've kind of organized some of the resources on the websites.

And before I leave this slide, I do want to mention that it's really important that a lot of these have been resources that have been developed from innovators in the field. So for those of you that may have already developed a job description that you use for a behavioral health consultant, or maybe you've got a really great training that you've utilized, you really want to use the website as a way to curate and pull valuable things that are being used in the field, very practical in nature. So please feel free at any time to e-mail us anything that you've developed or that you're aware of that we should add to their websites. We really appreciate that input and really depend on you to help share what's most useful to you as a provider. [1:02:20]

The resource I mentioned that I want to highlight and that will be coming out in the next week is a piece that we did to kind of look at the essential elements of effective integrated primary and behavioral healthcare teams. I'm happy to say that Cherry Street was part of this look at different practices, really kind of interviewing different practices that be, what has made for an effective team, and what are some of those tips and strategies to use, especially in the area of leadership and organizational commitment, team development, team process, and team outcome. So if you don't already receive CIHS e-mails, please make sure to sign up so that when this is released in the next week or two you'll make sure to get that as well as in the new resources we'll be adding to the website. [1:03:07]

For those of you in the behavioral health field that may be on the call today, I thought it was important to share with you the National Health Service Corp. I think those of you that are HRSA-funded are very familiar with the National Health Service Corp as a recruitment and retention resource. And for those of you in the behavioral health field, it's a really nice opportunity for you to become a HRSA site within the national professional shortage area. And through the center we were able to develop some resources in terms of understanding the National Health Service Corp and its application process, again for those in the behavioral health setting who may not be familiar with this important resource from HRSA.

So again, just more information and resources are available on the website. And now I'm really looking forward to turn this over to Rose, who is going to help us in filtering through some of the questions that have been coming in. [1:04:03]

ROSE FILIPE: Great. Thank you, Laura.

So one of the questions is you discussed a number of integrated care training resources for psychiatrists, social workers, substance use professionals, peers, and others. What training resources are available specifically for psychologists interested in working in integrated primary

care environments, and what level of interest do you believe exists in including psychologists into integrated primary care teams?

LAURA GALBREATH: That's a great question. There are a host of different clinicians that can play a role in integration, and psychologists are certainly one of those. We have linked on our website but haven't - you know, would like to make a more robust area specific to psychologists. And so if you go on our website, you will find a page for psychologists, but really APA has been a real leader in helping think about the role of psychologists in primary care. And they're used quite frequently in a lot of areas, and in a lot of states are actually able to be billed, if you would, under primary care using different codes for behavioral health intervention.

So they are an important behavioral health professionals that are embedded in primary care clinics across the country, and certainly look forward to seeing more coming out of there. I think APA even had some core competencies and some other pieces that they have developed specifically for psychologists that we're looking to link to. So we're eager to disseminate that and to hear from you about what's worked in terms of psychologists working in primary care and what tools would be best to share through the center's website. [1:05:51]

MICHAEL HOGE: Laura, this is Michael. I would just - in addition to the competencies that APA released that were in draft format, I would just also emphasize in terms of employment that psychologists are playing a very major role in the integrated care teams within the VA system around the country. There are I think lots of employment opportunities, a very sort of - significantly growing workforce of psychologists in integrated care in that setting. [1:06:17]

LAURA GALBREATH: And Kristin, I know you - I think you - believe you used a variety of different folks for your staff. Do you - you have psychologists?

KRISTIN SPYKERMAN: We don't currently have psychologists on staff right now. That's something that we've looked at and would love to eventually get a psychologist on staff, but at this point in time we don't have any.

LAURA GALBREATH: Great, thank you. Rose, next question you may have had?

ROSE FILIPE: Yes. How much is integrated care being done in the private sector as opposed to the public sector?

LAURA GALBREATH: Michael, do you have any thoughts on that from the development of the competencies and what you've heard when doing some investigations for the development of those? [1:07:10]

MICHAEL HOGE: No, there wasn't really much that came out about a public sector versus a private sector split. I think we drew… The distinction between public and private has increasingly blurred over the years; it used to be quite clear what the differences were. But we have a large number of privately funded organizations or private nonprofits that are - you know, draw on public funds. So I'm afraid I can't really give an evidence-based answer to that question.

LAURA GALBREATH: And this is Laura. I think from our perspective at the center we certainly have heard lots of innovations in the private sector. I think distilling that information down to kind of what are those common features across private plans, be it health plans or other managed care entities, has been a struggle to kind of get that picture across the different industries. [1:08:16]

So I think it's something we'd like to continue to promote and communicate wherever and whenever possible. So certainly want to see, you know, what's similar and what's different when you look at public versus private providers and their level of integration. [1:08:32]

Rose, I know there was a good question earlier that I wanted to make sure we got to. It kind of came up around productivity measures that often are set in a primary care environment. And Kristin, I know if you - did you ever de-individualize productivity measures to deal with between provider productivity concerns? So I'm wondering if you could speak to kind of how this team approach works when productivity measures come into play. [1:09:03]

ROSE FILIPE: Well, that's a good question because it's obviously been a topic of discussion many times. So what the organization - and this comes about from the organization's commitment to providing integrated healthcare. So the organization has said that our team huddles will not affect the overall productivity numbers of our providers. So in the way we calculate productivity in terms of clinic hours, those team huddles are not counting towards that. So that helps the individual provider not have to worry that, okay, I'm spending time in this huddle and now it's going to affect my productivity numbers at the end of the month.

So in terms of expectations, it's still, you know, fairly different. We're no longer doing the 15-minute primary care visit. So internist visits, our established patients are half an hour, and our new patients are an hour. And then with our social workers or their health coaches, their visits range anywhere from 15 minutes to an hour to an hour and a half, just depending on what the consumer needs at that point in time. So it could be that they've got a scheduled appointment where they're meeting with somebody for dialectical behavior therapy and that's, you know, 50 minutes to an hour. Or it could be that the internist is doing an exam and the patient breaks down crying and they bring the health coach into the exam room and the health coach meets with that patient for 15 minutes. So really, we try to tailor it depending to what the individual needs versus a set number that you have to complete. [1:10:46]

LAURA GALBREATH: Great. Thank you, Rose.

ROSE FILIPE: Great. So the next question is for all of the speakers. What role do you all see telemedicine plays in care integration, and examples include remote health coaches, care coordinators, as well as specialists in terms of integration into primary care? [1:11:13]

LAURA GALBREATH: Who would like to start? This is Laura. I'll go ahead and get started while others are thinking about this. We certainly see tele-behavioral health as a vital piece of the expanding behavioral health capacity in primary care settings and have supported a project this

last year to kind of look at how can we help providers to take those first steps towards utilizing tele-behavioral health.

And certainly there are differences in every state around, you know, the financing, regulatory policies that allow and support the use of tele-behavioral health. But if you do go on the center's website and just do a search for tele-behavioral health you'll find quite a wealth in terms of I think it was an eight-part training we did with recorded webinars and resources including maps that list out all the states and some of the available resources state by state when it comes to tele-behavioral health. [1:12:20]

So we have seen a certain growth in it certainly in our four years as a (ph) technical assistant center around the interest and the support for it, both at the state and federal level.

MICHAEL HOGE: This is Michael. I would just add that from a workforce competency perspective, you know, the major challenge is around staff knowledge about these techniques and staff comfort around using this, these techniques, and the sort of getting past a lack of knowledge and the discomfort with these approaches is - it was a major workforce challenge.

KRISTIN SPYKERMAN: This is Kristin. We have been - we're not currently using tele-behavioral health, but it's something that we've recently talked about, even in terms of trying to help move the integrated workforce forward at some of our other sites, and maybe sites that tend to be more rural, even just so that a primary care physician, if they want to consult with a psychiatrist, they could do that, you know, over tele-behavioral health versus trying to e-mail or pick up the phone. So it's something that we have been talking about but we haven't implemented it yet. [1:13:34]

LAURA GALBREATH: Rose, are you there?

ROSE FILIPE: Yes, great, thank you. Let's move forward with the next question. So we have one attendee who is part of a community health center with less than 30 employees and limited resources in the community. Do any of the speakers have first steps to begin to put together programs with their small center? [1:14:02]

LAURA GALBREATH: This is Laura. I certainly think this conversation around tele-behavioral health is an important one to start. I think one of the things that we always talk about, especially as you begin to look at the resources that you do have, is just to be able to go out and have a cup of coffee if there is a community mental health or addictions provider anywhere near you, just to learn about, you know, what are the resources and what are the challenges, what may be some opportunities to partner and take advantage of.

And certainly I think in the area of substance use, SBIRT is the really good one that I would encourage you to look at in terms of a model for doing screening, brief intervention, and then referral to treatment, and it is on the website. We have a lot, a lot, of resources that talk about resource, the SBIRT. But I think definitely connecting with those community resources, starting to learn about the different models, and identify what may work well in your community is a great place to start. [1:15:09]

MICHAEL HOGE: This is Michael jumping back in. One of the organizations that's been part of the Center for Integrated Health Solutions is the WICHE mental health program. And I know that they've been doing a lot of work on promoting integrated care in rural areas where clinics tend to be small and availability of collaborating agencies, collaborating providers including behavioral health providers, is often limited. I'm not intimately familiar with their specific strategies, but I think if you search them out on the net - that's W-I-C-H-E, it's wiche.edu, I believe - and then linked to their mental health program, you'd be able to tap into some contact information and perhaps some online information about their work in this area.

LAURA GALBREATH: Rose, I know I saw earlier there was a question I wanted to make sure we got to for Kristin about your team. And it did show that I think you use a peer support specialist half time in your center. Could you speak a little bit more about what that peer support specialist does as part of your team and staff. [1:16:21]

ROSE FILIPE: Sure. Actually we have several peer support specialists within Cherry Street Health Services and recovery coaches as well. But in terms of the Durham Clinic, we've got a peer support specialist who really helps identify and work with consumers with mental illness and give them the perspective of what it's like to have been there and then recover from mental illness.

So it's a supportive role. She has also run some groups. So she runs groups for consumers, whether that's a depression support group or an anxiety support group or, you know, RAP group. So she has really been key in helping to engage consumers around those needs. [1:17:09]

LAURA GALBREATH: Great, thank you. And Michael, there was a related question around peers and competencies. Are you aware of any development in that area?

MICHAEL HOGE: Well, I think the primary work that's been done has been done by Larry Fricks around the whole health curriculum. And I think he drew on the competencies that he had developed in Georgia and essentially embedded those in his work. And that work is available, whole health curriculum is available, through the CIHS website, is it not, Laura?

LAURA GALBREATH: It is, yes. And I know SAMHSA has a lot of robust information, too, on the peer workforce, so you can certainly kind of dive around the SAMHSA website and access some great things there as well.

MICHAEL HOGE: There is a SAMHSA-sponsored set of core competencies for peer specialists that is in the process of development, and that I believe is expected to be a sort of year or so before that's out. It's not specific to integrated care although it's certainly - you know, we'll look at integrated care as well as many other peer specialist roles. [1:18:31]

KRISTIN SPYKERMAN: Laura, just a resource for people, one of the resources that we've had our peer support specialist using, is living a healthy life with chronic conditions. And so our peer support specialist is able to work through some of that workbook with clients who have multiple chronic health conditions and that's been helpful.

LAURA GALBREATH: Thank you.

ROSE FILIPE: Great. So the next question is can either of the presenters speak about how the stages of change influence treatment supports and strategies for participants in terms of the team discussions? [1:19:06]

KRISTIN SPYKERMAN: Rose, this is Kristin. You know, stages of change was a new concept coming into primary care world, and now it's part of what we call our huddle script. So when we meet every morning to talk about everyone who's coming in that day, there's a stage of change that's associated with every chronic health condition that the consumer has, and that's updated at every visit and it's updated in the huddle, so then our interventions are tailored to the stage of change.

So I'll give you an example. When we first merged as a, you know, fully merged organization, I would see internist treatment plans that would read "Told the patient to stop smoking, come back and see me in three months." So now that we're actually working with stages of change, that might say something like "I did some motivational interviewing around smoking cessation." [1:20:05]

So we're really trying to tailor those interventions. We had - one of our first meetings we had a - our huddles - we had a consumer coming in who had relapsed, and the internist said, you know, "Quick, somebody help me develop a discrepancy." So those are the types of things that we now see every day from all the providers on the team and not just from the behavioral health providers.

MICHAEL HOGE: And in the competency set, we think of there are a number of competencies under intervention around using focused interventions to engage consumers and increase their desire to improve health, which really, you know, it enumerates the motivational interviewing and motivational enhancement, therapy approaches as well as the competency, around promoting healthcare consumer and family adherence to care plans and a variety of other competencies around education in order to support those goals. [1:21:00]

LAURA GALBREATH: Great, thank you. I think we're - just about time to wrap it up. Before we do so, I did see a comment that I thought I'd like to share with everyone around the question of public versus private. Someone shared a good point for us around the fact that integrated care is occurring quite a bit in some of the CMS/CMMI models of integration which are looking at bundled payments and different financing mechanisms. So I think there's a lot to be learned around some of these different models of doing integrated care across public, private, and different payment models, especially under that CMS innovation, so thank you for sharing that.

And also if you have other, again, recommendations or thoughts for resources or questions, feel free to type those in. Some of those we will try to follow up with you individually.

And with that, I want to thank you and encourage you to access the website. You can also contact us individually if you have a specific question that you want to follow up on that we weren't able to get to today; our contact information is there. [1:22:06]

And then lastly, we do have a brief survey that we have at the end of the webinar and we do value your feedback. It is used to inform the development of future CIHS webinars. And also I encourage you, a lot of you who may not have taken advantage of a webinar in the past, we do have an archive and have quite a bit when it comes to doing behavioral health in primary care as well as bidirectional integration of primary care and behavioral health, and in many cases we include providers that provide very practical tips and strategies that we think you'll find very useful.

So I want to encourage you, if you haven't viewed our archived webinars, to take advantage of that, and to let you know that the next webinar coming up will be on March 25th, where we talk about the role of peer support specialists; very specifically, their roles in integration of primary care and behavioral health with our deputy director, Larry Fricks. So we're really glad to have him onboard as well as one of the SAMHSA primary and behavioral health integration grantees.

So once again, a recording and transcription of today's webinar will be available on the website within this next week, and make sure, again, to provide your feedback. And just a big thank you to our presenters; we really appreciate your time with us today and all the work that you do to support integration. And thank you all for joining us, and have a wonderful day. [1:23:41]

END TRANSCRIPT