

TRANSCRIPT OF AUDIO FILE:

HOW ARE THEY DOING IT - BEST PRACTICES IN SUSTAINING ON-SITE TRAINING OF BEHAVIORAL HEALTH CLINICIANS

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BEGIN TRANSCRIPT:

LAURA GALBREATH: Good afternoon everyone. And welcome to the SAMSHA-HRSA Center for Integrated Health Solutions webcast entitled How are They Doing It – Best Practices in Sustaining Onsite Training of Behavioral Health Clinicians. My name is Laura Galbreath and I serve as the Director for the Center for Integrated Health Solutions and I'll be helping to serve as your moderator for today's webinar. Thank you for joining us.

To download today's presentation slides, you can go to, click on the drop down menu labeled "Event Resources" at the bottom left of your screen or you can go to the Integrations IH website under our website "About Us" and be able to download the slides there.

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[01:24]

Before we begin, if you'd like to submit a question to the speakers at any time during the presentation, you can do so by typing a question in to the "Ask a Question" box in the lower portion of your screen.

Finally, if you need technical assistance, please click on the question mark button in the upper right corner of your player to see a list of frequently asked questions and contact information for technical support.

I wanted to make sure that if you're new to this webinar, and there are many of you that are, as you may know, the SAMSHA-HRSA Center for Integration Health Solutions 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 settings.

In addition to the national webinars designed to help providers integrate care, we are continually updating and posting practical resources and tools to the center's website and providing direct phone consultation to providers and stakeholder groups.

[02:33]

Today's webinar is really going to be focused on the integration of behavioral health into primary care and on training and education from three perspectives – community provider, federal agency, and area health education centers, AHECs. And we'll be talking about everything from building community relationships for education and training to providing orientation programs for students and trainees and matching trainees with field sites.

We've got a great lineup for you today and you'll hear both presentations and a really nice robust discussion among our subject matter experts.

And to kick things off, we've got Julian Sheen-Aaron from HRSA who's going to provide a welcome. Our facilitator for our discussion today from HRSA and the Bureau of Health Work Force, Meseret Bezuneh. Then our two presenters from the New Mexico AHEC, Helene Silverblatt, and then Parinda Khatri, Chief Clinical Officer from Cherokee Health Systems.

With that, I'd like to turn it over to our first presenter and our welcome, Julia Sheen-Aaron, from HRSA and the Division of Nursing and Public Health and the Bureau of Health Workforce. Julia.

[03:46]

JULIA SHEEN-AARON: Thank you. Good afternoon and welcome to you. And thank you so much for joining today's webcast.

The topics that we're covering today are very important and timely as the behavioral health services and primary care settings become more widely implemented across the country. This underscores the need for well-trained behavioral health clinicians. These training experiences provide opportunities for trainees to become part of a primary care team and it prepares them to work with vulnerable and underserved populations.

Here at HRSA, we recently funded 110 grantees in support of the White House's Now is the Time Initiative which aims to expand the professional and paraprofessional mental health and substance abuse workforce who will eventually work with children and adolescents ages 16-25, particularly those with or at risk for behavioral health disorders.

I know that some of our grantees are on today's call and could benefit from this information since the behavioral health workforce education training for professional grant supports pre-degree clinical internships and field placements for various behavioral health disciplines.

Once again, I'd like to welcome you and thank you all for joining today's webinar. And I'd like to turn this portion of the presentation over to Meseret Bezuneh.

[05:19]

MESERET BEZUNEH: Thank you very much Julia. Again, I thank you as well for joining up on today's webinar. As Laura mentioned earlier, I'm the branch chief for the Health Careers Pipeline Branch and we can move on to the next slide, Laura.

The Health Careers Pipeline Branch houses the area health education centers program which we refer to as AHEC. The Health Careers Opportunity Program or HCOP, the HCOP skills training and health workforce development of paraprofessionals in the Centers of Excellence program.

These programs collectively address three overarching priority areas of the Bureau of Health Workforce here are HRSA. They support programs for training disadvantaged and underrepresented minority students. They focus a recruitment and training of clinicians to serve in rural and medically underserved communities. It provides training opportunities for health professions students, residents, and practicing clinicians for multiple disciplines and community based primary care settings.

To provide some context for today's webinar, I'll provide a quick overview of the AHEC program. Next slide please.

[06:36]

The purpose of the AHEC program is ultimately to enhance access to high quality culturally competent healthcare by improving the supply, distribution, diversity, and quality of the healthcare workforce especially in primary care. Eligible entities for the AHEC program awards are exclusive to medicine and in states where there's no School of Medicine, Schools of Nursing can apply. Next slide please.

An important aspect of the design and structure of the AHEC program is the emphasis on strong academic community partnerships and collaborations with state and local governments and local healthcare infrastructure. As a result, AHEC programs are responsive to their communities needs and have gained significant experience and expertise on how to reach rural and underserved communities.

One of the major activities all AHECs are involved with is health professions training of students and residents to community based clinical experiences or field placements in primary care settings. AHEC are also involved in the promotion of interprofessional education and collaborative teams as well as continuing education programs for health professionals. Next slide please.

[07:55]

Currently, there are 53 AHEC programs across the nation. These 53 AHEC programs are required to establish community based regional AHEC centers in one or more medically underserved regions of the state. At this time, there are 248 regional community based AHEC centers across the nation. So between the 53 AHEC programs and the 248 regional AHEC centers, it's very likely that there is an AHEC near you.

This is the AHEC program website which we've provided on this slide as well as the HRSA data warehouse to find an AHEC center or a program for collaborative opportunities. You can also, of course, contact us at the HRSA AHEC program office if you have any questions.

I'm very pleased to present today's webinar discussants who represents their perspectives of an AHEC program from an academic setting, Dr. Helene Silverblatt, Program Director of the New Mexico AHEC, the University of New Mexico's Club Medicine. And from the viewpoints of a community based healthcare provider which also serves as a host agency for regional AHEC center, Dr. Parinda Khatri, from Cherokee Health Systems, the host agency for the East Tennessee AHEC.

I'll turn it over now to Dr. Khatri to provide a brief overview of the Cherokee Health System.

[09:21]

DR. PARINDA KHATRI: Hello, well, thank you very much Meseret and Laura. I'm delighted to talk with everyone about our story and getting involved in training as a safety net organization in east Tennessee. So let me start by giving an overview of Cherokee.

Our mission is to provide the best possible healthcare through blending of behavioral health and primary care. We have – and I'll just ask next slide please – we always start with our mission. So in terms of our strategic emphasis as an organization, certainly integrating care, our mission really is to serve anyone in our communities, but certainly we have a special place in our hearts for underserved populations. We have a saying, Cherokee goes with the grass is browner. And training is critical for us. And, of course, we'll be talking more about that later. But as an organization, just really committed to improving the quality of health and life for our communities, we recognize that we have to get involved in training in order to meet that goal and to help build a workforce.

[10:36]

We've been doing quite a bit for tele-health for about 15 years. We've been involved in tele-health. We have some very rural sites. And we found that this level of technology has been critical in helping us provide access as well as teaching and technological applications for teaching and clinical supervision in our remote locations.

Value based contracting and population based care are really areas that we've moved to to help us have select abilities so we can provide the best quality of clinical care possible for the community and that, of course, involved looking at different ways for payment and financing the

care we provide and really expanding our paradigm to include taking care of everyone in the community, not just a subset. Next slide please.

So this is just a little bit about our activity. As you can see we've expanded quite a bit from, you know, 1968. We were one little tiny mental health center open on Tuesday and Thursday afternoons. And as you can see, we provide a lot of care to patients and we provide...we put a premium on access. So we saw 16,000 new patients last year and we're certainly hoping to see even more new patients this year. Next slide.

[12:02]

So this is a little bit about our provider staff. And I put this out there just so you can see the variety of professionals that we have in our organization. Next slide.

So let's talk about training. This is really the main focus of this conversation. We have been involved in training for over 30 years. I think very early on we recognized that we needed to be part of the solution in building a workforce, particularly building a workforce for the underserved. So, you know, often we say there's a small enough pipeline of healthcare providers, then when you take it down to healthcare providers who are committed to underserved populations, it becomes very very small.

We are, as Meseret mentioned, we are an east Tennessee outlet for the Area Health Education Center, AHEC. And so as part of it, our role as AHEC, we provide quite a bit of outreach and training to our community on healthcare professions. So we outreach anywhere from the schools – elementary schools, high schools, colleges. We do a lot of training continuing education for professionals. And, of course, training at the graduate level.

We have an AP accredited psychology internship program which has actually been supported for several years expansion of it has been supported by graduate psychology education funds through HRSA. So special thank you to HRSA that their support and mission to help build a workforce has been very very helpful to us to train healthcare providers committed to the underserved.

[13:53]

We expanded to a post-doctoral fellowship. We're involved in school psychology and we also have training partnerships in a variety of disciplines – family medicine, nursing, social work, psychology, and nutrition, pharmacy. So as you can see, we really want to train people to work together in teams. Next slide please.

So, as I mentioned, we train quite a few folks. This just gives you a sense of just the numbers. These are the numbers of the trainees we had last year come through our system. Next slide please.

So, what are our training activities? What kinds of things do our trainees do? Well, first we have them do quite a bit of shadowing, and not only a, not only shadowing of someone in their own

discipline, but they will shadow other healthcare providers. So we have our medical students and family practice residents who shadow our psychologists, our clinical pharmacists. We have our clinical pharmacists sit in on our alcohol and drug treatment program group so they can see what it's like so that we really want to broaden their view of what healthcare means and also give them additional skills and a perspective that they wouldn't get, necessarily, in just a silo'd program. Next slide please.

[15:21]

So, as you can see we have quite a bit of energy and effort that goes in to our training. And from that, I can tell you that we are able to create a structure that allows people to have direct patient care in a professional collaboration and then clinical supervision, which is very very important, and we also have them, you know, we have them do teaching of other providers.

The resources that are required are significant, so I think, you know, thinking about what you need to do to get involved in training, we have to be very honest and open with you. It's a lot of work. Clinical supervisors, mentors and preceptors, to have those people is absolutely essential. And more than having the bodies, having people who have a real heart in a mission to teach and to share their knowledge, it really is a special gift.

One of the ways we structure our supervision is we do make it within the discipline. So, for example, our Director of Pharmacy; so our Director of Pharmacy Services, she's the one who supervises and organizes all of the training for our clinical pharmacist. Our Director of Primary Care Services, in fact, we have a new Behavioral Medicine fellow starting today from the local family practice department. She's the one who coordinates the family practice residents and the behavioral medicine. So the way we've structured is we have a multi-disciplinary team and multi-disciplinary setting. But we really try to stay within discipline when it comes to developing partnerships and organizing the specific clinical training experiences.

[17:16]

Training does take time and certainly funding is an issue, particularly if you're investing a lot of supervision. Something that people may not think about is space. It's unbelievable how much, how tight space is for all of use. And so when you think about having a trainee, you have to think about things like where are they going to sit? What about a laptop for them? Who's going to manage their schedules when they see patients? So all those things are important considerations.

And then my final slide, the benefits, I will just say that the benefits of having a trainee far outweigh the costs. It has absolutely been a gift for us to be able to participate in training to build partnerships, #1, what it's able to do is help us with recruitment. Many, many of our staff now used to be our trainees. I say that it is the best job interview in the world to have someone stay with you for, you know, three months, six months, a year. So as an organization, that is, you know we're a safety net organization. It's hard for us to recruit. We can never compete with the very, very, you know, more for profit entities, so we build those relationships and then having that teaching component, actually helps retain staff. They're able to expand their role and stay excited and up to date about their field.

[18:50]

The one thing that has been hard to measure, but is so important is this concept of having a learning culture. It kind of lifts the entire organization in that we're always reaching, always wanting to learn what's the most up to date information? What's the most up to date treatment? They keep us on our toes and so what it's done is, I think, truly elevated us into a culture as a whole where we're always striving to learn and stay on top of things so we can provide the best care, but also do very good teaching.

And then certainly our partnerships with our community members with local universities, with other entities. It's been just very great to develop those partnerships. And some of them have been longstanding. As I mentioned, we've got some training partners for over 30 years.

So I hope that gives you a snapshot of our organization, how we came upon training, what kind of training we do, and the tremendous benefits that have been well worth the investment that we've made in terms of resources. Thank you Meseret.

[20:04]

MESERET BEZUNEH: Thank you so much Parinda. That was excellent. And we will have more questions and discussions after we get a brief overview from Dr. Silverblatt on the New Mexico AHEC program. Helene.

HELENE SILVERBLATT: Hello. Thank you very much, Meseret, and everyone else for inviting me to speak. It's always a pleasure to do that. The name of the game here is partnerships and I couldn't do anything without two partners who are sitting behind me and they are Tracy Ingles, and Maria Ward.

I want to tell you a little bit about our program, but first I wanted to introduce myself, and you can see that those of you who know me know that's an old picture, but I thought it was a good one. So let's move on ahead.

I've been on the faculty at the University of New Mexico for 30 years and that has given me an opportunity to work with this very innovative medical school and health sciences center in constructing integrated training both in a cross disciplinary way and also between behavioral health and general health.

My background is in psychiatry, but I also have an appointment in family and community medicine department where I've worked for many years.

The AHEC program and the University of New Mexico has been there for a very long time, but only in the last few years has it become an integrated part of our office for community health. And that office is a very important change in the development of our already progressive school because it really looked at the mission of our health sciences center, which, like the mission of Cherokee, is a mission that says that we have a responsibility to the citizens of our state. And that

mission is one that is now sort of broadcast everywhere, our vision 20/20 of improving the healthcare of the people of New Mexico, greater than any other state, is able to improve its healthcare in the next five years. That's a pretty humongous goal, but we hope to make it by really coordinating our resources. And one way that we were able to do that is by integrating AHEC into the Office for Community Health. In that way it was able to link us, specifically, with our other signature program, the Health Extension Rural Offices and our offices work together to build community capacity in healthcare.

[22:37]

One way we do it is by having hubs around the state that offer access to health science center programs in terms of many aspects of what a university can offer. And that includes our pipeline development programs, workforce development using tele-health where we can reach to communities for support of local providers where we can offer service, where we can provide a link for communication among different sites.

We offer community based health professions education in our AHEC program, clinical service improvement, program evaluation, technical assistance, and Affordable Care Act implementation. And this is all done in conjunction with our partners at the Office for Community Health because, as you know, we have been many institutions, I think, maybe once you have more than five people, you potentially have five people going in different, but exciting, directions. And the issue is how do you get people to work together and leverage resources? Next slide please.

[23:42]

So here you can see a map of New Mexico. It's a big and beautiful state. We have the hubs that are part of the PIROS program, on the left, and we have three AHEC centers in the southwest part of the state. The rest of the southern portion of the state, and then in the northern part of the state and/or little central office is in Albuquerque at the University of New Mexico. Next please.

So, one of our primary goals has always been to look at models for integrating primary care and behavioral health, both in training and in service. Health home models kind of got a shot in the arm when the Affordable Care Act was passed, but I think it's important to know that we, that there have been many models for integrating primary care and behavioral health as Cherokee shows. And that part of our interest in developing health homes was to look at health home models where we integrated primary care into behavioral health as well as integrating behavioral health into primary care. So we have models where we have primary care providers at some of the mental health centers around the state and as part of the university system and we also have models where we have psychologists, psychiatrists, social workers, pharmacists and others working directly in primary care sites.

[25:11]

We really feel that it's important to look at how we train all levels of healthcare providers and so our training models go from community based promotoro training and community health worker training up through residency and fellowship training.

Our interests in doing this is to really improve our community's health by increasing our access to reproductive health, for example, in our AHEC programs, and chronic disease self-management initiatives.

I'll speak at greater length about our rural psychiatry tract because it's been a recognized model for over 25 years now, but that'll come next. I also think some of our other integrated models include how we've conceptualized broadening the concept of who behavioral health, who our behavioral health workforce is to include both primary care providers and as well as peer specialists.

In doing this, it's important that we break down all of the silos that exist, and you know there are very many, are probably the biggest barriers that we faced initially, was not from the state, was not from the community based provider agencies, was not from community members themselves, but from the academic disciplines that were just – if you'll pardon the expression – neurotic about sharing training.

[26:37]

In terms of the different silos that we have broken down within the behavioral health fields, we have cross disciplinary as well as individual disciplinary focus in social work, psychology, psychiatry, counseling, pharmacy, dental, occupational therapy and physical therapy. Okay, next. Next please.

So, let me talk a little bit about the rural psychiatry residency program. This program started out about 25 years ago when there was a clear sense from the administrator of the state hospital, who was also a psychiatrist, who was concerned that there was such a shortage of psychiatrists around the state. There were, maybe, fewer than 10, outside of the hubs at UNM, the successful sort of new age psychiatry in Santa Fe, and the psychiatrist working at the state hospital in Las Vegas where we have an AHEC hub.

So we were initially able to get a small pilot grant to look at ways of training psychiatrists in the academic setting, but to set up a residency program that would allow residents to work around the state. And we wanted that training to be longitudinal, which runs a little bit counter to how most residency training programs work. Usually, as you know, residency programs are for one month at a time. We wanted this to be a longitudinal experience where residents were working for one to two days a week for six months to a year in a site so that they could develop a relationship in that site.

[28:26]

We started out by having our training primarily in community mental health centers. As you know, there is also a silo in funding at the state level, and that's how our funding worked. And

because of a request, a primary care providers at federally qualified health centers as well as from consumers who really did not like going to community mental health centers for their care, we started sending our residents to our federally qualified health centers. And, let's see, I have a different slide up than the one than I want to talk to. Something has...okay. Thanks. Now, we're okay.

So, following our interest in developing rotations in fairly qualified health centers, we then developed an interest in looking at population health and looking at systems development, and looking at the role of the psychiatrist in the local healthcare system in general and in the community.

So part of the role of the resident was to look at the potential for a true sense of place and a sense of purpose in the community that she or he was working in. And we then developed the academic backup that would allow the resident to be successful in that site linking up with formal training at the mothership in Albuquerque. Okay, next. Next slide please.

[30:08]

So how do we develop a community site? Well, it takes a lot of work. You have to develop the relationships and plan ahead. We were immediately able to take advantage of our already established partners and our AHEC, our longest surviving and vibrant passionate AHEC center leader, Elaine Luna, in Las Vegas, New Mexico, worked very hard to help us set up some of the most important community based partnerships that we have in the northern part of the state.

Forward AHEC in Silver City, was an example of a developing system of care of training and care that integrated both primary care and behavioral health and a pipeline development program. And so that is a model of a community initiated training program, much like Cherokee.

In Hobbs, New Mexico, which is in the southeastern part of the state, our AHEC leader in Las Cruces works with the Hobbs Hero to help develop an interdisciplinary training program where our trainees who are AHEC supported in pharmacy, psychology, occupational therapy, medicine, nursing, family medicine residents, and others not only work together but they live and eat together because the local community college gave us housing, which was a very important aspect to developing a community site because it's expensive for trainees to move out of town and offering food and, good food, and lots of chocolate, and very nice dormitories really has been a very successful way for a community like Hobbs, which is not considered part of the sort of sexy part of New Mexico, but which has huge needs and huge assets to become part of our training hubs.

[32:19]

As part of this, we developed a very successful rural and community training program which provides service to the community and has become successful as an academic enterprise as well as a clinical enterprise. Next slide please.

Some of the training sites that our residents have rotated in include, as I mentioned earlier, community mental health centers, federally qualified health centers, state facilities, which are often integrated, including a state run nursing home, VA community programs, Indian Health Service. We do outreach through tele-health that's also integrated. We also are part of the Esport program. And we also work very closely with the State Department of Health in outreach around developmental disabilities as well as with the behavioral health services division.

When a resident goes to a site, however, some questions have to be asked. The residents and learners world is new and is not always understood. It's important that sites understand what a resident can do and what happens when a resident or learner leaves. We have to ask the question as an academic institution, what happens when the supervisor leaves, who is responsible for training? We'll talk about this later, I'm sure. What kind of system support do we need? And how about non clinical time? That should be part of the rotation to allow the residents to form relationships. Next slide please.

[33:53]

So, just very quickly. We're very proud of our outcomes. And as Parinda said, we think community involvement is our best recruitment tool. Having a good rotation is the best recruitment tool. Thirty-seven percent of our residents in the rural program were practicing in rural communities as opposed to 10% in our traditional programs. Ninety-five percent of our residents continue to work with individuals in rural and underserved communities. Twenty-six percent live in communities where they practice, and 28% use tele-health.

Another very positive outcome is that we've gotten additional funding designated by the state for primary care residencies in, two in psychiatry a year and five in internal medicine, and two in surgery. This is new funding from the state, not through the federal government.

We've gotten funding from the MCOs for community health worker training. We've gotten additional state funding to augment our training programs and we are continuing to work with our vibrant communities to get continued endorsement and support to develop training hubs at their sites.

So, thank you very much. That was...I know I spoke more than my designated time, but I hope that I was able to give an overview of our programs and I welcome the next step of our conversation.

[35:10]

MESERT BEZUNEH: Thank you so much Selene. Very comprehensive and well done. Thank you again.

At this point, we'll go to questions. And I'll start with first question, and maybe Parinda, what kind of training or guidance do you provide for preceptors to help them provide the best possible clinical placement for the training?

DR. PARINDA KATRI: Yeah, that's a great question. Well, I think it's very important for use to orient all the preceptors on what the specific competencies are that we are trying to train. And so very, probably very routinely, we meet with the faculty who's in charge of the training program, and we will get a list of the expected competencies and as well as how we will evaluate those competencies, what kind of activities and training methods will be used. And then we typically meet as a group and that has been very critical, that anyone involved in training, we are going to be meeting as a group within the discipline to discuss how the training is going, to discuss how our structure is as well as how the specific trainees are doing. And what that does is serves as a check for all of us. If we're struggling with something, with a certain trainee, if they're having a difficulty with diagnostic clarification, then somebody else may be noticing the same thing or they may have input.

So I think it's very important to build, at least, those relationships of support, but also provide a review of what are the expected competencies so everyone is on the same page about, you know, what needs to happen during the training and what the goals and objectives should be of the training.

[37:05]

MESERT BEZUNEH: Thank you Parinda. And I think this is really important to, you know, you were talking about some of the sites perspective, what it takes to make the training smooth and efficient. And Helene, I just want to get your thoughts in terms of what kind of orientation do you need to provide to students who are going for the clinical placement and rotation? What does the orientation look like?

HELENE SILVERBLATT: I'm sorry. Oops. Can you say that again?

MESERET BEZUNEH: Sure. What does the...?

HELENE SILVERBLATT: Hello?

MESERET BEZUNEH: Can you hear me?

HELENE SILVERBLATT: Yes, I can. What does the orientation look like?

MESERET BEZUNEH: Mm hmm.

HELENE SILVERBLATT: We have, yes, yes. We have regular meetings with our preceptors who come, who meet with our faculty and talk about their responsibilities as preceptors. We also do very single things to what Parinda mentioned – talk about there are very clear competencies that have to be addressed or resident rotations don't pass and medical students are not allowed to move forward and that's also true for all the other disciplines.

And so we are very clear about what competencies to look for. We're also clear about what kind of evaluations have to be filled out. We're also clear about having a point person from UNM to be in touch with as well as having a point person at the site.

MESERET BEZUNEH: Thank you. We'll go to the next question. One of the topics that, I'm sure; that everyone is eager to ask about is sustainability. So, Parinda talked just a little bit about that, so what are the costs associated with the training program and how are you able to sustain the training financially? And what advice do you have for HRSA funded safety net providers interested in developing a training program?

DR. PARINDA KHATRI: Well, first of all, I would say, I'll start with the advice which is first start with the mission and the commitment to training. So we never look at a training program or a trainee as a way of generating revenue, and we never link the two because I think those are...those goals are really at cross purposes. So we have no productivity requirements, we're not looking at training as a way of generating revenue. We're just looking to offset our costs. So that is at the get go. I think I would really recommend do not mix those two things because I think it becomes a challenge, and then, frankly, you're not really able to provide the best training because you're so focused on just generating revenue.

[39:49]

The way we've been able to do it, it's been very different by discipline and by the academic institution. We have training relationships in which we are able to bill for students for on a sliding scale or with our Medicaid. Because we're a licensed community mental health center as well as a federally qualified health center, our psychology practicum students, clinical social work practicum students and interns and post hocs are all unlicensed but are in degree'd programs, graduate programs. They're operating under the supervision of licensed provider in their field who is signing off and actually reviewing and signing off on every note and they have between two to four hours of individual supervision every week.

We are able to bill Medicaid and they also are able to see patients who are uninsured on a sliding scale for organization like ours where we have upwards of 30% - 35% uninsured. What that does is provide access to care to people and then where our licensed people are able to see patients who are either commercially insured or have Medicare as well as Medicaid and uninsured.

So in those situations, it ends up being revenue neutral. On average, because we've investing so much time and supervision and training, that's pulling our licensed staff, but they are generating, you know, a certain amount of revenue for them, for the organization that offsets that. You know we also pay a stipend to the university to help, that helps the student live.

[41:34]

In situations like with clinical pharmacy, the school actually pays us. It's not much, but per every month, maybe it's \$500 or so to provide training. They're not generating direct revenue, but we are investing a lot. And then for a lot of other programs, no money exchanges hands. So we're just investing time and you know, mentorship. But the trainees are taking on projects that are very helpful to our organization. They have developed protocols. We've had nutrition students every year do weight management groups. They develop handouts for our staff. They develop handouts and do trainings for our patients. They do cooking demonstrations.

So even though they're not "generating revenue," they're doing a lot of wonderful things for the organization that can't be, you know, you can't have a number on.

So overall I would say that be as flexible as possible because there's no one size fits all.

MESERT BEZUNEH: Excellent. Thank you so much. That's very helpful. Again, you talked a little bit about, you know, being really mission driven and that's certainly critical. When you have more than one trainee at a time, is there anything special that you need to know or you need to do when you have several students at your site:

HELENE SILVERBLATT: Can I...Parinda? Go ahead.

MESERET BEZUNEH: We'll come back to you Helene in a minute.

HELENE SILVERBLATT: Okay, good.

DR. PARINDA KHATRI: Yeah, well we almost always have multiple students at the sites with multiple, for multiple disciplines. I think organization is important. We love to have the students work together and do projects together. And so I would say that the key is going to be collaboration among the staff. And as much as you can align the training experience, the better. So try to have them shadowing around the same time. We will have shared didactic seminars. And then try to see where there can be some complementarily and some overlap. You know, they'll all participate in our weekly treatment team. And also then balancing that with the competency development individually.

[43:57]

So, I think it's organization and communication. And once you've been doing it for a while, you just kind of know your schedule. We don't even think about it. We know this is what all the students do and we use a standard template.

MESERET BEZUNEH: Great. Helene, would you be able to respond to that as well?

HELENE SILVERPLATT: Yes, from the academic end, I think we need to set up the same level of coordination that Parinda's group has done. So, wonderfully within our own disciplines. And so a lot of our work is just being sure that the preceptorship offers in medicine, nursing, pharmacy, OT, etc. are all on the same page about sending trainees to different sites. And so one of our, I think, important AHEC functions that's developing is our role in coordinating those rotations, say, particularly in Hobbs, for example, where we have a model program, I think, for cross disciplinary training.

[45:04]

In our program in Las Vegas, one of our focuses in terms of having more than one trainee at a time is in our BAMD program where we take students; we have students designated after high

school who'll be going into medical school after they finish their undergraduate training. And Elaine Luna, who is our, who I mentioned before is really an expert at integrating these BAMD students, not only into the training site itself, or different; she's able to develop training sites at hospitals. She's able to devise training sites in private offices, but also to introduce the students to school based activities to programs in different agency, health related agencies or school related agencies in the state. We think that's a very important part of our training. So we rely on our AHECs to help us do that.

We often have to pay attention to the fact that in very small practices, there may not be room for more than one student at a time because we still have many individual practitioners and so we really have to pay attention to what the different sites themselves are able to accommodate and pay attention to that.

MESERT BEZUNEH: Thank you very much. Those are excellent suggestions and advice. Again, I'll ask this question, the next question is really both to Parinda and Helene, and I'll start out with Parinda first. How do you make sure that you've matched the trainee with the right preceptor?

[46:46]

DR. PARINDA KHATRI: Well, the first thing is we don't make anyone do it. So I think we...so I think the best thing is people who do this on a volunteer basis, they step forward and say, "I want to be involved in teaching." So, I would say the first thing is never force someone to do training because it is a lot of work and it does take a lot out of you to do a good job. But the people who really want to do it are just, they love it and it shows at every level. That naturally makes sense.

The other way we do the match is we get to know every preceptor very well, and I have a sense of what their strengths are, what their style is, and then I actually meet with each student – I or another person involved in the training – and then we will match based on the interest.

If someone, for example, is very interested in chronic care in the homeless population, if a student, and we have that right now, then I know we have a medical provider who works in our homeless clinic and has that. So I would look at shared interests, but, and that's the second step. But the first step is get people who really want it and get to know them well and get the students; get to know the students well and then you can make the match.

MESERET BEZUNEH: Great. Helene, any thoughts on that?

HELENE SILVERBLATT: Yes, you know, we're very...just for a few words, we're very lucky at UNM because we have done a lot of the training for a lot of the providers around the state so that many of the providers have a commitment and a fondness for UNM, I hope, so that many of them agree to precept because they are committed to us.

[48:33]

But we also know that sometimes the match won't work. I agree absolutely with Parinda, we try to match interests. If someone is interested in population health or systems health and a student is interested in that and a preceptor is interested in that, we link them up. Or if a student is from a small community and she wants to go back to that community for her rural rotation, then we try to set up a rotation there.

Sometimes, though, it doesn't work. One of the issues around setting up rural rotations, of course, is that you need staff who can supervise and if you don't have a qualified psychiatrist, for example, it makes devising a rotation doable, but more complicated.

If, and sometimes, unfortunately, the rotations don't work. I mean there sometimes, the personality clashes can happen or sometimes peoples' lives change and they move away and the person you hoped would be a preceptor is no longer there. And so some of it is really kind of being nimble and having back up plans if you need to have them.

MESERT BEZUNEH: Thank you, Helene. We have a couple more questions, and then at the top of the hour we will open the line for questions that may be from the audience and also have a couple of questions that we can respond to after that in the chat box.

So I have one other question for you. Again, this can be, and we'll start out with Parinda and come back to Helene. In terms of troubleshooting how do you intervene when needed with field placement or with the host organization or the preceptor or students when you see there's an issue, what is the process that you use to do intervention?

DR. PARINDA KHATRI: Well, I will say that it's very important to have an outline due process that we give to all of our trainees. Everybody knows. It's on our website. So they know what the process is.

I think having ongoing communication and having those meetings and dialogue between all the trainers, the supervisors, is important. And then our training staff meet very regularly with the trainees. So, hopefully, as soon as a problem starts simmering, we can address it very quickly. I always say I don't like surprises. So I want to know early on and I say that at orientation. You know, here are our goals. We say it to everyone. Here are our goals. We want to have a very...we want this to be a great training experience for you. Please let us know when there are any concerns as soon as it comes up. I would much much rather you bring up something small before it becomes very big. And I just set that stage and we can agree; we're all on the same page.

[51:33]

That said, you know, we are faced with things that we would have never anticipated. And we've had significant issues in some situations and you know, it can get very very concerning. And that is when I think it's very important to have a strong team. I think it's also very good to have people outside of your organization, maybe even at the national level with whom to consult, and we've had to do that before when we've had a trainee who had some significant impairments that emerged.

So, I would say build a network for consultation because issues can get very complicated in a way that you can never have anticipated. So, I would say that. I'm sure Helene has also had similar war stories.

HELENE SILVERBLATT: Yes, and you know, and they're always shocking. It's always; it's always disappointing when they happen. But we try to make the outcomes for both the community and for the individual as positive as possible.

[52:37]

Sometimes... I think one of the most difficult situations we run into is a little different because we send people around the state is that sites get mad if we don't send people to their sites when we don't have enough trainees to distribute around the state. And so one of the things that we have to do right off the top is just be clear what we are able to offer and what we can't offer. And how many trainees we have at any given time in our different fields.

We always have a point person in each agency that we work with so that if something does go wrong, both the trainee knows that's the person to talk to, and this is not the supervisor, but this is someone who's an administrator in the program, usually.

And we also have a point person in our own office in our different specialties. And I think that it's important when people are far away from the mothership to feel that they have... that they haven't lost ties with the people they are used to working with. So that's important, I think, both for the communities and for the trainees. Sometimes, as I mentioned before, we've had to change our point people. We've had to change supervisors in the middle of rotations. And that makes the rotation rocky. But we still try to maintain our commitment to excellence in training and excellence in accomplishment and clinical service because we trust that that's what we do and that even... and that we include that in our orientation.

Our orientation includes pitfalls because just things happen. And I think if we can approach things that happen in constructive ways, and in problem solving ways, it really gives our trainees and our community organizations an opportunity to learn really effective problem solving skills. So that's part of what we do when there are difficulties is troubleshoot together.

[54:53]

MESERET BEZUNEH: Thank you Helene. And thank you Parinda as well. We have one more question, but I just want to clarify we will not be able to open the phone line, however, if you do have questions, please type them in the chat box and we'll try to respond to them. I have one last question before we go to the chat. And I'll ask if you would be able to share examples of policies, procedures you have developed over the years to help facilitate your training program. And this would apply to both Helene and Parinda. And I'll start that with you, Helene.

HELENE SILVERBLATT: We have several series of policies and procedures that we've had to devise with our different agencies that we work with. We have a contract with... and a grant with

the state of New Mexico that has its own list of deliverables that I can send out to people so you can see the scope of our program.

We also have a Memorandum of Understanding with all of the agencies with which we work that delineates the responsibilities of the agency and our responsibilities. We also are sure that all of the supervisors of our trainees become part of our clinical faculty. I think that's important. It's, in many ways, it seems important to me to be able to say thank you to our preceptors and by having them join our clinical faculty, they have access to the University Library to up to date which is a very successful program and being up to date in clinical issues. They get reduced rates for Lobo basketball tickets. And they also get invited to CME events.

So those are...policies aren't all deadly and dreadful, but some of them we hope are uplifting and fun for our preceptors.

[57:04]

We also have special relationships with some of our grantors. We have a relationship with some of the managed care organizations who helped us with training. And we have very specific guidelines that many of which are really out of my control. They are really part of the legal risk management council of the health sciences center.

So what we often do, though, is have regular meetings with our legal people to be sure we understand what the issues are.

In addition, some of our, each one of our preceptor sites and centers in pharmacy, nursing, our physician's assistant program, all of the different student groups within the health sciences center have to negotiate their own protocols with each of the sites that they send their students to. And what's been complicated is that because of the different requirements of the different disciplines, each of the memoranda has been different. And so for like, the memorandum that pharmacy has with Clovis is different than the memoranda that nursing has with Clovis, even though it's the same hospital group. And we're trying to facilitate a kind of reduction in paper act law, whatever the federal government has, a similar kind of reduction in bureaucratic stumbling blocks so that the protocols that are used don't make life more difficult for our trainer, our training sites as well as our individual providers.

[58:50]

MESERET BEZUNEH: Thank you Helene. Parinda?

DR. PARINDA KHATRI: Yeah. Sure. If you go to, you know, what we've done is put up as much as we can on our brochures and our website. So if you go to CherokeeHealth.com and you look under our training, if you look under "Psychology Internship Program," or even our "Post doctoral program," you'll see the link. It'll take you to our due process, our list of competencies, our evaluation forms. It has a number of different policies and procedures and just resources. You know, we have a review of the developmental model of training that we utilize. I would also say if you go to, really, the best place to get resources is if you go to each of the disciplines

training, overseeing training body; if you go to those websites, so, for example, for psychology, there is the Association for Psychology and Post Doctoral Internship Centers. So what you'll have is APPIC.org. They have a training resources section, and that is unbelievable.

[1:00:03]

They have sample memorandums. They have all kinds of forms and competency checklists and legal guidance and how to start a practicum. And the same for medicine. There is just an enormous amount for nursing. So I would say go to the, you know, Associations and look on the websites because they really do want to help. And they have not just, you know, resources from one or two sites; they have resources from hundreds of sites. So I would really recommend building relationships with those associations and even just doing a quick search on the Internet for them. Many of them have great stuff on their website.

MESERET BEZUNEH: Thank you so much Parinda. Now, we'll go to the questions that are in the chat box. I'll read them out. One of the questions posted is what technology do you use in terms of tracking and supporting your internal training program? Helene?

HELENE SILVERBLATT: Yes, I'm sorry. You know what, it didn't come through. Could you say that again, please?

MESERET BEZUNEH: Sure. What technology do you use in terms of tracking and reporting your internal training program?

HELENE SILVERBLATT: I may have to punt on this. We use...some of the tracking that we use is part of what our AHEC program requirements are in terms of the AHEC students that we send, otherwise, each department maintains its own system of tracking and reporting its students.

In our own program, we keep, we have a log that all of our trainees have to fill in the residency program. I hope I'm answering your question. We have a log that the residents fill. We maintain that log. And we try to maintain information about the sorts of patients they see, the kind of dilemmas they face. We review their progress notes and that sort of thing. And we also keep track of our residents after they graduate as part of a new effort for our department.

It's hard to keep up with the data, but that's...we do try. We have lists of all our AHEC students and we have lists of our rural residents. And we coordinate some of that through the residency program in general.

[1:02:48]

MESERET BEZUNEH: Thank you Helene. Parinda, do you keep track of your trainees?

DR. PARINDA KHATRI: Yeah. My answer is going to be very similar to Helene. There is no one way. We have a number of different tracking mechanisms. Number one; we are an AHEC, you know, and like them, we get the most obsessive compulsive organized person on our staff to track all that and she has an unbelievable color coded filing system.

We actually use our electronic health records. So we have built in templates in to our health, electronic health record. So we actually do our evaluations of the students on there. They do all their documentation on there. And so we can, with a very quick query, we can see all the patients they've seen, what kind of patients, how old, how much of their time is spent, you know, on what activity. So that's been good.

We also ask each trainee to keep their own log and we do a breakdown. And that really is for them as well as for us over the years. And we show it too, you know, we're accredited, so by a number of the training organizations like APA, and so we'll show that to them. This is how they're spending their time and then this is the supporting documentation.

[1:04:10]

And then for some, it's just Excel spreadsheets, you know, for clinical pharmacy. So I would say that each department has their own. There isn't one way. I will say that it's very important, in our experience, to have several mechanisms of tracking because there are so many different aspects to training. Not just what they're doing, but how many trainees you have each year. Where you place them? So it's multi-layered and multi-systemic.

HELENE SILVERBLATT: Right. That's right. And people need different information. And so you want to...we want to keep records that are helpful to the trainees, helpful to the training programs and helpful to the sites.

MESERET BEZUNEH: That makes sense. Thank you both. I have another question that was posted, again, in the chat box. And this one is asking about, it's a behavioral health organization with social workers and psychiatry that will be a partnership with primary care physicians. The CNS will be in the physician's office. What are the first steps you think we need to take to begin the custom integration with the CNS and our social workers with the physicians? Parinda?

DR. PARINDA KHATRI: Can I clarify? What is CNS?

MESERET BEZUNEH: Clinical nurse specialist, I think.

DR. PARINDA KHATRI: Well, I don't know, Meseret, maybe you want to be the first person. When someone says Clinical, that's not something I'm familiar with here. Is that like a Nurse Practitioner at that level?

MESERET BEZUNEH: Yes. I think it's similar. Yes.

DR. PARINDA KHATRI: Yeah.

MESERET BEZUNEH: But it's a specialty. She may have a specialty in behavioral health, for example.

[1:06:05]

DR. PARINDA KHATRI: Ah, got I, got it. Yeah, well the first thing, I think, is building relationships and understanding the culture and the setting. So whenever we bring in anyone new for training, we just have them shadow. We have them shadow every single person on the team so they know what everybody's role is and they know the flow, they know the setting. And then those conversations, I think, then become very important in terms of where that person, whether it's a clinical nurse specialist or another provider, where they could fit in? So if you're shadowing and saying, oh, here's this patient, you know. They have paranoid schizophrenia. They don't want to take their medicine for their diabetes. Here's how I can do this. And then there's a dialogue. So what I found is that having the shadowing and that time together just to see the flow and the culture helps facilitate not only the relationship building but also gives kind of a telescope, a kind of microscopic view of how that person can fit in to that flow. So that's...that would...that's what I would say.

MESERET BEZUNEH: Thank you. And Parinda...thank you Parinda. Helene, do you want to comment?

HELENE SILVERBLATT: Yeah, I think that what's been very important and successful in sites that have integrated several different disciplines is their clear sense as you obviously see in the Cherokee model, a clear sense of the importance of learners in their program so that learners are welcome and that learners feel they have a role and that everybody who are learners are part of this new crew that's integrated in to the system itself.

[1:07:53]

Now, that's a first step. What, I think, brings people together often is actually having to focus on a particular dilemma, whether that's a patient's dilemma or a systems dilemma. And after the initial sort of culture sharing and responsibility sharing and most importantly, getting to know each other, I think it's very important that case conferences are, however you want to frame them, become part of the learning experience so that the learners get to see ways that the clinical nurse specialist may think of looking at a problem and how that's similar to and different from a view of a social worker or a physician. And I do think that that's, of course, the next step.

The first step is to get to know one another and understand and devise up a system of daily life that makes sense for everybody there. And then to really see that the mission to provide excellent care in an interdisciplinary way, looking at the community in which you're in is something that we all train for with little, with slight twists. And to learn from one another, talking about an individual who matters a lot to people, I think, is a very important part of the training and part of what each successful integrated system has to offer. It can't be just running in and running out. There has to be time for conversation.

[1:09:36]

MESERET BEZUNEH: Thank you. And I just want to add that, you know, we've been talking a lot about mental behavioral health topics, are the processes, would they be the same if you were

working with students with, say for example, like the professional clinical [inaudible – 1:09:56] or other professionals in the substance abuse arena? I would ask...Helene, is that you? Okay.

HELENE SILVERBLATT: Yes. You know, we have had an interesting experience integrating a family medicine physician into our, with trainees and learners, integrating her into our substance abuse program which has a kind of multi-faceted model for both addressing substance abuse issues. And I think in general, people are grateful. You know. Most staff are grateful to have more help because we're talking about systems that are underfunded and understaffed and, I think, providing physical health integration in to a substance abuse setting or providing substance abuse counseling in a general medical setting is extremely helpful.

One example I can give is the Espert program where we provide not only consultation, but training and where the person who really is the lead person in one of our clinics is a clinical psychologist, a LPCC, who is the person on the ground in the community beating the bushes to get participants from the community to join the program. And then he works with Espert and others, and there other providers, to develop a successful [inaudible – 1:11:39] program, for example, that also includes all of the other kinds of support that are needed.

[1:11:45]

I think that there are very, that most general clinics are very happy to get the support. Part of the trick is figuring out how to change the culture of providers who aren't used to talking in the same way. And how to get that, how to sort of teach, how to learn assimilation in both settings.

MESERET BEZUNEH: Thank you Helene. Parinda, would you like to respond to that question as well?

DR. PARINDA KHATRI: Yeah, I mean I would just echo what Helene said. I mean we've been...we are just so grateful and our staff and our clinicians are so grateful for any additional support that I think it's been very positive.

I will say, though, we have a selection bias. So, you know, we would never have people on our team who don't value the contribution of variety of different professionals and trainees in that area. So part of it is, you know, if you set up a culture in which diversity in thinking and interdisciplinary collaboration is prized and valued and seen as being really just the modus operandi, I think those issues really fall away. And I can see there may be some settings in which that is more of a challenge. They certainly would not be a place where I would do training and those people would not do well at Cherokee.

So I think building that culture and having the right, you know, having the right kind of paradigm in the staff selection at that site is very important.

[1:13:28]

MESERET BEZUNEH: Thank you Parinda. And I just want to follow-up with you, Parinda, one other question. Do you train peer counselors or community health workers?

DR PARINDA KHATRI: Absolutely. So we do, yeah, so we do both. We have community health workers from [inaudible – 1:13:50]. We have a number of peer counselors that we've trained and actually provide additional training for and they've been amazing. I mean they just are our stars. So yes, we do do that. We are like incredibly possessive of them, I have to say. So anybody we train, we really want them, particularly for people, our peer counselors to feel very comfortable in working with the SPI population as well as the with the health issues. So people who have, you know, really lived experience in substance abuse mental health, but also feel very comfortable talking with someone about their diabetes care or about their migraines and working with the medical providers.

So when we train them, and we love them, boy, do we keep them.

MESERET BEZUNEH: That's great. And I know, Helene, you have a training program for community health workers.

HELENE SILVERBLATT: Yes, we have several training programs for community health workers that are, many of which are based out of our local community colleges. And we also have at the UNM level, a very significant community health worker training program that will, and part of the job of that program as well as our AHEC side in Silver City, and our other two AHEC sites as well is to change the culture of the healthcare provider so that they understand what the role of the community health worker can be.

I mean, what we didn't want is a whole system of training and then have a great idea where people weren't sure how to use these newly trained providers. So part of what we do is, again, as Parinda said, we look at the culture and try to change that culture so that the community health workers can become an integrated part of the team. And our Silver City group has been particularly adept at that, the [Adocco – 1:15:57] Medical Center, which is a pretty broad based frontier and rural federally qualified health center.

[1:16:08]

I'd like to add that our AHEC Center Director in Las Vegas, Elaine Luna, has now been appointed to be part of the Department of Health Certification program for community health workers. That's where we're at now with the state. We've offered the training, but now we've finally gotten the state approval to have it become a certified program. We do have certified peer counselors already.

MESERET BEZUNEH: Great. Thank you. This has been great in terms of your responses for a multitude of questions. Before we close, I just want to ask, provide an opportunity to both of you to really highlight any other suggestions or thoughts that you may have for the center that, for the audience in terms of, again, community based clinical field placements. I'll start with you, Parinda, and see if you have any additional thoughts or comments that you want to provide.

DR. PARINDA KHATRI: No, I would just strongly encourage people, if you're not involved in training, please get involved in training. It's one of the most selfish things you can do for your

organization because I think it will be an infusion of energy and vigor to the organization. And selfishly, it's fantastic for recruitment and retention. It really is. So, you know, I just can't recommend it enough. Frankly, it's a survival strategy.

HELENE SILVERBLATT: Yes, I would absolutely agree that our successful models like Cherokee are ones where the systems themselves saw that this was the best way to get people to move in to their community. And they do...and let me just add it's strategies that are helpful. Finding apartments for learners, welcoming people into homes, paying attention to spouses, introducing families to the school system or to church groups, or to recreational activities or to music opportunities. Those are important to people who move to rural communities where they may not feel comfortable or even if they are from rural communities already may not know enough about the community they're working in.

So the success that we've had in keeping students across the board has been really the vibrancy of the community organizations themselves.

[1:18:48]

So I think that the other area that's important to look at is how to find financial partnerships and I think that there are little grants available everywhere to help get started. Not so easy to get and sometimes time consuming. But managed care organizations, for example, are often very interested in helping practices become more successful. And linking up with local community colleges who may have a very broad base of training of physical therapy technicians to occupational therapy technicians to blood drawers to associate degree nurses are always looking for training sites. Those programs are always looking for training sites. So it's a real opportunity, I think, for sites to kind of get their feet wet by maybe offering training to one discipline and see what happens.

MESERET BEZUNEH: Thank you both. I think that's certainly helpful. I just want to remind the audience that we have wonderful questions that we received. And this webinar is going to be archived, so the questions that you've posed that we didn't get to, we'll make sure that we get in touch with our presenters today and be able to get some responses for you so that it will be available in the archived webinar.

Also, I just want remind the audience about the slides are available and the link to access the center's information at the Center for Integrated Health Solutions. So take a look at this slide and the link to be able to access the webinar.

I think I'll turn it back to Laura.

[1:20:47]

LAURA GALBREATH: Great. Thank you so much Meseret, and yes, thank you everyone for joining us today. The recording and transcript for today's webinars will be available on our website within the next two days.

Once you exit the webinar, you will be asked to complete a short survey. Please make sure to offer your feedback on this webinar. Your input is very important to us. We review all of it and it does help to inform the development of future CIHS webinars.

Again, I'd like to extend a special thank you to all of our presenters for joining us on today's webinar. Great information, great strategies that we think will help providers as you develop training programs in your clinics and in your communities. So thank you all for joining our webinars and please stay tuned for more webinars coming up in the near future.

Have a great afternoon. Thank you.

END TRANSCRIPT