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[NO AUDIO]

>> MALE VOICE: So to start us off we would like to hear about who is out there in the audience. We have a great turnout for today's webinar which speaks to the criticalness of the topic. Who are you? Are you a primary care clinician? Behavioral health provider? Clinic administrator? Or D: Director or executive in some sort of health system? So take just a minute to get your responses there.

Okay so we are starting to get a good number of responses here and so it looks like we have a split between people who are in other categories versus a large number of behavioral health providers which is great to see out there. We also have a good number of clinical administrators around 60 percent. Similar numbers for health system directors and that's great. Very good, thank you everyone.

We'll go ahead and we can move right into Virna's presentation. Without further ado, Doctor Virna Little.

>> VIRNA: Good afternoon, thank you for joining us today. I really appreciate your time, I will also for those of you who are shy I will be looking at the question box, so if you have some questions and you want to put them out there I can look and follow this link as we go along.

[RECONNECTING]

>> VIRNA: They were talking about how they were addressing problems around scheduling and thinking about ways to double book providers and as a provider and as an administrator that is something that doesn't work out for either, so thinking about ways to optimize your system so the providers don't feel overwhelmed. That you can afford access to patients that need to see providers. But not leave providers feeling as if they don't have some predictability in the day and what that looks like. And part of this is really thinking about what scheduling looks like and thinking about ways to really watch, and I sort of call it painting a picture or looking at a picture of what your behavioral health providers are doing. So that you can really speak with them and work with them around where there may be needing some help and support and where there might be opportunities to increase access and allow for more patient care. One of the things that I tried to do really working is not focusing on productivity because I think a lot of organizations

will start there and really focus on productivity. Which often for behavioral health providers, or any providers, is not often a conversation that they really want to focus on. And so, really thinking about how you can broker that and talk about access. And so 1 of the things that I found to be really successful is looking at scheduling and working with providers to look at their capacity which is the amount of time and patient care along with their productivity and understand that there is a certain amount of time that they need to do other activities. It's really having that dialogue with providers was often really helpful and 1 of the things that we found doing some of the work with organizations is that sort of looking at scheduling and how a provider's day is managing how it that looks like for behavioral health providers is often a key piece to both morale and their retention and also beneficial to the organization as well.

And also, thinking about staffing optimization. This actually comes up quite a bit now as organizations are implementing collaborative care and what kind of behavioral health providers to hire for the different kinds of behavioral health services that an organization might have. So maybe they are part of care management, or some care management initiative. Maybe they have specialty mental health services. They have some integrated behavioral health. They might be doing collaborative care for patients with depression. And really think about the kind of things providers—behavioral health providers to really match and what are the skill sets for each of those different portions of your behavioral health services and who are the best matches? So people often ask can I hire a licensed mental health clinician for certain roles? And the answer is often yes or no based on state guides and billing and some of those other pieces that we all have to take into consideration. But also thinking about the kind of training and orientation that providers have and where might be the best fit for their skill sets. So really thinking about each of those behavioral health services and thinking about what some of the core competencies are. So thinking about someone doing collaborative care really needs to be able to present cases. They need to be able to be very flexible to do a lot of warm handoffs. Think about someone who is doing care management, may need to do some work in the community. And so really, thinking about that so you are matching people into the organization and many times you have a position and wouldn't be doing well and I would sit with them and say look at where their strengths were and think about places in the organization and some other services where they might be a better fit. And thinking about billing and coding and contracting and for those of you that know me I like to bring in the billing and coding and sort of that piece of it but also think about the contracting pieces and when you think about who you are hiring, it's really discouraging for providers who are hired into an organization on a grant and then worried about whether or not they're going to be sustained after the grant because maybe there is a certain time of licensure or they don't have a license.

So I really encourage organizations to think about some of those pieces because the whole purpose to get a grant is to be able to get someone to be sustaining, to get a program up and going, and then be able to keep that provider with that historical experience and settings. So really think about the provider that you are hiring in terms of someone who will be able to be there for the long term because many times organizations start over. And I think it's really hard for providers, you know, at that point to be able to focus on the work they are concerned with whether or not they're going to have a position after the grant. And thinking about how you can involve your behavioral health providers and some of the other initiatives that are going on in the organization, and so 1 of the things that I learned over time is that 1 of the big reasons for provider burnout was feeling unable to manage the patients that they were seeing clinically. And I really focused a ton of efforts on training providers and practices around patients at risk for suicide, around evidence-based practices for patients that they would be seeing and I found that providers became a lot more confident. And therefore, they felt less overwhelmed by the patient's that they were seeing. And I really spent a lot of time involving them in other efforts. So if the practice was working on a quality dollar initiative for certain pieces then I would involve the behavioral health providers and really thinking about incorporating them into the team and helping them feel part of the team and 1 of the ways to do that is to have shared accountability. So every provider, every visit, every discipline, every time, every problem thinking about all of the providers accountable for all of the quality measures really help people to feel like a team and if you feel like you're part of the team and you have shared accountability and you are a part of the organization's initiatives across the board, then that actually really helps to keep people and to keep them feeling as if they want to stay and as if they are a part in the organization. And really trying to teach behavioral health providers how to accurately document and code what they do. And thinking about that as sort of a retention tool and a training tool. And part of it is because many times where you see providers—behavioral health providers say I am struggling, I have open encounters, I have documentation that I need to do, so really teaching them about collaborative documentation so that your 1st 5 and last 5 minutes [indiscernible]. Many times behavioral health providers have a wrong perception about what collaborative documentation means, and actually doing documentation with a patient and using their 1st 5 minutes and their last 5 minutes of the session and really teaching them how to do that effectively is often really helpful because then they are able to really share that experience with patients. To engage them in care. And also be able to reduce the time that they are spending on documentation outside of that visit. And then, really teaching them about documentation so that they are documenting what needs to be documented and not overwriting and clear about it and they are well trained and it doesn't feel like such a burden. And they have some confidence

about what they're doing, so that it becomes a lot more manageable to them. And that's really thinking about for all of the payers, what you really need to do and making sure that you are hiring providers that are consistent with what your center is trying to do for all of your payers.

I was in an organization the other day and they had a whole scheme about which behavioral health provider could see which patient and really trying to think about the hiring and that was very frustrating to the providers and that was a primary issue for them and some of those things can be avoided. Think about who you are hiring for some of these roles. So I really encourage you to try to think about some of these things before hand and thinking about doing things that can really optimize the staffs that you are bringing in.

So when we talk about having a team-based care, 1 of the things that is really helpful in recruiting is to actually interview as part of the team. So that when I come in as a behavioral health provider to be interviewed, then I'm getting interviewed by the team that I'm going to be working with, not just another behavioral health manager, or maybe a medical director. And that actually I've learned over time was really helpful because people can meet the team that they're going to be working with. They felt part of that team right from the beginning. And that actually really changed and increased the number of people that we were both able to recruit and able to retain. And then, the people who are doing the interview felt like they were part of a process and they had some investment and really incorporated that person into the team. So sometimes really think about what that looks like and changing some of those internal practices. So I know we have a 2nd poll question here and I will turn it back over to the facilitator for the poll question.

>> ROARA: We have: Which integrated care record competency do you most often look for when hiring new staff? A: Strong collaboration and teamwork? B: Intervention skills? C: Cultural competency? D: Or other? And you will see it on the computer screen in just a second. We will give everyone a few seconds to answer and we will send the results to the audience.

About 67 percent says strong collaboration and teamwork. About 17 percent says intervention skills. About 14 percent says cultural competency. And we have 5 percent that says other.

>> VIRNA: Great, thank you very much. Also 1 of the things that we talked a little bit about focusing on a team-based is really thinking about what your job descriptions and your postings look like. So many times I worked with several organizations and they will post job descriptions, but really actually putting around what the position. So working as part of a team.

The ability to use evidence-based practices. The ability to work in an integrated setting and what that looks like. And be clear about if someone is going to need computer skills for an EMR, and many times we have been able to put down because the ability to work in an integrated setting like many community health centers offer who are on the line, you have the ability to do really diverse work across populations and across mental health diagnoses and so that is really appealing for many providers. And often if you look at job descriptions, that doesn't get conveyed in the job description. The ability for opportunity. The ability to participate in quality improvement activities, many times organizations will leave out of job descriptions and sometimes adding those pieces. The ability to take students. Many organizations have teaching components with teaching health center grants and residents and it is wonderful to allow behavioral health providers to be a part of that teaching. It helps retain them. It helps keep them relevant. It helps them feel a part of those initiatives. So many times we forget to put those in some of the job descriptions and postings, and really to talk about some of the virtual job fairs that the national health service corps offers and Craig is certainly going to talk about that.

And think about places where you might recruit people who are working with safety net populations. So I had quite a bit of success working with people returning from the Peace Corps. Who are coming back to the states after working on projects and looking for positions, they were very well trained, very flexible, very qualified providers that were looking for opportunities, that many of you have the ability to offer. So I encourage you also to partner. One of the things I found successful over the years was to have a really good student program and collaborative relationships with the local behavioral health schools and training programs and I actually found that we were able to both recruit and retain many staff who were originally students. And so really think about that and I know many organizations are hesitant to take out students – take on students and not sure what behavioral health students can do but I encourage you to look at that and to think about that as an opportunity.

And to really think about what your visit expectations are. Many times providers will ask and talk about people what a day is going to look like for them and doing a warm handoff and many times that can be intimidating if people have that practice in a setting. They say wait a minute, I'm going to have to take warm handoffs, what that's going to look like? And so saying to them in an interview that says well many providers do this and often they will say to patients do you remember when we had a chance to meet and I stepped away to be able to meet you for a few minutes so we could start working together? I'm just letting you know that might happen again. So giving in and enter you some examples like that so that providers can understand how that would flow in their day and what that might look like. And really balancing what your retention

efforts are versus your efficiency. And I know moving away from thinking about productivity and really focusing on what a provider station looks like and what that means to be sustainable but also what that means for them and generally 80 percent of health providers time and patient care give them time to be able to do part of those other activities that you need them to do. And is a model that really makes sense for them and that they can understand and really leads to their retention and morale.

So I really encourage you to think about all of those pieces. I'm going to turn it over to Craig Kennedy to take the presentation from here. So Craig, go ahead.

>> ANDREW: Virna, thank you very much. And this is Craig Kennedy.

>> CRAIG: I appreciate the introduction. I have been given the next 90 minutes to gather my slides so this will work out great until Andrew jumps in and tells me I don't have 90 minutes left. Is that right, Andrew? Anyway. I don't have 90 minutes I will be honest with you it's just going to be 15 and I'm going to run through the national health service corps for you because I am the executive director of the Association of Clinicians for the Underserved. AC was founded 21 years ago by alumni of the national health service corps and we retain that as our policy goal and objectives and our focus ever since that time. So I'm going to walk through for you the national health service corps and the background of the 4 different parts of the national health service corps. How it works, how you can use it to retain and recruit providers and so really going through a national health service corps 101, which is my 1st slide. So talk about the impact of the program nationwide, why we focus on it as an underserved association and how each of those programs specifically can be used by you in your local health center, mental health center, rural health clinic, private practice, a range of different organizations. But 1st I think we have a poll question 1st.

>> ROARA: So true or false: Available loan repayment options can help attract and retain qualified candidates. You'll be receiving that in one second. Take a few seconds to go ahead and answer the poll question.

All right, so we have 100 percent that says true. And then, well actually 97 percent now and about 3 percent says false. You guys will see that in a second. Craig, I will kick it back to you.

>> CRAIG: I think people the keyword in the poll question was *can* help to attract and retain qualified candidates. Think the folks that said no and I think that will be based on some of those

loan payment programs and knowing the details of those programs and how they can be helpful. So let me start going through the national health service corps. HRSA, but is in the Bureau of health workforce this is on a SAMHSA year and you've also heard of the Bureau of primary healthcare that runs the [indiscernible] program the national health service corps is really the largest part of – largest program within the Bureau of health workforce. And so a lot of people call it the Bureau but then when you're at a health center they also call the Bureau of primary healthcare so don't be confused. This is the Bureau of health workforce run by Doctor Louise [indiscernible], what most folks don't know is about the largest group of providers is mental-health providers in the national health service Corps. You can see on this chart that 30 percent of the national health service Corps today that all of the programs, there is 4 different programs and I'm going to walk through those 4, but 30 percent of them are mental health providers within the national health service Corps field strength. 24 percent are physicians. 90 percent are nurse practitioners. You can see the percentages here. A lot of people think doctors, dentists, nurses, it's actually the largest group are mental health providers, so I think this webinar is extremely important for folks to understand the impact it's having right now today and the potential it has for mental and behavioral health providers going forward. We will go through a list of what kind of Mental health providers in a bit, but this slide is just very important for folks to understand that this is a very important program for clinicians of all types, but mental health providers in particular.

What that means is there is more than 10,000 places in the national health service corps today. 10,493 if I was going to be precise. And if I go back to the other slide, 30 percent of that, that means there is 3172 mental health providers serving the national health service corps today. So there is 10,000 people; over 3000 of them are mental and behavioral health professionals serving the national health service corps today. And then extrapolates to 11 million people are getting care from the national health service corps providers across the country. One other statistic is that on the retention side and that was again back to the poll question attract and retain providers, is we find 87 percent of people who go through the national health service corps stay in their – stay in a HPSA and a lot of them actually stay where they are in but 87 percent stay and serve in the areas of greatest need which means they continue to serve in a health professional shortage area after completing their service individual, so these are committed and dedicated folks. They're not just jumping into get their loans repaid and that's where we're going in a second, they're coming to stay, coming to serve the highest need areas of the country. These are committed individuals and have a culture of service. So very excited to have them and have that program grow that is really our point. But I am going to start with the largest of the 4 programs in the national health service corps which is loan repayment.

So there is a loan repayment program. There is a scholarship program. There is a students to service program. And there is a state loan repayment program. Those are the 4 programs. The largest by far is the loan repayment program. I am going to go through some of the details of that right now. The loan repayment program is not – the national health service corps does not hire those providers. Those providers find a job at a national health service corps approved site. So you have to be an approved site. And you have to hire that provider. Using the national health service corps as the potential, so in the contract you say like to hire you we we are eligible for national health service corps loan repayment and you apply for that loan repayment and the way it works is – let me jump to the next slide here – is the higher score you have within the health professional shortage area across the country, the better chance you are at getting a national health service corps placement. So you are serving in Washington DC, I'm in Washington DC, you are in Washington DC you have a HPSA score goes from 0 to 25, so you have a 15 score, pretty high. What the national health service corps does is they get as much money as they get for the year they fund the 25, then they fund 24th, then they fund 23s and they keep going down that list until they run out of money. So I'm going to go back a slide. So you've offered a contract to somebody. You've hired somebody. Can you apply for loan repayment? Now what you want to look at is this past year they were able to go down to about 16/17, 17s they funded and some of the 16s. So if you have a HPSA score of 20 promotional you can get loan repayment so when you are here offering the job you say we have a 20, we are pretty sure we can get loan repayment for you going forward. But if you have a 5, that I probably wouldn't [CHUCKLING] promise I was going to get loan repayment because they have only been able to go down to a 17 more recently. So know what your HPSA score is, know that you can use the loan repayment program for them as an incentive. What do you get from that incentive? What the person gets is \$50,000 over 2 years. So in other words, \$25,000 a year to loan repayment. That's in addition to the salary. That's in addition to the benefits. That's in addition to you hiring them at your center. Everything else. This is an incentive above that offered by the federal government to pay off their loans. Now it's \$25,000 a year for halftime service, this started just a couple of years ago where they started doing halftime service and part-time service and that's anything less than full-time really. Says halftime but it's really anything less than full-time and it's part-time and you get \$25,000. For full-time service it is \$25,000 a year for 2 years. And with the option to extend so you can continue forward in the national health service corps by extending that loan repayment award and most folks have more than \$50,000 in loans. This is my off the record comment because I think there was a disclaimer in the beginning that said this wasn't a person or anybody else's views; I get to talk off the record so here I go. I think what's happening is you are seeing dentists come out of dental school with

\$300,000. And so \$50,000 in loan repayment is maybe not making the difference for them to go to an underserved community. Whereas, you see mental health providers are more in the 75, 80, 100, 125 ranges what we have been seeing and \$50,000 really, really makes a big dent in that debt. So the debt gets really too high it's really harder to use the national health service corps. To be honest with you, my stepfather is a mental health provider and he had \$60,000 in debt, so he went through the national health service corps, did \$50,000 in the 1st 2 years, extended for one more year and wiped out all of his debt. So he spent 3 years in the national health service corps because he had \$60,000 in loans and completely eliminated his student debt going through the national health service corps. So you can continue to extend going forward as long as you have qualifying educational debt.

This is 2 years, \$50,000 that's the initial, you have to promise you are going to be there for 2 years. But after that it's up to you. These are just some of the requirements. Don't worry about the top there, you can read them at your leisure, but the bottom is really the list. Physicians, nurse practitioners, certified nurse midwives, these are the folks a lot of people assume national health service corps but psychiatrists, psychologists, licensed clinical social workers, psychiatric nurse specialists, marriage and family therapists, licensed professional counselors, you see those are all blocked into that mental health and behavioral health space earlier in the 30 percent. These are the eligible provider types within the national health service corps. So any of those, any of these here at the bottom, this is a key slide I should have made it bigger [CHUCKLING], this part down here is really this list of provider types are eligible for loan repayment. National loan repayment through the national health service corps. So I will let you copy that down. I would keep the slide. I will look at that and say if I've a few of those on staff, or am looking to put a few of those on staff and I have a high HPSA score might be able to offer repayment. \$25,000 more than I'm paying them to pay off their student debt. So this is the eligibility.

This is just a quote from folks. I will be honest with you, I think the national health service corps allows people to do what they went into practice to do anyway. What they went to school to do. This is just a quote that says, "I am getting my salary, getting loan repayment, and I'm doing what I love." This is what I think folks came into practice to do. And the national health service corps just let them do it from a financial perspective, and so this is just a quote from 1 of the people.

The scholarship program is a bit smaller program but what this does is it really is for – where has my...? – too far forward. This is mainly for folks in residency. And so the scholarship program just pays for your education, straight up. And then what you do is you promise to have 4 years

out in the field. So I don't know, at the age of anybody on the call but the explanation I normally give is there was the TV show called *Northern Exposure* years ago, where a guy was forced to go to Alaska and practice medicine. He was actually in the national health service corps scholarship program [CHUCKLING] so that entire TV shows about the national health service corps. He wasn't forced to go to Alaska. He wasn't forced to go anywhere. What actually happens in real life is you apply for the scholarship as you're going into medical school. They pay for your entire medical school, you come out tax-free. You go through residency. And then when you go practice you will serve in a HPSA of 16 or greater. So you will go to a high HPSA score of 16 or greater and then we get to choose to go and where scholars get to go, so there are a number of scholars coming out every year and they have to find a place to practice. At a HPSA score of 16 or above so another way to get folks into your organization is to find scholars willing to serve in your area if you have a 16 HPSA score or above.

This is 2 years, it is really based on how long you are in training. What your schooling costs. And how long it takes. And so, the site is really about an eligible entity just like the loan repayment site but the scholarship program just has a base that says 16 and above. Scholars don't have to go to 25, then 24, then 23, they just set a floor and say 16 and above you can go. So those scholars can go to any of those places. These are the eligible provider types. A shorter list.

The 3rd program is the students to service program and this is where they thought it was kind of a bridge between the loan repayment program when you already done out of residency, out of training, out of everything going into practice in the field versus when you are just applying to your training program [CHUCKLING]. Way at the beginning. Years and years before they said maybe they're just out of school and going into residency programs, or trainings, or other type of training programs where they are going to choose primary care. So while they are making the decision, they've gone through some of the basic training but now they're going to choose whether to go into primary care or specialty care, that's when we can offer the students to service program. In a sense, we give them it says there is a tax-free loan, what it really does is loan repayment for what you have already accrued, kind of a reverse scholarship, to choose primary care and go into underserved practice. So student to service just started a couple of years ago, 2 or 3 or 4 years ago, it's growing, it's been growing. I think it's a great bridge program between the scholarship program way early and the loan program way late, it's kind of in the middle. And so it's the 3rd leg of the national health service corps stool.

Now this is the full-time practice. They have only been doing it currently for MDs and DOs, I think it will be bigger than that, I think there is some you see over here [indiscernible] Psychiatry, Geriatrics, family medicine. This will grow; it's a smaller program today but I want to make sure that you realize there was a student to service program and it will be a future pipeline for providers.

The 4th part of it is the state loan repayment program. This is where the federal government matches funds within a state. And they design their own programs. So many states have said I want to go lower on the HPSA score; I want to do different types of HPSA; I want to design my own program; and I want to share that cost with the federal government. And so the federal government has an eligible state loan repayment program that 37 states have applied for and been awarded. So there are 37 states out there that have designed and are awarding their own state health service corps I guess you would college programs. So look into that has well. If you are 1 of those 37 states you can look to the national health service corps loan repayment scholarship program, students to service, or you can look to your own state to see what they're doing that may be a little bit different than what the national health service corps is doing on a federal level. And one way to find that out for dedicated behavioral health staff or for mental and behavioral health providers is to call the dedicated behavioral Bureau of workforce staff and the regional offices, so you can ask them in region 10 or region 9 you can say what are they doing in Washington state? What's going on here? What is a HPSA score for the 2nd one to go to? What is my score? You can ask these 10 regional offices a number of questions about the national health service corps.

We can also do and this is where I would add to this chart, you can call the primary officer in your state, the PCO, or you can call the PCA, both of those organizations will have workforce professionals that understand HPSA scoring and also cite specific information about your organization and where the providers want to serve about national health service corps eligibility and potential. So do you have a 20 or above? Do you have a 17? What is the state doing? What are the different programs that are available? So I would reach out to not just your Bureau of health workforce regional office staff, the HRSA original office staff, I will look at the PCO's and PCA's in particular the PCO if you don't know them already your primary care officer is the state official that determines the score, the HPSA score for the federal government. It is a state official that determines your federal HPSA score that is a partnership position offended by the Bureau. There is a lot of clinic administrators. There was a lot of different folks that were in recruitment. Or the providers like your folks that are recruiting mental and behavioral health professionals, know the HPSA score. Know the potential use the national health service corps

and know the PCO and how to—because some folks we have seen it come in and say—this is a little trick by the way my off the record comment—and say look I have a 14,13, 12 I don't think that is right. I don't think you're including – we have a high need in our area. Maybe they're not taking something into consideration that you are seeing on the ground. Maybe you can sit down with your PCO and say these 3 providers left; we need to update our score. I had an organization in Georgia where a practice that was delivering babies just left, they closed, they are gone. We need to update the HPSA score to reflect that [CHUCKLING] the entire organization is gone. So there may be ways to work with your PCO to recognize real world – that's what it's supposed to do—your HPSA score is supposed to recognize your real world examples.

Resources for providers. So what to do, talk to your PCO, talk to your PCA, and talk to your regional office. It's always stunning to me that we don't have enough folks do this, which is make sure that you have posted your job on the national health service corps jobs board. They have a national health service corps job center with all of your jobs there. Post them all even if you have a HPSA score of 9, it doesn't matter, post them all. This is a free posting of your jobs to a nationwide audience of folks that are coming to the national health service corps job center because they want to do the right thing in this country. They want to serve in underserved communities. These are passionate committed individuals serving this job board. So post all of your jobs there. Even if you don't know you're going to get national health service corps loan repayment because you are at a 9 or 10, post the job and you still get applicants from there. Everybody should have an up-to-date, current, it's an organizational profile. There's a profile you put up there. And yours should look great. Spend a little bit of time on it. And post all of your jobs that you can up there. Because there's a lot of people. There's literally thousands of people who go through this job center with the national health service corps. ACU has a job board. I'm mandated to say that we also have a job board and you should come [CHUCKLING] use our job board as well but the national health service corps has a terrific one as well. 3RNet, you probably heard of 3RNet, rural recruitment and retention network, they have a great career center, but all of us working in collaboration with the national health service corps and so I strongly recommend posting your jobs or searching for candidates on the national health service jobs board, 3RNet's job center, it's everywhere that you can to flood the place.

And I'm going to spend 2 seconds, a lot of you may have heard that the national health service corps hasn't yet been funded for 2018, that is factually true. We are working really hard to keep that. It's currently funded at \$310 million, not currently, 2017 it was funded at \$310 million. Congress has not yet determined fiscal year '18. The president recommended 310 million for '18 and '19. And because he did that, because the president recommended \$310 million for '18

and '19, the national health service corps is still accepting applications, it's going through all of the functional processes applications and awards going forward. Even though there hasn't been funding allocated to the national health service corps for 2018, they are still able to administer and walk through all the processes with the expectation they will get \$310 million because that's what the president recommended and Congress hasn't finished their work. We will push for the full 310 million. House has passed and everybody has agreed that 310 is probably what we'll get. I say probably because we are actually asking for more but don't tell anybody that. Well, do tell everybody that. What am I talking about? We are asking for more! The hesitation is that we don't want to go down but we want it to go up, but \$310 million is where it was funded last year. A lot of Congress has agreed and the president has agreed to that number already going forward, so there is some assurance that it will occur but we need everybody and we are still pushing and pushing until it actually gets done. It will continue administratively as if they have the 310 and we are hoping to get that done as soon as possible.

Other things. I mentioned way in the beginning the nurses, the nurses are largely [indiscernible] Except for nurse practitioners, nurses are largely funded through the nurse corps which is a separate but sister program within the Bureau of Health Workforce, so nurses go through that separate program. So if you're looking for those things there is a native Hawaiian health scholarship program. There is faculty loan repayment. There's a bunch of different programs within the Bureau of Health Workforce. Look at them all, but national health service corps is the big one. I wanted to make sure you understand those 4 programs. And also that you understood loan repayment scholarship program in particular but also loan repayment for this audience and the importance there too.

Andrew, I think we go to questions after that.

>> ANDREW: Thanks Craig, excellent. Thank you Virna, as well. We have been getting plenty of questions coming through so we're going to take a few minutes to pose some of these questions to Verna and Craig and afterwards we will move on to Daniel Do's presentation. So the 1st question is for Virna. Virna, can you say a little bit more about the 1st 5 minutes and last 5 minutes of the session? Is that where you would recommend the focus be on indoctrination?

>> VIRNA: Sure, and I think there is a misconception of what collaborative documentation with patients is. So when a patient comes into a session I will say let's sit together. I pull up last time what was documented for that patient's care. The last note. And I will start and say okay, you are continuing to come in for depression and I viewed these symptoms last time and last time

you said you were having trouble sleeping. Is that still true? It's better, it's worse, and I document that. Assessment of the symptoms and reiterate why the patient is there and in the 1st couple of minutes review the notes with them. And then we would have our session and then I would say to the patient so we have a couple of minutes left, what I would like to do is come back and be able to put down what we covered in today's session and then think about where we are in terms of going forward. So reviewing progress towards treatment plans. And then I would document the clinical intervention provided. So as an example if it was cognitive behavioral therapy the thought may be that I was reframing and I would say did I get this right? Yes, you got it right or I have always been taken back by a patient saying no, actually you didn't and putting down what they think is appropriate and accurate. And closing out the notes. So that really allows for time to spend with the patient and really allows for the documentation. And that note is complete and I can go on to my next patient and I don't have notes that are there which can be very overwhelming particularly to providers who were to the field get overwhelmed with notes that aren't done and it becomes a retention issue, or morale issue, a quality issue.

>> ANDREW: Great, thanks. And I think the [indiscernible] is something an acquired skill for people in this environment. Another question, Virna, is can you talk a little bit about I think you noted that you made mention of making sure hiring for who is billable for those services but can you talk about that a little bit more?

>> VIRNA: Yes, I think unfortunately we live in a very complicated world and so every state varies in terms of what behavioral health services are billable. Some states have different licensure for substance abuse or specialty mental health and different providers can practice, so it gets very complicated and certainly taking that into consideration and making sure you are hiring people that are most optimal for billing and reimbursement for the organization and the setting and the work that you are trying to do. Because again, what we find out is that often it's very discouraging for providers to get hired and to find out that they're not billable after they have worked in the center and being on a grant, or that they can't bill many of the organizations providers and often then you wind up not keeping them, or they don't stay in the organization. And so really thinking about that from the beginning can save a lot of time and really help you with your morale and retention, as well as your sustainability.

>> ANDREW: Great. Thank you very much. This 1 is for Craig. Some folks have questions about locating and figuring out what their HPSA score is. How do they go about doing that?

>> CRAIG: Great question, several different ways. You can call your primary care office, or the PCA has it as well. But it is public information, so you can go to the personal data warehouse and look at your organization and look up the score and you can actually see all the scores of all the organizations in the country. Go to HRSA data warehouse and look at your organizations HPSA score and there's actually 3. I didn't go through this in my presentation, there are 3 scores for you. There is primary care. There is dental. And a mental health HPSA score. Most of the folks on this call will look for the mental health HPSA score. When you bring up your score all 3 will come up in the data warehouse. So the mental health score is publicly available on the data warehouse.

>> ANDREW: There is another one that dovetails pretty nicely, Craig, with that one. In addition, how does an agency become approved? Do they have to be nonprofit to be approved? Can others join?

>> CRAIG: Don't have to be a nonprofit. I think that is a common misconception, they don't have to be a certain type of organization. They have to meet the conditions of the law that says, and this is the critical component, you have to be open to all regardless of ability to pay. That provider's services, not your entire organization per se, but that provider's services needs to be open to all regardless of ability to pay. So you need to apply to become – you meet the terms and conditions of national health service corps eligibility and then apply to get a score through the primary care office but you don't have to be a nonprofit. There are many private practice placements today, hundreds of the 10,000, literally hundreds of private practice placements. However, even though they are private practice that provider needs to be open to all regardless of ability to pay. Now for SQHC's in the world that have a sliding scale it's almost automatic, actually it is automatic to be HPSA, so you have an automatic HPSA score, but you have to prove to the Bureau of workforce that you are meeting the terms and conditions of the law. The federal government didn't want to incentivize practice anywhere, they wanted to practice in underserved areas.

>> ANDREW: We have just a ton of questions coming in so we're going to have an additional Q & A after Daniel Do's presentation and so we will take questions for Daniel and addition to that point we can continue to respond to questions for Virna and Craig. Without further ado, we'll move to Daniel Do with the Lynn Community Health Center. Daniel, take the stage.

>> DANIEL: I'm a public health social worker. Right now, I work at the Lynn Community Health Center. It's funny, Lynn Health Center was actually founded in 1971 as a storefront

mental health clinic in Massachusetts, but early on 1 of the cofounders recognized the need to hire a primary care provider and so after he got licensed to provide mental health services he went back to the state and actually got a license to provide primary care services. So he is really a pioneer in integrated health. That is a picture of where we are today and today we offer the range of services from primary care, substance abuse, addictions, you guys can read those but we have over 600 staff who in 2016 provided over 280,000 visits for more than 40,000 individuals here in Lynn; which was a little over 40 percent of the Lynn residents. So a lot of my experience comes from integrating behavioral health into primary care and my work at this Health Center is Integrated Behavioral healthcare into behavioral health staff. But before I continue I think we have a poll question.

>> ROARA: [ASKING QUESTION] Which of the following best describes your organization's relationship to healthcare training? A: We have a robust relationship with a university or training institution and except trainees regularly and participate in educational opportunities. B: We have a formal or informal relationship with the University training institution and offer presentations or courses to their students. C: We are aware of a local training program and working to establish a relationship. D: We have no training affiliations. Take a moment to answer the survey.

[ANSWERING POLL]

We have about 34 percent for option A. 23 percent for option B. About 14 percent for C. And then 28 percent for D. You guys will be able to see these percentages in just a second and Daniel, I will kick it back to you.

>> DANIEL: Thank you, Roara. Here's what I will go over today, scope and frame. My work is integrating Departments already existed within agencies but not fully integrated. Really retention from a cultural diverse and environmental point. Bringing back to Theory, we all love theory. And in terms of talk about agreement things I learned along the way about characteristics and styles that fit well into integrated settings; it's also training the next generation of psychologists but also medical doctors, nurse practitioners, going back to what Virna said earlier today.

I am a very slide [indiscernible] person I had a cartoon here but we will go with Chicho; he is our team fish. And what I want you to envision is a wonderful quote by David Foster Wallace is where you envision a fishbowl, there is a grandpa fish on the right-hand side and 2 younger fish

on the left. And so the grandpa fish asks how's the water today boys? And the 2 fish look at each other and say what the hell is water? I love that metaphor because I relate it back to culture. We swim in it every day. We don't know if it is murky. We don't know if it's clean. Some are healthier than others. But for me, integration thinking about integration and doing integrative work is truly an opportunity and a gift for an agency to take a step back. To look at their culture. To talk about what's affecting disengagement, provider burnout, and what we can do to address it. So I'm going to leave you here with the fish but in terms of doing the work my 1st experience with integrated health was being hired as the only medical social worker in a large adult medicine center within an SQHC, my counterparts were across the parking lot in another building and both teams thought they had the patient's best interest in mind and they really did but there is a culture of distrust, no communication, and so what was I supposed to do when we were going to integrate the therapist into the clinic? I do think about what my goal was and my goal was not to think about who can make it in the setting, it was to create a structure for everyone to make it and luckily I work for an amazing director and senior team who had some experience doing interracial pediatrics before and truly understand the value of spending time on the culture part. So when I said relate it back to Theory, specifically I turn it over to Group work theory, the Boston model group work where you had the intimacy, differentiation stages, also separation but we are not going to talk about that in terms of integration. And then you also have Kotter, Kotter's 6 stages of organizational change. And so, I turn to those as I recognized in order to do the integration work, in order to learn how to work in these new workflows, or to learn how to do the warm handoffs, things we will talk about in the 2nd part – 2nd series of this webinar. Is that there needed to be a base level of trust and relationship building. I applied a similar framework when integrating primary care here into this behavioral health department. And so practical things I did: you had social events or people didn't talk about the P word—productivity. You didn't talk about integration but you talked about the level of trust with each other. We talked about warm handoffs and behavioral health. My patients feel comfortable going from their primary care provider to the therapist. I applied a similar lens that in order for therapists and for primary care providers to work together they had to know each other and it didn't need to be scary. So social events and you had moments of small wins. The interesting thing is it's less about the plan in terms of who wins but more about which group is being integrated into the other. Behavioral health into primary care; it's important for them to understand the wins.

Even when I found small wins I still got yelled at because change is hard and the integration work is hard. And so I will tell you more about that later but when people are anxious and there is the unknown, there can be misunderstandings in communication. So talk about a characteristic

that might be helpful in these integrative settings, I think Verna named most of the ones I have here which is flexibility. As a medical social worker I didn't know what was going to happen during my day, whether that'd be an assessment, counsel, or just talking to a provider about what's going on with their patients. The one who is flexible and that was in that 15 minutes to an hour. Communication skills and styles is all about teamwork and integrated settings. So will they function well on the team? Being able to hold the unknown and we will talk about when I talk about recruitment is if you are starting integration work a lot of it is kind of in the great unknown. Your job might look different in 6 months to one year.

And also need to have fun. The work is hard and without that team building and building the integration, people won't be open to learning these new workflows; we're changing the way they think. If you think about it, at the core, we are asking our behavioral healthcare providers and our primary care providers to change how they practice. So shift in mind practice methods. But, to maintain the discipline specific practice standards. And so, things that were helpful for an agency point was showing value to employees definitely increase retention. And, being able to pivot. Being able to do the continuous quality improvement. In terms of hiring, I'm always upfront, so for example when I got hired on they were like Dan, we are not sure where your job is but it will be along the way. That is similar to when I came to Linen High the 1st support specialist here. I was like hey man I have worked with peers before and I get to bring you on, but your job might be really different. And so it took a lot of coaching at 1st. It took willingness to make mistakes but not call them mistakes, learning opportunities. There was some missed communication along the way and it just took sitting down and having those conversations. You also want to think about who you are recruiting and who your patient population is. What your patients actually need? And what do they look like? And we can talk a little bit more about that as I continue with my fish analogy down the line.

And then just some other things about retention, trying to see what the water is. We also did a lot of work around creating frameworks for shared meetings so that everybody had a voice and you dismantle that hierarchical thinking between primary care and behavioral health professionals. And we also started to shift along between those are the behavioral health care providers or the primary care providers versus this is one team now and we are all here to care for the patients. And to continue the fish analogy is there is a wonderful story, actually a collection of stories called *What If*, short stories by Steve Robbins, and in the 1st story he talks about there is a man and his family of a large plot of land and a pond out in front and they are definitely not located in Boston. And he fishes. There is Sea Bass in the pond. And he remembers in his childhood he remembers fishing rainbow trout because they're harder to catch

and you need more skill. So he calls it the wildlife personality street, figures out he has rainbow trout and he goes over there to buy some of the guys like you're going to buy these fish, what type of environment do you have right now? He explained his environment and it gets kind of hot in the summer. And so the guy says you definitely need to add some logs in there, add an aerator, in order to create some shade and shelter, and add more oxygen to the environment. And he was like yeah. I will do that. He goes home with the equipment, goes home with the fish, puts the fish into the thing and lo and behold he does not do the prep work for it. He does not put in logs, he does not put in the aerator. But apparently a sign of life of the rainbow trout is that they blow bubbles. As the weeks go by, there is less and less bubbles in the pond. In the end all of the rainbow trout died. He goes back to the salesman and goes what happened? And he is like did you do what I said? He goes no. The man looks at him and says you know if you had done those things, it would have benefited the Sea Bass as well, like they would have benefited from the temperature, they would've benefited from increased oxygen, so the moral of that story is what I think about retention and recruitment if you do things that make it better for the people coming in whether you are trying to hire all new behavioral care providers or Medical care providers, if you were to adjust to the environment and culture for the people already there to work on retention when you recruit people, they will stay.

So afterward the peer that I hired probably had some challenges like adjusting to the environment and communication, I had already built a wonderful team that coached him along the way. That we could work on some of the more nitty-gritty practice standards. So interesting things for those kind of behavioral health into primary care and primary care into behavioral health is integration works! And after a while people communicated more. They felt more part of a team. And the initial resistance to integration became the butt of jokes in the department. I have gotten yelled at a lot along the way because this change work is hard and there was a situation were trying to integrate behavioral health into primary care we had a patient who would always stop by to get some emotional support but never see the therapist. Identify that is 1 of my small wins, I was like I will work with this nurse and we will talk with the therapist and ask her for some advice. When we got onto the phone, the therapist was like why am I reporting to a nurse? And the moral of the story is – not what was happening. 6 months down the road they were laughing with each other and working with the same department side-by-side. So the final lesson is to build your culture, community relationship and trust, there is a lot of work to be done, a lot of good work but if you tend to your water like ask yourself how is the water? How will you improve it? Are you going to add some shade through the logs? Aerators to increase oxygen and improve health? Or something else? So that I will wrap up with our final poll question and Q & A.

>> ANDREW: Excellent, thank you so much Daniel. We've been getting questions coming in as we continued here. We do have one polling question that I will ask the audience before we move on. As a result of the webinar that you have just heard and pending the Q & A, tell us what will you do? As you are mulling over this information and thinking about our 3 presenters today, would you like to just start reviewing some of your current staffing strategies? Do you plan to make new hires using core competencies or other purchases? Maybe you will market these positions differently or advertise for them differently? What kinds of ideas are you thinking about? We will take just a second for this.

So we are getting pretty good responses coming in. And it looks like the resounding kind of audience poll here is reviewing current staffing strategies. That is our hope that as you are hearing this information it's got to thinking what are we currently doing? Are there different directions we want to go? Can we update some of our hiring, is there more we can do to make sure that people are sticking around? We want to use National health service corps? So great, excellent.

So Daniel, the 1st question here is for you. You mentioned the misconceptions about hiring a specialist, you talked about what those things were how you made that job posting clear and what kind of need for coaching came up?

>> DANIEL: With any position if it's new to the agency it's going to be it's about what do they do? Basic questions, kind of like I remember coming up what parts of electronic medical record do they see? Do they document? How do they work with patients? And then, trying to help people identify how to utilize peers. If it is a new rule, how do you get them to get somebody in. And I just turn it back to those urbanization will change things you create small wins, we found one success, you told that success, and more people bought into it. But it's definitely a lot of groundwork to build those relationships.

>> ANDREW: Another one, we got a couple people asking about this throughout maybe you could take this 1 Daniel, where does cultural competency come into play when hiring?

>> DANIEL: That's a long question. I would definitely say I remember when I worked at the 1st health center there was a large Hispanic population, predominantly Dominican. And I am Asian but all of the other therapists were white and no one spoke Spanish. So we worked for a really long time to advocate to hire a Spanish speaking therapist so that we could actually serve

the population that was there. And so, really taking a look at what is your population look like? Do you have the ability to meet it? The health center I'm in now there is therapists that speak over 50 languages individually. And so you definitely want and people come back and see them because they make a connection and sometimes they don't want to see someone from the same culture, so you have to be mindful of that.

But the warning with hiring diverse staff is if the culture is not ready, or the environment is not ready for it, and often times those providers leave and they don't stick around due to XYZ.

>> ANDREW: Excellent. Thanks. So we have some other generals that are coming in also. I think Virna or Daniel, this I may apply, folks are asking about the recommended number of clinical contact hours that they should have on any given week. I know this varies in studies that I'm seeing but I'm curious if Virna or Daniel, what are the standards that you have seen?

>> VIRNA: Sure. I think it's really important to look at this and generally when you think about what this looks like, you are looking at productivity which is the number of people actually seen. And the time in patient care with patients because in an integrated setting of the behavioral health provider has lots of different types of visits so productivity often isn't accurate, it only paints part of the picture but we understand if you don't see patients you don't generate revenue, and that goes to sustainability. Although I never used to focus on productivity, I used to focus more on the capacity and open slots. So 80 percent of your time you really need to be seeing patients. That leaves 20 percent of your time that may be scattered throughout your week that has time to do other activities. And I used to pay really close attention to both productivity and capacity, although I really talk to staff about capacity because if you were high productivity and high capacity, and if you were low productivity and low capacity, both of those needed attention. So a lot of times what organizations do is say here is this provider they are seeing a ton of patients, their productivity is great, I am not really going to pay attention to them. I'm going to pay attention to the other providers but I would actually reach out to both providers and say listen, you are over productivity, you are over capacity. How can we help you? What do we need? And really try to work on that piece as much as I would also work with the provider who had a lot of open slots and still had some ability to create access for additional patients to be able to see them. And that actually goes very well for retention because people felt like you were paying attention and you were very conscious of when they needed support. Either to help them create schedules that allowed people who needed to get to them, or if they were getting to where the work on their plate was unmanageable.

>> ANDREW: Nice Answer, Virna. It's a hard number to pin down. This next question I think Craig or Virna, and it's been asked a few different ways but for things like loan repayment options, there is a question about clinicians who are working in collaborative care environment, particularly those in telehealth, how does that impact HPSA Reimbursement, any special considerations?

>> VIRNA: So for the collaborative care this comes up a lot from psychiatric providers who are doing telephonic consultations, and if they are employed by the organization that can sort of count. However, part of what the national health service corps requires is a particular amount of time in patient care and direct services and many times psychiatric providers were just doing the consultation and not providing any other services for the organization might struggle. This is also coming up as Medicare passes the non-collaborative care codes were telephonic care management can be provided for patients with collaborative care. Does not actually meet the criteria, they are often not employed by that organization, and if they're just doing that telephonic work. So I think it depends on how you have your collaborative models set up and whether or not those providers are employed and how much critical time they are actually doing in your organization. So, Craig, I don't know if you want to add to that?

>> CRAIG: The only thing I would add is that we had one side, one organization try to use telemedicine and get national service corps loan repayment for the person doing the telemedicine. But the trick is that both sites have to have a high HPSA score; they were in Iowa somewhere, they were doing telemedicine to Chicago with a person that they wanted to use and it was going to meet the full-time requirement. Going to do the time and everything else. But the score for both Iowa and Chicago matter. It wasn't just the Iowa score that mattered, I think people sit there and say we have a high score out here I should get loan repayment, but the person doing the care also has to be in a qualifying HPSA score and that's what disqualified them. [CHUCKLING]. It's not just about the site score when it comes to telemedicine.

>> ANDREW: Great, thanks Craig and Virna. We're running low on time so we will do one more question and then we will wrap up. Here's another one that I have seen many, many times. I think it's-I'm curious what folks answers are. So anyone on our panel can answer this 1. But the question is are there any work schedules that you found that optimize not only patient access but help manage burnout in staff? For example, offering 10 hour workdays or some type of schedule that's flexible? Is that something you have seen?

>> VIRNA: I would like to jump in. I'm sure others will have others as well. When I worked for the SQHC we opened 365 days a year and the 1st thing people thought is that was going to be problematic to recruit and retain people. And what we begin to realize was there was a lot of people who actually really liked to work a longer extended four 10 hour days and save the day in child care, or wanted a day of the week to be able to do errands, or go to school, or maybe do some practice work. And so we actually found that the ability to really sit with people and think about optimizing their schedules was incredibly helpful. And, in fact, they proposed that we reduce hours and change the schedules and the providers that don't actually want that. That was very interesting to me. And so that actually was a very high source of retention and recruitment. People liked the ability to do Sunday through Wednesday, or to work weekends or not. To do extended days. So I would encourage people to think about that

>> ANDREW: Great, thanks. We will wrap up our questions there. With some additional resources from our presenters. I think sometimes folks overlook social media accounts but there is so much valuable information. I would definitely suggest taking a look. And of course, we have a number of resources available through the SAMHSA-HRSA Center for Integrated Health Solutions, the host for this webinar. Our website is at the bottom of the slides and Integration.SAMHSA.gov and some of the items in particular what we are talking about today and these links are in the PowerPoint slides that are available for you to download. The 1st one is we have a whole list of our critical core competencies particular to Integrated behavioral health and primary care settings, so I definitely recommend checking those out and making sure that your job postings and evaluation strategies are mapped onto those core competencies. We have guiding principles to help you as you are developing your workforce. We have precisely on how to build culture within your staff. And also a number of sample job descriptions from health centers and other organizations who have successfully hired for these positions. And finally, we have our email address listed here integration@thenationalcouncil.org.

Please let us know if you'd like any training or systems on other topics. We offer free training and technical assistance to our national audience, really to anybody in the country who is starting or working on integration and wants additional assistance. So that is an excellent resource that I encourage everyone to consider. And so, with that, we certainly thank you for joining us today. You will be receiving a survey at the end of the Webinar. We request you fill that out and let us know and again we will have part 2 to this series coming up into summer so you should be hearing about that shortly. Thank you everyone for joining us today.

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