Mental Health and Substance Use Disorder Integration Workforce Shortages, Retention, and Resilience

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I am pleased to introduce you to today's presenter. Kerry King is a licensed clinical psychologist and behavioral health care leader with extensive experience in clinical change management, systems consultation, best practice implementation, and professional development training across a range of disciplines. It is now my pleasure to turn the webinar over to Kerry. Kerry, please go ahead.

Kerry King: Thank you so much, Kayla. Good afternoon to everyone, or good morning, depending on your time zone, to all of the folks who have joined us today for this webinar. I'll just walk you through our intention for today. We will cover a little bit of background to frame our topic. We'll talk about the current state of mental health and substance use disorder workforce. You will see lots of abbreviations on these slides. Some of them will be familiar to you. Just to level-set, we will be using “MH” to represent mental health and “SUD” to represent substance use disorder. We'll go on to talk about how we can leverage and support integrated care teams, and then we will leave some room at the end for questions.

Let's review our objectives. First, we want to talk about strategies for how you can build a workforce development framework to address today's integrated care staffing needs while creating a pipeline for future roles, outline the activities that facilitate a supportive work environment and enhance job satisfaction in integrated care settings, develop an effective peer support network, debriefing techniques for staff to process challenging experiences, and understand the role of continuous quality improvement in applying workforce development strategies.

Let's jump right in with a poll. This will just give us a little bit of context for your organization. If you can share by selecting as many as apply, what challenges you are facing at your health care center regarding workforce development? It might be recruiting trained mental health and SUD staff, retaining them, meeting the increased demand for services, providing access to specialized practitioners. For instance, those who provide services to kids, I would say, or elderly, or individuals with substance use disorder, preventing burnout amongst staff, dealing with financial constraints due to lower reimbursement rates and increased operational costs.

Then there is, certainly, the option for you to say, "Hey, we've missed this boat completely. There are other things," and then we will just ask that if you select that option, that you use the Q&A feature to indicate what are the other challenges that you're facing that perhaps we've not captured. It looks like we have a fair number of responses in. Why don't we go ahead and end the poll? Looks like that was slowing down.

All right. Let's see what you've said. I know I've done a crazy thing because I've expanded this on my screen, so let's hope I know how to undo that. It looks like the biggest one is recruitment, which actually does not surprise me. Recruitment has certainly been a challenge and aligns with perhaps

why you were interested in joining today's webinar, along with increased demand, which goes along with having sufficient team members, managing burnout, also flagged pretty high for folks, and then the issue around financial operations and constraints.

Okay, so appreciate your input on that. I would say that those responses certainly align with what we're seeing, I would say, industry-wide. It looks like someone also shared in the chat, and I'm just taking a quick look, about adjusting practice style. I'll just encapsulate by saying to the required or modalities, so changing their approach for the context. All right. Thank you for that.

When we look at the data around workforce gaps, we definitely see some of what you're indicating that you're feeling. We're seeing that, according to HRSA's (Health Resources and Service Administration) projections, by 2037, we can anticipate workforce shortages of the magnitude that you're looking at on the screen across a variety of mental health and substance use disorder-related disciplines, with addiction counselors, mental health counselors, psychologists, psychiatrists, marriage and family therapists.

What we are already seeing is the gaps that exist in those health professional shortage areas. We are seeing gaps, obviously, in the primary medical care. We're also seeing gaps in mental health practitioners showing up in those workforce shortage areas. This is, doubtless, not surprising, I would imagine to you. This just gives us a glimpse at what the impact is, and this one really shows us the need. We're seeing that there are gaps in workforce, but we're also seeing that the demand is there.

We can look at this slide as an indication of the percentage of the population that is in need of SUD services. We see somewhere between, let's say, 9% to 16% of teens, 12% to 17%. About 16% to 30% of adults, in the meantime, are still in need of SUD services. Demand exists while gaps simultaneously exist. This one indicates, and this really just gives you a glimpse, and we're pulling out addiction counselors by state.

The key to looking at this is to understand that the darker shades of blue indicate areas where the percentage of adequacy is greater, and lighter shades, more leaning toward gray, indicate where it's less adequate. That can give you a sense of where we're seeing some need for addiction counselors in particular. Similar with regard to the one that I showed before about SUD services, when we look at mental health treatment received in the past year, we're seeing on the left that the demand has been somewhere between 25% to just shy of 40% for ages 12 to 17.

Then, among adults on the right, we're seeing numbers up to 30%-plus as well. Again, indicating that within the United States population, there's certainly been demand for mental health treatment. If we just pull out psychologists, this is a similar encapsulation of where there are areas of larger saturation versus areas of lower saturation. Now, I will say that, obviously, this is telling a tale of when you see something like 94% adequacy in the United States in 2023.

The numbers that pertain in, for instance, the state of Texas, is not the same as for Wyoming. You notice that those percentages look quite different, and I'm just picking the first two that my eyes caught. Bear in mind that when you are reading these blanket percentages that it really does matter where you are regionally. We have a fair amount of data that says that we see differences in rural areas, in particular, where there really are shortages in staff.

What implications does this have, or what impacts are there for integrated care teams? Well, one of the things that we can call out right away is that many of the areas where we are seeing gaps in coverage in terms of role are the kinds of roles that show up on integrated care teams. Your mental health and substance use disorder clinicians, your care coordinators, peer support specialists, and so on. That's just in terms of having sufficient individuals available for the work.

There's also the nature of the work. Integrated care tends to add complexity, right? I think about this in terms of-- The example that comes to mind is in college. I was very much the kind of learner who shied away from group projects. Why? I like to work at four o'clock in the morning, the apartment is quiet, and I am able to give it my full attention. I can control my schedule. I can control my approach. If you translate that into the work setting, that is very much how we have approached care.

Individuals show up. We do our particular lane of care, according to our training, according to our preferences, according to the modalities with which we are comfortable within the time frames that are reasonable for us, and within a scope that feels comfortable for our practice. When you begin to work within an integrated care team, the needs for collaboration with other team members change. The extent to which you might feel professional control may change. Therefore, inherently, there is a different level of stress that might exist for some individuals who might have a preference for working independently.

There's certainly an increased requirement for care coordination and for being attentive to needs that may pop up for an individual receiving care that go beyond the particular scope of your professional domain. We notice that within integrated care teams and within, honestly, the mental health and SUD workforce in general. The nature of the job can lead itself to high turnover, burnout, and job dissatisfaction can be a characteristic of the type of work that we do. I found myself saying recently in lots of contexts that the healers are tired, and there does certainly seem to be a trend toward increase of these kinds of negative impacts within the mental health and SUD workforce.

Other factors that might impact your integrated care teams could be things like there being fewer practitioners in some of those regions that we indicated before in rural areas, having just availability of fewer practitioners, and availability of not only particular numbers within a discipline, but availability of multiple types of disciplines of practitioners to form an integrated care team.

Compensation might be inadequate in comparison with other disciplines of work. There are not many people I know who said to themselves, "I really have a life goal to be really wealthy," and then they choose to become a mental health or SUD practitioner. I would judge that one as bad judgment. That is typically not a thing that you see. It's not generally a profession that you pick for the compensation.

Certainly, when you consider the amount of effort in terms of cost of education, duration of education, and then you compare that with other disciplines with similar cost and duration of education, the compensation tends to be lower. There's high requirements for administrative burdens. There's a lot of paperwork increasingly in our field. I can't even say how many practitioners I have seen who are in jeopardy of losing their jobs, or in jeopardy of some kind of negative sanction within their job, because of the administrative piece of the job, right?

Excellent clinicians, terrible at paperwork, terrible at administrative reviews, and really frustrated as well because their sense may be that they didn't come into the field to do-- I can't tell you how many times I've heard that, "I didn't come into the field to do paperwork," but yet paperwork is the thing that shows up under performance evaluation consistently as their albatross. These are the kinds of things that pop up.

It's also a context that pulls for work-life balance, I would say. It really is a context and in any context where the resources available don't match the demand, and you throw into that, people who got into a role where their tendency was toward being a helper, that pull to overextend into other areas of your life being underscored or underfed as a result of the dedication to work, or organizations that themselves don't have sufficient resources, really depending on the employees who are invested.

That certainly becomes a strand for work-life balance. These are the types of things that might be impacting our care teams. Let me just ask at this point, does your office have an overarching workforce development plan for mental health and SUD staff? Do you have some kind of system that is clearly codified that you use to guide your workforce development?

[pause 00:17:13]

Kerry King: We're approaching about half of participants having responded, but so far, there is a clear trend indicating that this is not the case. Just give it a couple of more seconds. It looks like, for most folks, the answer is no, there is not a workforce development plan. I think we're okay to end the poll. I was seeing the results, but you were not.

Now, you can see that 53% of you indicated, so a little bit more than half, that there was not a workforce development plan in place. That didn't mean that the rest of you said that there was. Many people were unsure. For those purposes, that's pretty close to a no as well. Less than 20% of people

were clear that your agency has some plan for how to address workforce development. All right, I'll stop sharing. Okay.

Kerry King: I would say that you're in good company. That's not uncommon. It's certainly something that warrants addressing, but you're in the right place. How do we bridge the gap, and how do we prepare for the future? This is one of those things where you have to think, "What can we do in the near term?" How do you stop the bleed, versus how do you plan for rehabilitation?

Some of the shorter-term strategies in terms of really just stopping the bleed is using your staff who are cross-trained, and I would say cross-training staff. You cannot deploy cross-trained staff if you do not have cross-trained staff. The example that we use here is a primary care provider with mental health training or SUD training. That's really helpful when we start talking about screening, assessment, brief intervention in office and within the context of the practice.

You might be talking about a primary care provider that knows how to utilize motivational interviewing techniques and who is able to screen for an alcohol use disorder in office. Therefore, this does not require an individual to present to a primarily SUD-serving agency in order to be screened for this condition. They can be screened by their primary care provider, thereby supporting identification and then referral to treatment.

We have to think past the moment, and we really have to think about, well, what do we want to do to ensure that we have adequate role coverage across the domains? I'll talk more about additional strategies later on, but we really have to begin to think about how do we shape our partnerships such that we are developing the future-facing types of roles that we need. I'll talk more about that in a little bit.

We're talking about roles like mental health and SUD-informed care coordinators, so people who have visibility. Now, when I was early on in the system, and there was a piece in my career past where I worked for managed care. I would do lots and lots of onsite reviews. I could walk into a clinic with my eyes closed, look at their charts, look at their treatment plans, and I could tell you whether or not they were a primary SUD-serving agency or a primary mental health-serving agency.

Now, the individuals showing up for care are not necessarily different, but the tendency to be overly focused on one domain of an individual's presentation more so than the other was an artifact of the training and the setting, right? If I walked into an agency and let's say that Kerry presented with major depression and alcohol use disorder and I presented at an entity that saw itself as primarily mental health-serving, there was a very good likelihood that all of my goals, all of my strategies, and all of the interventions would very heavily focus on depression, but really not address my SUD concerns, or vice versa, where I might see lots of interventions around my alcohol use disorder, but not a lot for my depression.

That might look like the kinds of recommendations that we make for continuing care. We might see that engaging in a community-based peer fraternity, such as AA (Alcoholics Anonymous), might be recommended, but nobody might talk about engaging in a supportive living room environment, for instance, to address my mental health concerns, right? That's to the extent that we are cross-training staff in mental health and SUD-informed care, they are better able to attend to and facilitate connection with all of the relevant systems of care, including physical health.

Developing roles like integrated care navigators who really are trained to attend to the whole person. I always say, Kerry, before seeking care, should not, as the patient, have the responsibility to decide whether or not today I'm going to get my depression treated, or today, I'm going to go get the sick feeling in my stomach that I suspect might be an ulcer, or today, am I going to go get my alcohol use disorder treated.

The reality is that all three of those things might exist for me in context with each other. To the extent that my team is able to attend to them, they get treated contextually versus being treated individually by multiple individuals who may really be treating the same core symptoms, but not coordinating around that care. Then it's important for any future roles around integrated care to also leverage the technologies available.

Increasingly, as individuals, particularly as we look at strategies for engaging rural communities, are engaging increasingly with digital health platforms and apps and using telehealth, that we are training digital health coaches and that we are also training our telehealth team members. Important to know your community, recognize your community's needs, determine what your community risk assessment says in comparison with the composition of your team.

Some of these roles that we'll talk about today may not be relevant in the context of your agency, and that's okay. What I will share today are some best practices, but it's really important to consider them in the context and the light of your organization. That's really relevant to this next slide around sample team composition. Now, some people will be looking at this slide and saying, "Oh, yes, we have them. We have them. We have them."

There are other people whose blood pressure just spiked immediately looking at this slide because you think, "Oh, my goodness. There's no way. We don't have this, and we don't have the budget for it." Remember that some of this is what would be ideal future state, right? If we were going to consider who are the individuals that we would want to see represented on an integrated care team, this represents those individuals.

Your mental health and SUD treatment practitioners, but also support specialists, your care coordinators. Someone who's attending to housing needs, employment needs, helping individuals handle money and financial matters, because we know that these are factors that impact individuals' outcomes in clinical settings and in real life, right? Peer specialists, someone who has had the experiences of seeking recovery and resilience in the way that individuals seeking care do, and are able to support them differently.

Then we're looking at our clinical pharmacists and psychiatric providers with specialties across the lifespan. Ideally, your primary care providers, your psychologists, your marriage and family therapists, really, this list could be a lot more robust, right? In reality, these are some of the roles that we would like to see available. Now, does every individual seeking care need all of these people on their care team? Absolutely not. Absolutely not.

An individual showing up who has stable employment, who owns their own home, who is typically functioning by all measures, and has a major depressive disorder diagnosis that is typically well-managed, who might be coming into the office once a month for a med check and an individual counseling session does not need an integrated care manager, does not need a money manager, does not need a housing referral. It does not need all of those things.

It may need some check-in around whether or not they're seeing their primary care provider, whether or not there have been any changes in their physical health, those kinds of things. Care coordination still needs to happen to the extent that we are always attending to the factors that influence whether or not a person is getting better and staying better and whether their trajectory for staying on that path looks good.

To that extent, there's always a measure of care management, paying attention, boundary spanning. Who else is involved? Who else should be involved? Who are your support people? That does not necessarily need to be a role on your team. Here now, I'm really talking about risk stratification, which is beyond the scope of this webinar. Sufficient to say that people become really overwhelmed when they start thinking about who needs to be a part of their team, and how will we provide all of this for everyone?

The answer is that you don't. You don't need to provide all of this for everyone. What you do need is the ability to understand who needs what and to have adequate access to an integrated care team that can provide the level of scaffolded support that's required based on the needs of the individual or family. That's the, kind of, "Who's on your team, and does everybody know what their role is on the team?"

These are just examples that we pulled out. I'm really not going to even go into a ton of depth in them because the point really here is whoever is on your team needs to understand what they're expected to do. Why are they there? What is their role within the team? Certainly, what is their role for the

individual or the family or the group that is receiving care? It's very important for your organization as well to define the competencies of the individual, right?

It might be just, first of all, are they skilled in their discipline, and how do we know that? What are our indicators? Are they able to work within the team? What would be the indicators of that? What kinds of additional skills do we want them to have so that this integrated care coordination works well, and how do we provide training to support that? Do we need to support skill development in screening and brief intervention? Do we need to support skill development in care coordination, risk stratification, virtual care literacy?

Even leveraging AI (artificial intelligence), there's so many potentially useful things that are available to us, but really, as a team, having a unified approach supported by training so that everyone within the context of the team knows how what they're doing is supportive to the rest of the team. Another thing that comes up when you have an integrated care team is, well, all right, how do all these pieces fit together? This harkens back to some of what I was talking about before. We can think about this as four layers of the team. The session team is the individual or individuals who see the person seeking care on the day that they show up or in the encounter in which they show up. That's your session team.

Your planned care team is your treatment-as-usual team. There will certainly be individuals on the session team, but I might not see everyone on my planned care team every time I present for care. I may not see my psychiatrist every time I present for care. I may not see my primary care specialist every time I present for care. I might see my group therapist every time I present for care. I might see my case manager or my nurse navigator. Who is the planned care team is the treatment-as-usual team, all of the individuals, but the session team is who's going to touch that patient during this particular episode of care.

You might have multiple planned care teams, groupings of planned care teams who work together in pods. Having disciplines across these teams really allow you to also provide coverage. If, for instance, your psychologist is on maternity leave, you might be able to borrow coverage from another pod to provide support. You might be able to pull in a nurse who is able to do a quick panel on someone, even though they're not a part of their ongoing and care-as-usual team.

Then you might have what you call your complex care management team. I think of these as your bolt-on staff. These will be the people who you bring into play for individuals who have a higher level of complexity, and who you bolt onto your care team will certainly depend on how that complexity presents. You might have individuals who present with more complexity in needs for the kind of external supports that impact their day-to-day well-being.

They might need someone to help them figure out their money, someone to help them sort out housing, someone to help them to secure job skills. That might not be typical for most of the individuals seeking care, but it would be something that would be required and would be considered an increased level of complexity for others. It might be bringing in consultation with an infectious disease specialist or someone who can look to assess for ambulation difficulty.

That might not be something that would be typical. It might be someone who is going to make an assessment about whether someone is in need of a higher level of care. There's various ranges across your physical, mental health, and substance use needs that might require us to bring in more complex care team members. Now, that does not mean, and so it should be very clear within your team, for how long those members stay engaged, because it certainly is not one of those things where once I receive a nurse navigator, I need a nurse navigator forever.

That might be true that I will continue to need a nurse navigator across my trajectory of care, but it might not be. It's really important as well to not only have flags for when we increase the complexity of the care team, but when we decrease the complexity of the care team. Remember, one of the things that we're trying to do is be efficient in the use of resources, not burn out our team members, and also not overburden our clients with care that they do not need, because that's also negative in terms of its impact on outcomes. We want to be mindful of how we onboard individuals in integrated care.

Again, back to my example, if you're used to working just you, it requires some training around how do you work as us. Being clear about what the onboarding program looks like with supportive mentorship, one of the things that we don't do in our field is supervision. Whenever we get busy, the first thing that gets dropped is mentorship and supervision, but it also is one of the things that's really tied to fidelity of outcomes.

It's really tied to how well our teams are continuing to function as intended, as scripted, how well individuals within their roles are functioning, whether or not evidence-supported practices are being delivered with fidelity. Really, coaching, mentorship, supervision has strong impacts on that, but that is typically the first thing we stop doing when we start feeling bandwidth strain.

Important to have a clear mentorship program, have legitimate mechanisms in place for peers to support each other within disciplines, and to be clear with folks about what their potential career trajectory is. A lot of my career was in executive spaces within, primarily, SUD and mental health, co-occurring disorder treatment facilities. In that context, many individuals who themselves were in recovery would want to give back, become peers or gain entry-level roles into the profession.

One of the things that was really frustrating was that there was no deliberate career trajectory, that there was no deliberate path for education and training beyond their own interests within the context of many organizations. There just is not a path to grow and develop and to begin to gain competence beyond what you've walked into the organization with. Really important to have that be a part of your process.

This includes being clear about the team workflows we talked about before, making sure that everybody knows what their role is on the team, where they jump in, where they step out, who they communicate with, what their expectation is around communication. I'm going to talk about that in a little bit as well. I already hit on supervision. We also want to be doing training on the use of certain standardized tools. What is our philosophy around care planning? How do I engage patients in care planning? How do I engage family members and other supportive others in care planning?

Then the logistics, where do I chart it in the electronic care record? Is there a system where if nursing does not chart their assessment, clinical can't do theirs? This is team workflows. Are there contingencies in your workflows? It's important for people to understand if their work is impacting the work of other people. If I'm going to use information from the nursing assessment to inform a biopsychosocial assessment or something like that, it's just really important for individuals not only to have the workflow for their role, but understand contextually how workflows go across disciplines.

Having team dashboards that might be sharing information, whether it is about population health or whether it's information about a particular group of individuals who are seeking care, or if it's individual information about key performance metrics or indicators, it's just important to train on those dashboards and expectations around viewing those dashboards, especially if those dashboards contain flags from other disciplines that are informing other team members about pertinent information to the individual's care, that might be germane to decisions that they make in their episode of engagement.

Just trying to be mindful of time here and checking in. I think we're still okay. All right. Let's talk about how you structure the various types of communications and really making them efficient. Lots of meetings in organizations, not always many focused meetings in organizations. Just really important for us to define who talks to whom, who is responsible for bringing what information into that context, and what is the purpose of those contacts.

Huddles are quick team communication meetings. If we were going to talk about who was going to be in the huddle, it might be the team that sees the individual on the day of care for the episode of care. That's typically who's going to be involved in that huddle. There may be a rationale for your larger contextual care team to be involved, but typically, the huddle is really about immediate, emergent handoff of information that requires care coordination in that day, if we're talking about 24-hour level of care, or in that episode, if we're talking about a care engagement where people are coming into a setting for an appointment or a visit and then leaving.

It only includes the team members that are necessary to review the key workflow, its information that might have emerged since the last huddle. It typically is an opportunity to look at schedules or the people who were referred for psychiatry who no longer need psychiatry because something has been resolved and we're going to take them off the list. Is there somebody that we need to prioritize because we are aware that they have had a crisis episode of some kind and they're returning to care? It's really important that we see that individual today. No matter what, they get seen.

Is there someone who's due for a particular screener that must be done? It's important to assign those tasks to someone. Not sufficient to say, "Hey, Kerry's going to need a screener today." It's important to also say, "Joan, you're on point for Kerry's screener and you will report in evening huddle what the outcome was. Okay, thank you." Or "You'll call Dr. G and make sure that he is aware because he needs to know this before his 10:30 appointment with her." Those kinds of things. Those are the things that need to happen in a huddle. It should be quick. It should be efficient. It really is about just making sure people have the information that they need to be able to perform necessary task.

This one is probably more what people think about as meetings. Unfortunately, a lot of these types of meetings are happening at the beginning of shifts and it can be a little bit of overkill. This is a weekly or a biweekly meeting, and it really can be focused on depth of clinical exploration of a particular individual's needs. It can be a strategic meeting, it can be an operationally focused meeting. These types of team meetings are longer and they involve the broader care team.

The opportunity to look at complex cases. This is the teaching opportunity. This is also an opportunity for all of your various disciplines to share input and collaboratively brainstorm. It's a great opportunity to consider any needs that might be getting left out. It's a great opportunity to look at trends in screeners and assessments for particular clients who seem to not be making progress at the expected level.

It is a great opportunity to consider the trends of improvement across our population, across our programs, and flag where they may be opportunities for improvement. Always great to celebrate our successes and our achievements. It also can be a really good opportunity for team members to really just debrief after critical incidents, after something difficult has happened, to level set, to support each other.

It's a good opportunity to determine whether or not some of those bolt-on team members that we've talked about are necessary, and making decisions about who needs to join someone's care team, who needs to be removed from their care team. That might be internal resources and external resources. We're going to talk in this last section, which we will do pretty quickly, about your capacity, your perception of your capacity to assess and assist, ooh, it's afternoon, staff who are exhibiting signs of burnout, frustration, feeling overwhelmed.

[pause 00:45:05]

Kerry King: Okay. Looks like responses are slowing down, so we can probably end the poll. All right. You'll see that most folks indicated that they at least feel somewhat capable. Some feel capable, and then a few feel quite capable. Typically, there's some self-perception at least understanding or being able to perceive when your team is showing signs of burnout. Okay, I'm going to stop sharing.

We're going to talk about just some very high-level strategies for supporting well-being of our team members. One clear strategy is just making sure that people are being assigned a reasonable level of work. I often ask in organizations whether or not they have done a time study for their practitioners. Do you know what is a feasible caseload? Typically, when I ask that, I get told things about what a particular reg says. That's not the same. What I'm asking when I ask that is, do you know how many hours it legitimately takes to do the work that's been assigned?

If someone is assigned to do three IOP, intensive outpatient groups, per week for eight clients in each group, what does that look like in terms of planning time, direct engagement time, documentation time, utilization review with payers, training? Then you always have to leave time for the stuff that pops up. I remember walking into an agency and doing a time study and realizing that there was one practitioner in particular who, if they were doing their job reasonably, not if they were doing it well, if

they were doing their job reasonably, they would need to work about 65 hours per week. That person was on an action plan for not doing their work in a timely manner.

That would be an example of not having a realistic caseload. This was a really hardworking clinician who was feeling particularly demoralized because they could not keep up with the work. They were beloved by patients, seeing really good outcomes, and on an action plan because they weren't keeping up with their paperwork. When we looked realistically at what they were being asked to do, they couldn't do it in 40 hours. Sixty-five hours would have been-- and remember what I said earlier about work-life balance, that blows it up right there. There's no way.

Then in addition to that, we still have to make sure that we're protecting time for certain things. If you want people to have huddles and have case consultations and go to trainings and really attend and apply that information and be willing participants, it has to be a structured piece of their professional time. It has to be built into their FTE (full-time equivalent). It has to be built into their work.

We want to make sure that we are creating deliberate times to debrief when difficult things happen. This can be very heavy work. It has to be intentional, it has to be built in. We want to host peer support networks. There have been times where I, as the leader, have not necessarily needed to be in the room. Sometimes I was the thing they needed to talk about, but facilitating that happening and being able to receive the takeaways, but not necessarily being at the helm of it, knowing the difference, knowing what supports your team requires, but making sure that you have a repertoire of them to be able to offer.

This might look like utilizing your employee assistance program and sharing information about that, making folks know that burnout is real and that you understand it and support it. There are some organizations that offer a stipend toward seeking your own care and support. It's a blanket stipend, for instance. You never have to say, "Hey, I'm having a challenge. Can you give me the number for the EAP (employee assistance program)?" You just get a stipend that supports.

Or as a part of an ongoing communication, you might just share resources for signs of burnout or signs of overwhelm and what you do if. "Here are the support systems." Really setting a precedent in the organization that this is what we do so an individual who needs to rely on these services or groups that need to rely on these additional support services don't have to feel as though they're being singled out or somehow they're weak or that they're letting the team down because they need to engage in self-care. It really does need to be something that is clarified across the board that, "This is the way that we function. This is how we take care of each other and ourselves in this organization."

Encourage people to take their vacation. Please help people to understand that carrying over more than 50% of your vacation year over year is not a sign of being a good clinician. It's a sign of being a person who's at risk for burnout. It's those kinds of things. Really important for supervisors to lead by example. Being the ones who are well-versed in all of the stuff that I talked about before, understanding the various roles, functions, workflows within the integrated care team.

Being able to be themselves cross-trained and being able to support the team in myriad ways as is required. Respecting and supporting that supervision time. Being willing to reinforce the boundaries. Sometimes that looks like having the hard conversations. Knowing the resources and pointing your team toward resources. Always being available for your staff’s input and feedback, but that needs to have deliberate mechanisms around it too.

How often are you doing true staff surveys? How are you showing your team members that you're taking that input and that you are applying it so that it informs the way that organizational policies or workflows function? How often are you retraining on the basis of the information that you get through those feedback loops? Those kinds of things really send strong signals in organizations that you are attending to, mindful of, and deliberate about your engagement and your support of your team being able to not just do their job, but being able to themselves show up, be functional, and feel good as whole human beings.

Sometimes that might look like building our strategic partnerships and pipelines. HRSA has a Bureau of Workforce Development that has resources. It might look like investing in some of these community partnerships. This is not work that you can do alone. Academic institutions are great partners because

they are training workforce and they really always want feedback about what do we actually want in the workforce. Mentorship and training programs and clerkships and internships, those are great adjunctive workforce strategies.

Including trainees on your integrated care teams is also really important. I find that trainees can really bring new energy. I will also say it's very important to include some of your adjunctive clinical roles as well. When we talk about workforce development, oftentimes your mental health aides may not be included in your team meetings because they aren't seen as true clinicians. They also have great insight into what may be happening with a client. It is an opportunity for them to learn on the job and get key insights themself.

We want to attend to continuous quality improvement. What are you monitoring? What are you gathering? What is the information that allows us to know that this is going well? I've talked about gathering staff surveys. What do you do with that information? Where do you display those analytics? Do you pay attention to what your staff retention and turnover numbers are telling you? Are you paying attention to whether or not outcomes look better for individuals who are on care teams? How certain care teams may or may not be functioning together, does that inform the composition of your care-as-usual team? It's really important to make sure that we have that information.

Key takeaways. This is really just a summary of what we've covered very quickly today. At least it feels like it went by quickly to me. Making sure that we have structured team meetings and that each meeting we're clear on the purpose, clear on the roles of the team members. We are assigning team members, team composition based on the risk stratification of clients.

We are supporting a clearly defined onboarding process that involves mentorship, peer support, and career path discussions, deliberate opportunities for professional development. We are promoting actively wellness initiatives, resiliency support, and stress management, and we are gathering data that lets us know whether or not how effective we are. All right. With that, I am going to actually hand over to you, Kayla. I think maybe I went a little over my allocated time. I'm going to hand over to you, Kayla, and also open up for any Q&A.

Lisa Jacobs: No worries, Kerry. That was a wonderful presentation, and really actionable. Just returning back to, really, that bedrock principle that you led with, that cross-training is essential in integrated care settings. We had one behavioral health provider share that working as part of a medical care team, they get a lot of back fights in terms of learning or practicing with mental health and substance use disorder knowledge. Staff have shared with her that they don't feel comfortable asking questions to understand those challenges that people are facing when trying to access care. Kerry, what strategies would you recommend to address this challenge?

Kerry King: Yes. I think of two things immediately. One thing I think of is education for the team. It's so important to understand the impact that you can have if you engage in this way. I'm thinking about a training I did recently on compassion and the impact of compassion for practitioners, and pulling out a piece of data that talked about the 45-second engagement that changed the trajectory of outcomes for clients, and how illuminating that was for practitioners who might otherwise have said they don't have time for that.

Similarly, finding those nuggets to be able to say, "Okay, here's the impact that inquiring about SUD or mental health concerns will have." Sometimes people shy away from asking these kinds of questions because they feel really out of scope and they don't know what they're going to do or say if they get a yes answer. It's not sufficient to put people into the crosshairs and say, "Oh, yes, go out there and do this screener and ask."

There needs to be also training that says, "What do I do when I get this response? Who do I leverage within the team? Who else can support me? What resources are there that are available?" Because you really don't want to have them lose credibility by asking a question and then not being able to provide a support. Really, education. On impacts, but also training, support, and availability of resources on the backend.

Lisa Jacobs: Kerry, thank you so much. It looks like we are running out of time. It did go fast.

Kerry King: It did. [chuckles]

Lisa Jacobs: For everyone on the call, the slides are available. If you check the chat, there is a link to download them immediately, or you'll receive an email after the presentation with the link. I'm going to turn this back over to Kayla to close this out.

Webinar support: Thank you so much. We offer mental health and substance use disorder continuing education units for participation in our technical assistance events. You must attend the event and complete the online Health Center TA satisfaction assessment form after the event. CE (continuing education) certificates will be sent within five weeks of the event from the TA team via Smartsheet.

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Thank you again for your attendance. This does conclude today's webinar, and you may now disconnect.