Opportunities for Strengthening Behavioral Health Workforce Capacity in Nevada

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Nevada Statewide Mental Health Workforce Development Forum
October 7, 2016
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Clinical Assistant Professor, Department of Health Behavior and Health Education
Presentation Outline

I. About Us: Behavioral Health Workforce Research Center
II. Profile of Nevada’s Behavioral Health Workforce
III. Data Limitations Impacting Workforce Planning
IV. Best Practices: Case Study of Team-based Care
V. Behavioral Health Scopes of Practice: Impact on Workforce Capacity
About the BHWRC

- Established September 2015 at the University of Michigan School of Public Health
- Part of HRSA’s Health Workforce Research Center Network
- Jointly supported by HRSA and SAMHSA
- Work through a Consortium model
- Interdisciplinary core research team with expertise in: public health systems, health services, social work, qualitative methods
Core Research Team

Faculty

Angela Beck, PhD, MPH
Director

Matthew Boulton, MD, MPH
Deputy Director

Brian Perron, PhD, MSW
Investigator

Kyle Grazier, DrPH
Investigator

Elizabeth King, PhD, MPH
Investigator

Staff

Jessica Buche, MPH, MA
Program Manager

Phillip Singer, MHSA
Research Assistant

Cory Page
Graduate Research Assistant
Partner Consortium

- National Council for Behavioral Health
- NAADAC, the Association for Addiction Professionals
- Community Partners, Inc.
- Southwest Michigan Behavioral Health
- Behavioral Health Education Center of Nebraska
- National Association of State Alcohol and Drug Abuse Directors
- Association of State and Territorial Health Officials
- National Association of County and City Health Officials

Consultants:
- Ron Manderscheid, PhD
- Peter Buerhaus, PhD, RN

Federal Partners:
- HRSA
- SAMHSA
“A Workforce Crisis”

- Increased demand for behavioral health services
- Too few workers
- Poorly distributed workforce
- Need for additional training
- Emphasis on integrated care and treatment of co-occurring disorders
- Lack of systematic workforce data collection
BHWRC Focus Areas

Minimum Data Set
- Individual Data
- Organizational Data

Characteristics and Practice Settings
- Workforce Diversity
- Service Provision to Special Populations
- Team-based and Integrated Care
- Core Competencies
- Telehealth
- ACA Changes

Scopes of Practice
- Legal SOPs
- Professional SOPs
- Studies on Specific Disciplines and Services
- Billing Restrictions
Who is the Behavioral Health Workforce?

Addiction Counselor  Psychiatric Nurse  Peer Counselor
Psychiatric Rehabilitation Specialist  Case Manager  MARITAL AND FAMILY THERAPIST
Licenced Professional Counselor  Psychiatrist  Peer Support Specialist
Psychiatric Health Worker  Community Health Worker  Clinical Social Worker
Peer Navigator  Aide/Technician  Behavioral Health Specialist

Anyone involved in prevention or treatment of mental health and/or substance use disorders.
Profile of Nevada’s Behavioral Health Workforce
Behavioral Health Workforce: Nevada

Psychiatrist: 14%
Psychologist: 17%
MFT: 14%
MH Counselor: 13%
SA/BD Counselor: 13%
MH/SA Social Worker: 13%
Psych Aide: 18%
Psych Tech: 21%

N=3,260

Workforce Composition

## Provider Supply

<table>
<thead>
<tr>
<th>Provider</th>
<th>U.S.</th>
<th>Region IX</th>
<th>Nevada</th>
<th>State Rank</th>
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<td>24,060</td>
<td>3,990</td>
<td>40</td>
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<td>105,600</td>
<td>22,270</td>
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<td>16,480</td>
<td>580</td>
<td>0.59</td>
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<td>Psychiatric Aide**</td>
<td>69,550</td>
<td>3,110*</td>
<td>560</td>
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<td>Psychiatric Technician**</td>
<td>58,450</td>
<td>9,280</td>
<td>70</td>
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</table>

*Clinical, Counseling, School Psychologists  
**Missing data for some states  

Location Quotient: ratio of the area concentration of occupational employment to the national average concentration.  
LQ>1 - the occupation has a higher share of employment than average  
LQ<1 - the occupation is less prevalent in the area than average.
Provider Demand/Population Needs

• To determine SHORTAGE, you have to know what size and type of workforce you need

• Studies show that Nevada:
  • Has prevalence rates of mental illness at or above national averages\(^1\)
  • Challenges with mental health service utilization: waiting periods, not enough providers\(^2\)
  • Has 54 HRSA-designated Mental Health Professional Shortage Areas\(^3\)

• Our challenge is determining ideal workforce size, composition, and methods of service delivery

\(^1\)SAMHSA. Behavioral Health Barometer, 2015.
\(^3\)HRSA. Mental Health HPSA, 2016
Strategies for Strengthening Workforce Capacity

Better workforce data collection to inform planning efforts

Embrace best practices: utilization of team-based care service delivery models

Assess and refine legal scopes of practice
Data Limitations Impacting Workforce Planning
How Many Workers Are There? It Depends.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Institute of Medicine Report*</th>
<th>Mental Health, United States, 2010*</th>
<th>Other Sources (Membership and Licensing)</th>
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<tbody>
<tr>
<td>Psychiatrist</td>
<td>23,140 (BLS, May 2011, estimate of psychiatrists (SOC 29-1064). Excludes the self-employed.)</td>
<td>24,758 (American Psychiatric Association, 2006, membership. Excludes students, residents, fellows, international members, and inactive members. Not all psychiatrists are members.)</td>
<td>50,981 (American Medical Association, 2012, Board Certified Psychiatrists. Includes psychiatrists who are not practicing (e.g., researchers or retired).)</td>
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<tr>
<td>Clinical Psychologist</td>
<td>100,850 (BLS, May 2011, estimate of clinical, counseling, and school psychologists (SOC 19-3031). Excludes the self-employed.)</td>
<td>92,227 (American Psychological Association, 2006, Member Directory. Not all psychologists are members.)</td>
<td>124,000 (American Psychological Association, 2013, members. Includes members who are not mental health providers (e.g., experimental psychologists). Excludes non-members.)</td>
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<td>Clinical Social Worker</td>
<td>115,390 (BLS, May 2011, estimate of mental health and substance abuse social workers (SOC 21-1033). Excludes the self-employed.)</td>
<td>244,900 (Calculated as 79% of the number of licensed social workers (per the Association of Social Work Boards), the estimated percent eligible to hold clinical licenses.)</td>
<td>185,723 (Association of Social Work Boards, Inc., 2011, sum of state-level numbers of MSW’s with experience. May double-count those licensed in multiple states. Excludes those from states that did not report.)</td>
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<tr>
<td>Advanced Practice Psychiatric Nurse (APPN)</td>
<td>19,126 (National Sample Survey of Registered Nurses, 2008, estimates of psychiatric advanced practice registered nurses.)</td>
<td>9,742 (American Nurses Credentialing Center, 2006, Advanced Practice Psychiatric Nurses.)</td>
<td>9,780 (American Nurses Credentialing Center, 2008, sum of state-level numbers of APPNs. May double-count those licensed in multiple states.)</td>
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<td>33,990 (BLS, May 2011, estimate of marriage and family therapists (SOC 21-1013). Excludes the self-employed.)</td>
<td>48,666 (American Association for Marriage and Family Therapy, 2006, Membership Database of clinical members.)</td>
<td>58,007 (American Association for Marriage and Family Therapy, 2013, sum of state-level numbers of fully licensed MFTs from state boards. May double-count those licensed in multiple states. Excludes those with provisional licenses.)</td>
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Minimum Data Set Development

**Purpose:** develop a set of common data elements to improve consistency and comparability of behavioral health workforce data collection and use

- **Data elements include:**
  - Demographics
  - Education and Training
  - Licensure and Certification
  - Occupation/Area of Practice
  - Practice Characteristics/Settings
Existing Behavioral Health Workforce Data: Where are the Gaps?

• Nearly 150 behavioral health workforce data sources have been identified and assessed according to MDS data elements

• Data were rated according to: validity, reliability, frequency with which data are collected, and accessibility of data
### National Data Sources: MDS Content

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<thead>
<tr>
<th>Data Source</th>
<th>Enumeration</th>
<th>Demographics</th>
<th>Education</th>
<th>Training</th>
<th>Licensure</th>
<th>Certification</th>
<th>Occupational Category</th>
<th>Area of Practice</th>
<th>Employment Setting</th>
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## National Data Sources: Usability

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<td>Frequency</td>
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<td>Accessibility</td>
<td>The extent to which data are available for public use</td>
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<td>5</td>
<td>2</td>
<td>1</td>
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</tbody>
</table>
State-based Data Sources
Nevada Workforce Data Sources

University of Nevada, Reno
School of Medicine
Health Workforce Research and Policy Program

Nevada Department of Employment Training and Rehabilitation Research and Analysis Bureau
Addressing Workforce Data Limitations

• Use of an MDS can help with data standardization and quality

• We do not have a data source/comination of data sources that will provide all of the information we need for behavioral health workforce planning

• Unlikely to be a national source for data collection in the near future- can provide technical support on a state and local level

• Licensing boards have a big role in data collection- encourage adoption of MDS data elements
Best Practices: Team-Based Care
The Benefits of Integrated Care

By "integrated", we mean integration of behavioral health and primary care services, as well as integration of mental health and substance use disorder services.

Integrated care has been shown to:

- Increase access to services
- Reduce readmission rates
- Improve patient outcomes
- Reduce reimbursement issues
- Increase employee productivity and satisfaction
- Decrease costs

Overall, the field seems to support the idea of integrated care, but barriers to adoption exist. Integrated care provision can be implemented in many ways.

Team-based Care Case Studies

- **Study purpose:** identify cases of primary and behavioral health care services integration and the effects of implementation on the workforce.

- **Methods:** Completed eight key informant interviews with integrated care sites in MI, NC, UT, ME, GA, CA, NY, and TN. Interviewees included clinical professionals and organizational leadership.

- **Interview themes included:**
  - Composition of workforce engaged in integrated care
  - Worker satisfaction with team-based care model
  - Workforce development and training initiatives
  - Barriers and best practices
Case Study Findings: Top 5 Barriers to Implementation

#1: Clinicians may initially be resistant to this transition: often lack knowledge about integrated care and workflow

#2: Insufficient number of providers: workforce challenges across all roles; clinician shortages

#3: Difficulties in record sharing: particularly for patients with SUD
Case Study Findings: Top 5 Barriers to Implementation

#4: Administrative/workflow concerns: unsure how to implement effectively; physical space constraints make co-location difficult

#5: Lack of financial support for integration: billing and reimbursement obstacles

- Reimbursement structure was not built to really value team-based care (state and federal policies)
- Policy gaps in insurance reimbursement
- Cannot bill for physical and mental health services on the same day

“...you don’t have as many available providers in [behavioral health] as you do in other fields, so access is really not there. We have to increase that access and then of course reimbursement for it.”
Case Study Findings: Best Practices

• Important to get buy-in from leadership and providers at the beginning- work together on developing the model

• Help providers to understand their collaborative roles and importance of developing an ongoing relationship with the team

• Be clear about the benefits: when collaboration occurs, caseloads often feel easier to handle; patients have access to the services they need, and respond better to treatment

• In-house training is key; most providers are not learning skills for implementing team-based care in their degree programs

“...bringing all relevant parties to the table, to the same table, at the same time.”

“The communication is constant between all the team players. Team players have complex treatment cache that they follow based on the level of complexity of the patient and each of the team members are called in and perform their activities, that goes into the medical record and gets communicated throughout.”
Behavioral Health Scopes of Practice: Impact on Workforce Capacity
Scopes of Practice Research

- Legal scopes of practice delineate authority to perform certain tasks

- Professional scopes of practice describe responsibilities/capabilities of different occupations

- There is recognized misalignment of scopes of practices among behavioral health professions driven by:
  - Legal restrictions imposed by states
  - Billing restrictions for services
  - Protection of legal/functional authority by professional groups
Scopes of Practice Research

Key Research Questions:
• For which professions are state SOPs accessible?
• What elements do they contain?
• What is the variability of SOPs across states and occupations?

Project goals:
• Provide greater accessibility of SOPs to the behavioral health community
• Determine whether policy recommendations related to SOP changes are appropriate
Analysis of State SOPs for Behavioral Health

**Purpose:** review every state’s statutes, administrative codes, certification programs, and job classification materials to find scope-of-practice language for 10 behavioral health professions:

- Psychiatrist
- Psychologist
- Advanced Practice Registered Nurse (APRN)
- Licensed Professional Counselor (LPC)
- Marriage and Family Therapist (MFT)
- Social Worker
- Addiction Counselor
- Prevention Specialist
- Psychiatric Rehabilitation Specialist
- Psychiatric Aide
Macro State Analysis

- Compares the names of certifying/licensing bodies, published dates of statutes/rules/materials, and professional definitions across all U.S. states.

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<thead>
<tr>
<th>Variable Name</th>
<th>Type/Code</th>
<th>Coding Notes</th>
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<tr>
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Licensure Variables

• Compares the varying qualifications professionals in each state must have in order to apply for licensure or renewal, such as supervised work experience, examination, or continuing education; also considers reciprocity.

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<tr>
<th>A: Plain language concept</th>
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Available Services

• Compares the varying services professions from each state is legally allowed to provide, such as diagnosis, crisis intervention, or psychotherapy.
Assessment of Social Worker Scopes of Practice

**Purpose:** compare Social Worker occupational SOPs across states for similarities and gaps and assess whether elements should be added to the state or occupation SOP.

**Progress:**

- SOP data is being coded for a macro analysis, licensure, and service variables.
- SOP Documents from all 50 states and the District of Columbia have been collected. The research team continues to code and analyze the SOP data.
- Coding and analysis of SOP data is complete. An initial report will be available in late August.
Nevada’s Behavioral Health SOPs: Best Practices

• Nevada permits MFTs, LPCs, APRNs, and social workers to diagnose behavioral health disorders.

• Nevada allows LPCs and MFTs to be trained/supervised by other licensed professionals.

• Nevada has a licensed position for addiction counselors.

• Nevada has included telehealth authorization in almost all of its professional SOPs. Telehealth provisions are explicitly included in each SOP, as opposed to having a general statute referring to telehealth and who can provide it.
Opportunities for SOP Improvement

• No SOP information found for prevention specialists or psychiatric rehabilitation specialists.

• Many states have a certification board for behavioral health.

• Social workers and addiction counselors are required to have advanced degrees before entering practice, but there are no specifications as to core curricula or academic credit hours each professional must cover in order to qualify for licensure.

• Nevada offers few routes for out-of-state professionals to get a license through reciprocity. This could inhibit quality workers from moving to the state and exacerbate potential problems of having an insufficient behavioral health workforce.
## Services Defined in Nevada SOPs

<table>
<thead>
<tr>
<th>Service</th>
<th>Assessment</th>
<th>Diagnosis</th>
<th>Psychotherapy</th>
<th>Crisis Intervention</th>
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Supervision Hour Requirements

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<th>National Average</th>
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Note: The chart shows the supervision hour requirements for different professions in Nevada compared to their national averages.
Average Supervision Time Required (Months)

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In summary...

Need better data to address workforce size and composition problems

Address barriers to adopting best practices: payment mechanisms, training

Refine legal scopes of practice: lack of license reciprocity is a workforce barrier
BHWRC Future Directions

Will continue to focus our work along several themes:

- Vulnerable/underserved populations
- Workforce factors that impact service delivery
- Discipline-specific studies: initiate studies of other worker groups
Contact Us

Research to produce a behavioral health workforce to meet the nation’s needs

www.behavioralhealthworkforce.org

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Behavioral Health Workforce Research Center

bhworkforce@umich.edu