Immediate Policy Actions to Address the National Workforce Shortage and Improve Care

Introduction

Mental health and substance use treatment organizations are struggling to meet the increase in demand for services, due in large part to a national workforce shortage. The psychological distress of the COVID-19 pandemic on the workforce will continue to impact mental health and substance use treatment organizations' ability to hire and retain staff beyond the pandemic.

A recent survey of National Council for Mental Wellbeing (National Council, 2021) member organizations revealed that nearly all respondents are experiencing difficulty with employee recruitment and retention due to occupational burnout from the COVID-19 pandemic, administrative barriers and historically low compensation rates.

Clinical transformation is essential to addressing the workforce crisis as well as administrative burdens that exist within behavioral health. Health Management Associates (HMA) and the National Council have prepared a series of three issue briefs outlining short-term recommendations to support states in addressing the workforce crisis.

Topics include:

- Policy, Financial Strategies and Regulatory Waivers (November 2021)
- Clinical Care Delivery Models and Digital Solutions (January 2021)
- Strategies to Address Diversity, Equity and Inclusion (February 2022)

Impact of the COVID-19 pandemic on Retention and Recruitment

Morning Consult, a survey research company, found one in five health care workers have quit their jobs since the pandemic began, while 12% have been laid off. Additionally, 31% of the remaining healthcare workforce have considered leaving their work and 79% said the national worker shortage has significantly affected them and their place of work. Staff and employers cited the following factors as contributors to the exodus of healthcare workers:

- COVID-19 pandemic
- Insufficient pay and opportunities
- Burnout

Workforce shortages result in reduced access to mental health and substance use treatment and maldistribution of mental health and substance use providers (Morning Consult, 2021).

Transforming Through Crisis

Occupational burnout and compassion fatigue have pushed workforce shortages to crisis level. The increase in demand for mental health and substance use treatment services, the higher acuity of need due to COVID-19's impact on families, and administrative burden all contribute to the emotional exhaustion and occupational stress that behavioral health providers face. Burnout among healthcare providers is driven by high job stress, time pressure, over-capacity workload, and poor organizational support (Dugani et al., 2018). These factors have been compounded by the COVID-19 pandemic.

The workforce crisis requires immediate action to ensure individuals in need of care receive timely access to quality services. As the pandemic continues, the workforce exodus threatens to buckle the U.S. mental health and substance use delivery system. This brief builds on the first brief, which focused on policy, financial strategies and regulatory waivers outlining recommendations for states to enhance the workforce through clinical transformation. All recommendations have been developed by HMA and National Council subject matter experts, with input from state leaders, to help address provider burnout and improve recruitment and retention efforts.

Immediate Action Recommendations:

The following recommendations are intended to be short-term, state-driven strategies to address the workforce crisis and to enhance recruitment and retention efforts to meet the growing demand for mental health and substance use treatment services.

RECOMMENDATION:

Support the adoption of transformative clinical approaches to care to relieve the burden of increased demand on the behavioral health workforce.

Problem with Current Status:
Limited funding to states and provider organizations has slowed adoption of new models and approaches to care that increase access and quality, while impacting workload and satisfaction of the care team. Integrated care is associated with greater job satisfaction, less burnout and increased access to care (Au et al., 2018)

Potential Solution and Outcome:

Prioritize emergency funding (e.g., Federal Medical Assistance Percentages (FMAP), American Rescue Plan Act (ARPA) funds, state/local cannabis tax dollars and opioid settlement funds) to expand access to integrated behavioral and physical health services across the care continuum to optimize the workforce, reduce burnout and increase job satisfaction.

- Fund technical assistance to healthcare institutions and other governmental and nongovernmental stakeholders on statewide implementation of integrated care, including evidence-based practices such as team-based care, collaborative care and Screening Brief Intervention and Referral to Treatment (SBIRT).
- Promote the adoption of integrated care workforce training on staff roles, clinical interventions, complex health conditions and diverse patient needs.
- Drive the adoption of Centers for Medicare and Medicaid Services (CMS)-approved collaborative care by state Medicaid as an interdisciplinary care model. Collaborative care supports a bundled reimbursement option for integration elements such as care management for behavioral health,

consultation and communication between behavioral health providers and other clinical care teams, such as primary care providers.

- Drive adoption of care management and related reimbursement by state Medicaid, including chronic care management and transitional care management, as well as ICD-10 Z-codes for social determinants of health. Advance currently available reimbursement mechanisms for care management to develop and support care teams.
- Initiate state-led adoption of evidence-based practices such as SBIRT and adolescent SBIRT in pediatric settings that identify and address substance misuse in adults and youth.
  - Expand coverage for screening and assessment of behavioral health conditions in primary care, pediatric settings and women's health to maximize access to care.
  - Prioritize children's mental health screening and assessment in state policy.
    Example: Connecticut legislators have hosted forums with behavioral health providers, state agencies and child experts to identify system improvements for discussion during the 2022 session. Colorado used an interim committee to create a Behavioral Health Transformational Taskforce made up of legislators, state officials, advocates and providers to create recommendations for the legislature to spend $450 million of stimulus funds on behavioral health.
- Leverage emergency funds to support the startup costs of implementing team-based care and care management in mental health and substance use treatment organizations.
  - Strategize a long-term goal of adopting or expanding coverage for reimbursement of these services through existing models or alternative payment models such as value-based payment.
- Initiate all-payer integration initiatives to reduce variability across payers and incentivize integrated care, including team-based care and collaborative care. Utilize managed care organization contract opportunities, value-based payment requirements and investments in state Medicaid system upgrades to support all-payer integration to achieve shared goals related to improved workforce maximization, retention and morale.

Evidence supports that team-based care has delivered:

- Increased access to care and reduced complications (Weller et al., 2014).
- Improved safety and better communication (Smith et al., 2018; Dehmer et al., 2016).
- Decreased burnout, turnover and tension and conflict among care providers (WHO, 2010), and increased productivity and satisfaction (Smith et al., 2018; von Peter et al., 2018).

Spotlight: Clinical Transformation Model

The national mental health and substance use workforce shortage requires immediate attention to restoring diminished morale and mitigating burnout. The Certified Community Behavioral Health Clinic (CCBHC) demonstration offers an opportunity to transform clinics sustainably and is structured to train, recruit and retain highly qualified staff, as well as build a supportive system of care to handle increased demand, with far-reaching impact. **Recommendations for states include:**

Prepare for further expansion of the CCBHC demonstration that has received bipartisan support. The House passed the Build Back Better (BBB) Act on Nov. 19, 2021, which includes several key Medicaid provisions. The BBB Act includes language that would, if passed, allow any interested state and territory to apply to join the 10-state CCBHC demonstration. In essence, the BBB Act would fund additional CCBHC grantee sites ($125 million) and provide $5 million for a TA provider to state officials as they develop their CCBHC model.

Extend the CCBHC model beyond the demonstration utilizing Medicaid state plan amendments (SPA) or 1115 waivers to enhance the workforce. CCBHC status and funding significantly impact an organization's ability to enhance the workforce by offering a sustainable payment mechanism to support the workforce and the training necessary to ensure quality services and local access to care. For states that are not participating in the demonstration, adopt CCBHC standards. The SPA or 1115 waiver should include program requirements at least as comprehensive and rigorous as the current Substance Abuse and Mental Health Services Administration and CMS CCBHC program requirements and prospective payment system (PPS) methodology that adequately covers the actual costs of care.

Support SAMHSA-funded CCBHC expansion grantees in advancing beyond grant funding to adopting the full CCBHC model.

Utilize mental health block grant dollars for technical assistance to plan for adoption of the CCBHC model. SAMHSA guidance can be found here.

Short-term implementation timelines associated with grant programs in a time of widespread workforce shortages remain a barrier to success. Consider advocating for extended implementation timelines and request free technical assistance and support on CCBHC implementation and best practices.

A clear impact:
The adoption of CCBHCs helped organizations expand their workforce, however, only select states can participate in the full demonstration. As a result of becoming a CCBHC, over 9,000 staff have been hired and roughly 41 new positions per clinic were created, including youth psychiatrists and staff representing the demographics of communities served.

See **Appendix A:** Immediate CCBHC Actions for States and Options for Long-term CCBHC Planning Strategies.

RECOMMENDATION:

Identify short-term actions to measure the impact of the workforce shortage and develop long-term strategies for improvement.

Problem with Current Status:
Lack of clear measures limits identification of workforce shortage gaps by geography and provider type, as well as a method to monitor the success of improvement efforts. Current and future burnout among providers could be mitigated by actions from healthcare institutions and other governmental and nongovernmental stakeholders aimed at potentially modifiable factors, including providing additional training, organizational support and support for family, personal protective equipment and mental health resources (Morgantini et al., 2020).

Potential Solution and Outcome:

- Convene providers as stakeholders to actively seek feedback related to the workforce barriers and challenges they face. Use that feedback to inform policy changes that will drive systematic improvement.
- Develop a standardized workforce data tracking system to identify causation and impact of workforce shortage.
  - Measured by states as part of a system of metrics to understand how workforce shortages and mitigation strategies are working, where to focus effort and funding, where best practices are emerging, etc.
    - Examples of measures may include the Maslach Burnout Inventory, Short Form Health Survey (SF-8/12/36), Utrecht Work Engagement Scale, Stress Meter or Mini Z Survey.

> Burnout is presently higher than previously reported rates among providers working during the COVID-19 pandemic, and is related to high workload, job stress, time pressure, and limited organizational support (Morgantini et al., 2020).

- Invest federal relief funds (e.g., FMAP, ARPA) in supporting hiring and incentive programs to address occupational burnout and promote workforce wellness.
  - Support the adoption of digital tools and resources to strengthen the workforce such as Supportiv, a support network for employees to connect with mental wellness peers.
  - **Example**: The American Medical Association's Coping with COVID-19 Caregiver Survey which aided organizations in monitoring and assessing the wellbeing of physicians and care teams.
- Identify opportunities such as the Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR LRP) and the National Health Services Corps (NHSC). The STAR LRP provides loan repayment for individuals working in either a full-time substance use disorder (SUD) treatment job that involves direct patient care in a county/municipality where the average drug overdose death rate exceeds the most current national average overdose death rate per 100,000 people -- as reported by the Centers for Disease Control and Prevention (CDC) -- or in a mental health professional shortage area (MHPSA). Connect with current approved STAR programs to identify lessons learned and to scale future opportunities. NHSC provides scholarships and loan repayments to health care providers in exchange for a period of service in a health professional shortage area (HPSA).

RECOMMENDATION:

Expand the workforce through innovative approaches to building a behavioral health workforce pipeline.

Problem with Current Status:
The pipeline for a new and adequate workforce, including peer support specialists and community health workers, has dwindled. Organizations and systems must adapt recruitment strategies to address shortages and lack of adequate and diverse employees.equipment and mental health resources (Morgantini et al., 2020).

Potential Solution and Outcome:

» Align funding to support training programs to strengthen and enhance the behavioral health workforce pipeline.
  - Invest in improved training, preparation and competency of health professional students to increase access to services and enhance the pipeline.
  - Fund student placements and internships for high school and university students as recruitment pipelines and incentivize more training programs.
  - Encourage collaboration between education and mental health and substance use treatment organizations to identify volunteer and job shadowing opportunities for middle and high school students interested in behavioral health.
  - Analyze and support investments in training infrastructure, including the number of qualified faculty, clinical sites, classroom space, clinical supervision opportunities and budget constraints. Ensure the level of faculty compensation is commensurate with their education and experience to enhance recruitment.
    - Review lessons learned from the social work training field that impact recruitment to the substance use, mental health and integrated care field through enhanced training.

» Explore and support approaches to building the workforce using nontraditional workers.
  - Leverage public health services such as AmeriCorps Programs (e.g., National Health Corps and State and National Public Health AmeriCorps) to develop a public health workforce pipeline and expand coverage for communities most in need of public health services.
  - Consider recruitment of workers displaced by COVID-19, foreign-born trained staff and older people who want or need to work past retirement age.
  - Increase entry-level employment opportunities for high school and undergraduate students in mental health and substance use treatment organizations -- as seen in the Texas statewide initiative -- to move the behavioral health workforce forward.
  - Explore partnerships that support both ends of the pipeline providing meaningful training and experience for graduate students and growth and stability in the future workforce. In Virginia, community stakeholders convened to create innovative partnerships between universities, K-12 schools and organizations to provide meaningful placements for graduate students and prevent school-aged youth mental health crises.

» Support apprenticeship models to create interest in healthcare careers among high school and college students and as a pathway to hire.

» Institute onboarding practices and peer mentorship models that support retention of new workers and streamline cumbersome hiring processes.

» Convene behavioral health providers likely to consider retirement to identify elements to support retention, which may include strategies such as flexible work hours, mentoring opportunities and enhanced compensation for workforce recruitment and retention initiatives.

RECOMMENDATION:

Increase adoption of in-person/telehealth hybrid models of care and advancement of digital innovation/telehealth, identifying and mitigating technology dissatisfiers, supporting flexible work environments and enhancing autonomy in work schedules.

Problem with Current Status:
Workforce shortages result in reduced access to mental health and substance use treatment and maldistribution of mental health and substance use treatment providers. Startup costs, network bandwidth, training and competency limit implementation of mitigation strategies.

Policy Recommendation:

- Support using telehealth and offering flexible work-from-home options as a mechanism to reduce occupational burnout.
- Explore allocating funding to improve electronic health record implementation and test methods to reduce stress and inefficiencies associated with navigating the applications and documentation.
- Leverage competency frameworks and guidance to train providers on approaches to telehealth such as A Framework for Competencies for the Use of Mobile Technologies in Psychiatry and Medicine: Scoping Review (JMIR mHealth and uHealth) and Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders (SAMHSA).
- Expand or support modifications to licensing requirements to provide telehealth services across state lines for all mental health providers and organizations.
  - Examples for how states have waived requirements and leveraged emergency rules can be found here.
- Leverage funding to support provider compliance with the HHS Interoperability and Information Blocking Final Rule to ensure patient data is automated through web-based applications, helping providers by improving coordinated care.
- Cover payment of virtual provider-to-provider case consultation to extend the impact of the limited behavioral health workforce, including asynchronous consultation.
- Ensure clients have digital literacy and competency to access digital care by supporting communities in developing and implementing training and resources. Learn from best practice models such as:
  - The Digital Opportunities for Outcomes in Recovery Services (DOORS) program that offers six to eight weeks of group sessions to develop smartphone skills and competencies for individuals living with or experiencing mental illness.
  - The Nashville Public Library's Digital Inclusion Initiative with Vanderbilt University Medical Center that convenes focus groups to help understand patients' telehealth barriers.
  - Establish a statewide evaluation process to identify and continually improve the effectiveness of telehealth services.
  - Support the adoption of innovative in-person/telehealth hybrid care models through startup funding, with the long-term goal of expanding payment methodologies to cover the cost of providing expanded digital healthcare.
  - Leverage telehealth platforms such as innovaTel and Motivo to expand access to mental health and substance use treatment services and ensure that clinical staff have the supervision and support they need.
  - Utilize innovative data-driven tools such as Owl and Eleos Health, which offer innovative digital solutions to inform clinical decision-making and triage service recipients to the right level of care
  - Ensure clinical staff have the skills and knowledge needed to deliver telehealth or hybrid care services through workforce development companies such as Tri-ad and Relias.
  - Support statewide network availability and client access to equipment to expand the utility of telehealth options.

Adopting virtual and hybrid models of care helps to achieve borderless recruitment, expanding access to care by enhancing the workforce.

Accelerating digital health adoption as a tool to improve access and quality of care will help to ease the burden on the existing workforce.

As mental health and substance use treatment organizations continue to struggle to meet the growing demand for their services, states can take immediate action to address the workforce crisis. Adopting policies that impact clinical transformation will help to support provider organizations on enhancing the workforce to improve access to quality mental health and substance use services.

Appendix A

Immediate CCBHC Actions for States and Options for Long-term CCBHC Planning Strategies

Immediate CCBHC Actions for States			Options for Long-term CCBHC Planning	
Join the CCBHC Demonstration to Launch the Model	**Legislative Action to Implement CCBHC Model**		**State Plan Amendment**	**Medicaid Waiver (e.g., 1115 waiver)**
Kentucky, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, Pennsylvania	Kansas, Illinois, Maine, Texas		Missouri, Nevada, Oklahoma, Minnesota	Texas
States receive an enhanced FMAP for any clinics approved to join the demonstration and convert to CCBHC	States will not receive an enhanced FMAP, but may leverage other Medicaid funds to support implementation		Enables states to permanently amend Medicaid plans to include CCBHC provider type, scope of services, requirement, etc.	Enables states to experience delivery system reform
Vetted outcomes and data from current states	No data or outcomes yet		Does not require budget neutrality.	Must be renewed every five years
Ensures all clinics and states meet uniform foundation for care delivery	Provides some flexibility in crafting the model and its PPS rate		Can continue PPS with CMS approval	States must specify inclusion of selected CCBHC services
Planning dollars are provided by the federal government	No planning dollars provided, but ARPA dollars could be utilized		Cannot waive state wideness; may have to certify additional CCBHCs (phase in)	Can continue PPS with CMS approval
Goal is to establish CCBHC model in federal statute.				

Appendix B

State Examples of FMAP and Other Funding to Address Workforce

- Ten states — Arizona, Colorado, Connecticut, Kentucky, Maine, Michigan, Montana, New Hampshire, Oklahoma and Virginia — have announced return-to-work bonus offerings or similar financial incentives for workers to rejoin the labor force.
- Arizona plans to use FMAP funding to implement several initiatives to enhance the home and community-based services (HCBS) workforce through sign-on bonuses, retention payments, reimbursement for tuition or continuing education, childcare, and more.
- Rhode Island plans to use FMAP funding for HCBS workforce recruitment and retention. Recruitment efforts will include incentives for new hires that will be paid after six months of employment. See more here.
- Maine plans to invest FMAP funds in three areas: timely access to services, innovating service delivery and improving quality and accountability. Approximately 60% of these funds will directly increase wages for the HCBS workforce through special recruitment and retention bonus payments.

References

Au, M., Kehn, M., Ireys, H., Blyler, C., & Brown, J. (2018). Care coordinators in integrated care: burnout risk, perceived supports, and job satisfaction. *American Journal of Preventive Medicine (AJPM)*, *54*(6): S250-S257. https://www.sciencedirect.com/science/article/pii/S0749379718316027

Dehmer, S. P., Baker-Goering, M. M., Maciosek, M. V., Hong, Y., Kottke, T. E., Margolis, K. L., Roy, K. (2016, May). Modeled health and economic impact of team-based care for hypertension. *AJPM*, *50* (5 Suppl. 1): S34-S44.

Dugani, S., Afari, H., Hirschhorn, L. R., Ratcliffe, H., Veillard, J., Martin, G., ... & Bitton, A. (2018). Prevalence and factors associated with burnout among frontline primary health care providers in low- and middle-income countries: A systematic review. *Gates Open Research*, *2*. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6030396.2/.

English, C. I. (2021). Integrated primary care is associated with greater job satisfaction and less burnout among Montana's medical and behavioral health care providers. *(*Publication No. 11701.) [Doctoral dissertation, University of Montana]. *Graduate Student Theses, Dissertations & Professional Papers.* https://scholarworks.umt.edu/etd/11701/.

Galvin, G. (2021, October 04). Nearly 1 in 5 health care workers have quit their jobs during the pandemic. Retrieved January 26, 2022, from https://morningconsult.com/2021/10/04/health-care-workers-series-part-2-workforce/

Kisely, S., Warren, N., McMahon, L., Dalais, C., Henry, I., & Siskind, D. (2020, May 5). *Occurrence, prevention, and management of the psychological effects of emerging virus outbreaks on healthcare workers: rapid review and meta-analysis*. The BMJ. Retrieved from https://www.bmj.com/content/369/bmj.m1642.

Morgantini, L. A., Naha, U., Wang, H., Francavilla, S., Acar, Ö., Flores, J. M., ... & Weine, S. M. (2020). Factors contributing to healthcare professional burnout during the COVID-19 pandemic: A rapid turnaround global survey. *PIOS ONE*, *15*(9): e0238217.https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0238217.

Morning Consult (2021, September). Impact of COVID-19 on Behavioral Health Workforce. https://www.thenationalcouncil.org/wp-content/uploads/2021/10/NCMW-Member-Survey-Analysis-September-2021_update.pdf?daf=375ateTbd56

National Academy of Medicine; National Academies of Sciences. (2019, October 23). Taking action against clinician burnout: A systems approach to professional well-being. Retrieved from https://www.nap.edu/catalog/25521/taking-action-against-clinicianburnout-a-systems-approach-to-professional

Shah, T., Kitts, A. B., Gold, J. A., Horvath, K., Ommaya, A., Opelka, F., & Sandy, L. (2020, August 3). Electronic health record optimization and clinician well-being: A potential roadmap toward action. (2020, August 04). Retrieved from https://nam.edu/electronic-health-record-optimization-and-clinician-well-being-a-potential-roadmap-toward-action/

Smith, C. D., Balatbat, C., Corbirdge, S., Dopp, A, L., Fried, J., Harter, R., Sinsky, C. (2018, September 12). Implementing optimal team-based care to reduce clinician burnout. NAM. Retrieved January 26, 2022 from https://nam.edu/implementing-optimal-team-based-care-to-reduce-clinician-burnout/

Torous J., Jän Myrick, K., Rauseo-Ricupero, N., & Firth, J. (2020, March 26). Digital Mental Health and COVID-19: Using technology today to accelerate the curve on access and quality tomorrow. *JMIR Mental Health*, *7*(3):e18848.

von Peter, S., Ignatyev, Y., Johne, J., Indefrey, S., Kankaya, O. A., Rehr, B., Heinze, M. (2019, January

22). Evaluation of flexible and integrative psychiatric treatment models in Germany -- A mixed-method patient and staff-oriented exploratory study. *Front Psychiatry*, *9, 785*.

Weller, J., Boyd, M., Cumin, D. (2014, March). Teams, tribes and patient safety: overcoming barriers to effective teamwork in healthcare. *Postgrad Med J., 90*(1061): 149-154. https://pubmed.ncbi.nlm.nih.gov/24398594/.

World Health Organization. (2010). Framework for action on Interprofessional Education and collaborative practice. Geneva, Switzerland. https://www.who.int/hrh/resources/framework_action/en/.