

Washington’s Behavioral Health Workforce Assessment: Input from Key Informants

November, 2016

Rachelle L. McCarty, Malaika R. Schwartz, Susan M. Skillman
University of Washington Center for Health Workforce Studies

EXECUTIVE SUMMARY

BACKGROUND

In July 2016, Governor Jay Inslee tasked the Workforce Training and Education Coordinating Board (WTECB) to assess the behavioral health workforce in Washington State. As Washington moves toward greater integration of behavioral health and physical/medical care, the WTECB has been charged with creating an action plan to address behavioral health workforce challenges and training needs to facilitate this emerging integrated healthcare model.

The first phase of this assessment identifies barriers and short-term solutions related to Washington’s behavioral health workforce. These findings were informed by a series of meetings with stakeholders and interviews with key informants, the latter described in this report. Longer-term solutions to the barriers identified here will be evaluated during the project’s second phase in 2017.

The University of Washington Center for Health Workforce Studies (UW CHWS) team conducted the key informants survey in Fall 2016. Potential key informants were identified by the UW CHWS, with input from a wide range of experts. Key informants included clinicians, administrators, advocates, educators, and regulators serving in mental health and chemical dependency inpatient and outpatient facilities, hospitals, schools, and private practice settings. Telephone interviews and online surveys were conducted with 41 key informants over the course of seven weeks. Participants were asked about barriers and solutions, recruitment and retention challenges, and training needs related to the behavioral health workforce in Washington. Additional probes expanded on specific settings, occupations, and incumbent versus new workers’ needs.

This report summarizes the common themes related by the key informants, and provides further background to the workforce-related challenges to providing behavioral health care in Washington.

CONTENTS:

Executive Summary	1
Key Findings	2
Introduction	3
Methods	3
Results	4
Workforce-related barriers to delivering behavioral health care in Washington	4
Issues specific to behavioral health care settings and occupations	6
Issues related to behavioral health education and training	7
Recommendations	9
Discussion and Conclusions	12
References	14
Appendix	15

KEY FINDINGS

Barriers: Key informants described a wide range of barriers that affect behavioral health workforce recruitment, retention, and quality in the state. The most commonly mentioned were:

- Limited availability of quality supervision
- Too few professional development opportunities
- Administrative requirements that compete with patient care
- Limited resources to access education and clinical training
- Low reimbursement rates

Challenges in Settings and Occupations: Key informants described many healthcare settings where it is difficult to recruit or retain behavioral health workers, as well as shortages among specific occupations. The most commonly mentioned settings were:

- Rural facilities
- Residential facilities
- Community mental health centers

The most common occupations mentioned were:

- Chemical dependency professionals and addiction specialists
- Psychiatrists
- Other occupations able and trained to prescribe pharmaceutical treatment for mental health and substance use disorders

Challenges in Education and Training: This was an important topic for key informants, who described many barriers and recommended measures for improving workforce education and training. The most commonly mentioned challenges were:

- Education in evidence-based practice and integration of behavioral health with physical health care
- Too few clinical training sites and trained supervisors
- Continuing education opportunities for the behavioral health workforce

Recommendations: Many of the workforce-related recommendations to improve behavioral health care suggested by key informants were specifically targeted to identified barriers. The most common themes were:

- Increase Medicaid reimbursement rates
- Expand opportunities for programs that provide loan repayment in exchange for service
- Better leverage the use of telemedicine and telehealth to address workforce gaps
- Increase access to clinical training sites and residency opportunities
- Increase the availability of quality clinical supervision
- Increase resources for continuing education and training support

SUMMARY

Major workforce-related barriers to providing behavioral health care described by key informants include pay, rural location, quality education and training resources, opportunities for advancement, and general burnout due to high caseloads working with complex, high-need clients. These challenges leave many employers with inadequate resources to attract and retain a high-quality workforce to deliver necessary behavioral health care services.

Several key informants stressed that only by prioritizing behavioral health and recognizing its value can long-term, actionable solutions be effected. This assessment is one among a number of efforts underway in Washington to improve access to and effectiveness of behavioral health care, and should help inform changes to improve the ability of the state to meet increasing behavioral health care needs.

Washington's Behavioral Health Workforce Assessment: Input from Key Informants

INTRODUCTION

In July 2016, Governor Inslee tasked the Workforce Training and Education Coordinating Board (WTECB) to assess workforce needs across behavioral health disciplines and charged the WTECB with creating an action plan to address these needs. The WTECB assembled a project team involving the University of Washington Center for Health Workforce Studies (UW CHWS) to assess the range of workforce-related barriers to improving access to behavioral health in Washington, and identify recommendations for solutions. The behavioral workforce assessment is one among a number of efforts underway in Washington to improve access to and effectiveness of behavioral health care in the state.

The first phase of the 22-month project focuses on initial findings regarding barriers and short-term solutions related to the behavioral health workforce. Phase II will focus on longer-term solutions to the barriers identified in Phase I, and will provide the Governor's office and appropriate Legislative committees with a final report and recommendations by December 15, 2017 for the 2018 Legislative Session and beyond. Phase I was informed by a series of meetings of stakeholders who identified barriers recommended measures to address them. In addition, the UW CHWS conducted interviews with key informants across the state to further assess the barriers and potential solutions to addressing Washington's behavioral health workforce needs. This report summarizes the information provided by the key informants, providing further details on the workforce-related challenges to providing behavioral health care in Washington.

METHODS

The UW CHWS team identified 277 potential key informants as candidates for in-depth interviews to provide greater context and details regarding the barriers and potential recommendations identified by the project's stakeholder group. Seventy-eight potential key informants were invited to participate. Between August 19th and October 6th 2016, 34 telephone interviews were conducted, most lasting 30-45 minutes. Seven informants who preferred to contribute in writing used an online version of interview questions to provide their responses.

Key informants were in part selected to represent a broad cross section of occupations, behavioral health settings, and geographic areas across the state. Appendix A lists the organizations represented by the key informant interviews, except where the key informant did not consent to have the organization identified. Participants worked in organizations providing services in 19 counties (12 rural and 7 urban) (Department of Health, 2008) and statewide. Key informants included clinicians, administrators, advocates, educators, and regulators serving in mental health and chemical dependency inpatient and outpatient facilities, hospitals, schools, and private practice settings.

This study was classified as "Exempt" from human subjects review by the University of Washington Institutional Review Board. After verbal consent to participate, two interviewers used a semi-structured interview guide to elicit answers to questions addressing barriers and solutions, recruitment and retention challenges, training needs, other suggested key informants, and potential data sources related to the behavioral health workforce in Washington. Additional probes expanded on specific settings, occupations, and incumbent versus new workers' needs. With permission, audio recordings of the telephone interview were collected for reference and clarification as needed to supplement interviewer notes. Completed key informant interview notes were analyzed to identify common themes, and within the themes, specific barriers and recommendations to improve access to and delivery of behavioral health care in the state.

RESULTS

WORKFORCE-RELATED BARRIERS TO DELIVERING BEHAVIORAL HEALTH CARE IN WASHINGTON

Key informants described a wide range of barriers to delivering behavioral health care (mental health and chemical dependency treatment) in the state. Major themes included issues related to difficulty meeting supervision needs; administrative issues related to paperwork; hindrances to professional development; limited clinical training opportunities; and the overarching problem of low reimbursement rates for behavioral health care, leaving many employers with inadequate resources to attract and retain a high-quality workforce.

Challenges in providing quality supervision

The current behavioral health care system creates significant barriers to promoting quality supervision. While key informants suggested that “on the job” teaching that reinforces evidence-based practices introduced in didactic or continuing education settings may be the best means of increasing skills in new and incumbent workers, onsite guidance, training, and skills development requires attention and time. The term *supervision*, as used by key informants, referred to everything from state-required oversight of a degreed professional seeking credentialing to informal mentorship of students and staff by experienced providers.

Supervisory duties are not reimbursable tasks under most payment systems, and so time spent in this role can count against billable productivity for the agency. Persistent personnel shortages and vacancies exacerbate the problem because supervisors must cover for direct care staff, reducing their time available to provide supervision. The unreimbursed burden on agencies leads to a shortage of supervised clinical training sites available for trainees, which is a barrier to expedient credentialing of new workforce entrants. Several key informants noted that having a positive clinical training experience is a strong draw to later employing those trainees upon licensure.

Administrative burden, paperwork and credentialing

Many key informants in publicly funded agencies reported that documentation required for payment and audit was a major contributor to job dissatisfaction. The general sense of the respondents was that the

paperwork required for Medicaid reimbursement was much more onerous than that for other payers and was one reason that many employees migrated to private practice and other clinical settings. Time spent in documentation activities, while a necessity, is not always billable and reduces the overall measured productivity of a clinician. For example, one informant was required to ask minors about advanced directives though they are unable to legally execute such a document.

“Charting fries people. Clients are in distress, clinicians need to be present and can’t hide behind a computer or clipboard. But if they take organic notes, they spend hours doing charting work on their own time. We need to redefine work to include downtime for charting, or create a new class of people to do charting.”

“We love having ... students [in non-behavioral health occupations] at our clinic but they don’t know anything, they don’t have a behavioral health course, so it takes an enormous amount of time to bring them up to speed, with students sitting in in a fast environment you have to have downtime to go over things with them and you don’t get paid for that time.”

Those charged with hiring behavioral health workers were frustrated by perceived delays in processing applications for licensure/credentials, especially for potential hires from out of state. Some key informants disagreed with the Medicare limit to reimbursement for care provided by those with a licensed independent clinical social work (LICSW) credential but not a master's level licensed mental health therapist (LMHC, LMFT). Finally, there was a call to clarify roles in behavioral health care provision of service so that each staff member is encouraged to work at the top of their scope of practice.

Hindrances to professional development and skills training for the incumbent workforce

High turnover rates in behavioral health settings discourage management from committing resources to employee retention, said key informants. This has two major impacts: 1) too few career ladders and clear pathways within the behavioral health professions for advancement, and 2) a lack of supported professional development activities. Community behavioral health agencies tend to attract younger, committed mission-driven people but once in the field many find barriers to improving their skills and few opportunities for advancement. In some settings behavioral health positions have very few wage steps before reaching the salary limit for their job class.

“[There are] not enough renewal activities (professional development, personal time)... [We] need better understanding of the wear and tear on people managing stressors of working in this environment.”

Clinicians want to learn new evidence-based practices and obtain advanced degrees/certifications, but the combination of low wages, high tuition, and difficulty acquiring required supervised hours to licensure dissuades many from pursuing additional credentials. This means lost opportunity for employers as well, because advanced credentials may allow the organization to bill for services at higher rates. Mentorship, even informally, by more experienced clinicians is hampered by the high turnover of experienced staff and extremely high caseloads. Agencies that stress high productivity may not allow sufficient time to participate in continuing education or supervised learning, and may not adequately promote self-care, resulting in burnout and turnover.

Low reimbursement rates

Of the 41 respondents, at least 34 (83%) cited low reimbursement rates, particularly in community behavioral health agencies, as a major workforce barrier to accessing and delivering behavioral health care. One key informant noted that Medicaid rates of payment to behavioral health providers, including both mental health and chemical dependency treatment, are at the bottom of the rate bands in the lowest quartile of the reasonable range for credentialed professionals. Low reimbursement means low salaries, making publically funded behavioral health agencies “non-competitive” in the job market. Key informants used terms such as “poaching”, “vultures waiting to land”, and “agencies cannibalizing each other” to describe the difficulty in recruiting and retaining qualified staff. Most described high turnover in community mental health centers, leading to a severe outflow of personnel to higher-paying private or government agencies or to other states or jobs in other sectors. The resulting instability in the behavioral health workforce increases costs for recruitment and hiring, dis-incentivizes investing in workforce training, reduces the number of experienced clinicians left to mentor newer employees, and decreases worker morale as remaining staff must assume greater caseloads. Many key informants agreed that the pay in the publicly funded settings is not commensurate with the amount of education needed for credentialing and the costs of that education, which may reduce interest in behavioral health occupations as well as the flow of new students entering the education and training pipeline.

“[There] needs to be acceptance of the value of behavioral health and pay for that value...”

“[The work is] mission-driven and people do want to work for that reason but have to pay for their rent.”

Finally, several key informants described a “disconnect” between how behavioral health services are actually provided and how they are paid for. Mental health and chemical dependency treatment, particularly in the public settings where patient acuity tends to be higher than settings with mostly privately insured patients, may require coordination with housing and social services, law enforcement, justice, hospitals, families, or schools. Coordination of care and service referrals may be vital to the success of treatment, but often mean unpaid hours for the providers.

ISSUES SPECIFIC TO BEHAVIORAL HEALTH CARE SETTINGS AND OCCUPATIONS

Key informants were asked in which settings they found it particularly difficult to recruit or retain behavioral health professionals, which occupations’ positions were the most difficult to fill, and whether this challenge varied by types of clients served.

Settings

Key informants consistently reported recruiting to fill vacancies in rural positions was most difficult, as well as resource intensive. Although the cost of living may be less (excepting rural areas with a high retiree population or resort regions), agencies need to offer better compensation packages to draw providers to their area. Concerns about isolation, lack of continuing education and professional development opportunities, and barriers to conducting research or consulting were cited as possible reasons providers eschew rural practice. Filling low-level case manager or front desk positions in rural sites can be just as difficult as hiring licensed practitioners.

Residential facilities also presented some unique challenges. As with other settings, pay is low and patient acuity is high, but in residential facilities “recovery successes are small”. It can be perceived as an entry-level position, and as demand for behavioral health workers increases, fewer are willing to take jobs which require working nights and weekends. Training opportunities for after-hours shift workers are rare.

“[Residential] Counselors have told me they can make more money working for the fast food restaurants.”

Occupations

Though key informants reported shortages in nearly all behavioral health occupations, several professions were most frequently cited:

● Chemical dependency professionals (CDPs)/addiction specialists

In publicly funded settings, there are not enough chemical dependency treatment providers (CDPs, physicians and advanced practice nurse addiction medicine specialists), and demand is anticipated to increase with Washington State’s move toward integration and health care reform. Master’s level therapists who are dually credentialed for mental health and treatment of substance use disorders are highly sought after since they can provide and be reimbursed for the widest range of clinical services.

● Psychiatrists

Less than 4% of physicians nationally specialize in psychiatric health (Association of American Medical Colleges, 2015). Key informants confirmed a critical shortage in this occupation. As psychiatrists are the most highly trained professionals in the medically assisted treatment of psychiatric conditions, substituting a greater number of master’s level professionals cannot entirely fill this gap.

“Employment of substance abuse and behavioral disorder counselors is projected to grow 22 percent from 2014 to 2024, much faster than the average for all occupations. Growth is expected as addiction and mental health counseling services are increasingly covered by insurance policies.” (Bureau of Labor Statistics, U.S. Department of Labor, 2015)

However, psychiatrists are also the most expensive care provider in the mental health system, which may price them out of many settings. Many are in solo practice, and may not have the business infrastructure to support management of third-party payers (Cummings, 2015). Where deployed in publicly funded settings, psychiatrists' services are at times reserved for prescribing only rather than other therapeutic interactions, which reportedly can diminish the job satisfaction for these professionals.

● **Medical “prescribers” with training in mental health and substance use disorder treatment**

Currently, physicians (including primary care physicians and psychiatrists), advanced registered nurse practitioners (ARNPs) including psychiatric ARNPs, physician assistants (PAs), and pharmacists working under a physician’s prescriptive authority may prescribe medications for behavioral health conditions. Medical providers who have experience with prescribing and monitoring patients on psychiatric and chemical dependency pharmaceuticals are in high demand.

Client types

Key informants were asked if there are differences in the ability to recruit or retain behavioral health workers in settings that serve different types of clients. No one population was consistently reported as difficult; rather, several reported that there is ‘someone for everyone’, and for any given client population there is a person whose mission it is to serve them.

That said, a number of key informants did assert that community mental health centers and substance use disorder treatment facilities were particularly difficult to work in because of the nature of the population served there: very sick clients with complex social needs who are often difficult to stabilize, monitor, and serve due to homelessness, involvement with law enforcement and justice, and co-occurring disorders.

“200 beds in a shelter and only 1 shelter counselor is there overnight, or case manager has 70 people on their caseloads; [these situations pose] legitimate safety risk to clients and workforce.”

ISSUES RELATED TO BEHAVIORAL HEALTH EDUCATION AND TRAINING

Education and training were important topics to our key informants, and were readily discussed in terms of barriers and recommendations. At least 11 of 41 respondents (27%) expressed concerns about the qualifications of the workforce pool, suggesting that some deeply committed and well-meaning workers are not adequately trained for the work that needs to be done. Key informants reported that positive experiences in clinical training lead to greater success in hiring and retention, whereas lack of adequate training creates discomfort in practice (as confirmed by Olfson, 2016), reduced morale, and likely leads to poorer patient outcomes (van der Leeuw, Lombarts, Arah, & Heineman, 2012). Providing hands-on experience in real-world settings, from serving high-acuity patients to experiencing rural healthcare, introduces the new generation of behavioral health workers to underserved areas where they might gain competency and have greater success in the workplace. Key informants’ issues fall into three major categories: education received in behavioral health professions training programs, clinical training opportunities after completion of program, and continuing education of incumbent workforce.

Behavioral health professions training programs, including practicums

Issues in the behavioral health pipeline included the need for outreach for behavioral health literacy early in educational pathways to promote interest in these professions, a reported lack of specialty training programs (e.g., infant and child

“We built our history on the 1 on 1 [provider-patient] relationship and that will always be a foundational piece. [T]he adoption of practice guidelines and evidence-based models and use of data ... our academic institutions have not really taught that as well as they need to.”

psychiatric nurse practitioners, child psychiatrists, behavioral health integration coordinators), and the need to provide high-quality and sufficient numbers of practical training sites for students. The most common comment about behavioral health professions' curriculums was the need for improved education in evidence-based practices (EBP), and preparing students to be accountable for patient outcomes. The need for practical skills in documentation, coding, and self-care were also mentioned. Tuition costs were a commonly cited barrier to optimizing the supply pipeline.

Post-completion of training programs, including internships and residencies

For most behavioral health professions, national certifying bodies and state credentialing authorities require supervised clinical training after completion of a didactic education program before one is eligible for full licensure or credentials. Key informants reported a lack of residencies available for psychiatrists and psychologists. In addition, formalized training opportunities for mental health counselors and chemical dependency professionals are limited outside of community mental health centers or community substance use disorder treatment facilities. As a result, these settings readily hire new graduates by providing the required supervision, but generally lose these professionals to higher paying practice sites after the supervision period is completed.

Improving the skills of the incumbent workforce

The most-sought skills training requested by key informants for incumbent workers included evidence-based practices, electronic health records systems, and efficiency in documentation and coding. Several key informants suggested that primary care providers needed additional training to increase their comfort in treating, prescribing for, and monitoring behavioral health clients rather than regularly referring patients to other providers for these health concerns. In treating youth, some key informants recommended that primary care providers needed to obtain further training in best practices to reduce overprescribing and to promote evidence-based treatment alternatives.

"...focus on evidence-based approaches, not just the propriety evidence-based program models, but the whole concept of treating to target, using data to inform clinical care, is the person getting better and 'is what I'm doing making a difference?'"

Education and training to support the integration of mental health, chemical dependency treatment, and primary care

The educational and training needs described by key informants for integration varied by type of agency or provider. For mental health and primary care professionals, many key informants supported increasing provider knowledge in the treatment of substance use disorders, citing how commonly their clients presented with co-occurring disorders (as described by Druss & Walker, 2011). To integrate mental health professionals into the primary care setting, the emphasis was on changing the expectations of practitioners trained in a traditional mental health model (e.g., 1-on-1 hourly therapy sessions, seen weekly, for 12 weeks) to learn and adopt new models of care, including evidence-based brief interventions that can be more readily employed in the clinic setting. There is also need for training practitioners on the importance of addressing patients' behavioral health needs in the primary care setting to reduce stigma and integrate care. For physical health integration in behavioral health settings, behavioral health practitioners are being made aware of how common medical concerns co-exist with mental health and chemical dependency issues and how to be partners and advocates in whole-person health.

Generally, key informants expressed that every health profession needs to break down occupational "silos" to better understand each other's lexicons and practices, promote effective referrals, and best use the talents of a team of complementary professionals in the new integrated settings. There was strong interest in team training and having more opportunities to shadow other providers. As stated by one key informant, "putting people together doesn't make them a team".

RECOMMENDATIONS

Organizations and providers of behavioral health care in Washington are finding creative solutions to workforce-related barriers to delivering services. Many key informant recommendations were general (“increase salaries”, “need integrated inpatient-outpatient system that works”), but the leading specific suggested solutions are reported here.

Medicaid reimbursement rates

- The reimbursement structure incentivizes hiring particular clinicians: LICSWs are reimbursed for behavioral health services by Medicare where other master’s level counselors (LMHCs) are not; and LMHCs instead of associate or bachelor’s level-trained staff due to licensure required for Medicaid reimbursement. It is suggested that payers be allowed to contract with a greater range of professionals to allow flexibility to use non-licensed staff as case managers, care coordinators/navigators, integrative care specialists, peer support, recovery support, etc.
- Create financial incentives to encourage practice sites to offer training positions to interns/trainees by allowing sites to bill for service provided by qualified trainees.
- Create reimbursement codes for time spent providing direct supervision to behavioral health students, interns/trainees, and clinical staff.
- Clarify acceptable treatment settings for children’s behavioral health care and expand covered services to include caregiver-child therapy, evidence-based observational therapy, and family unit work
- Reimburse services provided by peer counselors/specialists in substance use disorder treatment.
- Provide a rate for medical professionals in outpatient addiction treatment facilities to improve treatment of dually diagnosed individuals and opioid misuse.
- Allow organizations that contract with state or county agencies for services to bill at those higher salary rates.
- Increase patient access to private practice clinicians by offering competitive pay rates for like services.

“Many child psychiatrists accept cash pay for services and do so because there is enough demand...that they opt out of many insurance plans.”

Promote team-based and integrated care

- Create a new staff position (Master’s or Bachelor’s level) trained in behavioral health and primary care for tracking and organizing integrated team work.
- Support worker efforts to seek dual credentials (mental health and chemical dependency treatment):
 - Build on the pilot program, funded through a Healthcare Employee Education and Training (HEET) grant, that has created a fast track for Masters-prepared therapists to become chemical dependency counselors via a distance learning course delivered by Whatcom Community College in collaboration with Spokane Falls Community College.
 - Align educational requirements for mental health counseling to include those required for chemical dependency professional credentials.
 - Incentivize existing mental health and chemical dependency treatment staff to pursue dual credentials through tuition assistance, financial support for examinations and licensing fees, along with built-in salary increases once credentials are obtained.

- Provide free, accessible training on best practices in integration, such as from the Center for Integrated Health Services (a joint Substance Abuse and Mental Health Services Administration [SAMSHA] and Health Resources and Services Administration [HRSA] collaborative); and the University of Washington’s Advancing Integrated Mental Health Solutions [AIMS] Center “Collaborative Care” model online resource library.
- Expand capacity for remote consultation models (such as the University of Washington’s Partnership Access Line [PAL], Psychiatry and Addictions Case and Conference [PACC] remote collaboration program).

Improve retention of the behavioral health workforce providing care to underserved populations

- At least 20 out of 41 (49%) key informants cited loan repayment as an effective method to enhance recruiting and/or retaining the workforce. Nationally, there is evidence for this sentiment: four years after completing their National Health Service Corps (NHSC) service commitment, 61% of mental health care professionals were found to have continued to practice in underserved areas. (National Health Service Corps, 2012)
 - In loan repayment programs, expand the definition of “underserved” to include both rural underserved sites and sites that serve high-need clients such as community mental health and chemical dependency treatment facilities.
 - The attractiveness of loan repayment varies by occupation and amount of financial benefit to the recipient. For some high demand occupations, additional incentives may need to be incorporated into a larger recruitment/retention package.
- Offer quality supervision to improve the efficacy and morale of the clinical workforce.
 - Provide training in best practices for clinical supervision (a skill not generally taught in clinical programs), such as statewide management training institutes to ensure agencies meet value-based incentives and quality standards via improved oversight and downstream compliance.
 - Pay for and protect supervisors’ time for mentoring duties.
- Support rural agencies’ efforts to provide training programs (e.g., internships and residencies), because of evidence that providers are more inclined to practice in the areas where they receive training (Fagan, et al., 2015).
- Commit to improving workers’ sense of self-efficacy by promoting professional development.
 - Provide free, accessible training in key areas of interest identified by key informant clinicians: integration, EBP intervention, chronic pain, trauma-informed care, and cultural competence.

“Our clients are made up of a diverse group of people, and the business we’re in is working with clients individually to improve their lives, and the therapist needs to understand their culture to do that, it’s part of the pieces that make up a person.”

“Shine a spotlight on the hard work these folks do. Law enforcement and fire and first responders get recognized for public service—behavioral health workers are working with the same folks but [don’t receive] acknowledgement for the lifesaving work [and] working with violent offenders. Often a social worker is there with law enforcement and not recognized.”

- At least one agency reported using integrated “payback” models to support education and training pursuits as well as retention: they offered financial support for clinical degree programs or EBP skills training in return for a contract to pay back (in the form of payroll deduction) those costs over 2-3 years. It was noted, however, that “payback” programs

are considered a service obligation by the National Health Service Corps and state loan repayment programs, rendering recipients ineligible for those programs.

- Provide financial or advancement incentives for being a “lifetime learner”, especially for highly sought skills or credentials. One key informant gave the example of a basic training in psychiatry course offered by the American Psychiatric Nurses Association as a resource to develop for valued nursing skills.
- To reduce caseloads and burnout of licensed behavioral health and medical care providers, support the development of teams that include paraprofessionals and well-trained staff members to provide triage, brief interventions, screening, motivational interviewing, and assist with care coordination.
- Acknowledge the difficulty of the work of these providers, their compassion, the need for their safety and well-being, and commitment to clients.

Increase access to basic and clinical training for students entering behavioral health occupations

- Promote behavioral health literacy early in educational pathways as a means of increasing interest in behavioral health professions, and to reduce the stigma of the behavioral health field and clients.
- Provide greater resources to increase the number of clinical training sites for students in educational programs, early clinicians working towards credentialing, and specialists (e.g., psychiatrists and psychiatric nurse practitioners, pediatric specialists, and clinical psychologists).
- Leverage stepwise credentials to recruit and train staff while also supporting retention through financial incentives.
 - Consider as a model for behavioral health occupations the “tech-to-nurse program” model from nursing which promotes hiring nursing students before completing their nursing degree by paying them as certified nursing assistants or technicians and providing flexible schedules that accommodate their schooling, in return for their commitment to stay in that work site for two years after graduation.
 - Explore a postdoctoral residency program designed for licensed, master’s level counselors upon completion of their clinical psychology doctoral studies, which allows the agency hosting the residency to bill supervised psychology licensing hours under the master’s credential.
- Increase access to behavioral health educational curricula that convey evidenced-based practices, administrative efficacy, and best practices in integration that are “taught to fidelity”, increase understanding of “treat-to-target”, and promote skills to evaluate outcomes.

Expand the workforce available to deliver medically assisted behavioral health treatments

- Increase the number of psychiatrist, psychiatric advanced practice nurse, and psychiatric physician assistant residencies in Washington State, and provide incentives for entering the field.
- Promote parity in pay between comparable positions in behavioral health and primary medical care.
- Improve the confidence of primary care providers to prescribe to their full scope of practice, including psychiatric medications, through training and specialty consultation services.
 - Encourage access to the University of Washington’s PAL and PACC programs and AIMS Center Mental Health Integration Program (MHIP).
- Increase the confidence and appropriateness of prescribing to pediatric populations through increasing the number of behavioral health pediatric specialists, enhancing the behavioral health training of primary care providers who see children,

“Enhance the support and training for primary care [providers] since they prescribe the majority of psychotropic medication to children...”

and better disseminating effective evidence-based, non-pharmaceutical interventions for pediatric behavioral health issues.

Increase diversity in the workforce

- Examine pathways by which tribes could bill the Health Care Authority for work by Native interns in behavioral health occupations training.

Increase the efficiency of the behavioral health workforce by streamlining paperwork and compliance reporting requirements

- Create more universal billing procedures and regulations to reduce the difficulty agencies and providers face in keeping up with administrative changes, especially for individual and small group practices who do their own billing work.

OTHER SOLUTIONS ENDORSED BY KEY INFORMANTS

Technology

Key informants were enthusiastic about the potential for technology to address some of the challenges in providing effective expert consultation (PAL), improving competency (PACC and virtual meetings between providers), addressing training site shortages (simulation labs), and using online cognitive behavioral therapy and apps like MyStrength to extend contact and support with clients between visits. Some cautioned, however, that with the proliferation of web-based continuing education and consultation resources, targeted providers in smaller and rural sites frequently lack the time to keep up with all of the offerings.

Coordination of care

Key informants from different settings reported challenges to making referrals. As the administrative landscape shifts, familiar resources may disappear (e.g., Regional Support Networks' websites). Behavioral health organizations and managed care organizations are key to helping their providers understand their local networks of care. Use of care navigators, nurse managers and peer mentors was commonly cited as important for their ability to provide "a warm hand-off". Key informants also expressed the desire to use electronic health records as tools for coordinating care, but were frustrated with the many systems that were not sufficiently integrated to achieve that goal.

Community-based care

A subset of key informants clearly expressed the desire to take behavioral health care into the community. These providers believed that providing behavioral health care in the community and in patients' homes stabilizes patients, increases medication compliance, and helps prevent crises such as suicide and homelessness. Specifically, these providers advocated for their ability to monitor and assist patients at the time of discharge from clinical settings.

DISCUSSION AND CONCLUSIONS

While many common themes emerged from interviews with key informants, there was a wide range of specific comments and recommendations for workforce-related solutions to improving access to behavioral health care in Washington. These were not vetted to determine the accuracy of their underlying assumptions, and were expressed in this report to reflect the variety of informants' sentiments. The extent to which there are misunderstandings by key informants of system processes, regulations, or the availability of resources, provides argument for an overall recommendation to improve communication among behavioral health service providers, regulatory agencies, and educational programs. In some cases, barriers identified by key informants were already being actively addressed, such as planned improvements to the credentialing system to increase the processing rate, laws enacted to improve expand the use of telemedicine in Washington (SB 6519, 2016) (SB 5175, 2015), and the availability of a variety of free education and training resources.

Clearly, integrating mental health and chemical dependency treatment with physical health has the potential to alleviate some of the issues raised by key informants by providing better coordination and referral processes for clients, greater flexibility and freedom in service provision, increased parity among settings, and more collaboration among providers. Some key informants expressed concern, however, that integrated funding and records does not equate to integrated care delivery, and many were unclear about the State's vision and milestones for integration. Key informants urged that demonstrated successful integration models and practices be used to guide this endeavor. While there was general agreement that patients would be best served by whole-person care, many informants with ties to specific professions tended to advocate for the best use of their occupation's particular expertise. Nonetheless, the overall sentiment was that there needs to be understanding, respect, and opportunity for each provider's contribution to that care.

Key informants introduced other specific areas of concern, including staffing issues at state hospitals, lack of chemical dependency professionals to provide services for opioid use; the role of social services, law enforcement, and corrections in the integration model; and special concerns in providing care to infants and children. The behavioral health workforce assessment is one among a number of efforts initiated by the Governor and Legislature to improve access to and effectiveness of behavioral health care in the state, and there are projects specifically dedicated to these topics that can provide greater detail on these issues and recommendations. Many of these efforts are taking place concurrently, and where preliminary findings have been made available, findings tend to be similar. For example, the Public Consulting Group charged with synchronization of these projects released a summary including the major findings "Best practices for mental health funding are incentivizing reduced institutionalization and increased outcomes-oriented community care". This was a theme of key informants, and described clearly by one: "If funding were shifted upstream rather than to state hospitals, we might be able to provide more front-end prevention and keep individuals from progressing to acute crises and needing hospital care".

Behavioral health care delivery involves a wide array of professions that must be deployed across a variety of settings to deliver effective services to the state's population. The clearest themes that emerged from this study's key informant interviews were: low reimbursement for behavioral health services is a barrier to workforce recruitment and retention; it is difficult to fill positions in the community behavioral health system; and there is strong desire for the workforce to be able to deliver the best practices in effective behavioral health care. Several key informants stressed that only by prioritizing behavioral health care and recognizing its value can long-term, actionable solutions to these barriers be effected. The state's commitment to behavioral health improvement initiatives, such as this study, suggest that is happening.

ACKNOWLEDGMENTS

The authors would like to thank the interview participants for their valued time and insights.

FUNDING

This study was funded through contract # IAA-860-17 between the Washington Workforce Training and Education Coordinating Board and the University of Washington, supported by Governor Inslee's Workforce Innovation and Opportunity Act (WIOA) discretionary funds.

CONTACT

Rachelle L. McCarty, Research Scientist | rmccarty@uw.edu | 206-685-1969

Malaika R. Schwartz, Research Scientist | malaika@uw.edu | 206-685-1990

Susan M. Skillman, Deputy Director | skillman@uw.edu | 206-543-3557

Center for Health Workforce Studies, University of Washington, Seattle, WA

SUGGESTED CITATION

McCarty R, Schwartz M, Skillman SM. Washington's Behavioral Health Workforce Assessment: Input from Key Informants. Center for Health Workforce Studies, University of Washington, Nov 2016.

REFERENCES

- Association of American Medical Colleges. (2015). 2014 Physician Specialty Data Book. Center for Workforce Studies. Association of American Medical Colleges. Retrieved from <https://members.aamc.org/eweb/upload/Physician%20Specialty%20Databook%202014.pdf>
- Bureau of Labor Statistics, U.S. Department of Labor. (2015, December 15). Occupational Outlook Handbook, 2016-2017 Edition. Substance Abuse and Behavioral Disorder Counselors. Retrieved from <http://www.bls.gov/ooh/community-and-social-service/substance-abuse-and-behavioral-disorder-counselors.htm#tab-6>
- Cummings, J. (2015). Rates of psychiatrists' participation in health insurance networks. *JAMA*, 313(2), 190-191.
- Department of Health. (2008). County Classification Systems - Washington State Department of Health. Department of Health. Retrieved from <http://www.doh.wa.gov/Portals/1/Documents/2900/CountyDef.xls>
- Druss, B. G., & Walker, E. R. (2011). Mental disorders and medical comorbidity. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation. Retrieved from http://www.integration.samhsa.gov/workforce/mental_disorders_and_medical_comorbidity.pdf
- Fagan, E. B., Gibbons, C., Finnegan, S. C., Petterson, S., Peterson, L. E., Phillips Jr, R. L., & Bazemore, A. W. (2015). Family medicine graduate proximity to their site of training: policy options for improving the distribution of primary care access. *Family Medicine*, 47(2), 124-130. Retrieved from <http://www.stfm.org/FamilyMedicine/Vol47Issue2/Fagan124>
- National Health Service Corps. (2012). NHSC clinician retention: a story of dedication and commitment. Washington, DC: Department of Health and Human Services. Retrieved from <https://nhsc.hrsa.gov/currentmembers/membersites/retainproviders/retentionbrief.pdf>
- Olfson, M. (2016). Building The Mental Health Workforce Capacity Needed To Treat Adults With Serious Mental Illnesses. *Health Affairs*, 35(6), 983-990.
- SB 5175, Regarding telemedicine (Washington State Legislature April 17, 2015). Retrieved from <http://apps.leg.wa.gov/billinfo/summary.aspx?bill=5175>
- SB 6519, Expanding patient access to health services through telemedicine and establishing a collaborative for the advancement of telemedicine (Washington State Legislature March 29, 2016). Retrieved from <http://apps.leg.wa.gov/billinfo/summary.aspx?bill=6519>
- van der Leeuw, R. M., Lombarts, K. M., Arah, O. A., & Heineman, M. J. (2012). A systematic review of the effects of residency training on patient outcomes. *BMC Medicine*, 10, 65.

APPENDIX

A. ORGANIZATIONS REPRESENTED BY KEY INFORMANT INTERVIEWS

- American Indian Health Commission for Washington State
- Amerigroup Washington
- ARNPs United of Washington State
- Association of Advanced Practice Psychiatric Nurses
- Central Washington Family Medicine
- Children's Home Society of Washington
- Clallam County Juvenile & Family Services
- Columbia River Mental Health Services
- Confluence Health
- Cowlitz Indian Tribe
- Department of Health
- Department of Social and Health Services Eastern State Hospital
- Department of Social and Health Services Office of Behavioral Health and Prevention
- Educational Service District #112
- Educational Service District #113
- Evergreen Recovery Centers
- Great Rivers Behavioral Health
- Harborview Medical Center
- Kitsap Mental Health
- Lifeline Connections
- Mason General Hospital
- NAVOS
- NeighborCare Clinics
- Office of Superintendent of Public Instruction
- Partners for Our Children
- Pacific Lutheran University School of Nursing
- Private Mental Health Practice
- Seattle Children's Hospital
- SEIU Healthcare
- Sound Mental Health
- St. Martin's University
- Sundown M Ranch
- Harborview Medical Center-Psychiatry
- Washington Association of Community & Migrant Health
- Washington Council for Behavioral Health
- Washington State Development Disabilities Council
- Washington State Society for Clinical Social Work
- Willapa Behavioral Health
- Yakima Catholic Family & Child Services
- Yakima Valley Community College

University of Washington • School of Medicine
Box 354982 • Seattle WA 98195-4982
phone: (206) 685-0402 • fax: (206) 616-4768
<http://depts.washington.edu/uwchws/>