Research to Strengthen Behavioral Health Workforce Capacity

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

Behavioral Health Workforce Webinar Series
February 16, 2017

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Presentation Outline

I. State of the behavioral health workforce

II. About the Behavioral Health Workforce Research Center

III. Strategies for strengthening workforce capacity
"A Workforce Crisis"

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

Annapolis Coalition, 2007
Behavioral Health Occupations

Licensed professionals
- Psychiatrists
- Psychologists
- Marriage and family therapists
- Social workers
- Licensed professional counselors
- Psychiatric nurse practitioners

Certified professionals
- Addiction counselors
- Peer providers
- Psychiatric rehabilitation specialists
- Psychiatric aide/technicians
- Case managers

Primary care providers
Behavioral Health Workforce Supply

- Child, Family, and School Social Workers: 291,990
- Mental Health Counselors: 128,200
- Psychiatric Aides & Technicians: 128,000
- Mental Health/Substance Abuse Social Worker: 110,070
- Clinical, Counseling, School Psychologists: 105,240
- Substance Abuse/Behavioral Disorder Counselors: 94,900
- Marriage and Family Therapists: 32,070
- Psychiatrists: 24,210
- Advanced Practice Psych Nurses*: 13,701

Total: 928,381

Sources:
- SAMHSA, 2012
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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<tr>
<td>Psychiatrist</td>
<td>BLS, May 2011, estimate of psychiatrists (SOC 29-1066). Excludes the self-employed.</td>
<td>24,758 American Psychiatric Association, 2006, membership. Includes 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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<td>Clinical Psychologist</td>
<td>BLS, May 2011, estimate of clinical, counseling, and school psychologists (SOC 19-3011). Excludes the self-employed.</td>
<td>92,227 American Psychological Association, 2006, Member Directory. Not all psychologists are members.</td>
<td>134,000 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>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 MSWs with experience. May double-count those licensed in multiple states. Excludes those from states that did not report.</td>
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<td>Marriage and Family Therapist (MFT)</td>
<td>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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Source: Congressional Research Service. The Mental Health Workforce: A Primer, 2013
## Behavioral Health Workforce Projections: 2025

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<th>Occupation</th>
<th>Supply</th>
<th>Demand</th>
<th>Difference</th>
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<td>School Counselors</td>
<td>243,450</td>
<td>321,500</td>
<td>-78,050</td>
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<td>Clinical, Counseling, School Psych</td>
<td>188,930</td>
<td>246,420</td>
<td>-57,490</td>
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<td>MH/SA Social Workers</td>
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<td>157,760</td>
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<td>172,630</td>
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<td>SA/BD Counselors</td>
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<td>MFTs</td>
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<td>BH NPs</td>
<td>12,960</td>
<td>10,160</td>
<td>2,800</td>
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<td>1,800</td>
<td>1,690</td>
<td>110</td>
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<tr>
<td>TOTAL</td>
<td>883,020</td>
<td>1,133,530</td>
<td>-253,310</td>
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Maldistribution of Workforce Limits Access

- 4,000 mental health Health Professional Shortage Areas (HPSAs); approximately 2,800 psychiatrists are needed to address the shortage
  - Increase from 2012: 3,669 mental health HPSAs, 1,846 psychiatrists needed
  - 55% of U.S. counties (rural) have no practicing psychiatrists, psychologists, or social workers

Sources: HRSA Data Warehouse, 2016; SAMHSA, 2012
Summary: State of the Behavioral Health Workforce

- Behavioral health workforce is broad in scope: many occupations, levels of training, scopes of practice/authority, and functions

- Research efforts are primarily focused on the core licensed professionals

- We know there are supply challenges (too few, maldistribution): lack of data on the full workforce makes SHORTAGE difficult to determine

  Focused research efforts can help inform strategies for addressing workforce capacity
About the Behavioral Health Workforce Research Center
BHWRC Background

• 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
BHWRC Partners

- **Peter Buerhaus, PhD, RN**, Director, Center for Interdisciplinary Health Workforce Studies
- **Ron Manderscheid, PhD**, Executive Director, National Association of County Behavioral Health and Disability Directors

- National Council for Behavioral Health
- American Psychological Association
- American Association of Marriage and Family Therapy
- Council on Social Work Education
- National Board for Certified Counselors
- NAADAC, the Association for Addiction Professionals

- Community Partners, Inc.
- Southwest Michigan Behavioral Health
- Behavioral Health Education Center of Nebraska
- Association of State and Territorial Health Officials
- National Association of County and City Health Officials
**BHWRC Focus Areas**

### Minimum Data Set
- Individual Data
- Discipline-specific Data Collection
- Organizational Data

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

### Scopes of Practice
- Legal SOPs
- Professional SOPs
- Studies on Specific Disciplines and Services
- Billing Restrictions
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
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

- Themes 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 national and state-based behavioral health workforce data sources have been identified and assessed according to MDS themes

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

<table>
<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>
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<td>American Psychological Association: APA Survey of</td>
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State-based Data Sources
Addressing Workforce Data Limitations

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

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

- 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 service 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

[Site] is “constantly recruiting, trying to get the right person that will work in [the integrated care setting], and constantly dealing with primary care [providers] that just don’t get it…”
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
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
Analysis Themes

• **Summary Analysis:** Compares the names of certifying/licensing bodies, published dates of statutes/rules/materials, and professional definitions across all U.S. states.

• **Licensure Analysis:** 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.

• **Service Analysis:** Compares the varying services professions from each state is legally allowed to provide, such as diagnosis, crisis intervention, or psychotherapy.
SOP Key Findings

Support positions

- SOP availability for paraprofessional/direct service support professions was limited
- Paraprofessionals and addiction counselors are an under-researched segment of the behavioral health workforce
  - There is overlap of job responsibilities and job inconsistency that makes categorizing/quantifying workers difficult

Core licensed professionals

- Some states explicitly deny authority to diagnose patients for some licensed professionals
- MFTs were most likely to have education requirements outlined in the SOP (49 states), followed by mental health and addiction counselors (48 states)
- Billing/reimbursement exceptions and variability exist under Medicare and Medicaid for behavioral health services
  - MFTs and LPCs cannot be reimbursed by Medicare
  - Psychiatric diagnostic evaluation often limited to physicians and APRNs
In summary...

Need better data to address workforce size and composition problems

Address barriers to adopting best practices: payment mechanisms, training

Consider what factors may be limiting scope of practice
Workforce Development Challenges and Opportunities

• Recruitment and retention of workers
  • High turnover
  • Aging workforce
  • Need recruitment into rural areas

• Ensuring a diverse workforce

• More specialized training needed for serving special populations
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

Produce research findings that inform policies to strengthen behavioral health workforce capacity
Thank You

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