Governor's Behavioral Health Advisory Council

Workforce Affinity Group

Meeting Summary for February 10, 2020, 1:30 to 4 pm.

Training and Competency

Training and Competency includes education for workforce as they prepare to enter the field and ongoing training while they are working. Competencies may be for a specific part of the workforce or to work in certain settings.

1. Consistent alignment of work with identified national competencies for all THW's- specifically for peer, family and youth support specialists and peer wellness specialists. For example, Family Support has national competencies and Oregon/OHA has even approved a set of Oregon specific competencies that were developed by Oregon Family Support Network and are recognized as leading the nation in advancing family support practice, however, it is rare that other workforce types are aware of these competencies and the efficacy of the workforce is diminished.
2. Development of a scope of practice for workforce training programs.
3. Training program cross training/understanding of other workforce areas for maximum efficiency and effectiveness of the workforce.
4. Any provider who is authorized to independently do a comprehensive evaluation (90791 or 90792) and/or develop comprehensive treatment plans needs to be licensed for that scope of practice (e.g. LCSW, LMFT, LPC, PsyD, PhD, NP, MD) or, at a minimum, registered with the appropriate licensing board, actively working toward licensure and with on-site supervision by licensed staff. While addressing access is critical, we cannot lower standards to allowing non-licensed providers do the most clinically challenging tasks with some of the state's most complex patients. We don't do this in any other medical specialty so why would we lower standards just for BH?
5. BH providers need to have competency in some core medical studies, including chronic medical conditions (e.g. diabetes, COPD, CHF, etc) as well as medical diagnoses that can masquerade as primary BH conditions (e.g. delirium masquerading as psychosis or depression). This is especially important for BHCs working in medical settings like med-surg units, EDs. PCPCHs, etc.
6. Collaboration with statewide nursing education for immediate increase in trauma-informed training capacity for: 1) PMHNPs equipped to assess and treat all BH and co-occurring disorders in urban, rural, and school locations throughout the state, and 2) RNs in BH in traditional settings (e.g., integrated primary care as nurse navigators), as well as non-traditional settings (e.g., school-based health centers, etc.).
7. Training in developmental disabilities.
8. Enhance training in team-based care models for both primary care and BH settings
9. Resources for training a non-traditional workforce (THW) roles needs to keep in pace with the increase in demand for training and workforce development. Competencies for some of the roles involved have been well articulated, however not for others.
10. Training is local to the clinicians in the locations (as opposed to driving 5 hours one way).
11. Training and education that is subsidized either by the future or current employer.

12. Standardized onboarding that requires certain classes, CEU's.
13. Cultural responsiveness
14. Standardized knowledge, skills and ability for peers. Trainings that can be taken over time.
15. Code of ethics for peer workforce
16. Development of career ladder for PDS providers
17. Trauma informed practices and organizations
18. Support workforce with trauma
19. Funding and expanded opportunities for training to certify peer workers
20. Cultural change at organization leadership level to be inclusive of peer workforce
21. Move from siloed approach (separating MH and SUD)
22. Incentivize dual certification or expand training
23. Core competencies identified by role have been developed within the THW Commission. These are not widely known in the behavioral health system throughout the state – which has an unintended consequence of impacting the quality of work and understanding of these roles. Anyone receiving a THW service should have a reasonably consistent service throughout the state.

Composition

Composition includes the actual make up of the workforce and may address language access and diversity.

1. Increase access and availability of THW workforce and maximize their ability to meet the cultural and language needs of communities.
2. Increase funding and support for community-based organizations/PRO's/non licensed providers supporting the BH system prescribers and licensed providers to increase effectiveness and reduce system costs.
3. Increase recognition and solutions related to inherit barriers that exist in accessing services such as destigmatizing or stereotyping BH, using culturally appropriate conversations, language and engagement strategies, meeting individuals in their most comfortable environment, practice 'true' family driven care.
4. Leverage the use of the most highly trained, expensive and scarce providers (e.g. psychiatrists) to provide consultation to other providers – both in BH and in medical settings – as this will allow for a population health approach that can cover a much larger panel of patients. Example is the Collaborative Care Model (CoCM) out of University of Washington AIMS Center.
5. Greatly increase THW workforce and figure out how to reimburse them more effectively.
6. Increase size of workforce doing MAT and trained in co-occurring disorders.
7. Housing support – tax credits for employers that support housing for employees
8. Fund education with retention bonuses for culturally specific workforce to get bachelors and masters level education and serve their local communities
9. Use of culturally specific peers could be supported through expanding funding mechanisms to support peer delivered services
10. Most of the licensed workforce is located on the west side of the state, even when looking at it per capita the east side is low. 2.More support for peers and more allowances for the work that QMHA's engage in.

11. Strategic increase in recruitment of BH nursing, BH nurse practitioner, and BH THW workforce from traditionally underrepresented populations/tribes/rurally through creative and targeted marketing such as bus ads, job fairs, school-based programs, etc.
12. The capacity to serve language and diversity across the state is limited in the Traditional Health Workforce. In fact, these services in general lack consistency across the state. Specifically, the peer workforce is well funded for certain populations, but not for others. As an example, a behavioral health provider may hire one peer, because that is what they can afford. That one peer will not be able to meet the diverse and linguistic needs of members within that provider system. While the behavioral health provider wants to ensure peer support is available, the dynamic in this situation is that very few members within it will be able to receive the support. For those members who deserve and require cultural and linguistic supports, their needs typically go unmet, or poorly met because the resource itself is not adequate.
13. Setting a payment structure that incentivizes linguistic and culturally diverse practice is just one way to begin to increase services that are truly responsive to culturally diverse communities. It is important to bring the expertise of linguistic and culturally diverse providers together to ensure that other strategies may be adopted to address these workforce issues. Recommendations then need to be legislated or contractually required of all CCO's, which are passed through to behavioral health providers.
14. There are still significant barriers around increasing linguistic and culturally diverse workforce because of Oregon's licensing rules. This is another area that could use a closer look from the Behavioral Health Advisory Council. I am not as aware of changes that have been made related to this issue, however it is still a perceived barrier in Oregon.
15. Need for ongoing data so we understand composition of population served (demographics, prevalence, mobility and location)
16. Telemedicine
17. Health Professional Shortage areas (master's level or higher and SUD tx)

Capacity

Capacity refers to the supply and demand of the behavioral health workforce. Is there sufficient workforce? Is the workforce allocated throughout the state? This may include strategies around recruitment and retention.

1. Create equity of pay for non-licensed providers in rural communities and recognize the unique needs/additional funding needed for travel, time, cultural needs, etc.
2. Increase the availability of training, professional development and mentoring for potential workforce members and reduce the barriers of access to those by creating opportunities in their home communities.
3. Focus recruitment strategies in areas in which services are limited and build retention strategies from the onboarding process. This includes recruitment and retention prioritization of people who are members of groups that are not equitably represented in the workforce.
4. Further incentivize rural practice via loan forgiveness, housing assistance and supplemental increased pay.

5. Increase use of value-based contracting that can pay providers significantly more than FFS if they are creating better outcomes and decreasing total costs of care.
6. Advocate at state and federal level for more in-state Graduate Medical Education (GME) residency and fellowship positions for psychiatry.
7. Reduce the administrative burden for documentation, particularly around assessments and treatment plans, to allow for more time spent with clients, thereby increasing capacity, lowering barriers to access and improvement engagement in services. Also allows COA agencies to compete with primary care and other settings where the requirements are substantially lower and the pay is higher.
8. Fund retention bonuses for staying in community mental health positions post licensure.
9. Expand regulatory framework to allow more broad adoption of telehealth
10. If we reduced turnover it would improve access, and capacity as clients would complete treatment more quickly – all agencies should have funding to offer retention bonuses to all staff for 1,3,5,10 years
11. "Work-life Balance Retention Package" for BH workforce across all workforce sectors (licensed, unlicensed, prescribers/providers), to include but not be limited to: housing supports/subsidies, part-time/flex-time schedules, tax and/or other incentives for precepting/supervising subordinates/students and/or for working in rural settings; comprehensive telehealth capacity; employee-led, individual professional development and acknowledgment; childcare onsite, etc.
12. Education and outreach regarding different BH specialties and job types(what does an NP do?)
13. Address trauma, workload, quality of life issues for providers
14. Best practices grounded in dominant culture. Be creative about how we are serving and supporting people (beauty shop example).
15. Diversify our offerings of services.
16. The workforce is not sufficient. Furthermore, the public behavioral health system struggles to keep qualified licensed and non-licensed staff because of the pay/benefits, or other incentives that could provide more stability – such as student loan forgiveness, and other strategies. The impact of this is tragic because it results in constant interruption of services for customers who use the service. Oregon has done a lot of work over the years to build a sense of choice in the behavioral health system. However, choice does not exist in this scenario. If I were to find a therapist, for example, who I really liked and felt that they could help me, it is highly likely that this individual will leave their job within a year, and I will be left with having to find another therapist. My mental health may be significantly impacted because this is the third time this has happened in the last two years. I may also believe that the system just isn't really able to meet my needs, and so stop going in for treatment altogether. This experience is very common.
17. Recruitment and retention has to do with two things primarily: 1) Am I making a difference in my work? 2) Can I afford to do this work? Strategies that are needed most must consider these two things. Our current payment system (Medicaid) does not reimburse at the full cost of service- using a fee for service model. This has resulted in behavioral health practice that incentivizes the wrong thing – higher productivity standards that limit good quality care and practice one hand, and a provider system that does not allow for training, workforce development and self-care. The payment structure afforded the Certified Community

Behavioral Health Clinics is a better model, although I do not know that this has actually reduced turnover rates.

18. Increase the number of tuition reimbursement programs, including programs that pay for bachelors degrees,
19. Increase funding or provide stipends to programs to provide housing allowances, sign on bonuses (that have a requirement to stay for x number of years)
20. Provide funding in the way of scholarships to graduating seniors to pay for a part of the degree
21. More robust loan repayment/tuition incentive programs/scholarships
22. Support to navigate, understand and access programs.
23. Look at regulatory/admin burden for providers that result in decreased capacity
24. Develop robust BH integration in medical settings that treats the non SPMI population so that we can focus resources on the SPMI population. CCBHCs and BHH make super robust.
    a. Adequately fund the programs that are treating the SPMI population.
    b. Need more trained, graduate level (pipeline, ladders, etc…)
25. Get real about capacity and what we can do with what we have right now.
26. Rural rotations
27. Welcoming people

Next Steps

Staff will narrow policy ideas down using a decision matrix and meet with co-chairs to further explore prioritization process.