Issue Brief
May 2018

The Reforming States Group

Behavioral Health Integration and Workforce Development

By Rachel Block

Introduction

States are paying increased attention to the behavioral health needs of their residents as part of larger strategies to improve health outcomes and make the health care system operate more effectively and efficiently. Behavioral health integration, or BHI, requires that the health and mental health systems are organized through integrated care models that address the full spectrum of health needs. Integrated care delivery and financing requires a workforce specifically prepared to practice in these new models. However, states have found that there is not sufficient supply, distribution, and training for this workforce, and there are legal and policy barriers to facilitate practice in these settings.

The Milbank Memorial Fund and the Reforming States Group (RSG) have a track record of work in this area, including convenings and presentations for state leaders on behavioral health integration. The Fund has published several reports documenting the evidence base for BHI and its effectiveness, including within specific populations such as pediatrics and individuals with serious mental illness. In 2017, the Fund conducted a technical assistance meeting for state health policymakers in which representatives from eight states met with national experts to discuss BHI program design as well as federal policy issues, quality measurement, and value-based payment models.

Supported by the Milbank Memorial Fund since 1992, the RSG is a bipartisan group of state executive and legislative leaders who meet annually to share information,

develop professional networks, and commission joint projects. In 2017, the RSG identified BHI workforce as a topic on which it wanted more information, and the Fund convened a workgroup comprised of RSG members to guide the project.

The group heard presentations from two leading state-focused organizations about work supported by federal and state grants related to behavioral health and workforce. These presentations focused on three areas that will be described in this report: state data collection, policy barriers to integrated practice models, and coordination of resources for training and recruitment. This issue brief grew out of these presentations as well as interviews with many experts from federal and state agencies and from various national organizations devoted to improving behavioral health services and outcomes.

Key themes emerged from the Fund's research and the RSG workgroup's discussion—namely, that to address BHI workforce needs systematically, states need to have dedicated and coordinated resources focused on:

- Assessing BHI workforce needs (i.e., how many practitioners and what types of practitioners are needed to support BHI programs);
- Identifying legal and policy barriers to practice that state policymakers can address to make BHI programs work more effectively; and
- Aligning workforce development resources based on state priorities and effectiveness of programs to train and retain these practitioners, particularly in underserved areas.

In this issue brief, case studies are used to illustrate these themes. The brief is intended to assist state policymakers such as legislators and executive branch staff who are responsible for BHI policy in their states. It may also be helpful to academic research organizations that could apply these findings and resources in the context of their research, operations, or evaluation activities for states.

Background on State BHI Strategies: What Populations Need BHI Services and What Are the Models?

States are implementing BHI models to meet growing population needs:

- More health care costs and utilization are driven by high-cost, high-need patients.
- Many of these patients have health and mental health comorbidities that cannot be well addressed through "siloed" treatment models.
- People with these comorbidities not only cost more to care for, they are more likely to die from common, treatable chronic diseases,[1] so there can be significant benefits if their health and mental health needs are managed simultaneously.

- The increase in substance use disorders, often co-occurring with other health and mental health issues, presents new challenges.

Research and program initiatives have shown that to address these challenges, the health and mental health systems need to be organized, staffed, and reimbursed differently through integrated care models that address the full spectrum of health needs, including behavioral health. BHI encompasses integrated care delivery and financing, staffed by a workforce equipped to practice in these new models.

While there are a variety of BHI models, they can be grouped into two broad categories, each with their own workforce impacts:

Primary Care and BHI. These models focus on changes in primary care practice roles and support in which primary care and behavioral health services are co-located or coordinated to address populations with mild to moderate behavioral health conditions. The predominant models for BHI in primary care are the patient-centered medical home (PCMH),[2] that include recently developed PCMH enhanced standards for BHI care management,[3] and the collaborative care model, that coordinates primary and specialty care for behavioral health conditions.[4] These models require significant workforce-related changes including, but not limited to, use of team-based care and/or dedicated care managers, telehealth consults with specialists, and expanded prescribing authority for nurse practitioners and physician assistants.

Specialty Care and BHI. These models focus on stronger coordination between specialty behavioral health care, the medical care system, and community services that support people with more complex health and social needs. Examples of specialty BHI models may include health homes and new accountable care models, such as Oregon's coordinated care organizations that focus on the full continuum of population needs.[5] In addition to the issues raised in patient-centered BHI models, the specialty BHI models may utilize new workforce categories such as peer support[6] and recovery counselors,[7] and require policies, mechanisms, and special training to appropriately share patient information across a broader array of personnel and care/service settings.

In addition to changes at the delivery system level, BHI initiatives may involve new administrative, policy, and operational approaches for states. Arizona has focused on integrating state-level functions to improve their approach to BHI.[8] Washington State Governor Jay Inslee has created a new health sub-cabinet to coordinate policies, and consolidated health agency management responsibilities, with the goal of accelerating BHI.[9]

More states are contracting for new managed care and accountable care models that include BHI; there is an opportunity to embed workforce considerations in these requirements. This may include, but not be limited to, numbers of behavioral health personnel relative to enrolled populations; policies and procedures to reduce barriers to practice; and performance measures that reflect workforce issues (e.g., patient experience and staffing).

State Policy Levers for BHI Workforce Development: Three Case Studies

Once priority populations and models have been identified, BHI workforce development becomes an important component of state program design and implementation for those populations and models. The supply, distribution, and training of behavioral health professionals and personnel are important to BHI success.

Addressing these needs requires coordinated state strategies. Through the Fund's research, we identified three organizations and models that exemplify this coordination:

- **The University of Washington Center for Health Workforce Studies** is conducting a comprehensive assessment of BHI workforce policy issues informed by state data and stakeholder input.
- **The Behavioral Health Education Center of Nebraska at the University of Nebraska Medical Center** has a legislative mandate to collect and analyze data on behavioral health workforce needs and to administer and measure outcomes for training and recruiting programs.
- **The Behavioral Health Workforce Research Center at the University of Michigan** is conducting BHI workforce policy research activities in a joint initiative with the Health Resources & Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration. Its research focuses on improved data collection and identifying policy barriers.

The following case studies describe these models and provide links to specific resources on these activities:

Case Study: Washington State Behavioral Health Workforce Assessment

Washington's governor and legislature commissioned the Behavioral Health Workforce Assessment to evaluate the state's behavioral health workforce needs and develop a recommended action plan to address those needs. The state's Workforce Training and Education Coordinating Board and the University of Washington Center for Health Workforce Studies collaborated on this work.

The comprehensive workforce assessment is one of several initiatives designed to improve Washington's behavioral health system. According to Governor Inslee's press release, "Behavioral health encompasses mental health as well as behaviors such as drug and alcohol use. Integrating primary care and behavioral health services will ensure that treatment is better coordinated, and conditions are caught earlier and treated, or even prevented.... It is not clear from current data how many Washington health care professionals offer behavioral health services and if they are adequate in number to meet demand. This evaluation will establish a baseline for behavioral health workforce shortages and provide a plan for improving how we coordinate the right services for patients."[12]

The state's workforce assessment has been conducted in two phases: phase I provides a preliminary analysis of priority issues, while phase II updates the earlier report and includes more in-depth workforce data as well as additional recommendations on the initial set of priorities.

Data Collection

The phase I report published in 2016 summarized feedback obtained through an extensive consultation process with state officials and stakeholders to identify barriers and potential short-term solutions related to the behavioral health workforce.[13]

The Washington Health Workforce Sentinel Network conducted a parallel study that focused on changes in behavioral health workforce demand.[14] It featured an employer survey to determine specific categories of the behavioral health workforce for which employers reported shortages or increased demand for personnel, as well as the need for particular skills and training.

The phase II report provides more information on current workforce characteristics, including detailed occupational profiles.[15] Some key findings:

- The landscape of behavioral health practice is very complex, making it difficult to monitor supply and distribution. There are 24 occupational categories that can provide some form of services, and there are significant differences in education and training requirements among these categories.
- There is increased urgency to address behavioral health workforce needs because the current workforce is getting older (mean age is above 50 years old).
- Less than 5% of behavioral health practitioners work in rural areas, creating access problems.

Policy Barriers

The stakeholder input gathered during phase I identified policy challenges in four key areas:

- Recruitment and retention.
- Skills and training.
- Credentialing and licensing.
- Paperwork and documentation.

The phase II report builds on this framework and provides recommendations for state action:

- Address behavioral health provider reimbursement rates to improve workforce recruitment and retention. The legislature approved increased managed care rates in 2017, but these increases were offset by additional cuts to community mental health services. The report suggests adding more community-based services to the Medicaid state plan and continuing support for value-based payment models.

- Promote team-based and integrated care models through health plans and managed care organizations, as well as with continued technical assistance. The report suggests streamlining and standardizing credentialing processes for health plans and managed care organizations and modifying current policies and processes to credential behavioral health practitioners in the context of new care and payment models.

- Increase access to clinical training and supervised practice for new behavioral health practitioners. The report suggests building capacity within practice settings and providing financial incentives for providers to offer clinical training and for staff to take on training supervision roles.

- Build more capacity for treatment. The report suggests expanding behavioral health prescribing capacity through training and practice support, including increased use of telehealth.

- Improve supply, distribution, and diversity of the behavioral health workforce. The report suggests a need for better matches of training and employment, increased financial support, increased use of a community-based workforce, and development of new career pathways.

Coordination of State Agencies and Resources

Coordination and targeting resources to support BHI models including workforce models are an important component of Washington's Behavioral Health Workforce Assessment process. This includes defining organizational relationships and pooling resources focused on behavioral health workforce support.

Coordination of State Agencies: Washington's Behavioral Health Workforce Assessment project was conducted in collaboration with the state's Workforce Training and Education Coordinating Board. The Health Workforce Council is part of the board and focuses on data collection and programs to address emerging health workforce needs. These activities are described in more detail in the council's 2016 annual report.[16] The council includes a behavioral health stakeholder group giving input into the Behavioral Health Workforce Assessment project. As a result, the board and the council provide a focal point for the state to determine health workforce needs and identify solutions. The governor also created a health sub-cabinet specifically focused on strengthening BHI. The sub-cabinet is charged with developing a strategic plan to accelerate BHI. State oversight of the county-based mental health agencies and services will be consolidated and focus on advancing BHI efforts. The state will also facilitate coordination between these county agencies and managed care organizations—including alignment of contracts, administration, and financing—to develop fully integrated care models including behavioral health.[17]

Coordination of Resources: The phase I report provides detailed information about the state's approach to coordinating training and technical assistance resources. Healthier

Washington is the organizing framework for the state's health care transformation and population health improvement strategies (including behavioral health integration).[18] Healthier Washington is promoting the development of new organizations, payment models, and data analytics capacity to drive health improvement. These activities are also aligned with the state's Medicaid Transformation Demonstration that includes a major emphasis on expansion of BHI.

More specifically, the Healthier Washington Practice Transformation Support Hub provides technical assistance to clinical practices to promote and expand patient-centered BHI models; to support adoption of value-based payment; and to improve population health by strengthening connections between clinical and community settings.[19] Practice coaching, facilitation, and training services that support clinical and administrative staff are among the hub's core functions.

In addition to practice transformation support, Healthier Washington focuses on workforce needs through two other programs:

- The Health Workforce Sentinel Network reports on real-time training and workforce needs by collecting information from providers, as well as education and training programs. The availability of a trained behavioral health workforce is often cited as a critical need.
- The Community Health Worker Task Force provided recommendations to key state agencies regarding definitions of roles, skills, and training for community health workers to work in integrated health systems.

The hub is one of two centralized resources for BHI practice support. The University of Washington AIMS Center also focuses on advancing BHI, specifically through adoption of the evidence-based collaborative care patient-centered BHI model.[20] The center contributes resources to the hub in support of practice- and site-level implementation, training, and workforce development; clinical consultations; and research partnerships. It also serves as a national resource center to further develop evidence and experience with the collaborative care model.

Case Study: Behavioral Health Education Center of Nebraska

The Behavioral Health Education Center of Nebraska (BHECN) was established by legislation in 2009 to provide data on and develop programs to meet the state's behavioral health workforce needs. One of the BHECN's core functions is to facilitate the collection, analysis, and dissemination of behavioral health workforce data. This includes monitoring workforce trends and establishing priorities for workforce development by gathering valid data to inform workforce practices.

The BHECN has published several reports tracking the state's behavioral health workforce supply, as well as statistics on its training and recruitment activities. A summary of these data can be found in two reports—one provided to the legislature[21] and another summarizing workforce statistics.[22] The BHECN also developed the Nebraska Behavioral Health

Workforce Dashboard that maps behavioral health personnel availability by county,[23] allowing visualization of high-priority shortage categories and geographic areas. These data resources help the BHECN to systematically develop programs and target resources to train, recruit, and retain behavioral health personnel based on the state's needs.

Training, recruiting, and retention coordination is a major focus for the BHECN. In addition to its role collecting and presenting BHI workforce data for policymakers and behavioral health professionals, the BHECN coordinates statewide actions and investments in programs to train, recruit, and retain the behavioral health workforce based on its statewide needs assessment. Key strategies include:

- **Behavioral health regional education and training sites** to support local participation in interprofessional workforce development.
- **Behavioral telehealth and integrated care training**[24] and other innovative means of care delivery to the entire behavioral health workforce. For example, the BHECN partners with the Munroe-Meyer Institute, a state developmental disabilities clinical and educational center, to sponsor and support 42 integrated behavioral health clinics in primary care statewide, 24 of which are rural. The model has been replicated in several states.
- **Interprofessional behavioral health training, curriculum development, and outcomes research** through collaborative partnerships to create, link, and disseminate education and training materials for the development of the behavioral health workforce, with emphasis on the recovery-focused needs of consumers.
- **Funding for psychiatry residents and other behavioral health trainees** prepared for interprofessional and telehealth service delivery to rural and underserved areas.

A detailed description of these activities is included in the BHECN's recent report to the legislature.[25] The BHECN also provides learning collaborative resources focused on building interdisciplinary training and practice.[26]

Case Study: University of Michigan Behavioral Health Workforce Research Center

The University of Michigan Behavioral Health Workforce Research Center (BHWRC) is one of six state-based academic organizations funded by HRSA to address a variety of health care workforce policy issues through collaboration with national and state organizations.

It is working under a federal contract to focus on several key areas related to building behavioral health workforce capacity: how are behavioral health personnel defined and counted; where and how do behavioral health personnel practice; and how do state scope-of-practice laws affect behavioral health workforce capacity. The products from this work will help states design their BHI workforce strategies.

Behavioral Health Workforce Data

One of the BHWRC's key tasks is to develop a behavioral health workforce minimum data set. To assess the availability, type, and distribution of the behavioral health workforce at the state level, it is important to define what data elements are needed and how the data

will be collected. There is significant variation in what national or state data sources can measure and report on.[10] Many federal and state agencies are involved, including those with jurisdiction over labor and employment, education and training, professional licensing, regulation, and payment (e.g., Medicaid).

In addition to documenting the wide variety of existing definitions, metrics, and data sources, the BHWRC is working with a cross-section of stakeholder groups to build consensus for a minimum data set that will standardize data collection processes and improve data quality for the behavioral health workforce. Data collection domains would include: demographics; licensure and certification; education and training; occupations and areas of practice; and practice characteristics and settings. Once completed, these data specifications can be incorporated more consistently into federal and state data collection and reporting requirements and yield more reliable and comparable results. State policy action (e.g., legislation and regulations) will be needed to adopt the recommended standards and ensure that data is submitted in a complete and timely manner.

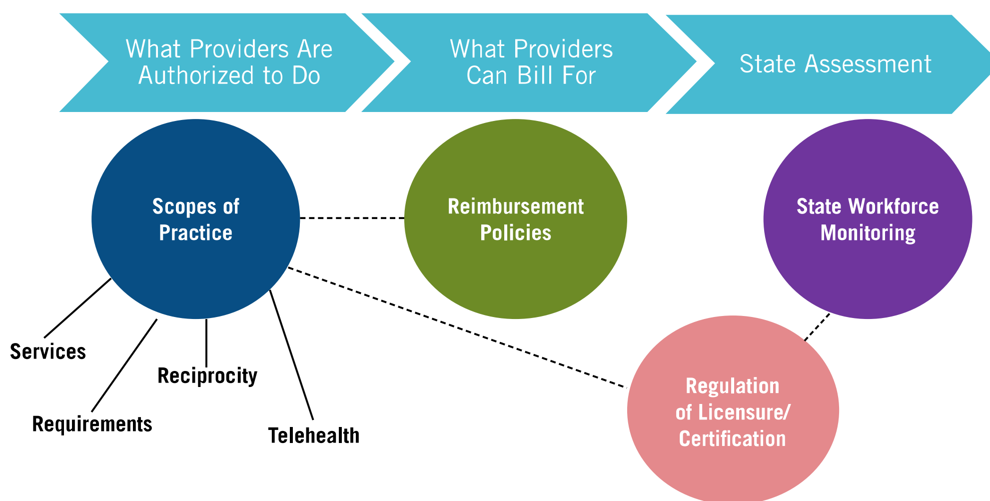
Policy Barriers to Practice in Integrated Care Models

Integrated care models require practitioners to work in new ways, triggering several policy issues. How will practitioners and services be reimbursed in new models such as telehealth? Do scope-of-practice laws limit new roles and responsibilities within an integrated care team? Because behavioral health information is subject to specific federal (and, in some cases, state) protections, how will the exchange of information be facilitated across a system of care involving multiple practitioners and organizations? State policymakers need to address these potential policy barriers to advance new BHI models.

A conceptual model illustrates the interrelationship of policy issues affecting practice in integrated care models. (See Figure 1.)

Figure 1.

Addressing Integrated Care Barriers through Policy



Source: Behavioral Health Workforce Research Center, University of Michigan School of Public Health

The BHWRC is focused on two broad areas related to policy barriers for BHI:

Practice Characteristics and Settings. Any assessment of a behavioral health workforce needs to match workforce characteristics with the types and settings for behavioral health practice. The BHWRC has conducted studies on the diversity of population needs, workforce diversity, behavioral health practice competencies, and new models or settings of care, such as team-based care or corrections facilities.[11]

For example, a report on team-based care features results from a survey of eight organizations that are implementing patient-centered BHI models. Some of the barriers (and policies) identified through the survey include:

- Restrictions on sharing personal health information across treating providers and settings (privacy) and across different electronic health record systems (interoperability);
- Restrictions on reimbursement for team-based care encounters (billing policies and codes); and
- Sustained funding for operational practice changes (payment reform).

The study also identified several barriers to organizational culture, such as agreement on new roles for care team members. Integrated care models require new ways to communicate and organize workflow within and across practice disciplines and settings. Policy and operations need to be aligned to achieve more robust integration.

Additional BHWRC studies are exploring the use of telehealth to strengthen behavioral health workforce capacity, how state telehealth policies differ, and the evolving role of social workers practicing in health care settings.

Scope of Practice. A scope of practice (SOP) defines what services or activities a licensed professional can perform, including the authority to diagnose, treat, and prescribe. The SOP definition also outlines who is precluded from engaging in that practice.

The BHWRC conducted a survey of state SOPs for nine common behavioral health professions and found significant variation as to whether and how SOPs were defined. There were gaps among states in three areas that are important components of integrated care: SOP definitions for paraprofessionals (such as peer support); authority to participate in telehealth; and authority to administer medication-assisted treatment for substance use disorders.

Conclusion

These case studies suggest a series of steps that state policymakers can take to address BHI workforce needs:

1. Develop a BHI strategy including priority target populations and a model to meet those population-based needs for behavioral health services, with a focus on integrated care.
2. Within that strategy, specify how workforce needs will be identified and reported to the state.
3. Designate an executive branch focal point to set goals and priorities for the state's BHI needs, including workforce development.
4. Create mechanisms to collaborate with external partners including state health research entities and organizations dedicated to improving behavioral health services and outcomes.
5. Identify specific priorities for workforce development based on assessment of need and resources available, and target resources to those needs, either through existing channels or new competitive awards.
6. Identify lessons learned within this field and related fields. Examples include defining scope of practice and core curriculum for community health workers and recruiting and retaining various health workers in underserved areas.
7. Decide on some goals and measures and regularly report on progress—what gets measured is improved.

Workforce planning and capacity development is a long-term effort. As we learn more about the significant effects of behavioral health on physical needs and health care and how to address them in an integrated matter, government will have to provide leadership and support to encourage the development of a workforce able to respond to these discoveries. The likelihood of success will be far greater if state policymakers focus on these three broad areas of work and specific topics within:

1. Identifying priority populations and models for BHI work;
2. Organizing core state policy levers for BHI workforce development, including assessing BHI workforce assessment needs, identifying policy barriers to practice in integrated care models, and aligning resources for BHI workforce development; and
3. More strategically utilizing available federal resources.

Resources

Federal Resources

In addition to the state-based models described in this issue brief, there are significant federal resources available to support state BHI and workforce development initiatives. This section provides a brief overview of the key federal agencies and programs:

Health Resources & Services Administration (HRSA)

Bureau of Primary Health Care

- Supports health centers adopting PCMH and integrated care models, including expanded access to treatment for substance use disorders.

Bureau of Health Workforce

- Analyzes health workforce availability and needs through the National Center for Health Workforce Analysis, which conducts analyses and projections on a wide range of health care occupations; develops and distributes results through reports, briefs, and fact sheets; collects and distributes data through mechanisms such as surveys and the Area Health Resources Files; provides technical advice to states on health workforce data collection, analysis, and interpretation; and supports Health Workforce Research Centers at various universities through cooperative agreements.
- Makes grants for behavioral health workforce training.

Federal Office of Rural Health Policy

- Publicizes opportunities for rural health stakeholders to review and comment on federal policy and regulations (e.g., opioid prescribing guidelines).
- Makes grants for rural health system development (e.g., telehealth).
- Funds rural health research centers that have published reports on BHI-related topics.
- Designates state offices of rural health that serve as focal points for rural health issues within each state, linking communities with state, federal, and nonprofit resources, and helping to find long-term solutions. Depending on the needs in each state, the state offices may focus on increasing provider awareness of new health care initiatives, collecting and disseminating and/or data and resources, offering technical assistance for funding and quality improvement, and/or supporting workforce recruitment and retention efforts.

Substance Abuse and Mental Health Services Administration

Develops and oversees the nation's strategy for mental health and substance abuse prevention and treatment, including support for integrated systems and workforce development.

Funds the Primary and Behavioral Health Care Integration grants program. Among the resources developed through this program is sample job descriptions for key staff participating in BHI.

Provides policy and funding support for the behavioral health workforce.

Co-manages the Center for Integrated Health Solutions with HRSA. It serves as a focal point for resources on BHI, including clinical policy and workforce issues.

National Organizations

The Annapolis Coalition on the Behavioral Health Workforce

National Association of State Mental Health Program Directors

National Council for Behavioral Health

State Examples

Alaska

Alaska Mental Health Trust Authority: Alaska Health Care Workforce Profile

Alaska Health Workforce Coalition: Webinar on behavioral health workforce

Colorado

Eugene S. Farley, Jr. Health Policy Center: Core Competencies for Behavioral Health Providers Working in Primary Care

Hawaii

Behavioral Health, Workforce, and a Better Health Care System for Hawaii

Minnesota

Behavioral Health Collaborative

New Mexico

New Mexico Behavioral Health Collaborative: Strengthening New Mexico's Behavioral Health Service Delivery System

New York

DSRIP/SIM Workforce Workgroup: Guidelines for Core Curriculum to Train Care Coordination Workers

Oregon

Behavioral Health Collaborative: Workforce Workgroup

Vermont

Blueprint for Health Hub and Spoke Vermont's Opioid Use Disorder Treatment System

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Notes

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About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly,* a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

About the Reforming States Group

The Reforming States Group (RSG) is a nonpartisan, voluntary group of state health policy leaders from both the executive and legislative branches who, with a small group of international colleagues, gather regularly to share information, develop professional networks, and commission joint projects—all while using the best available evidence and experience to improve population health. Supported by the Milbank Memorial Fund since 1992, the RSG brings together policymakers who usually do not meet together outside their states, to share information they cannot obtain anywhere else.

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