Panel I: Current Issues in Behavioral Health Workforce Policy

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Panel I: Current Issues in Behavioral Health Workforce Policy

Panelists:

Glenda Wrenn, M.D., *Director, Division of Behavioral Health, Satcher Health Leadership Institute, Morehouse School of Medicine*

Paul Mackie, Ph.D., L.I.S.W., *Professor, Minnesota State University*

Andy Cummings, *Consultant, Casey Family Programs*

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The Satcher Health Leadership Institute

DIVISION OF BEHAVIORAL HEALTH

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Behavioral Health Workforce Policy: Hope for the Urban Underserved

The 31st Annual Rosalynn Carter Symposium on Mental Health Policy
November 12, 2015

Glenda Wrenn, MD, MSHP
Director, Division of Behavioral Health
Satcher Health Leadership Institute
Morehouse School of Medicine

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Solution Focused: Invest Upstream

- ★ Enable Engagement
  - ✓ Meet people where they (already) are
  - ✓ Meet them earlier
- ★ Multi-sector Partnerships
  - ✓ Housing-Education-Justice
  - ✓ Community Development Organizations
- ★ Advance Primary Care Integration
- ★ Transform Systems
  - ✓ Trauma Informed Environments

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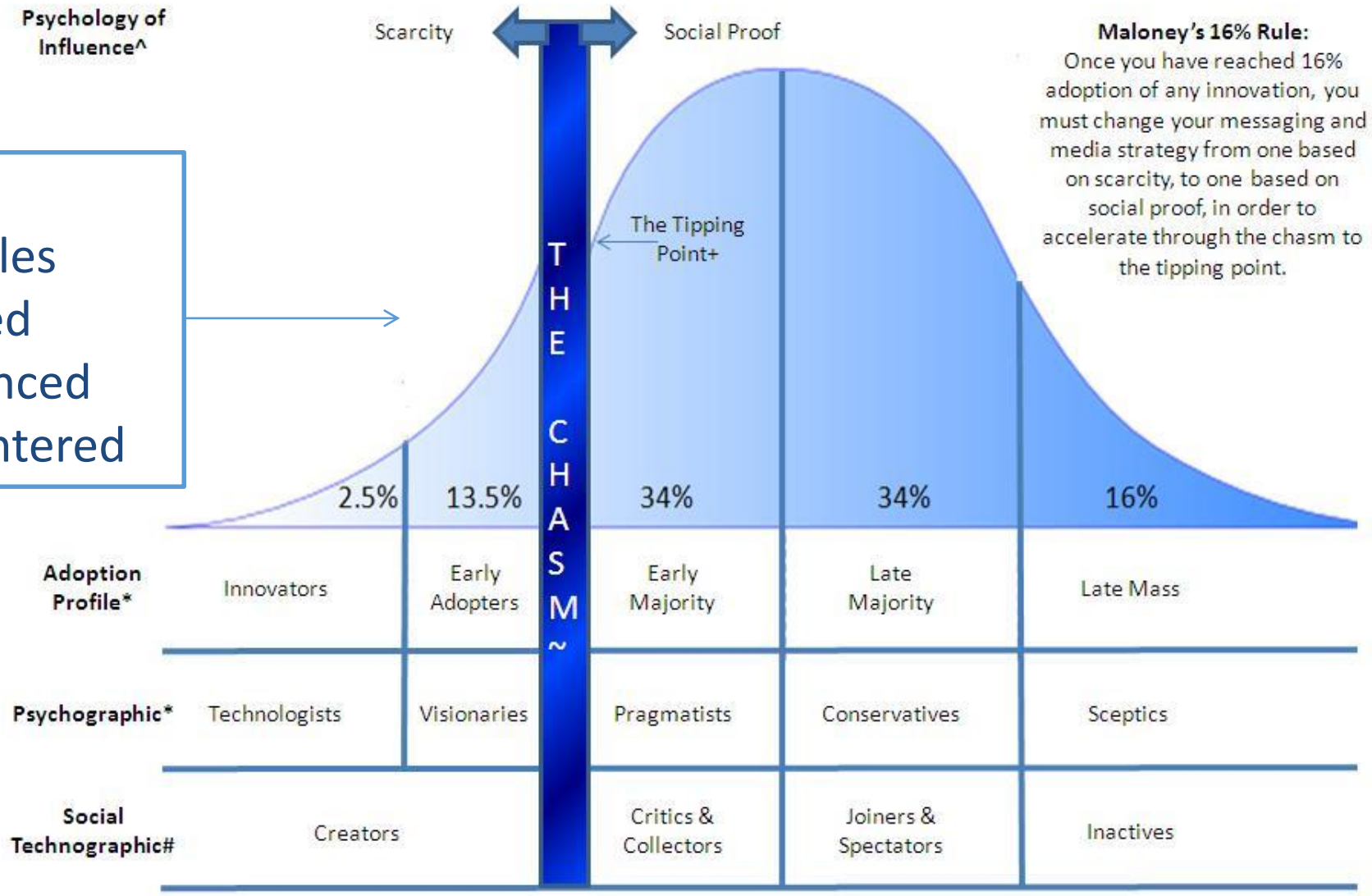
Accelerating Diffusion of Innovation: Maloney's 16% Rule©

- Integrated
- Flexible Roles
- Coordinated
- Tech-enhanced
- Person-Centered



Maloney's 16% Rule:
Once you have reached 16% adoption of any innovation, you must change your messaging and media strategy from one based on scarcity, to one based on social proof, in order to accelerate through the chasm to the tipping point.

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^ Robert Cialdini *Everett Rogers #Forresters ~Geoffrey Moore + Malcolm Gladwell

Artificial Turf?

- ★ Rethinking Roles
  - Widen the Scope (of practice)
  - Train Interprofessional Learners in Teams
- ★ Replace Volume with Value
  - Align Resources with Need->Health Equity
  - Allow Innovation- Scale with Policy
  - Customize the Model-Agree on Outcomes

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KENNEDY CENTER *for* MENTAL HEALTH POLICY & RESEARCH

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Vision: To ensure that all people have equitable access to behavioral health care and the opportunities to achieve optimal health outcomes.

Mission: Establish a national center for mental/behavioral health policy and research, provide thought leadership, and engage key stakeholders to advance mental and behavioral health equity

Priority Impact Area: Develop a state behavioral health database to track, monitor, and support the analysis of behavioral health policies and their impact.

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Integrated Care Leadership Program

From 2016-2017, participants at 20 selected clinical sites in Georgia will be **fully sponsored for all program activities** including

- ★Structured monthly leadership and capacity-building activities
- ★In-person engagement with the ICLP training team
- ★Eligibility for **high impact innovation awards** with technical assistance for implementation of improvement projects**.**

Online-only participants will have access to the web-based program and receive mentorship and coaching from established integrated practices and integrated care experts

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ICLP launches January 11, 2016

Partner With Us

www.satcherinstitute.org

Kennedy Center for Mental Health Policy and Research

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Behavioral Health Workforce Policy Issues: A Rural Perspective

Paul Force-Emery Mackie, Ph.D., LISW
Professor of Social Work, Minnesota State University Mankato
&
President, National Association for Rural Mental Health

31st Annual Rosalynn Carter Symposium on Mental Health Policy
The Carter Center, Atlanta GA
November 12th, 2015

The Problem

- **60% of rural America underserved for behavioral health needs** (New Freedom Commission on MH, 2003).
- **85%+ of US behavioral health shortage areas are rural** (Bird, Dempsey, & Hartley, 2001).
- **90% of psychologists & psychiatrists and 80% of MSW social workers located urban** (Mohatt, 2014).
- **65% of rural Americans get behavioral health care from primary care providers** (Mohatt, 2014).
- **Access to behavioral health services in rural too often limited or non-existent** (Mackie, 2012).
- **When access to rural behavioral health services is available, too often quality of care is less than typically accessible in more urban areas** (Fortney, Rost, & Zhang, 1999).
- **Rural access to specialized behavioral health care is limited, often non-existent** (Wang et al., 2005).
- **Stigma associated with accessing services continues to be a serious and pervasive challenge, which creates additional challenges for providers** (Carter & Golant, 1998; Mackie, Zammitt, & Alvarez, 2016; Mohatt et al., 2015).
- **Hiring & retaining rural behavioral health practitioners continues to be a ongoing problem as identified by rural-based supervisors and hiring officials** (Mackie & Lips, 2010).
- **The use of tele-technology to "bridge the divide" - increase access - to behavioral health care continues to present challenges** (Mackie, 2015).

Answering the "Why"

Several explanations have been posited, including:

- **Demographics:** Rural = 15-20% of total U.S. population,
- **Lower higher ed degree attainment** (rural = 18.5% bachelor's and higher whereas urban = 32%) (Marre, 2014),
- **Lower higher ed degree attainment** = reduced pool of potential indigenous providers,
- Rural areas seen as **less "viable" or "desired"** places to practice due to limited access to resources, supervision, social & professional opportunities, dual relationships, general challenges associated with geographic isolation (Mackie & Simpson, 2007),
- **Burnout** in rural areas higher, or at least **perceived higher** among potential practitioners (Mackie, 2008),
- State & federal responses (e.g., National Health Service Corp, grants/scholarships, loan repayment programs). **All respond to workforce needs, but lack long-term sustainability.**

The Research

Research suggests rural behavioral health professionals are more likely to have grown up in a rural area & the further one moves from urbanized areas, the more difficult it is to hire rural behavioral health practitioners.

- **For every 10 miles we move from an urban center, difficulty in hiring increases by 3%.**
  - 30 miles = 10% more difficult
  - 115 miles = 35% more difficult
  - 180 miles = 54% more difficult

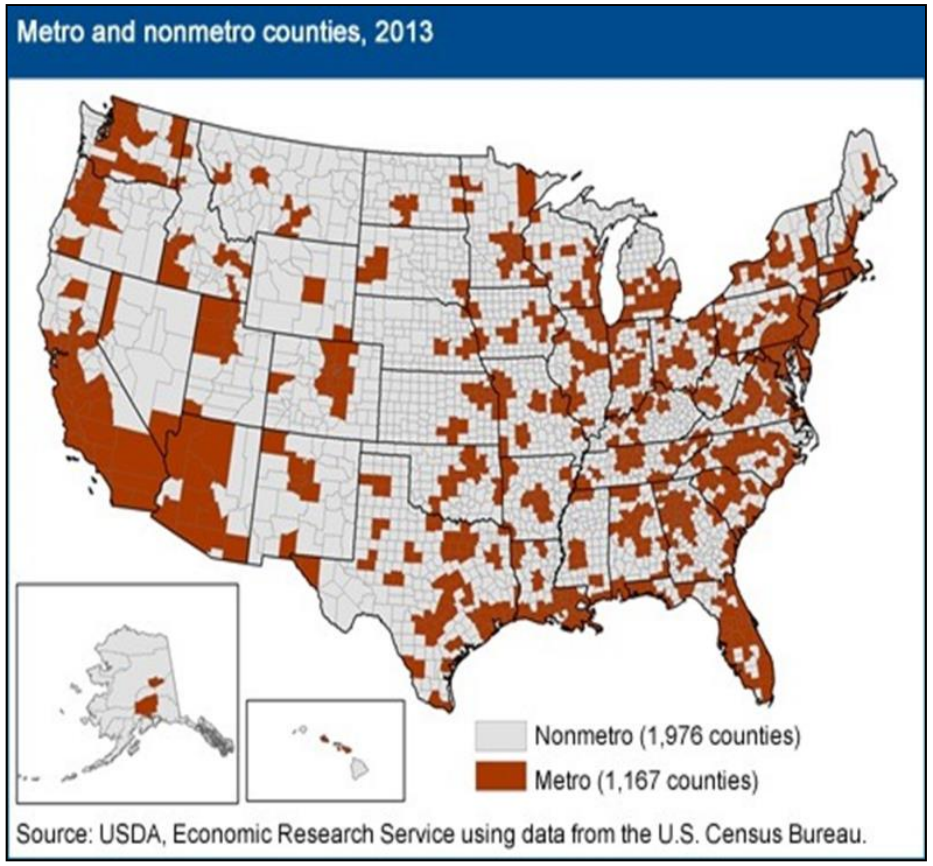
- **Rural providers surveyed and interviewed - main reasons for practicing in rural:**
  - They have rural roots (grew up where they are), want to be close to family/friends,
  - They have rural roots (but not from where they are), want to be in rural environment generally,
  - Understand rural culture and people, want to help others with similar background (familiarity),
  - See living rural as safer, more enriching, more “family” friendly, more aligned with personal values,
  - Generally more comfortable living rural than urban.

- **Predictors to hiring and retaining rural providers based on the following three key elements:**
  - Provider grew up in a rural area,
  - Provider education focused on rural concepts,
  - Provider completed internship in rural location.

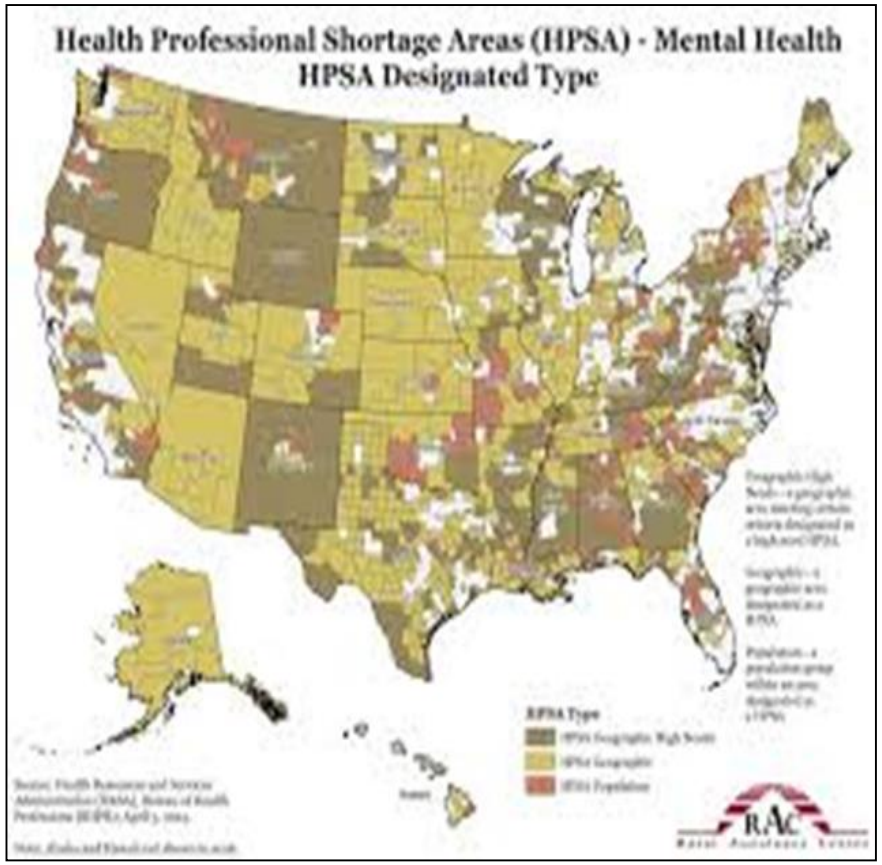
Illustrations

Example: 10 miles = 3%

2013 U.S. Metro/Non-Metro Counties



Health Professional Shortage Areas



Recommendations

Growing Our Own rural behavioral health providers – How:

- **Focus recruitment** in rural areas toward youth and **target** populations more likely to become rural behavioral health providers.
- **Create viable introductory pathways** beginning with entry-level positions that can lead to higher practitioner levels.
- **Develop advanced educational pathways** through collaborations with higher education institutions, includes:
  - Online & extended education, focused rural internships, and infusion of rural-focused knowledge, skills, & curriculum development.
- **Develop mentorship programs** to support rural practitioners,
- **Create funding opportunities** to support pathways concept,
  - Grants, scholarships, support for internships, educational advocacy, outreach.

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Andy Cummings

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Behavioral Health Workforce Research Initiatives

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University of Michigan School of Public Health

“A Workforce Crisis”

Behavioral Health
Workforce
Research Center

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

Mission

Behavioral Health
Workforce
Research Center

To conduct research to help produce a behavioral health workforce of sufficient size and skill to meet the nation’s behavioral health needs

Partner Consortium

Behavioral Health Workforce Research Center

- National Council for Behavioral Health
- NAADAC, the Association for Addiction Professionals
- Community Partnership of Southern Arizona
- Southwest Michigan Behavioral Health
- National Association of State Alcohol and Drug Abuse Directors
- Association of State and Territorial Health Officials
- National Association of County and City Health Officials

Expert Work Group:

- Ron Manderscheid, PhD
- Peter Buerhaus, PhD, RN
- Ariel Linden, DrPH

Federal Partners:

- HRSA
- SAMHSA

Minimum Data Set

Behavioral Health
Workforce
Research Center

- Define the workforce
- Identify/evaluate data sources for an MDS
- Develop MDS
- Pilot test an MDS

Characteristics and Practice Settings

Behavioral Health Workforce Research Center

- Enhancing workforce diversity
- Service delivery for vulnerable and underserved populations
- Team-based care studies
- Core competencies for social workers

Scopes of Practice

Behavioral Health
Workforce
Research Center

- Analysis of state SOPs
- SOPs and professional responsibilities: social workers
- SOPs and professional responsibilities: paraprofessionals
- Billing restrictions that limit SOPs

Contact Us

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