# California Mental Health Planning Council

## Human Resources Committee

## Policy Paper

# "HOW HEALTHCARE REFORM WILL INFLUENCE BEHAVIORAL WORKFORCE"

## August 2011

# SUMMARY

Healthcare Reform developed from two bills, the Patient Protection and Affordable Care Act (ACA). These two bills together were intended to enact a large-scale comprehensive health reform of the U.S. healthcare system. The overall approach of healthcare reform focuses on provisions to expand coverage, control health care costs, and improve the health care delivery system. The new law sought to improve the health of the population by enhancing the patient experience of care, including quality, access, reliability, and reducing the per capita cost of total healthcare. However, there has been no major reform of the healthcare system. "**Additionally Healthcare Reform must execute a greater level of financial support directing at restructuring the educational and workforce development system in order to create or maintain a sufficient Behavioral Workforce, especially in California."**

Healthcare reform set out to provide the following opportunities for the behavioral workforce by establishing a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy, but the workforce advisory committee has not been established: increasing the number of Graduate Medical Education training positions; increasing workforce supply and support training of health professionals through scholarships and loans; addressing the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing; and supporting the development of training programs that focus on primary care models such as medical homes.

Though healthcare reform provides some opportunities for Americans, there are challenges that need to be addressed. Such challenges included lack of racial and cultural diversity among the mental health disciplines; workforce problems with its geographic distribution, more than 85% of the federally designated mental health shortage areas are rural in nature and half of the counties in the United States do not have a single mental health professional. Additionally, the vast majority of mental health providers is certified or possesses a bachelor's degree. Most do not have graduate-level professional or systematic training and education. Lastly, money is not appropriated in Healthcare Reform.

This paper reviews the role of California Mental Health Planning Council in California's public mental health workforce development efforts, opportunities provided by the ACA, and explores challenges and stresses recommendations for the financing of public mental health workforce development and deployment strategies. It is imperative that state-level workforce policy organizations understand the challenges presented in this paper and how critical mental health and substance use interventions and treatment, or behavioral health care, is to the health and wellness of Californians. Healthcare Reform brought about many promises, but with the lack of workforce funding, nothing may come of the opportunities presented and Californians are left with few if any financial options to execute the workforce requirements. Healthcare reform has to do a lot more than what it intends to do federally in order to have impact in California and other states.

*Recommendations*

1. **Federal dollars need to be appropriated to support for financial relief programs that incentivize individuals to enter into and complete educational pathways that lead into to career in public mental health**
2. **Federal dollars need to be appropriated to support loan repayment programs that are designed to retain staff in hard to fill positions, especially in rural and geographically remote areas, as well as urban areas where high crime rates makes it hard to retain staff**
3. **Federal and state financial support to develop career pathways in public mental health that articulate from secondary educational programs of study into**
4. **Federal and state financial support for grants that assist organizations in the development of distributive educational approaches to delivery of educational and training programs to increase the supply of a trained and certificated mental health workforce**
5. **The creation of a centralized clearing house for each state's public mental health workforce education, training, and workforce development efforts.**
6. **The Federal financial support of each state's behavioral health workforce implementation efforts, as was previously provide for in ACA through HRSA.**
7. **Align licensing and certification requirements**
8. **Bridge disconnect between behavioral health providers and educational institutions to ensure future professionals are competently able to address needs of consumers**
9. **Federal and state financial support to further develop the pool of trained professionals already committed to the behavioral workforce**
10. **Federal and state financial support to develop high school outreach program to reduce stigma**

## Background

In 1999 California Mental Health Planning Council (CMHPC[1]) identified the critical shortage of mental health workers at all levels of service as a crisis that will prevent the expansion and provision of mental health services throughout California. As a means of confronting the crisis the CMHPC convened a statewide human resources summit to focus on strategies to alleviate the critical shortage of mental health workers at all levels of service and to develop strategies to increase the cultural and linguistic diversity of staff, expand educational capacity and the participation of consumers. An action plan emerged and the implementation of that plan delegated to the Human Resources Committee (HRC), a functional committee of the CMHPC.

The Human Resources Committee was established in 2000 as a functional committee to study, disseminate, and at times implement state, regional, and local policy and program strategies to meet the mental health workforce goals and objectives of the CMHPC. The HRC in partnership with the California Institute for Mental Health (CiMH) and the Department of Mental Health (DMH) initiated the Human Resources Project (HRP). The HRP was implemented through funding from Zellerbach Family Foundation with sustained funding and support from the DMH through the Substance Abuse Mental Health Services Administration (SAMHSA) Community Mental Health Block Grant.

The overall mission of the HRP is to assist the CMHPC HRC in serving as a statewide catalyst to increase: 1) the capacity of public mental health workforce, 2) eligibility for all workers among statewide and federal financial relief programs, 3) access to state-of-the-art competency-based educational and training programs, and 4) most importantly its cultural competence, representation, and diversity. Diversity is defined very broadly to include ethnicity, language, gender, age, individuals with lived experience, family members, parent partners, and members of the cross disability community. To meet the goals of the HRC, the HRP developed special projects to produce publications, facilitate projects with partner organizations, and advocate for state and federal administrative and policy strategies. The HRP also assists the HRC in participating in state and national workforce development and deployment efforts.

In 2004 the Mental Health Services Act (MHSA) was passed. The CMHPC advocated for the MHSA to include a Workforce Education and Training (WET) component, workforce needs assessment, and a strategic plan for workforce education and training to serve as a guide for WET implementation. The CMHPC delegated to the HRC the responsibility of working with DMH and numerous associations statewide to inform the vision, objectives, and structure of the five-year plan and advocate for the implementation and evaluation of WET component locally, regionally, and statewide.

Currently, the MHSA WET component has been implemented and the focus has shifted to the problem California's economic crisis is causing in behavioral workforce. Workforce problems have an impact on almost every aspect of prevention and treatment across all sectors of the diverse behavioral health field. The issues encompass difficulties in recruiting and retaining staff, the absence of career ladders for employees, marginal wages and benefits, limited access to relevant and effective training, lack of resources for

[1] CMHPC is a forty-member body, appointed by the State Department of Mental Health (DMH) Director to provide oversight of California's public mental health system. The roles and responsibilities of the CMHPC are in both state and federal statute.

supervision, a vacuum with respect to future leaders, and financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources[1].

**Exploring Health Care Reform**

The HRC seeks to explore how the implementation of ACA will impact workforce development and deployment opportunities and challenges facing the behavioral workforce at both the State and Federal level. While the behavioral healthcare workforce encompasses occupations in the substance use field, for the purposes of this paper behavioral health will be used to describe the public mental health workforce. In this paper we will examine the opportunities healthcare reform presents to build the capacity of the current behavioral health workforce. Additionally, we will provide an overview of the supply and demand and training component of the current workforce capacity. Lastly, we emphasize critical recommendation for developing the behavioral workforce California so desperately needs:

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## Healthcare Reform Behavioral Workforce Opportunities

### What is Healthcare Reform?

In March 2010, President Obama signed into law two bills that together enacted a large-scale comprehensive health reform of the U.S. healthcare system, the Patient Protection and Affordable Care Act. The overall approach focuses on provisions to expand coverage, control health care costs, and improve health care delivery system. The new law seeks to expand access to coverage by requiring U.S. citizens and legal residents to have health insurance. Those without coverage pay a tax penalty[2] of the greater of $695 per year up to a maximum of three times that amount per family or 2.5% of household income. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8% of an individual's income, and those with incomes below the tax filing threshold. Another expansion method is requiring employers to offer coverage. Employers with more than 200 employees will automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage. The expansion of public programs, such as Medicaid to all individuals under age 65 for all newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits through state and federal funding. Additionally, states are required to maintain current income eligibility levels for children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019 and extend funding for CHIP through 2015.[2]

The new law provides provisions to control health care costs includes the limited availability of premium credits and cost-sharing subsidies to U.S. citizens and legal immigrants who meet income criteria. Verification of both income and citizenship status is a requirement in determining eligibility for the federal premium credits. Federal subsidy funds, for premiums or cost-sharing, must not be used for the purchase of the abortion coverage and must be separate from private premium payments or state funds. Premium subsidies to small business employers, with no more than 25 employees receiving less than $50,000 in annual wages, by providing tax credits in two phases and creating a temporary reinsurance program for employers to provide health insurance coverage to retirees over age 55 who are not eligible for Medicare.

Healthcare reform proposed laws seek to improve workforce training and development in the following ways:

- Establishing a multi-stakeholder Workforce Advisory Committee to develop a national workforce strategy. (Appointments made by September 30, 2010)
- Increasing the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability

[2] The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016. Beginning after 2016, the penalty will be increased annually by the cost-of-living adjustment (The Henry J. Kaiser Family Foundation, 2010).

of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including federally qualified health centers and other federally-funded health centers that are eligible for Medicare payments for the expenses associated with operating primary care residency programs. (Initial appropriation in fiscal year 2010)

- Increasing workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals. (Effective dates vary) Support the development of interdisciplinary mental and behavioral health training programs (effective fiscal year 2010) and establish a training program for oral health professionals. (Funds appropriated for six years beginning in fiscal year 2010)

- Addressing the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing. (Initial appropriation in fiscal year 2010) Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics. (Funds appropriated for five years beginning in fiscal year 2011)

- Supporting the development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and those that integrate physical and mental health services. (Funds appropriated for five years beginning in fiscal year 2010)

**Opportunities: Building the Behavioral Health Workforce Capacity**

Healthcare reform includes several provisions for the development of the behavioral health workforce:

- **Training for Behavioral Health Professionals:** Authorizes $35 million for awarding grants to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, and child and adolescent mental health.

- **Loan Repayment for Pediatric Behavioral Health Specialists in Underserved Areas:** Establishes a loan repayment program for individuals employed in medically underserved areas who provide child and adolescent mental and behavioral healthcare, including substance abuse prevention and treatment services. $20 million is authorized for each year from 2010-2013.

- **Educating Primary Care Providers about Behavioral Health:** Establishes a Primary Care Extension Program to educate primary care providers about chronic diseases, including mental health and substance use disorder prevention and treatment. $120 million is authorized for 2011 and 2012, and such sums as may be necessary for 2013-14.

- **Community Mental Health Services Improvement Act (H.R. 1011/S. 1188)**

Rep. Gene Green (D-TX) introduced H.R. 1011, co-sponsored by Reps. Sheila Jackson-Lee (D-TX) and Tim Murphy (R-PA), on February 12, 2009. Sen. Jack Reed (D-RI) on June 4, 2009, introduced companion legislation, S. 1188, co-sponsored by Sens. Lisa Murkowski (R-AK) and Sheldon Whitehouse (D-RI). The bill, which includes several provisions to expand and improve the behavioral health workforce, would:

- Authorize grants for demonstration projects to provide coordinated and integrated care to individuals with mental illnesses who have co-occurring primary care conditions and chronic diseases through the co-location of primary and specialty care services in community-based mental and behavioral health settings;
- Specifically make funds available for the development or expansion of programs to provide integrated care for individuals with a serious mental illness and a co-occurring substance use disorder; and
- Establish grants for programs to address behavioral and mental health workforce needs of designated mental health professional shortage areas. [3]

[3] Insert from "Behavioral Health Workforce Legislation in the 111th Congress" (National Council for Community Behavioral Healthcare, 2010)

## Healthcare Reform Behavioral Workforce Challenges

Historically, neither state agencies nor professional associations have collected information routinely on the workforce using a standardized data set or common schedule. Thus it has been difficult to assemble a unified picture of the mental health workforce or to compare the various disciplines that constitute it. The Alliance of Mental Health Professions has been developing a standardized data set and working to generate comparable data across disciplines (Duffy et al., 2004). However, further progress on this agenda is sorely needed.

The best available estimates indicate that there were slightly more than a half million clinically trained and active mental health professionals in the United States in 2002 (Manderscheid & Henderson, 2004). This indicates that there is a pool of trained people who are committed to the mental health field, but can be further developed.

There are differing trends regarding the growth rates of the various disciplines within the field, with psychiatry essentially static in terms of growth, psychology doubling in size over the past 25 years, and social work increasing by 20% over the past 1 ½ decades. Increases in the number of psychiatric nurses with graduate-level preparation largely have been offset by the number of nurses leaving the active workforce and by sharp reductions in the number of students who are enrolling in this discipline's graduate programs.

**There is a notable lack of racial and cultural diversity among the mental health disciplines**. The vast majority of professionals are non-Hispanic Whites, often exceeding 90% of discipline composition (Duffy et al., 2004). For most disciplines, substantially more than half of the clinically trained professionals are over the age of 50, raising serious concerns about whether the pipeline of young professionals will be adequate to compensate for both the growing service demand and the approaching retirement of large segments of the workforce (Duffy et al., 2004). The following table examines professions by ethnicity:

| Occupation | American Indian/ Alaskan | Asian/ Pacific Islander | Hispanic | Black (not Hispanic) | White (not Hispanic) | Other |
|---|---|---|---|---|---|---|
| **Psychiatrists (1999)** | **0.1%** | **9.5%** | **4.5%** | **2.4%** | **75.5%** | **8.0%** |
| **Social Workers (1996)** | **0.5%** | **1.7%** | **2.7%** | **5.0%** | **88.9%** | **1.2%** |
| **Psychiatric Nursing (1996-*women only*)** | **0.2%** | **1.9%** | **1.1%** | **2.3%** | **94.6%** | **No data** |
| **Psychosocial Rehabilitation (1996-*men only*)** | **0.4%** | **2.0%** | **6.4%** | **20.8%** | **69.8%** | **0.6%** |

Ethnicity by Occupation
Source: Mental Health, United States (2002)—Mental Health Practitioners and Trainees, Chapter 21

Compounding concerns about workforce size are problems with its geographic distribution. Holzer, Goldsmith, and Ciarlo (2000) provide evidence that the heaviest concentrations of highly trained professionals are in urban centers. **In fact, more than 85% of the 1,669 federally designated mental health shortage areas are rural in nature** (Bird, Dempsey, & Hartley, 2001). Half of the counties in the United States do not have a single mental health professional.

In addition to graduate degreed professionals, there are 145,000 members of the mental health workforce who do not have graduate-level professional training but rather possess a bachelor's degree or less (Morris & Stuart, 2002). This segment of the workforce includes registered nurses, bachelor's-prepared social workers, and various technicians or aides. **This group of individuals too seldom receives systematic training and support despite the fact that it accounts for up to 40% of the workforce in many public-sector service settings.**[4]

**Occupational demands**

There is overwhelming evidence that the behavioral health workforce is not equipped in skills or in numbers to respond adequately to the changing needs of the American population. In 2002, The President's New Freedom Commission on Mental Health stated the following*"...the Commission heard consistent testimony from consumers, families, advocates, and public and private providers about the workforce crisis in mental health care. Today, not only is there a shortage of providers, but those providers who are available are not trained in evidence-based and other innovative practices. This lack of education, training, or supervision leads to a workforce that is ill-equipped to use the latest breakthroughs in modern medicine."*[3]

There are behavioral workforce challenges Healthcare Reform must address to fulfill current occupational demands throughout the nation. The following is a brief summary of supply and training issues related to workforce challenges:

*Supply*

- There is a critical shortage of individuals trained to meet the needs of children and youth, and their families.
- The current workforce lacks providers with expertise in geriatrics, and this deficit is expected to worsen.
- In rural America, the workforce crisis is particularly acute. More than 85% of the 1,669 federally designated mental health professional shortage areas are rural and typically lack even a single professional working in the mental health disciplines.
- It has been extraordinarily difficult to recruit, train, and retain mental health professionals in rural areas.

*Training*

- Only five states require adolescent-specific knowledge for licensure.

[4] Insert from "An Action Plan on Behavioral Health Workforce Development: Executive Summary" (Annapolis Coalition, 2007)

- Behavioral health professionals who have been trained to provide behavioral health prevention and intervention in the nation's schools are in significantly short supply, or are hindered by the constraints of their position to use such skills.
- Training programs that do focus on prevention and treatment for children and youth, and their families, have not kept pace with current trends in the field, which have been shifting toward strengths-based and resilience-oriented models, a systems-of-care approach, and the use of evidence-based practices.
- Only 20% of the individuals in this country who need substance use disorders treatment each year receive it.
- Huge need for cross-cultural training to improve quality of care and service use among people of color. U.S. Census figures indicate that 30% of the nation's population is drawn from four major ethnic groups: Latinos, African Americans, Asian American/Pacific Islanders, and Native Americans. However, the behavioral health workforce lacks such cultural diversity, particularly in mental health.[4]

The State of California faces similar challenges with the following future trends to be considered as current occupational demands:

- Aging workforce: 33.1% of California's population will be 55 and older by 2018
- Increasing diversity: by 2018 California will be 37.3% Hispanic, 12.9% Asian, 5.5% Black, and 41% White
- An increase in the number of workers with only two years of education beyond high school, currently at 29.3%
- Vacancies for "hard-to-fill" positions and among under-utilized occupations
- **Lack of any sustainable mechanism to promote MH careers to ethnically and linguistically diverse communities**
- Lack of articulation among educational programs
- Increasing gap between secondary education and postsecondary training
- **Few financial incentives, no sustainability**
- A soon approaching competitive employment horizon

**Educational capacity and demands**

Institutions of higher education, from community college to academic health centers, play an indispensable role in nearly all aspects of workforce development, including outreach to K-12 students, education of health professionals, and analysis of workforce data[5]. The behavioral health workforce depends on a strong educational system capable of producing a sufficient supply of future professionals. However, limited educational capacity posses a major obstacle across workforce professions. Some of the challenges in educational capacity **Healthcare reform will need to address are: faculty shortages, which pose a problem for many health profession schools; lack of placement opportunities for graduate students; lack of financial resources for students; limited capacity of postsecondary education; and more part-time graduate programs are needed.**

In 2005, the University of California Health Sciences System analyzed the state's health workforce and developed recommendations for the university system to implement. The report's recommendations largely focused on expanding enrollment, meeting the needs of the underserved, diversifying the student body and faculty, developing new curricula, especially collaborative or technology-based programs, and recruiting and retaining faculty.

**Licensing capacity**

State professional boards oversee the licensure of health professionals in each state, and states have struggled with the impact of state-specific licensure on the workforce. In California, the Department of Consumer Affairs (CDA) oversees the Board of Behavioral Sciences (BBS). Due to the current state of the economy, hiring constraints are in place and the BBS is unable to fill vacancies, including those occurring in licensing, the application evaluation and renewal processing units.

**Training Demands**

There is a critical shortage of individuals trained to meet the needs of children and youth, and their families. As just one example, the federal government has projected the need for 12,624 child and adolescent psychiatrists by 2020, far exceeding the projected supply of 8,312. Currently there are only 6,300 such psychiatrists nationwide, and relatively few are located in rural and low-income areas (Mokowitz, 2007). Furthermore, **behavioral health professionals who have been trained to provide behavioral health prevention and intervention in the nation's schools are in significantly short supply, or are hindered by the constraints of their position to use such skills.**

Managers within organizations that employ the workforce are concern that recent graduates of professional training programs are unprepared for the realities of practice in real-world settings, or worse, have to unlearn an array of attitudes, assumptions, and practices developed during graduate training that hinder their ability to function. In an era of scarce resources, the specter of education and training programs that lack relevance to the needs of the American population and to current prevention and treatment approaches raises considerable alarm.[6]

Beyond the issue of workforce size, the training programs that do focus on prevention and treatment for children and youth, and their families, have not kept pace with current trends in the field, which have been shifting toward strengths-based and resilience-oriented models, a systems-of-care approach, and the use of evidence-based practices (Mokowitz, 2007). Training in behavioral health now occurs in disciplinary or sector silos. In addition, there is little collaboration among the disciplines on workforce development efforts, such as competency development, despite the presence of many shared competencies across professions. **As training, prevention, and treatment organizations attempt to address workforce issues, there is a notable tendency to do what is affordable rather than what is effective.**

Additionally, other training issues the behavioral workforce faces are: inadequate resources amongst agencies; limited access to relevant and effective training; erosion of supervision; training programs have not altered their curricula to address the changing needs of the American population; and lack of training in geriatrics, fellowship opportunities.

## Conclusion

**Behavioral health care is critical to the health and wellness of Californians**. Multiple professions constitute this workforce, each possessing specific education and licensing requirements. Many colleges and universities educates behavioral health professionals in six different fields including: counseling, marriage and family therapy, nursing, psychiatry, psychology and social work. A large portion of the delivery system of behavioral health services is funded and provided for by the State of California. **There are few financial resources directed at building the capacity of the behavioral health workforce and with federal financial investment states, such as California, will not have the means to implement the programs necessary to overcome challenges.** The following is a list of recommendations for federal financial support that would greatly assist California and other states.

**Recommendations**

Appropriations

1. **Federal dollars need to be appropriated to support for financial relief programs that incentivize individuals to enter into and complete educational pathways that lead into to career in public mental health**
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5. **The Federal financial support of each state's behavioral health workforce implementation efforts, as was previously provide for in ACA through HRSA.**

Granting

6. **The creation of a centralized clearing house for each state's public mental health workforce education, training, and workforce development efforts.**
7. **Align licensing and certification requirements**
8. **Bridge disconnect between behavioral health providers and educational institutions to ensure future professionals are competently able to address needs of consumers**
9. **Federal and state financial support to further develop the pool of trained professionals already committed to the behavioral workforce**
10. **Federal and state financial support to develop high school outreach program to reduce stigma**

[1] Annapolis Coalition. 2007. *An Action Plan for Behavioral Health Workforce Development: Executive Summary*. Cincinatti, OH.

[2] The Henry J. Kaiser Family Foundation. 2010. *Focus on Health Reform: Summary of New Health Reform Law*. www.kff.org

[3] California Workforce Investment Board. *California's Strategic Plan: For Title I of the Workforce Investment Act of 1998 and the Wagner-Peyser Act* , 2009-2010.

[4] National Council for Community Behavioral Healthcare. 2010. *Behavioral Health Workforce Legislation in the 111th Congress*. www.TheNationalCouncil.org.

[5] Moskowitz, M.C. 2007. *State Actions and the Health Workforce Crisis*. Washington, DC: Association of Academic Health Centers.