Recommendations for PMHS Workforce Planning Models in California

Deliverable 8: Research Question 2:

What health workforce planning model(s) would most effectively address public mental health system (PMHS) needs in California?

Overview

OSHPD
Office of Statewide Health Planning and Development

Prepared by:

Resource Development Associates

June 2017

RDA

Executive Summary

This report presents cumulative findings addressing Workforce Planning Research Question 2, ("What health workforce planning model(s) would most effectively address public mental health system (PMHS) needs in California?"). This report focuses on identifying and reviewing workforce planning practices within and outside of the California public mental health system (PMHS). This report also synthesizes recommendations on workforce planning models and strategies to most effectively address PMHS needs in counties throughout California.

Methods

To explore RQ2, RDA used a mixed-methods approach employing both qualitative and quantitative data collection and analysis to capture various perspectives, triangulate research findings, and develop an in-depth understanding of the context, planning process, strategies, and outcomes of workforce planning efforts conducted within and outside of California.

Primary data were obtained through interviews with key stakeholders to understand workforce planning models conducted within and outside of California, including the following:

- State, regional, and county Mental Health Services Act (MSHA) Workforce Education and Training (WET) leaders.
- Professional practice organizations across all licensed provider types.
- National, statewide, and regional workforce planners.

Secondary data related to public mental health trends, legislative and regulatory policies, and workforce planning models were obtained through literature review, document review, and a number of quantitative data sources. These data activities provided a foundation of evidence for workforce planning recommendations and a six-component workforce planning model framework.

Findings

The research yielded several trends that counties should consider when undertaking workforce planning efforts. RDA's review and analysis of the data identified the following trends in the consumer population:

- The volume of mental health consumers across the acuity spectrum is increasing.
- A greater number of consumers have co-occurring mental health and substance use needs.
- The number of consumers with criminal justice involvement is growing.
- Expanded access to mental health services for foster children and youth could increase the number of child and youth consumers.

RDA also conducted in-depth research to understand the provider population, staffing models, and emerging models of care. The following trends emerged as important considerations for county workforce planners:

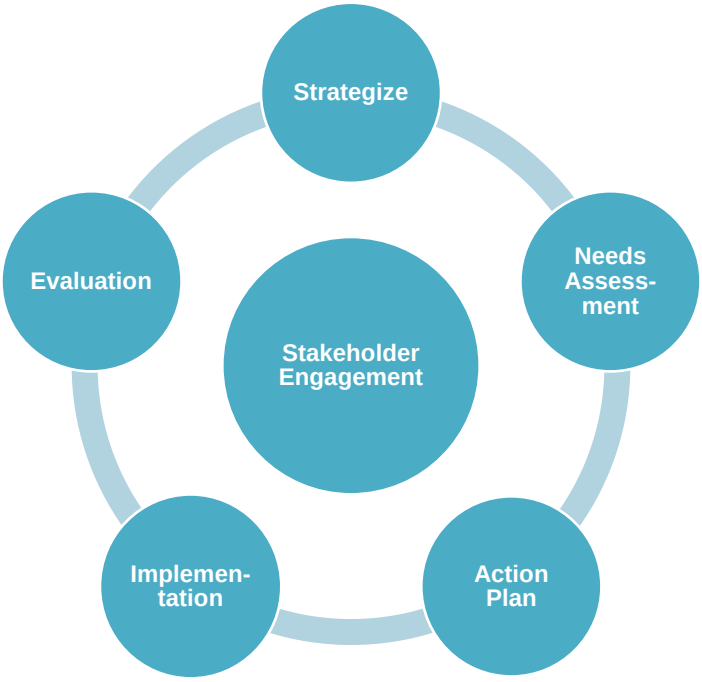
- The mental health workforce has been growing over time.
- Non-licensed providers are the fastest growing sector of the mental health workforce.
- More peer positions are being created and peers are increasingly being employed as integral mental health service providers.

Recommended Workforce Planning Model

Given the trends in consumer and provider populations, the shift towards integrated care, and the continued challenges in workforce planning, counties are encouraged to use an evidence-based framework for planning and developing the public mental health workforce.

In order to integrate with existing systems and local practices, RDA reviewed historical and current workforce planning processes used by counties throughout California. Then, drawing from a review of best practices—including current practices conducted by California counties—RDA synthesized the most salient features into a workforce planning model (Figure 1).

Figure 1. Recommended Workforce Planning Model



Drawing from the workforce planning best practice research, RDA identified the following six key strategies counties should consider when implementing the recommended workforce planning model:

- Strategy 1: Conduct succession planning and foster leadership.
- Strategy 2: Invest in education, training, and professional development.
- Strategy 3: Leverage varied types of licensed providers to balance workloads.
- Strategy 4: Use non-licensed providers to extend the workforce.
- Strategy 5: Meaningfully engage peers in the workforce.
- Strategy 6: Plan for integrated and coordinated care.

Conclusion

The original WET workforce planning model was fairly aligned with best practice. The six-component workforce planning model builds upon existing county best practice and serves as a guide to bring counties closer to best practice. The model also provides a framework for intentional and responsive planning that includes specific steps to anticipate, confirm, and adapt to the needs of the public mental health workforce and mental health consumers.

Across the study of past, present, and promising PMHS workforce planning efforts, a tension rises between mandated staffing requirements and critical staffing needs. Traditional fee-for-service delivery models do not usually have billable line items for key services like transportation, warm handoffs, systems navigation, and coordination of care. In reviewing staffing practices, challenges, and creative solutions across the state, many counties' efforts to integrate services, create practice flexibility, and onboard peer providers ultimately work toward addressing this gap.

In addition, counties need to be flexible in order to respond to changes in legislation affecting service delivery, as well as changes in providers' scopes of practice. Several counties noted that being in communication and/or working with their MHSA Regional Partnerships, as well as with smaller regional workgroups, has helped them be more responsive to emerging needs, plan more intentionally and creatively around addressing staffing shortages, and more meaningfully engage peers as a part of their workforce.

Therefore, it is RDA's overarching recommendation that MHSA Regional Partnerships should take the opportunity to strengthen their model and establish greater opportunities for counties to come together, learn about each other's challenges, share creative responses, and brainstorm additional solutions. Likewise, counties should leverage their local and regional resources and systems to identify and adapt promising practices to improve their workforce planning and development efforts.

Overview of Findings

The following is a high-level summary of the findings and recommendations RDA compiled in addressing Research Question 2 for the Office of Statewide Health Planning and Development's Health Workforce Development Division, regarding the Workforce Education and Training (WET) component of the Mental Health Services Act (MHSA):

What health workforce planning model(s) would most effectively address public mental health system (PMHS) needs in California?

This report recommends a workforce planning model that would address PMHS needs in California, distilled from best practices conducted across the country and in other public service industries. To successfully implement the six-step model, however, there are many additional trends and factors counties should consider. Therefore, this report also provides a cursory discussion of trends that impact the PMHS workforce and strategies for how county behavioral health departments and other agencies may leverage these findings to inform their workforce planning and development efforts. The high-level summaries of these areas are presented in the following order:

1. Current trends in the public mental health workforce, including consumer trends and provider trends.
2. Trend toward integrated care.
3. Workforce planning models, including the recommended model.
4. Key strategies for addressing common workforce planning and development challenges.

A more thorough report of findings and recommendations is available upon request. The detailed technical report is geared toward county behavioral health administers and others interested in the details of the study design, execution, and findings and recommendations. To access the technical report, please contact OSHPD.MHSAWET@oshpd.ca.gov.

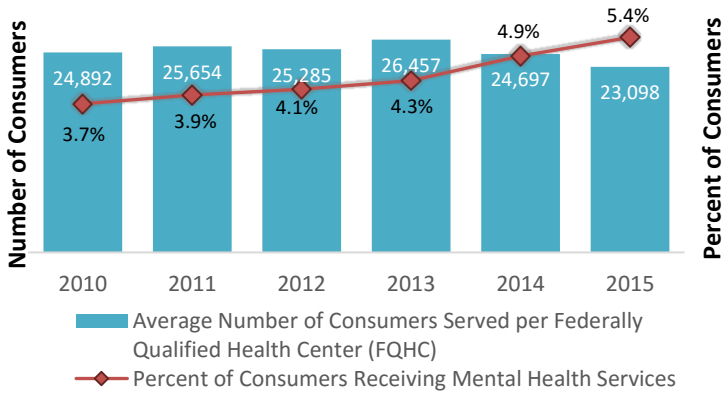
Current Trends in the Public Mental Health Workforce

Several trends emerged that counties should consider when undertaking workforce planning efforts. These trends include changes in the consumer and provider populations, the shift toward integrated care, and specific recurring challenges in workforce planning.

Consumer Trends

The volume of mental health consumers across the acuity spectrum is increasing

Recent legislation such as the Affordable Care Act (ACA), and Medicaid expansion, have influenced the volume of mental health consumers. In addition, the volume of consumers seeking and receiving mental



health services has been increasing across the acuity spectrum.

A greater number of consumers have co-occurring mental health and substance use needs

According to county behavioral health departments, they have noticed an increase in the number of consumers who have co-occurring mental health and substance use needs. Recent legislation, such as the Drug Medi-Cal Organized Delivery System, has increased the demand for substance use services in California. Certified alcohol and drug counselors, however, have high turnover rates (20 to 50 percent annually).

The number of consumers with criminal justice involvement is growing

Due to recent legislation such as Assembly Bills (AB) 109 and 1421, counties also reported serving more consumers with criminal justice involvement over the past 10 years.

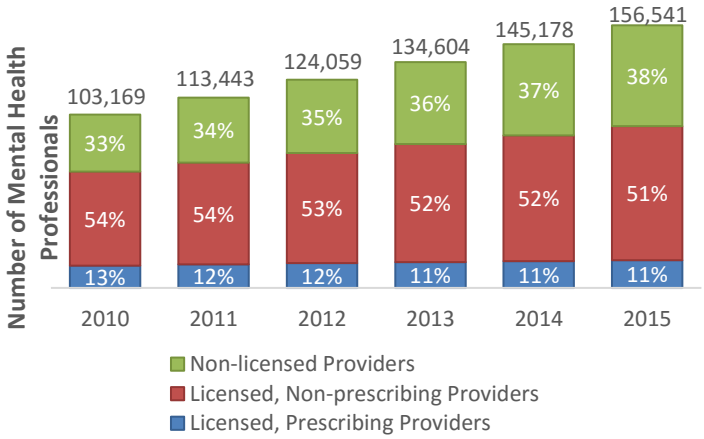
Expanded access to mental health services for foster children and youth could increase the number of child and youth consumers.

Recent legislation including AB 403 (2015) and *Katie A.* support expanded mental health services for foster children and youth. This may create an increase in the number of child and youth consumers as the foster care population experiences a disproportionately high prevalence of mental health needs.

Provider Trends

The mental health workforce has been increasing over time

The mental health workforce is growing, with 52 percent growth from 2010 through 2015, growing from 103,169 providers in 2010 to 156,541 in 2015. Counties, however, continue to experience workforce shortages and high turnover across all mental health professions.



Non-licensed providers are the fastest growing sector of the mental health workforce

Non-licensed professionals (e.g., case managers, counselors) are the fastest growing provider type, with the number of non-licensed providers increasing by 78 percent between 2010 and 2015, increasing from 33,806 providers in 2010 to 60,060 in 2015. Non-licensed providers also comprise an ever-growing proportion of the workforce, comprising 33 percent of the workforce in 2010 and growing to 38 percent in 2015.

More peer positions are being created and peers are increasingly being employed as integral mental health service providers

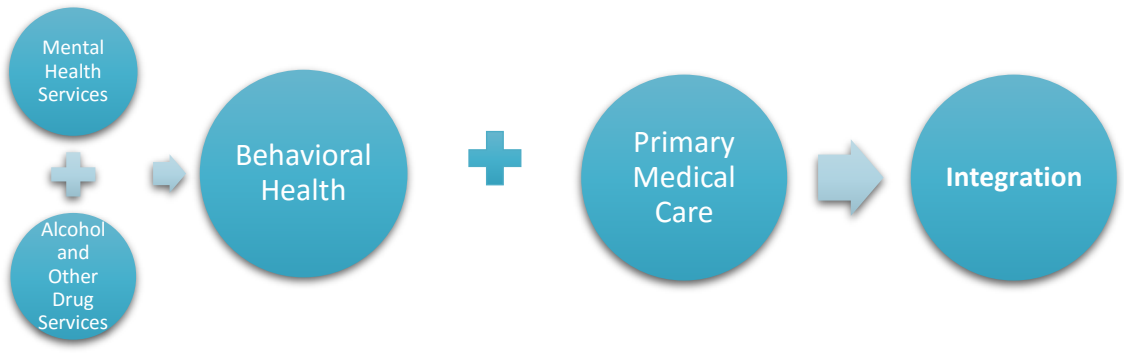
There is an increasing emphasis on the recovery model and recognition of the importance of peers in the public mental health workforce. Peers are increasingly serving on interdisciplinary treatment teams as mental health service providers.

Implications for Workforce Planning

- Despite workforce growth, all provider agencies have an increased need for mental health providers to meet the growing demand for mental health services. Due to this, there has been increased competition for mental health providers between counties and Managed Care Plans (MCPs), Federally Qualified Health Centers (FQHCs), and other non-profit or community-based organizations (CBOs), which could lead to further staff shortages.
- All provider agencies have an increased need for substance use providers to meet the growing demand for substance use treatment services. Additionally, both mental health and substance use providers need cross-training to improve service delivery and care coordination within and across treatment teams.
- The growth of non-licensed providers' share of the workforce offers an opportunity for counties to employ non-licensed providers as workforce extenders to provide important case management, administrative, and support services.
- The role of peers is expanding, with more opportunities for career development and growth. In addition, there has been an increased demand for peers with criminal justice involvement to support consumers in their recovery. Since California is one of the four states that does not have peer certification, counties will need to work with their operations departments to categorize peers as staff and to set expectations for how peers may participate on interdisciplinary treatment teams.
- There is increased competition with criminal justice institutions for mental providers.
- Expanded mental health services for foster children and youth could lead to an increased need for specialized providers, nurses, and case managers.

Trend toward Integrated Care

Integrated care is an emerging model that key stakeholders repeatedly highlighted as important to consider when conducting workforce planning. In an international review of workforce development approaches, policy makers increasingly recognized the value and need for more integrated planning of human resources in health care.



Progressing toward Integration in California

Many recent legislative and regulatory changes are steering California's PMHS toward collaboration between two disciplines and systems (e.g., mental health and substance use, mental health and children's services, behavioral health and criminal justice). Informants identified that the change in laws, regulations, and court decisions create a trend toward overall social services integration, but that the legislature has yet to propose comprehensive change.

At the state level, the California Department of Health Care Services has absorbed the functions of the California Department of Mental Health and Department of Alcohol and Drugs, in a move that will influence the implementation of integrated systems across the state. Further, across California, there are programs, CBOs, and county departments that have integrated mental health and substance use services to varying degrees.

Why Integration is Important

20% of adults in California have some form of mental illness

4% of adults in California have severe mental illness, like schizophrenia

60% of premature deaths among people with schizophrenia can be attributed to treatable/preventable medical conditions

25 years reduced from lifespan: People with severe mental illness die 25 years earlier than their peers, often from physical illnesses

Barriers to Integration

Counties may encounter barriers when implementing strategies for integrative care, including the following:

- Staff shortages exist in both primary care and in the PMHS.
- Disagreements about provider roles often result from ineffective communication about integration. Changing culture around integration takes intentional orientation and training.
- Restrictions on sharing patient information can hinder treatment planning.
- State and federal policies can complicate care reimbursement; often Medicaid will not reimburse for medical and behavioral health services on the same day.
- Workflow and logistical obstacles (e.g., lack of physical space, cost of medical equipment) can also serve as a barrier to effective integrated care.

Workforce Planning Models

When the MHSA WET Component was introduced for FY 2006-07, the former California State Department of Mental Health (DMH) provided counties with WET program development and implementation support. DMH provided counties with the following workforce planning model for developing their WET Component Plans.

Original WET Workforce Planning Model Used by California Counties

Initial development of the WET Component was an onerous undertaking. While maintaining and updating the plan has become less strenuous and more routine over time, most counties have forgone the intensive needs assessment phase, relying instead on self-reports from the

workforce and qualitative information collected through stakeholder engagement, resulting in the following planning model.

Current WET Workforce Planning Model Used By California Counties

In order to identify workforce planning model best practice, RDA conducted a literature and document review of workforce planning models implemented within and outside of California. These activities provided RDA with a foundation of evidence, from which RDA synthesized a six-component workforce planning model framework. While this model is more rigorous than previous county WET planning efforts, it is quite similar.

1. **Strategize.** The initial steps of planning involve setting a strategic direction and conducting an environmental scan of factors influencing workforce planning.
2. **Stakeholder Engagement.** Soliciting support and input from key stakeholders using meaningful engagement strategies plays a critical role in workforce planning and should be conducted throughout the planning process.
3. **Needs Assessment.** Collect data on the current and projected workforce, and synthesize these findings with input from stakeholders to identify strengths, needs, and gaps.
4. **Action Plan.** Prioritize and outline in an action plan the strategies to address needs and gaps.
5. **Implementation.** Implement the action plan through coordinated activities and clear delineation of responsibilities.
6. **Evaluation.** Monitor progress and evaluation of outcomes; this is an iterative process throughout workforce planning and development activities. Report evaluation findings on an annual basis, with the action plan revised accordingly.

Recommended Workforce Planning Model Based on Best Practices

Key Strategies for Addressing Common Workforce Planning and Development Challenges

While a workforce planning model outlines the steps to conduct planning, there are additional challenges and needs that such a model does not address. Many of the challenges and needs that arise in PMHS workforce planning are commonly experienced across California counties. This section presents key strategies that have been effective for addressing common challenges and needs.

Strategy 1: Conduct succession planning and foster leadership

As a part of their **action planning** process, counties may consider implementing leadership development strategies to build a pipeline for leadership succession.

Strategy 2: Invest in education, training, and professional development

As a part of their **action planning** process, counties should work with local colleges to ensure that staff have access to training and continuing education units so that staff can boost on-the-job competencies and be responsive to changes in service delivery requirements.

Small and rural counties, in particular, should cultivate and maintain partnerships with entities who touch other parts of the workforce pipeline.

Strategy 3: Leverage varied licensed providers to balance workloads

All counties should consult the dashboard (see Table 7 in the technical report) of provider types during their **needs assessment** and **action planning** processes to identify opportunities to balance workloads and prioritize responsibilities across different provider types. To do so, counties should:

1. Understand the minimum staffing requirements of certain service delivery models.
2. Understand where there are overlapping responsibilities among different provider types and how this redundancy can be leveraged to alleviate strains on other responsibilities in high demand.
3. Be nimble and creative in addressing chronic workforce shortages.

The following table shows a list of common challenges and some solutions that have been successful:

Challenges	Solutions
Licensed Clinical Social Worker (LCSW) and Licensed Clinical Psychologist (LCP) shortages	Leveraging Licensed Marriage and Family Therapists (LMFTs) and Licensed Professional Clinical Counselors (LPCCs) to provide direct services, allowing LCSWs and LCPs more availability to provide the supervision necessary to grow those positions in the workforce.
Chronic psychiatrist shortage	Hire Psychiatric Mental Health Nurse Practitioners (PMHNPs) and Physician Assistants (PAs) to extend prescribing workforce.
General prescribing workforce shortage	Hire temporary employees, use telepsych/telemed, source providers from abroad via the J-1 Visa program
Shortages due to staff attraction and retention challenges	Invest in staff in multiple ways, including developing and promoting clinical staff from within, establishing a welcoming environment for employees, providing effective orientation and ongoing professional development, conduct trainings on self-care, and allow part-time and/or flexible schedules.

Strategy 4: Use non-licensed providers to extend the workforce

As a part of their **needs assessment**, counties should evaluate whether licensed staff are overburdened with administrative tasks or if they are providing services that could be performed by non-licensed staff. During the **action planning** phase of their workforce planning efforts, counties may consider hiring more non-licensed staff to reduce the administrative burden on licensed staff.

Strategy 5: Meaningfully engage peers in the workforce

During the **action planning** phase, counties may consider identifying ways in which peer providers can respond to consumer needs. In addition, counties may consider providing education opportunities to reduce stigma against peers in the workforce, developing training curricula for peer positions, creating more peer positions, and developing a career ladder for peer providers.

Strategy 6: Plan for integrated and coordinated care

New legislation has set the stage for increased collaboration and coordination across service providers. This trend toward integration suggests that counties should incorporate considerations for integrative care throughout their workforce planning process.

Counties that wish to encourage integration efforts should use the Levels of Collaboration framework and Four Quadrant Model during the **needs assessment** phase to determine where gaps exist along the continuum of care. During the **action planning** phase, small counties should focus on filling those integration and coordination of care gaps, while large counties should identify opportunities to leverage CBOs and partners to cover those gaps.