Behavioral Health Collaborative

Workforce Work Group Report to Steering Committee

Instructions: Please complete the work plan as well as this template for the BHC Steering Committee. Please be brief in your response, but include all relevant details.

Deliverable 1:

Workgroup will recommend retention and recruitment strategies for a well-trained BH workforce, inclusive of certified, licensed and unlicensed, peer support specialists and community health workers throughout the state.

Summary of work group's recommendation:

The BHC Workforce Workgroup focused on expanding and enhancing the initial recommendations that had emerged from Oregon Health Policy Board's Health Care Workforce Committee, recommendations from the Farley Center, and Washington's Behavioral Health Workforce Assessment. The workgroup primarily identified issues and possible recommendations to help recruit and retain the BH workforce through a focus on early training through educational institutions, incentivizing providers for practicing in rural and non-rural underserved areas, utilizing telemedicine and other innovative technological approaches to increase efficiency of workforce, and expanding the list of provider types who can bill for behavioral health services. The group also reviewed the requirements under HB 3261 and were in consensus that some of their recommended actions could be addressed by workgroups that would take address the actions required by the bill.

The workgroup also identified the issue of insufficient wages for individuals working in the behavioral healthcare field (including non-licensed and non-certified professionals). Even though the workgroup endorsed the recommendation of utilizing innovative and non-monetary compensation methods such as training, mentorship, flexibility of work hours etc., they also pointed out the limitations of these methods in retaining workforce without an increase in wages.

For each of the overarching recommendations, the workgroup has identified specific action items that can be implemented in the current system to track, recruit, and retain BH workforce in Oregon. The following are the recommendations from the Workforce Workgroup:

Recommendation 1

OHA, in collaboration with OHPB, will establish or designate and invest in an entity to analyze specific integration workforce needs and capacity for state and localities. Describe the current and long term distribution of the workforce necessary to provide integrated care, with special attention to diversity and geographic proximity to populations being served.

Action Items

- Use the BH Mapping Tool to identify provider access and shortage across the state. Add feature in the map for one to identify access to trainings and education for BH providers. Add feature in the map to be able to identify where clinical supervision for each provider types are, whenever possible.
- Use the Workforce Report created by Office of Health Analytics to understand trends in provider availability across specialties. Stratify data to specialty level within each provider board to assess full extend of need within the BH network.
- Use the BH System relationship map created by the Oregon Health Workforce Subcommittee, OHPB, to identify a formal workgroup that performs assessment of BH workforce in the state at an ongoing basis. Add Corrections, and System of Care to the relationship map. This could be accomplished by including this component in the biennial health care work force needs assessment.
- Include map to assess and track various programs and settings where medical students can undergo rotations in integrated settings to get more exposure to behavioral health care.
- Expand the BH mapping tool to include assessment of social determinants of health.

Recommendation 2

Remove certification and licensing barriers to providers who come to Oregon from other states, especially form neighboring states.

Action Items

- OHA, in collaboration with OMB, will establish a workgroup to review existing standards and competencies required for certification and licensing in Oregon and neighboring states to identify certification reciprocity across states, and provide recommendations to remove burdensome requirements while maintaining standards of care
- OHA will contractually require CCOs, who in turn will contractually require their providers to train new providers who join their organization from a different state, on the standards, competencies, and language of integrated care as is understood by providers in the State, before new out-of-state providers start delivering service.

Recommendation 3

Provide trainings endorsed by national professional organizations for licensed practicing healthcare professionals on the recognition and intervention of BH issues. Increase access to clinical training for students entering BH occupation. Increase the ability of BH clinical training sites to accept students/trainees by incentivizing and supporting clinical training sites

Action Items

- OHA will work with higher educational institutes to incorporate relevant BH and integrated BH training in undergraduate and graduate programs.
- OHA, in collaboration with OHPB, will work with educational institutions to implement curricula in health care degree programs where students can do rotations in integrated care setting.
- OHA, in collaboration with OHPB, educational institutions, and licensing boards, will establish a workgroup or assign as task to an existing appropriate workgroup, to identify existing curricula in BH sciences in higher education institutions, and recommend additional standards and trainings for inclusion to prepare the new workforce entering the integrated care system.

Recommendation 4

Increase primary care providers' confidence to use their full prescriptive authority for psychiatric medications.

Action Item

- OHA will establish Oregon Psychiatric Access Line for Adults (OPAL-A) program across the state. A similar program has been very successful for kids.
- OHA can use OHSU's tele psychiatry model as a reference to establish coordinated consultation between BH providers and PCPs.

Recommendation 5

Establish and disseminate best practices for incorporating the National Standards for CLAS in health and health care in integrated care delivery

Action Items

- OHA will require CCOs to have an equity coalition or at least a committee that focusses on health equity and Trauma Informed Care, including ways to have a workforce in the CCO region that is well trained in CLAS standards, Implicit Bias, and TIC.
- CCOs will include equity measures as part of their Alternative Payment Methodology models. One example is Allcare who has two equity measures as part of their APM: 1) at least 70% of the provider's staff has to be trained in at least 1 of the available equity and TIC trainings and 2) provider has at least one interpreter on staff.
- OHA will work with educational institutions to include Trauma Informed Care and CLAS Training in curricula for Psychiatry and Psychology students.

Recommendation 6*

Ensure a culturally diverse workforce is available in urban, rural, and frontier regions to match the diversity of the community the workforce serves.

Action Items

- OEI will work with community stakeholders to incorporate diverse stakeholder input while creating training materials for culturally diverse workplace, to ensure training materials are accepted widely by minority workforce

- OHA will establish a workgroup to identify issues behind workforce capacity of medically certified interpreters and recommendations to increase access.
- OHA will work with CCOs, CMHPs, certified Peers and other BH provider entities to increase awareness and availability of standardized Implicit Bias training.

* For special populations, such as prison population, it is not possible to connect individuals with providers who are culturally compatible to the individual, since inmate population cannot be moved from the county they have been assigned to while in prison. For such populations, a statewide stakeholder workgroup should be established to identify innovative solutions to provide culturally sensitive care to the prison population.

Recommendation 7

Locate prevention in non-office based settings to increase access and availability, thus normalizing the need to seek out and accept BH health care.

Action Items

- OHA will establish payment reform to compensate BH providers when they take services to the community: schools, WIC office, Family resource Centers.
- CCOs can incentivize providers for establishing performance improvement projects that focus on utilizing innovative technology solutions: Ex. Virtual Reality Therapy. One of the ways CCOs can address this is bundle innovative efforts with their APM models; where providers can choose form a range of innovative ways to use technology to increase access and availability.

Recommendation 8

Invest in outreach efforts for rural recruiter to ensure providers are aware of incentives such as loan repayment programs, and Tax Credits.

Action Item

OHA should work with rural providers and CCOs to establish outreach and communication efforts to ensure incoming BH workforce are aware of loan repayment and tax credit incentives available to them.

Recommendation 9

Consider reintroducing the concept of upstream community level prevention aligned with the Institute of Medicine Model that spans BH services across a continuum of care.

Action Items

- Continue investing in the Certified Prevention Specialist program which is standardized by the International Certification and Reciprocity Consortium, and as exists in OAR 415-056.
- Require counties and CCOs to work with community BH prevention Service providers and/or recruit community prevention specialists in CCO Community Advisory Councils, to create a biennial implementation plan which should be consolidated/aligned with the CCO Community Health Improvement plan. The biennial implementation plan should be reported to OHA.

Recommendation 10

Invest in early BH education programs through community colleges, that focus on leading students to completion certificates and/or degrees that identify students as being qualified to work in a particular field.

Action Items

- Invest grant and non-grant funds to establish and expand BH course-work in the Career Pathways programs in community colleges across the state.
- Invest is adopting and establishing Washington's I-BEST model in community colleges.
- In rural areas, work with DOE to do outreach to School District leaderships and providers to increase awareness of certification and licensing programs 9relevant to BH) that are available in community colleges.

Please identify any barriers or challenges to implementation. Have any efforts to mitigate these been identified?

BH service providers who are not certified or licensed, would be difficult to track while assessing workforce on an ongoing basis.

Older providers who have been certified and trained in the past decades, tend to look at evolving integration training as additional burden. This leads to less availability of mentors for the new and incoming workforce.

In the past OHPB had tried to introduce CLAS training as mandatory but push back from OMB prevented such efforts.

Silos in understanding of BH integration needs to be addressed before establishing new standards for workforce across the state.

BH service providers who work in rural and other minority communities, do not stay long enough o transfer knowledge and training to the provider workforce within the community.

OHP payment and reimbursement system is based on the 15 minute appointment time, which makes providing BH services in non-office based settings difficult.

For collocated providers, if BH services are provided to patient and family, provider cannot bill for BH service sunless a diagnosis exists.

Currently, no workgroup exists that explores and recommends BH trainings that are also cost effective.

For medical interpreters, training does not require customization to assessment of population needs for the community in which interpreters are serving.

How will this move Oregon towards full integration of BH, physical and oral health?