The Thirty-first Annual Rosalynn Carter Symposium on Mental Health Policy

HELP WANTED: RESHAPING THE BEHAVIORAL HEALTH WORKFORCE
Opening Keynote

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The Behavioral Health Workforce: Evolution, Transformation or Revolution?

31st Annual Rosalynn Carter Symposium
November 12, 2015

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Dean, Medical University of South Carolina, College of Nursing
Board President, Annapolis Coalition for the Behavioral Health Workforce
Life in our Field

• Two years & 5,000 participants
• Federally funded
• Mental health, addictions, treatment & prevention
• Identified:
  – A core set of strategic goals & objectives
  – High priority ACTION items by stakeholder
• A planning resource with levers of change
• Call to action
Seven Goals

1. Expand the role of individuals in recovery, & their families
2. Expand the role and capacity of communities
3. Implement systematic recruitment/retention strategies
4. Increase the relevance, effectiveness, and accessibility of training and education
5. Actively foster leadership development
6. Enhance the infrastructure for workforce development
7. Implement a national research and evaluation agenda
What We Learned

• Potential for endless “process”
• 1000 points of “No”
• All solutions are flawed
  – Narrow: more effective, less overall impact
  – Broad: potential for greater overall impact, yet outcomes more uncertain
• Need to pair workforce development and organizational change strategies
Since the Report

• Technical assistance to 13 states:
  – AK, CA, CT, IA, LA, MD, NJ, NM, NC, NY, VT, WA, WI

• Developed Alaska Core Competencies for Direct Care Workers with WICHE
Integrated Care

• Care rendered by a practice of primary care and behavioral health providers, working together with patients and families and using systematic and cost-effective approaches to provide patient-centered care
Integrated Care Models Vary

- Team members
- Spatial arrangements
- Patient protocols for detection, treatment and follow-up
- Collaborative care
- Primary care behavioral health
- Behavioral health primary care
- Co-located primary care and behavioral health
Continuum of Physical and Behavioral Health Care Integration

Coordinated Care

- Screening
- Navigators
- Care & Case Managers

Colocated Care

- Colocation
- Health Homes

Integrated Care

- System-Level Integration
Successful Integrated Care Programs

• ACT – Advancing Care Together
  – The Colorado Health Foundation
• Intermountain Healthcare
• Collaborative depression care
• Stepped care
• VA clinical programs
• IMPACT – focused on elderly
Integrated Care: Evidence

- Improved process of care
- Better clinical outcomes for *common* medical and behavioral health problems
- More preventive services
- Understudied and needs much more research
- Lack of widespread adoption and “scaling up”
Primary Care Setting

Behavorial Health Setting
Integrating *Behavioral Health* in Primary Care Settings: Evidence

- Reduced psychosocial barriers to care
- Lifestyle changes to improve physical health
- Focus on mental health and addiction problems
- Needs addressed of patients with chronic conditions
Integrating Primary Care in Behavioral Health Settings: Evidence

• Reduced medical barriers to care
• More preventive services
• Most common medical focus is often on metabolic syndrome
• Only some needs addressed of patients with chronic conditions
Integrating behavioral health (mental health and substance use) services into a primary care system involves changes across an organization's workforce, administration, clinical operations, and more. Providers adding behavioral health services as part of a developing integrated care system have many options to explore and paths to take.

Behavioral health integration encompasses the management and delivery of health services so that individuals receive a continuum of preventive and restorative mental health and addiction services, according to their needs over time, and across different levels of the health system. Successful integration involves more than increasing access to behavioral health services through enhanced referral processes or co-location; the system of care delivery is transformed.

The following decision chart points health care providers wondering where to begin, or seeking more information about implementing a specific aspect of integrated care, to available resources.

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1. WHO definition of Integrated Care - [http://www.who.int/healthsystems/service_delivery_technote1.pdf](http://www.who.int/healthsystems/service_delivery_technote1.pdf)

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Cassandra McCallister
Board Member, Washtenaw Community Health Organization
Ypsilanti, MI
CORE COMPETENCIES FOR INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE

SAMHSA-UBSA
Center for Integrated Health Solutions

www.integration.samhsa.gov

JANUARY 2014
Core Competency Categories

1. Interpersonal communication
2. Collaboration & teamwork
3. Screening & assessment
4. Care planning & care coordination
5. Intervention
6. Cultural competence & adaptation
7. Systems oriented practice
8. Practice-based learning & quality improvement
9. Informatics
Medical Model
Population Health
Public Health Model
Revolutionary Targets and Strategies
The Smart-Talk Trap

by Jeffrey Pfeffer and Robert L. Sutton

FROM THE MAY-JUNE 1999 ISSUE

Consider two stories, both sadly true and sadly typical.

• An international metals and oil company was posting terrible numbers—sales and profits were down, as was share price. The company's senior executives were mortified by the results; they knew major changes in strategy and operations were imperative. Their response: to spend at least half their time in darkened rooms, watching elaborate presentations about the company's performance.

• Faced with a wortisomely slow time-to-market for its new products, a large furniture company conducted a careful benchmarking study. The results were clear: a project-based organizational structure would help solve the problem. But more than a year later, the company had not instituted a single change. Senior executives, although uniformly supportive of the idea of restructuring the organization, were still discussing it in meetings that ended with decisions to have more meetings.
1) Setting: Where Do We Practice?

- Hospitals
- Clinics
- Homes
- Medical Homes
Emerging Technologies
Revolutionary Strategies - Settings

- Schools
- Churches
- Community centers
- Telehealth
- Retail stores
2) Providers: Who is our Workforce?
Our Future Workforce?
Behavioral Health Workforce

Behavioral Health and Other Related Providers, by Field

- Counselors: 37%
- Social Workers: 29%
- Psychiatrists: 9%
- Psychologists: 16%
- Other Mental Health Related Professionals: 2%
- Marriage and Family Therapists: 7%

Source: Centers for Medicare and Medicaid Services, National Provider Identifier (NPI) Database (2014)
So Where Are the Nurses?

- 17,000 Psych APRNs
- 82,000 RNs working in mental health settings
- 3.8 million RNs
And Where Are the

- Peers and consumers
- Families and friends
- Lay community workers
Can We Learn Lessons from Other Countries?

- Stepped care for depression in primary care in Nigeria
- Lay workers deliver problem-solving therapy in Zimbabwe
- Web-based screening effective in the UK
- Mental Health Nurse Incentive Program - Australia
Scaling up care for mental, neurological, and substance use disorders
What We Can Learn From the “Low and Middle Income Countries”

Task - sharing ➔ Task - shifting
Rational distribution of tasks among health care workforce teams

Task - retention ➔ Task - withholding
Restrict scope of practice of other professionals
Liberian Mental Health Program
Curriculum Overview

• Six months length of study
• Classroom study - 440 hours
• Clinical practice/supervision - 300 hours
• Specific end of course competencies
• Multiple evaluation strategies - tests, clinical demonstrations, class discussions
Liberia

Distribution of Credentialed Mental Health Clinicians 2015

36 Mental Health Clinicians in Montserrado, where ~40% of population resides

MONROVIA
Helping Families in Mental Health Crisis Act – HR 2646

- SEC. 207. Workforce development. Telepsychiatry and primary care physician training grant program
- Implications for SAMSHA, Assisted Outpatient Treatment, Legal Rights
- Endorsed - APA, MHA, ApA, NAMI
Revolutionary Strategies - Providers

✧ Allow for full scope of practice for all licensed/credentialed clinicians
✧ Allow for reimbursement by all licensed/credentialed clinicians
✧ Fully utilize non-behavioral health providers as core behavioral health service providers – nurses, peers, lay community workers
3) Practice: What is our Focus of Care?
Treatment/Interventions

• Move beyond medications
• Identify “active ingredients” of psychosocial interventions
• Develop quality structure, process and outcome measures
• Effectively train providers in these interventions
Revolutionary Strategies - Practice

New roles/functions for behavioral health care providers – half of their practice time needs to be devoted to:

- Consultation
- Training of generalist providers
- Education of patients and families
- Supervision of generalist providers
- Quality assurance activities
Revolutionary Strategies - Practice

✧ Implement simplified screening tools
✧ Standardize screening tools across settings
✧ Triage patients based on symptom severity and type and intensity of service needed
✧ Specify treatment pathways/interventions
✧ Establish clear referral guidelines
Revolutionary Strategies - Practice

✧ Change the nature of our research
  ▪ Evidence base of psychosocial research
  ▪ Focus on quality measures for treatment
  ▪ Health services/delivery model research
  ▪ Implementation science
  ▪ u19 – research partnerships and scaling up
  ▪ Workforce data that can lead to forecasting
4) Education: Living in the Nostalgia District
Are We Really Teaching to Collaborate and Be Team Members?
This is the Real World!
Revolutionary Strategies - Education

✧ All pre-service health care students need essential behavioral health skills:
  - How to screen, triage and refer – “6th vital sign”
  - Mental Health First Aid – like CPR and BLS
  - Motivational interviewing
  - Stress, Trauma, Crisis intervention and De-escalation
  - Suicide prevention
  - Brief interventions - SBIRT, CBT
**Revolutionary Strategies: Education**

✧ Take down specialty and disciplinary silos
✧ Teach only evidence-based interventions
✧ Focus on how to do task-shifting/sharing and delegation
✧ Utilize technology for anytime, anywhere learning
✧ Create “virtual learning pods”
✧ Develop “certificates” for specialty areas – PTSD, Trauma
✧ Work with accreditors/regulators to remove barriers
We need the right workers with the right skills in the right place doing the right thing
“Insanity: doing the same thing over and over again and expecting different results.” A. Einstein
Thank You