Workforce Development Strategic Initiative
Conference Call with Maryland Representatives
March 25, 2015: 1:15 p.m. (EDT)

SAMHSA Facilitator: Jean Bennett (Region III SAMHSA Administrator)

State Participants: The following participants from Maryland were on the call: Michelle Darling (Workforce Development, Behavioral Health Administration); Nancy Shrout-Wankowski (Training Manager, Behavioral Health Administration); David Barnes (Maryland Addiction & Behavioral-health Professionals Certification Board); Eileen Hansen (The University of Maryland Training Center); Carole Frank (Mental Hygiene Administration), Cindy Shaw-Wilson (Universal Counseling Services), Herb Cromwell (Community Behavioral Health), and Holly Ireland (Mid-shore Mental Health Systems)

Below is a summary of the call as it relates to ideas and strategies in developing the behavioral health workforce:

Dr. Bennett noted that SAMHSA has designated behavioral workforce issues as a strategic priority. This was due to ongoing requests from stakeholders, regional administrators, and SAMHSA's advisory council. As a first step, SAMHSA wants to capture more granular detail about the concerns from the states. These ten questions are intended to guide the conversation and the summaries generated from these discussions will be distilled into summaries by region as well as a national summary. It is hoped that the summaries will identify recurring themes as well as promising practices.

Ms. Darling noted that three years ago the Medical Director of the Department of Health and Mental Hygiene convened a Behavioral Health Integration Stakeholder Workgroup. They meet quarterly and Ms. Darling is a co-chair. One tangible outcome of the workgroup is the integration of Alcohol and Drug Abuse Administration (ADAA) and Mental Hygiene Administration (MHA) into one entity (the Behavioral Health Administration). Stakeholders in the

workgroup include higher education, providers, peer and consumer groups, and credentialing boards. The next meeting in on April 15th.

Maryland did provide some written responses to the questions below that are incorporated into the summary below.

1. What is your definition of a **behavioral health workforce**? What types of professions are *included in this definition? (e.g., preventionists, peers, etc.)*

Workforce Development efforts are aimed at strengthening the professionalism of behavioral health providers. The behavioral health workforce encompasses prevention, intervention, treatment and recovery professionals, with a focus on promoting behaviors that support health and wellness and recovery from emotional, psychiatric disorders and/or substance use related conditions. This workforce is comprised of trained professionals, direct care staff with on the job training and experience, and persons in recovery from behavioral health conditions and their family members.

The Behavioral Health Administration emphasizes a population-based approach to health care with emphasis on prevention, education, health maintenance, strengthening of connections with other health agencies, capacity building and community outreach.

This workforce includes, but is not limited to: psychiatrists and child psychiatrists, psychologists, physicians with a specialty in addictions, social workers, advanced practice psychiatric nurses, marriage and family therapists, addiction counselors, mental health counselors, psychiatric rehabilitation specialists, psychiatric aides and technicians, peer support specialists, recovery coaches, and unlicensed paraprofessionals.

The state would also include somatic providers that offer early intervention. This might include a primary care physician or even a pediatrician.

The state does not have a certification for mental health counselors. Maryland is working toward having a common language between substance abuse and mental health providers. Peers are credentialed. Maryland has met with agencies in Pennsylvania to compare implementation of peers.

Maryland has an SBIRT grant and is using waivers to get more primary care physicians engaged in these services.

2. Does your state have a **behavioral health workforce plan**? If yes, please explain.
    a. If yes, explain the priorities and strategies
    b. If no, do you plan on creating one?

Yes, Maryland has workforce development goals specific to behavioral health. It is a one-page report that was recently released and Goal V is focused on workforce development. In April, they will post a stakeholder's report that pertains to workforce development.

Maryland provided a supporting document on their plan specific to their peer program entitled "Enhancing the Peer Provider Workforce: Recruitment, Supervision and Retention.

Regarding the content, it is the recommendation of BHAs Office of Workforce Development and Training to align the FY16 Workforce goals with SAMHSAs Strategic Initiative #6, Workforce Development Goals, from the attached document, SAMHSA Leading Change 2.0: Advancing the Behavioral Health of the Nation, 2015-2018.

BHAs FY16 Statewide Plan for Workforce Development includes the following goals: develop and disseminate evidenced-based training and education tools based on the core competencies, support deployment of peer providers in all public health care delivery settings, develop data collection methods to identify and track workforce needs, and to support funding for the behavioral health workforce.

Core Competencies for Integrated Behavioral Health are used to help shape training we provide. The competencies play a role in the design and delivery of training, in identifying needed courses and content, developing job descriptions, clarifying roles, and also used in the recruitment process.

3. Is there an entity responsible for any/all workforce issues at the state level (not just health or behavioral health)?

The Maryland Addictions Director Council has worked on workforce issues including legislation related to loan repayments and higher education. Their focus has been more on behavioral health rather versus substance abuse.

Legislation has also looked into certifications for lower level (Associate or Bachelor degrees) positions. There is less of a reliance on "life experiences" so individuals without graduate degrees find themselves starting at entry level.

Other entities include the Office of Primary Care Access (within the Department of Health and Mental Hygiene-DHMH) which has looked at the issue of psychiatric nurse practitioners and the Governor's workforce investment board. DHMH Secretary Mitchell is in charge of the Health and Behavioral Board which is a hiring board. There is also the Maryland State Drug and Alcohol Abuse which has a plan.

Maryland provided a copy of their state workforce plan entitled "State of Maryland: Integrated Workforce Plan." In addition, in their written notes, they detailed some of the goals of these state workplans.

4. What behavioral health workforce **data** do you have, and what do you need?

There is data from certification and licensing boards for all professions even peers. There was a workforce study in 2005 (a copy of it was provided to SAMHSA) ten years ago that was helpful but it did not include care coordinators or case managers on the mental health side. While there is some geographical information that could be used for geomapping. However, the callers were unsure if the zip codes corresponded with the location of the professional or their workplace.

Maryland also has an annual training report. There is also peer-specific data from ValueOptions Maryland. And lastly the Access to Recovery Grant has some GPRA data.

Maryland callers were interested in having data which was more regional and could map their inventory against population totals. Dr. Bennett indicated that SAMHSA is working to provide more data to states, but it is not that simple. For example, in Pennsylvania there was a contractor that collected data on

psychiatrists not realizing that these professionals often have multiple locations. As a result, they didn't capture information correctly.

Callers also said they could benefit from information on turnover and vacancy rates. This should be stratified between public and private since there are different access barriers in the public sector. In places like Baltimore, agencies "cannibalize" off each other resulting in a lot of lateral turnover.

Maryland would like an update to the 2005 report.

5. Describe your regional **workforce needs**. What are the current levels, the gaps, and what changes do you see in future demand?

Pre-service—Maryland has a higher education collaborative that has been meeting monthly for the past 2 years. It has done work towards funding loan repayment and providing funding to help get licensing for addiction counselors The Behavioral Health Administration (BHA) is not directly involved in the effort but every higher education facility participates. The Maryland Plan has worked to entice psychiatrists to come work in state hospitals and it was effective. They promoted the work environment rather than monetary incentives.

With regard to social workers, they have aimed to develop internships and placement. One caller noted that the study of addictions is optional rather than mandatory. There is a hope that it would become mandatory.

In rural areas, the universities are adequate but the community and high school level education is a problem. There is a need to entice the young so that the state can "grow their own" clinicians across the spectrum.

The callers provided information on MADC's efforts with grants and loan repayments specific to LPCs and LADCS. One missing piece is the work on the mental health side to address those shortages.

Recruitment and Retention – The hiring practice in state agencies is quite slow and the hiring process can take up to 6 months. This means a gap in service and also that managers are taken away from direct service work to work on hiring needs.

Recruitment and retention is hard at the micro level. There is a need for a large marketing campaign (perhaps national). In fact, one caller noted that he got engaged in the field after meeting someone who presented about their recovery

The state has been losing the workforce to the VA which pays better.

Training -- Maryland's training has put a high priority on peer training and the Academy has tried to be innovative. As an example, they have developed a small human resources learning collaborative and also are providing school internships.

With regard to the larger behavioral workforce, Maryland has tried to focus on quality. A university-based trainer is more expensive than perhaps a third party. But do these alternatives provide the best quality? It has been a struggle to retain good trainers. It is also hard to fit in time for training in evidence based practices. Co-occurring disorders and integrated care are areas that need to be provided through continuing education since this is typically not a part of the curriculum in higher education.

Supervision – Maryland has been providing training of peer supervisions so that they use their peer staff appropriately. One concern was that peers were actually doing case management and shouldn't. In another instance, a peer spent 2 years just being a receptionist. It was also found that peers were failing certain domains of the credentialing exam. This was because the supervisor never made sure that their job responsibilities included that particular work. They do have a checklist but it can be falsified. There was some speculation that if the supervisor actually took the exam, they would better understand the role of these paraprofessionals.

A survey was done on supervisors to identify gaps. Some of the issues related to better compensation and more training. There is legislation to provide a contract for licensing which outlines expectations for the next three years. Supervisory responsibilities takes away billable hours and also a center loses good caregivers because it is the best direct providers who are promoted into these roles. Back to the compensation, if better services are expected, it is important to incentivize and provide better compensation.

Leadership – Maryland has an aging workforce and expect in the near future to have some leaders retire and some positions, due to budget issues, to be cut. They note that this could be a 50% loss of leadership which would cause "chaos." To try to capture the institutional knowledge, Maryland is focusing on ways to retain middle managers and to have more interns which creates a built-in knowledge sharing component. The state has a Leadership Empowerment and Advocacy Project (LEAP) which provides leadership training. However, there are over 20 positions so it is difficult sometimes to determine what training to offer. Leaders need to have clinical, business and entrepreneurial skills.

Telehealth—There was a training for rural communities and only 7 professionals came. They were mostly interested in whether teleservices would be reimbursable. Maryland has found that, for technology transfer, this is best done agency by agency rather than through individual staff. Baltimore did receive a waiver for telehealth. Dr. Bennett noted that there is a rural telehealth ATTC that can assist Maryland.

Finance, Research and Legal – Once caller noted that this is an area that SAMHSA needs to step in and work on. Behavioral health and substance abuse services are not valued and there is an issue of equity. For example, there has rarely been inflationary adjustments to salaries for the past 20 years. This is why the workforce has been shrinking. It is the most critical need and also shows that these services are not valued.

There are a number of services that are not reimbursed and should be. There is a need for some type of IT waiver at the national level. Dr. Bennett noted there is a CMS innovation grant. The callers noted that CMS is prescriptive on its use and the turnaround time has been problematic.

6. What are the **challenges** in achieving an adequately trained and credentialed/licensed behavioral health **workforce** in your state? This may include policy issues, training availability, scope of practice issues, etc.

In addition to the concerns mentioned in question 5, the hiring process is cumbersome with delays and denials of applications. There is no reciprocity and

the State wants to eliminate the trainee status position. For peers, there is a high failure rate on exams. Some of the rational for that is explained in question 7.

7. What role do you see **peers** playing in the behavioral health workforce currently and in the future?

Though Maryland considers the use of peers as a priority, reimbursement and compensation are key issues. Maryland received a BRSS TACS grant and has been using that to work on Medicaid reimbursement and providing peer-to-peer training. There is a consumer affairs entity that works on this. Maryland has been looking at the Rhode Island model for using peers in hospitals. There is an inventory of peers that just have to take the appropriate tests. The Administration has a listserv so that that they are still in touch with potential peer providers.

There are some concerns about how to integrate substance abuse with mental health for peers. On the substance abuse side, there is a preference for fee-for-service. On the mental health side there is a concern about not being complicated and thus losing staff. Connecticut has a model that they might look into to address this.

With regard to training, Maryland provides statewide workshops and conferences, including a co-occurring disorder training. There is credentialing/certification for peers. Maryland has "grandfathered" 91 existing peers and hopes to have 100 peers by the end of April and 120 by the end of the year. One cost issue is that while Maryland can offset costs for credentialing, they do not pay for peer recertification. This can cost up to $130. However, it is believed that many employers will cover these fees.

There is a career ladder for peers but also there is still turnover. Dr. Bennett noted that there is a National Advisory Council that relates to relationships with consumer groups that Maryland might find of interest.

8. Identify any **promising/successful practices** as well as any other **challenges** to developing the state's behavioral health workforce that has not been discussed.

The BRSS TACS Policy Academy brought both mental health and substance use disorder professionals together to address issues related to peers. The outcomes indicated that this was a successful collaboration.

The efforts behind integration also proved to be successful.

9. Identify the **key influencers or stakeholders** regarding workforce needs and development (e.g. County leadership, consumer groups, community groups, FQHC or CHCs, Training or educational institutions, etc.)

The stakeholders and committee members of BHA's workforce development committee. Higher education, most specifically the University of Maryland's evidence-based practice training center and its child and adolescent psychiatry program along with all institutions affiliated with MADC. Other suggestions included On Our Own (OOO) Of Maryland, local addiction authorities, Core service agencies, and preventionists.

10. Do you have specific ideas on how SAMHSA and/or other Federal agencies can assist you?

Maryland welcomes help with the integration process. As well as leadership development opportunities. Growing peers is an important goal for Maryland and it was suggested that the Veterans model might be a good resource.

The callers in Maryland felt that the issue of compensation has to be done at the national level. They also welcomed some models in terms of growth potential for peers (i.e., a pathway to move up the career ladder).