American Mental Health Counselors Association
Emerging Clinical Practice Brief

The Changing Behavioral Health Care Workforce Under Health Care Reform: New Opportunities and Roles for Clinical Mental Health Counselors

Introduction

There has been a widely recognized workforce shortage in the field of behavioral health for many years. It involves both specialty-level providers in mental health and addiction services as well as primary care providers who frequently are needed to respond to the physical health needs of persons with behavioral health conditions. According to the Health Resources and Services Administration (HRSA), in 2013, 77 million Americans live in areas that are not adequately served by substance abuse or mental health professionals, the majority of which are rural and remote.

That shortage could enter a crisis phase as the practical implications of behavioral health parity and the changing health care landscape take hold over the coming months and years.

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The role of the specialty behavioral health sector will continue to change and modify, as it has in recent decades, but perhaps with more rapidity. The need for behavioral health services within primary care settings will be in much higher demand.

Effective workforce development strategies must address the following challenges:

- Education from appropriately accredited programs;
- Recruitment and retention;
- Accessibility, relevance, and effectiveness of training;
- Staff competency in integrated care, communication with medical professionals and ability to work as part of multidisciplinary treatment teams, evidence-based practices, and recovery-oriented approaches, and substance abuse training
- Attitudes and skills in prevention and treatment of persons with mental and substance use conditions;
- Leadership development; and
- Workforce roles for persons in recovery and family members.

Advancements in technology such as tele-mental health under the Affordable Care Act, offer great promise. In addition to bringing greater access togeneral and specialty behavioral health services in underserved areas (which will experience even greater challenges in the coming years), technological advances such as telemedicine and telehealth facilitate the ability to provide real-time access to culturally competent providers of services to highly diverse communities.

There is an urgent need to plan for the increased demand in behavioral health services, both in primary care settings as well as in specialty clinic environments. Priority should be given to programs that educate students in team-based approaches to care, including the patient-centered medical home.

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The patient-centered medical home (PCMH), is a team based health care delivery model led by a physician that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes. It is an approach to providing comprehensive primary care for children, youth and adults". The provision of health homes may allow better access to mental health care, increase satisfaction with care, and improve overall health.

Care coordination is an essential component of the PCMH. Care coordination requires additional resources such as health information technology, and appropriately trained staff to provide coordinated care through team-based models. Additionally, payment models that compensate PCMHs for their effort devoted to care coordination activities and patient-centered care management that fall outside the face-to-face patient encounter may help encourage coordination.

An emphasis on and strong commitment to the use of technology must be a cornerstone to addressing this rapidly growing workforce shortage.

Technology also dramatically increases efficiency for the workforce, allowing for greater productivity, and can offer additional part and full-time employment opportunities for providers who wish to work from home or while traveling.

An emphasis on and strong commitment to the use of technology must be a cornerstone to addressing this rapidly growing workforce shortage. Alternatives to face-to-face interaction, i.e., tele-health and tele-psychiatry, must be optimized, which requires funding to facilitate further development of technological advancements as well as adequate reimbursement for provision of such services.

Moreover, there is also a training need here regarding the effective and ethical use of telehealth. For example, protocols for how best to address clients and structure sessions using this format (using "read-backs" by both practitioner and client to ensure the practitioner understands the client and vice versa); ethical issues and legal requirements regarding practicing outside of one's state of licensure; using secure servers and programs that encrypt information and ensure client confidentiality (e.g., not Skype!)

The Changing Health Care Landscape that Addresses Workforce Issues

The changing health care landscape has the capacity to address shortage and mal-distribution of the behavioral health workforce. Several strategies could increase the supply and the range of behavioral health professionals.

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In particular, the establishment of a national commission tasked with reviewing healthcare workforce and projected workforce needs could dramatically help with the alignment of federal healthcare workforce resources with national needs.

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Competitive grants have been created for the purpose of enabling state partnerships to complete comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the state and local levels. Grants will support innovative approaches to increase the number of skilled healthcare workers such as building healthcare career pathways for young people and adults. Grants have been created to develop and operate training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and to establish, maintain and improve academic units in primary care.

Progress toward the better integration of physical and behavioral health services means that all health professionals need to have adequate training in managing behavioral health issues. Priority should be given to programs that educate students in team-based approaches to care, including the patient-centered medical home.

Behavioral health education and training grants have been created across a broad range of professions, and ensure that some of these grants go to historically black colleges or universities or other minority-serving institutions. There are some training grants for Universities that are population-specific, i.e., children/ adolescents/transitional aged adults; substance abuse, etc.

There has been an expansion of programs to support the development, evaluation, and Dissemination of model curricula for cultural competency, prevention and public health proficiency and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs. these CE programs open to individuals who are looking to develop the competencies to be able to become part of a group or as collateral services to those groups?

Programs are available that include scholarships for disadvantaged students who commit to work in medically underserved areas as primary care providers, and some of these programs expand loan repayments for individuals who will serve as faculty in eligible institutions. New funding is available to establish community-based training and education grants for Area Health Education Centers (AHECs) and Programs. Two programs are supported – Infrastructure Development Awards and Points of Service Enhancement and Maintenance Awards – targeting individuals seeking careers in the health professions from urban and rural medically underserved communities.

The HHS Secretary – in collaboration with SAMHSA -- will establish a comprehensive methodology and criteria for designating medically underserved populations and health professional shortage areas. This work must include a consideration of behavioral health needs. It is important to ensure that current and new education and training programs and recruitment and retention programs have a behavioral health focus that reflects the current and projected needs.

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Progress toward the better integration of physical and behavioral health services means that all health professionals need to have adequate training in managing behavioral health issues. And, given the shortages and recruitment challenges in rural areas, there is a need to consider training for non-physician professional and non-professional groups, including peers, to serve as physician and specialist extenders.

Next Steps for CMHCs

Without changes in the workforce, the field will have difficulty meeting the increased demand for specialty mental health services:

- There are known shortage areas for behavioral health practitioners, and these are likely to correlate with locations of the newly insured.
- There is a gap between the typical current competencies of CMHCs and those needed to practice in integrated care models. Thus there may not be sufficient numbers of trained individuals who can meet the demand for mental health care to be appropriately embedded in integrated models.
- All physicians, especially those in primary care, need a stronger focus on mental health training.

The future workforce should be directed toward CACREP programs. If the current workforce is not from CACREP program, they should become certified via specialty exams through the NBCC (i.e., NCMHCE) and established transitional periods.

Curriculum, accreditation standards, new Continuing Medical Education (CME) trainings and collaboration with primary care practitioners are needed to meet newly insured patient needs as well as provide for new care delivery models.

- The future workforce should be directed toward CACREP programs. If the current workforce is not from CACREP program, they should become certified via specialty exams through the NBCC (i.e., NCMHCE) and established transitional periods.

- Curriculum and accreditation standards should be developed for all residents on the core competence and skill sets needed for integrated medical and behavioral health care.

- Practice management modules, like CME, should be developed in the following areas:
    - Reviewing common medical problems in general medical care and public-sector populations,
    - Leading teams of behavioral health professionals, setting up and/or participating in integrated care settings,
    - Teaching primary care providers about identifying and screening for mental illnesses and substance use disorders, and using health information technology.

- Primary care and other medical specialties must develop enhanced competencies and expertise in behavioral health care, evaluation and management.

- CMHCs and other behavioral health providers should collaborate with primary care providers regarding needed education and training to practice in this care model.

- Clinical mental health counseling education programs would best serve their communities by preparing practitioners who are trained in the following areas:
    - Multidisciplinary treatment teams, communication with medical professionals and ability to speak their common language;
    - Ability to conduct brief sessions and evaluations on short notice; and
    - Understanding of issues that typically present in primary care settings.

- It is critically important to establish internships in primary care clinics; to best prepare the workforce, the counselor education profession has a role in placing students into primary care internships.

The data on stability in the front-line workforce suggests that if there are limited strategic actions available because of constrained resources, then those resources are best targeted at supporting the effectiveness of first-line supervisory staff. States could provide technical assistance to help provider organizations with retention and competency of staff, including continuing education opportunities, strengthening career ladders and targeting front line supervisors.

CMHCs, with SAMHSA, HRSA, CMS and NASMHPD, could collaborate along with other systems, to develop pilot reimbursement models that incorporate on-going training and supports (especially those linked to evidence-based practices), including reimbursement for clinical supervision, into rate structures. The Pennsylvania Health Home demonstration provided differential payments for primary care physician participation in training.

The Connected Care Pilot is based on the Patient-Centered Medical Home model with an integrated team and care plan to address physical, behavioral and social needs. High physical and high behavioral health needs were defined by specific criteria (e.g., three or more inpatient admissions for physical health and admission to a state mental hospital for behavioral health). High-need members were stratified into three intervention levels: Tier 1 (High BH/PH and High PH and Low BH); Tier 2 (High BH/Low PH); and Tier 3 (Low BH/PH).

The program focused on Tier 1 members. Coordination between the physical health plan and behavioral health plan included: an integrated care plan, multi-disciplinary care teams, early identification of admissions and ED visits, concurrent case discussions, and 24-hour phone service to answer questions about the program. Consumer group input was used to design the program and develop materials. Providers were engaged early on in the program using mailings to explain Connected Care as well as visits to primary care offices and behavioral health providers.

CMHCs could seek to facilitate collaboration between workforce development partnerships and local educational institutions (including community colleges), provider groups, and behavioral health organizations to reinforce state planning and implementation activity and promote career development opportunities. These strong partnerships may help CMHCs in their State to obtain funding for their services.

CMHCs could form strategic partnerships at the state level with Primary Care Associations to address workforce issues. These organizations will be facing the same increased demand for basic care and will be unable to address the demand for behavioral health services that will come with that increased demand.

CMHCs could look to expand the use of e-Learning strategies to strengthen and expand access to practice development curricula designed specifically to target public safety-net providers such as state behavioral health providers.
CMHCs also could increase the use of available and emerging technology such as tele-medicine, on-line/web-based healthcare, smart phones and electronic medical records at the community level. CMHCs should pursue additional recruitment and training opportunities.

Roles and Skills Needed by Individual CMHCs

Clinical Mental Health Counselors will be ideally situated to provide Behavioral Medical Interventions based on their expanded training and implementation of AMHCA's Clinical Standards. They will then need to promote themselves in the following settings:

- Patient Centered Medical Homes (PCMH's) and Affordable Care Organizations(ACO's)
- General Medical Practices: Family Practice & Internal Medicine Clinics
- Rehabilitation In-patient and out-patient Centers
- General and Specialized Hospitals
- Senior Citizen's Independent housing, Assisted Living & Nursing Homes

Basic knowledge needed by CMHCs about key health behaviors and physical health indicators (normal, risk and disease level blood chemistry measures) routinely assessed & addressed in an integrated system of care, including:

- body mass index
- blood pressure
- glucose levels
- lipid levels
- smoking effect on respiration (e.g., carbon monoxide levels)
- exercise habits
- nutritional habits
- substance use frequency (where applicable)
- alcohol use (where applicable)
- subjective report of physical discomfort, pain or general complaints

CMHC skills & knowledge needed to effectively function on an integrated health team and new workforce include:

- Medical Literacy
- Consultation Liaison skills with medical problems
- Population Screening
- Chronic Disease Management
- Care Management Skills
- Educating medical staff about integrated care
- Evidence-Based Interventions
- Group Interventions
- Working within the fast-paced, action-oriented ecology of primary care

CMHC skills needed by CMHCs in integrated Medical approach:

- Engaging, Connecting, and Enhancing Motivation Skills
- Teaching skills: Imparting Information Based on the Principles of Adult Education
- Comprehensive Integrated Screening and Assessment Skills
- Brief Behavioral Health and Substance Use Intervention and Referral Skills
- Comprehensive Care Coordination Skills
- Health Promotion, Wellness and Whole Health Self-Management Skills in Individual and Group Modalities
- Basic Cognitive-Behavioral Interventions

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