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National Dialogues on Behavioral Health Conference

Knowing Your Behavioral Health Workforce Capacity

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October 29, 2018

Learning Objectives

- To demonstrate the association between BH workforce shortages & access to BH care in a rural & underserved state
- To apply findings from a statewide survey of healthcare providers to current BH system
- To discuss the implications of the BH workforce shortages in rural communities & to identify strategies to address these shortages

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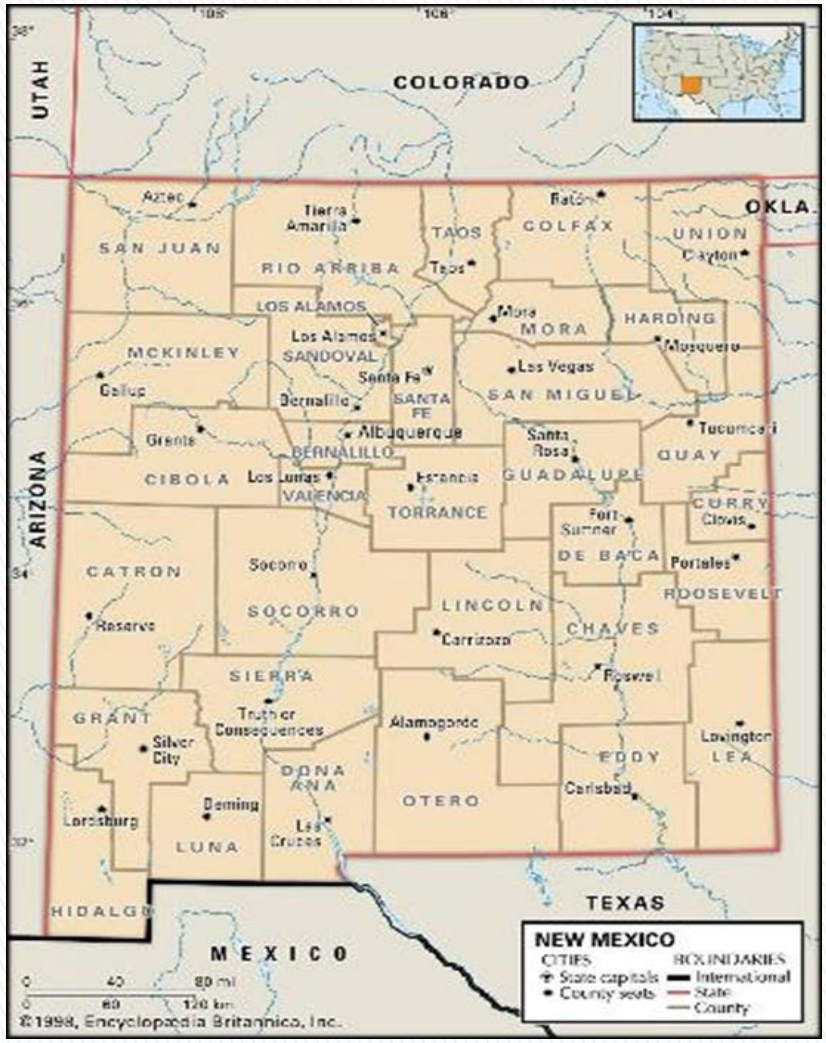
New Mexico

- 121,298 square miles – 5th largest state
  - 17 people per sq. mi.
  - 19 pueblos, 3 Apache tribes, & Navajo Nation
- Population: 2,088,070
  - 49% Hispanic
  - 11% American Indian
  - 20% living in poverty
  - 72% of births on Medicaid
  - 43% pop. on Medicaid

Land of Enchantment



Background

- NM is a national leader in health workforce data collection & analysis
- In 2011, State Legislature mandated collection of a core dataset across all healthcare professional licensure boards at the time of license issue & renewal
- The Healthcare Workforce Committee oversees the analysis of data and makes recommendations based on findings
- UNM Health Sciences Center is the data steward
- For the past two years, BH clinicians have been highlighted
- The number of providers located in each county was determined using the practice address of surveyed providers, & the mailing address of non-surveyed providers

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Background

- **Datasets**
  - Licensure Data: Type, specialty, & duration of license
  - Statewide Survey: Upon licensure renewal, all BH professionals are surveyed to determine if practicing & at what locations
    - These results allow us to calculate density of BH providers in all 33 counties
  - Medicaid Claims Data: Currently
    - One-year snapshot of healthcare utilization patterns of 178,555 individuals with SMI, SED and SUD
    - Determined prevalence of physical comorbidities for each individual & identify inpatient & outpatient utilization

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Background

- **Categorization of BH providers**
  - Prescribers (psychiatrists, advanced practice nurses, prescribing psychologists)
  - Independently licensed therapists who treat MH and SUD (psychologists, LCSWs, LPCCs, LMFTs)
  - Non-independently MH licensed therapists (LMSWs, LMHCs, Psychology Associates)
  - Substance use counselors (LADACs and LSAAs)

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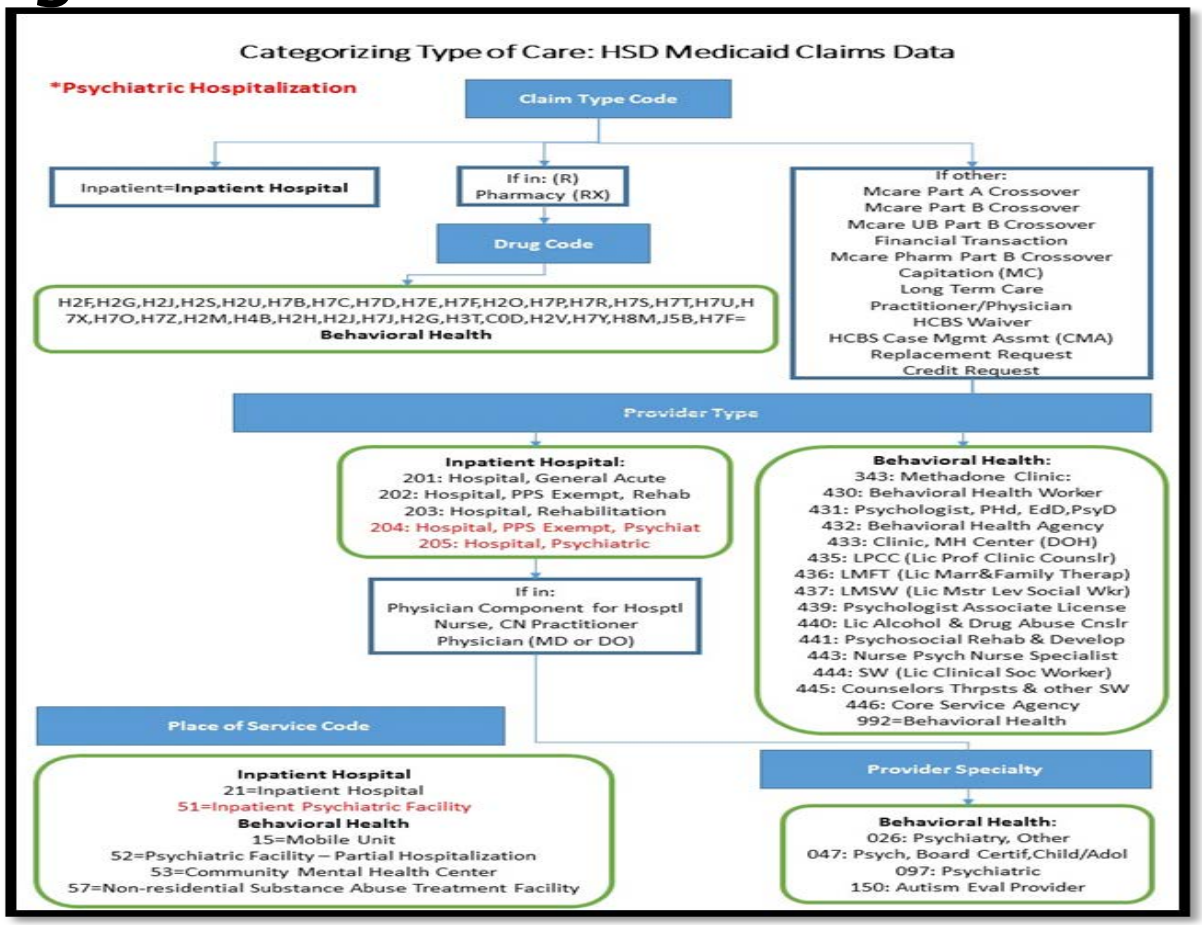
Background

- Categorization of Medicaid Claims Data



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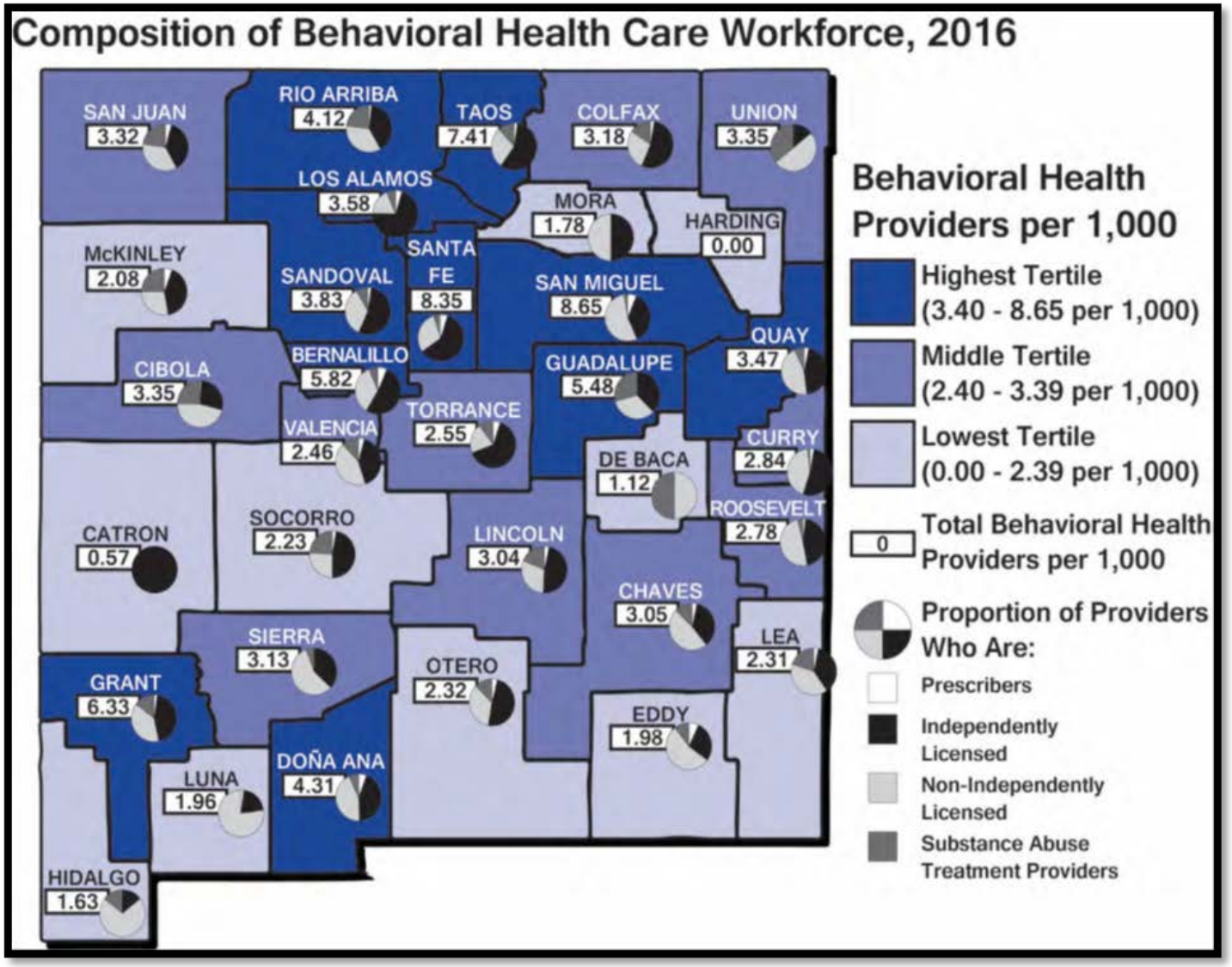

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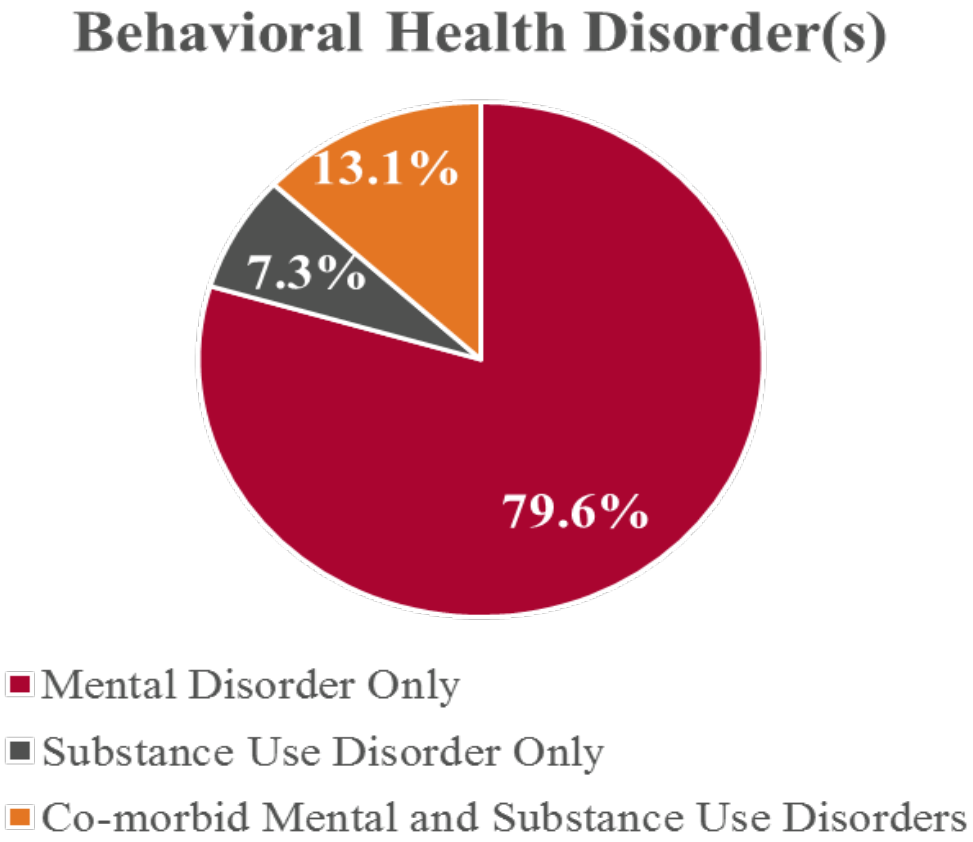
Medicaid Claims Data



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Medicaid Claims Data

- 178,555 unduplicated clients treated for MI and/or SUD during CY2016
- 68% hospitalized with 2.7% psychiatric hospitalization
- 81% treated in BH outpatient setting
- 22% Native American
- Most common mental disorders were depressive disorders (46%), anxiety disorders (43%), and trauma-related disorders (31%)
- Most common substance use disorders were opioid use disorder (10%) and alcohol use disorder (8%)

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Medicaid Claims Data

Demographics of Clients with BH Conditions

Characteristic	Hospitalized	Non-Hospitalized
Male gender	40.1%	49.7%
Age	36.4 years	30.3 years
Co-morbidities*	3.1 mean	1.4 mean
Number of outpatient visits	16.2	13.1
Diagnosis		
• Depression	50.0%	35.9%
• Anxiety	47.8%	31.6%
• Trauma-related	30.6%	31.6%
• Bipolar	11.7%	6.0%
• Opioid Use Disorder	11.1%	8.6%
• Alcohol Use Disorder	8.5%	5.3%
• Neurodevelopmental	9.6%	17.4%
• Schizophrenia	6.8%	3.4%

*Co-morbidities: list of 27 possible chronic physical conditions

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Predictors of Hospitalization for BH

- Multilevel model was built, with clients nested within counties, with a binary outcome distribution for hospitalization
- Model included variables to control for Medicaid enrollment months (2016), type of BH disorder(s), & availability of psychiatric beds in each county
- Findings:
  - Higher density of BH workers significantly decreases risk of hospitalization for:
    - Younger-than-average clients
    - Clients with fewer-than-average physical comorbidities
    - Clients who received OP BH care in the same year

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Predictors of Hospitalizations for BH

- **Relationship of workforce & healthcare utilization**
  - Initial analysis suggested that increased ratios of BH workforce were associated with increased risks of hospitalization
  - Once data was adjusted for other risk factors for hospitalization, this relationship changed
  - Individuals with a BH diagnosis who are not already at higher risk of an inpatient hospitalization (younger individuals and those with fewer comorbidities), higher-than-average availability of BH workforce in their communities is associated with a decreased likelihood of hospitalization
    - For those who receive OP, higher-than-average availability of BH workforce is associated with a decreased likelihood of IP
    - Odds of hospitalization in Harding County (no BH workforce) was 42% higher than San Miguel (most BH workforce), even though San Miguel is where the state psychiatric and other hospitals are located

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Next Steps: NM Strategies to Address BH Workforce Issues

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NM Strategies to Address BH Workforce Issues

- Addressing BH workforce challenges identified as a PRIORITY in NM BH Strategic Plan
- Convened statewide NM Behavioral Health Workforce Coalition with stakeholders including BH providers, institutions of higher education, professional licensing boards, independent practice associations, clinicians & state agencies
- Clinical Director position created for Workforce Initiative
- Developed & implemented pilot clinical tele-supervision program targeting masters level clinicians in rural areas in public BH to increase independent licensure
- Created the CBH Workforce Development Team

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CBH Workforce Development Team

- **Information Gathering**
  - Survey of all clinical social work supervisors in NM- location, cost, group/individual, type, theoretical approach, how many years in practice
  - Focus group on barriers of working in public BH
  - Survey of social workers at NM NASW conference regarding barriers to behavioral health care in New Mexico

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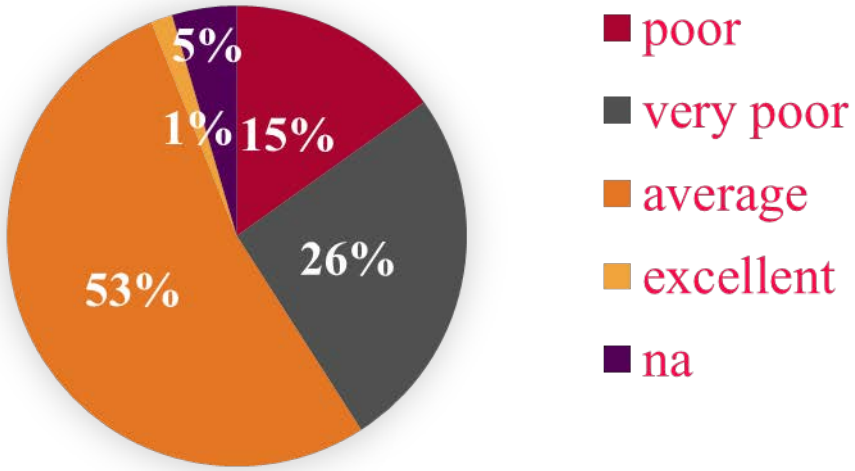
- **Clinician's Needs/Priorities:**



  - Assessment of Community's Ability to Provide BH Services

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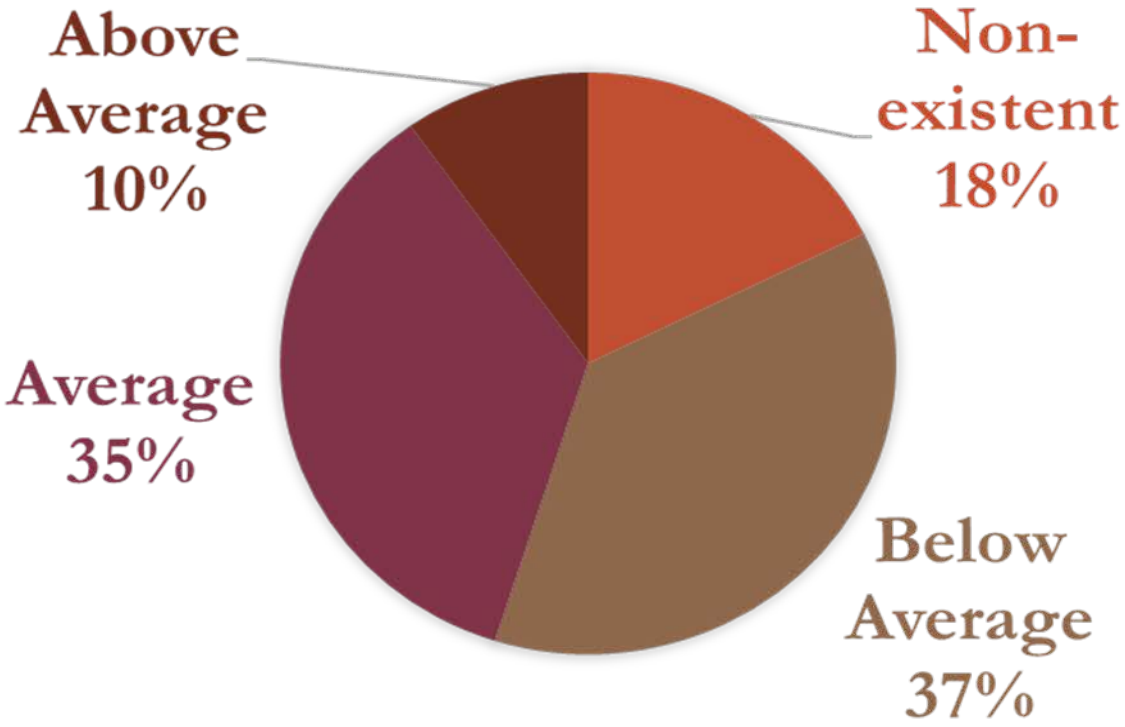
- Clinician's Needs/Priorities:
  - Ability to Attain Independent Licensure



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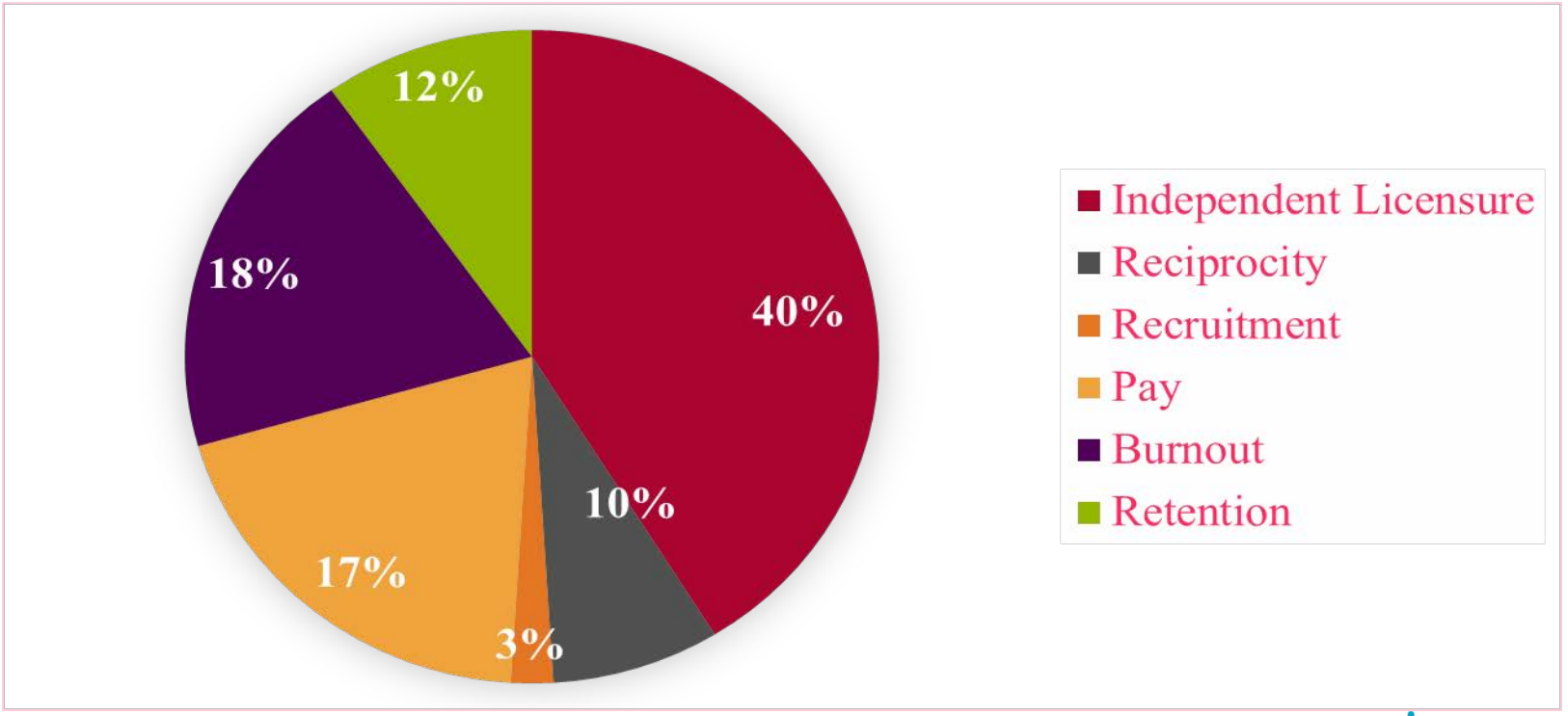
- **Clinician's Needs/Priorities:**
  - **Professional Practice Barriers**



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CBH Workforce Development Team

- **Response: Offer Research, Resources, & TA**
  - Developed flowchart to simplify steps for MSW and BSW licensure
  - Composed white paper on licensure reciprocity, intern reimbursement
  - Established a clinical supervisor guideline working group
  - Reduce barriers and to ensure current training meets needs
  - Convene annual NM Behavioral Health Summits

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CBH Workforce Development Team

- **1st Annual NM Behavioral Health Workforce Summit 2017**
- Workgroups
  - Education
  - Supervision
  - Recruitment of new workforce and Retention of aging workforce
  - Systems
- Goals and Quarterly Meetings for each workgroup in 2018
- Summit Agenda and focus in 2018:
  - Youth Involvement
  - Honoring our leaders
  - Layering of experiential opportunities
  - Recognition of different levels of participant commitment

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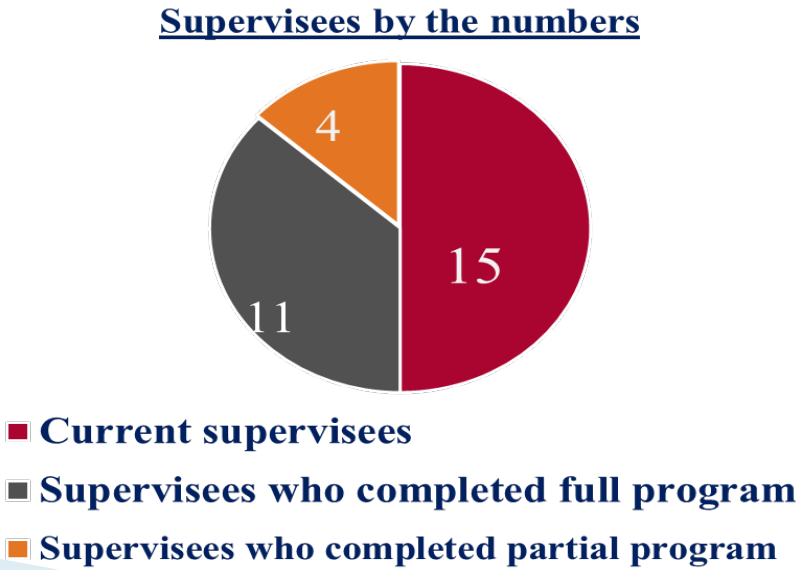
- **Response: Offer Research, Resources, & TA**
  - Clinical Tele-supervision
    - Identified need for more independently licensed providers without means to get supervision
    - Started in July 2014 with 1 LCSW, Counseling n/a
    - Currently 2 LCSWs, 1 licensed psychologist, and 1 LPCC



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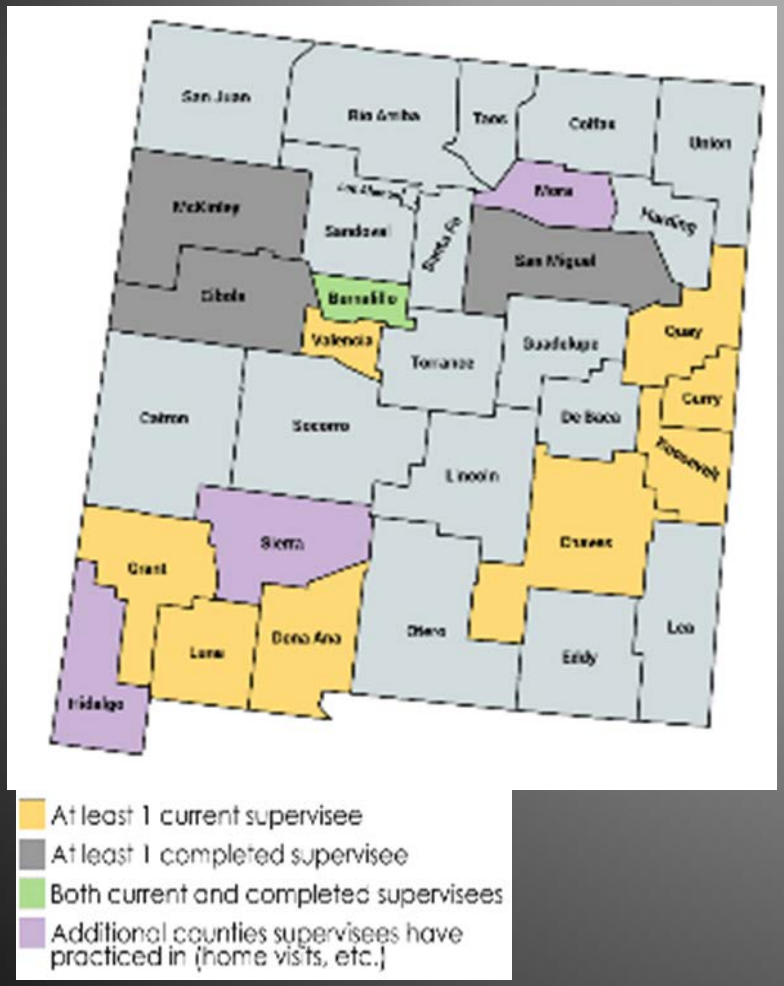
Clinical Supervision/Tele Supervision Program



- 3 counties of current supervisees (Luna, Quay, Roosevelt) have fewer than 25 independently licensed BH providers
- 2 counties supervisees have practiced in (Hidalgo, Mora) have fewer than 10 behavioral health providers (independent + non-independent)
- 5 counties of current and former supervisees (Cibola, Grant, Luna, Quay, Roosevelt) have fewer than 10 people per square mile

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Clinical Supervision/Tele-Supervision Program

- Results
  - 1,910 hours of supervision provided
  - 11 supervisees have completed the program
  - 5 have passed the LCSW exam
  - 4 have a provisional LCSW & preparing for exam
  - 2 are applying for a provisional LCSW
  - 2 supervisees will be finishing hours within 1 mth.
  - 2 supervisees left program early to start new jobs & had 25%-50% of their supervision completed
  - 15 people on wait list

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Clinical Supervision/Tele-Supervision Program

- What has it meant for individual supervisees?
  - "I feel fortunate to receive supervision at no cost, but more importantly, to receive QUALITY supervision…I am benefiting in my personal growth & my patients are benefiting as well." – Edith
  - "I had a difficult time finding a supervisor nearby until I found the supervision program…I could not be happier with them." – Katrina
  - "I had tried to pursue [supervision] in the past, but with the financial burden of student loans, it was not possible to pay an additional fee for supervision. I am blessed to be part of the program, and do not take it for granted." – Juliette
  - "LCSWs were charging a lot per hour, which is not something I could afford…it is immeasurably valuable to me to have supervision…it has vastly improved my clinical decision-making ability & has put me on track towards achieving my clinical license much faster than I imagined." – Shelby

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Other Workforce Developments

- Incentives
  - Higher reimbursements for group therapy, after hours service delivery, for CCSS delivered in the community, & ACT Teams
- New Medicaid BH Rules
  - Reimbursement for peer support services, including family & youth peer support; multidisciplinary teaming; & Physician Assistants
- New 1115 Waiver
  - Expansion of BH "Health Homes" to 11 sites with monthly capitation for care coordination, outreach, health promotion, disease management, & data collection
  - SBIRT Medicaid reimbursable
- Other
  - Community Psychiatric Residency Program
  - Rural Psychology Internship Consortium (WICHE)

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Questions

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