Workforce Factors Impacting Behavioral Health Service Delivery to Vulnerable Populations: A Michigan Pilot Study

February 2017

Jessica Buche, MPH, MA, Angela J. Beck, PhD, MPH, Phillip M. Singer, MHSA, Brad Casemore, MHSA, LMSW, FACHE, Dawn Nelson, MS

KEY FINDINGS

Despite legislative efforts to improve coverage of mental health and substance use disorder treatment, there are subpopulations within the United States that continue to have high prevalence of and poorer access to behavioral health services, often deemed *vulnerable populations*. As part of a vulnerable population, patients face numerous barriers to accessing quality behavioral health care that are not easily remedied. To better understand these challenges, a pilot study was conducted to assess behavioral health workforce supply and need, barriers to recruiting and retaining care providers, and the extent to which care coordination occurs with primary care providers in underserved, rural populations in southwest Michigan.

Key study findings indicate a need for more provider training on addressing cultural and language barriers between patients and providers, implementing integrated care models, management training, and leadership development; a need for more qualified candidate pools to fill positions; and a need for recruitment incentives such as flexible work hours or financial incentives to attract providers to rural areas.

Policies and programs focused on addressing recruitment and retention barriers, enhancing training initiatives, and implementing integrated care to treat co-occurring disorders may help enhance workforce capacity and access to care for underserved populations.

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BACKGROUND

Studies show that the nation's mental health care system is not sufficiently meeting the needs of the public. Data from the National Survey on Drug Use and Health suggests that 18% of adults had a mental illness in the past year[1] and only 43% received services for their condition.[2] Further, almost half (49%) of children diagnosed with mental health disorders do not receive any treatment.[3] In response, broad policies, like the Affordable Care Act, have been enacted to help correct these imbalances by increasing healthcare access and service provision for Americans.[4] Yet, there are many subpopulations within the United States that continue to have a high prevalence of mental health disorders and/or less access to mental health services, and they are often deemed *vulnerable populations.*

As part of a vulnerable population, patients are defined by many different traits, including homelessness, age, incarceration status, geographic isolation, and race/ethnicity. These patients face numerous barriers to accessing quality behavioral health care that are not easily remedied. This is especially true for individuals living in HRSA-designated Medically Underserved Areas (MUAs), Medically Underserved Populations (MUPs), and Health Professional Shortage Areas (HPSAs). MUAs and MUPs identify "geographic areas and populations with a lack of access to primary care services".[5] MUAs may include an entire county, a group of counties, or a group of urban census tracts.[5] MUPs include groups of persons who face economic, cultural, or linguistic barriers to health care.[5] Finally, HPSAs may be designated as having a shortage of primary medical, dental, or mental health care providers.[6] This includes geographic areas, defined as a shortage of providers for the entire population within a defined geographic area; population groups, defined as a shortage of providers for a specific population group (e.g. low-income individuals, migrant workers); and facilities such as state mental hospitals, tribal hospitals and clinics, and correctional facilities.[6]

The provision of care for vulnerable populations presents substantial challenges for the behavioral health workforce related to its supply, recruitment, and retention of clinicians. A 2009 study of county-level estimates of mental health professional shortage in the United States found that approximately one in five counties (18%) in the country had an unmet need (i.e., being able to access a mental health professional within a 60-minute drive or less) for behavioral health, with non-prescribing capabilities, while nearly every county (96%) had an unmet need for professionals prescribing capabilities.[7] Rural counties in particular had higher levels of unmet need than suburban and urban counterparts.[7] These issues pose a barrier to providing accessible services to those most in need.

Ensuring access to high quality behavioral health care requires sufficient staff, in terms of numbers and

training/skill level. In Michigan, much of the state is designated as a mental health HPSA and the northern and southwest sections of the state are designated as MUAs/MUPs, making it an ideal area to study behavioral health service delivery. The purpose of this study is to identify workforce factors that impact behavioral health service delivery to underserved populations, assess organizational-level perceptions of behavioral health workforce development needs, summarize factors impacting recruitment and retention of behavioral health providers to HPSAs, MUPs/MUAs, and identify barriers and facilitators associated with adoption of integrated care/care coordination with primary care providers serving primarily underserved populations. The focus of this pilot study is on provider organizations in chiefly located in southwest Michigan; study results will inform the development of a larger study on behavioral health workforce factors associated with service delivery to vulnerable and underserved populations.

METHODS

This study consisted of an organizational survey of behavioral health provider organizations and was conducted by the Behavioral Health Workforce Research Center (BHWRC) at the University of Michigan School of Public Health. The survey instrument was developed from literature review findings and existing workforce questionnaires for study populations in other occupations. Prior to administering the survey, questions were reviewed by two BHWRC Consortium partners and tested with four human resource/clinical executives from behavioral health organizations in Michigan to ensure the survey was valid and understandable.

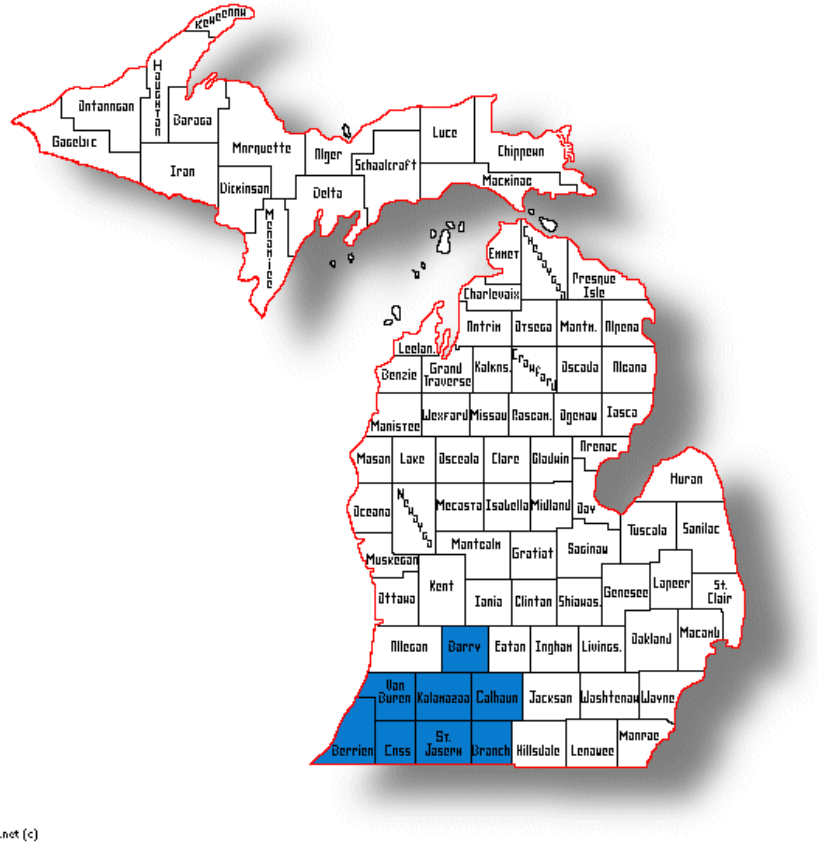
Qualtrics survey software was used to develop the online survey questionnaire. The University of Michigan Institutional Review Board reviewed the study and deemed it exempt from ongoing review. The 30-question survey required approximately 25 minutes to complete and was organized into the following themes:

- Behavioral health needs of the population and services currently provided
- Cultural and linguistic competence of the existing workforce
- Workforce development initiatives
- Factors impacting worker recruitment and retention
- The status, future plans, barriers, and facilitators to adoption of integrated care

The survey was disseminated in June-October 2016 by Southwest Michigan Behavioral Health (SWMBH) to 52 of its member organizations, which represent community mental health organizations and substance use treatment facilities in Barry, Berrien, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties (Figure 1). These counties reflect a mix of urban and rural communities, with Branch and St. Joseph

designated as rural counties. Barry, Branch, Cass, St. Joseph, and Van Buren counties are designated as Medically Underserved Areas (MUA), and Calhoun and Kalamazoo counties are designated as having a Medically Underserved Population (state mental health facility). Van Buren, Berrien, St. Joseph, Barry, and Branch counties are designated mental health HPSAs; 21 rural health clinics and 6 Community Health Centers are within this catchment area.

Figure 1. Counties Represented by Southwest Michigan Behavioral Health



Source: diymaps.net (c)

Representatives at the SWMBH organizations were sent a recruitment email, providing them with an overview of the BHWRC's research activities, a summary of the study, and an invitation to participate in the interview. The survey was completed by clinical and/or human resource executives employed at each organization. A $25 gift card was used as a response incentive.

RESULTS

Respondent Characteristics and Services

Sixteen SWMBH organizations (31%) participated in the pilot study, including 7 non-profit organizations, 3 community health centers, 3 private practices, a social service agency, and a hospital/health system. On average, respondents employed 137 workers in total, which equaled 109 Full Time Equivalent (FTE) employees. In terms of behavioral health workforce composition, on, average, organizations employed 17 support staff, 11 administrators or managers, 10 clinical social workers, 6 addiction counselors, 6 case managers, 4 counselors, 3 community health workers, 3 registered nurses, 2 psychologists, and 1 peer support specialist.

Fourteen (88%) responding organizations offered only behavioral health/substance use disorder treatment services, while 2 (12%) offered both behavioral health and primary care services. One-quarter of respondents reported that their organization annually served fewer than 500 patients per year; 5 (31%) served between 500-2,499; 2 (13%) served between 2,500-4,999; 3 (19%) served between 5,000-9,999; 1 organization served between 10,000-24,999; and 1 served 25,000 patients or more annually.

All organizations accepted Medicaid patients, while 75% (12/16) accepted Medicare patients. Under-insured patients were served by nearly all respondents (94%, 15/16), as were uninsured patients (93%, 15/16). Respondents reported providing mental health or substance use disorder services several types of patients typically considered vulnerable or underserved including: medication-assisted clients (88%; 14/16); homeless/near-homeless patients (81%; 13/16); public housing patients (81%; 13/16); veterans (75%; 12/16); school-based health patients (63%; 10/16); farmworker patients (56%; 9/16); and victims of trafficking (56%; 9/16) (Table 1).

Table 1. Populations Served by Study Participants (n=16)

Population	No.	Percentage
Medication-assisted clients	14	88%
Homeless or near-homeless patients	13	81%
Public housing patients	13	81%
Veteran patients	12	75%
School-based health patients	10	63%
Farmworker patients	9	56%
Victims of trafficking	9	56%

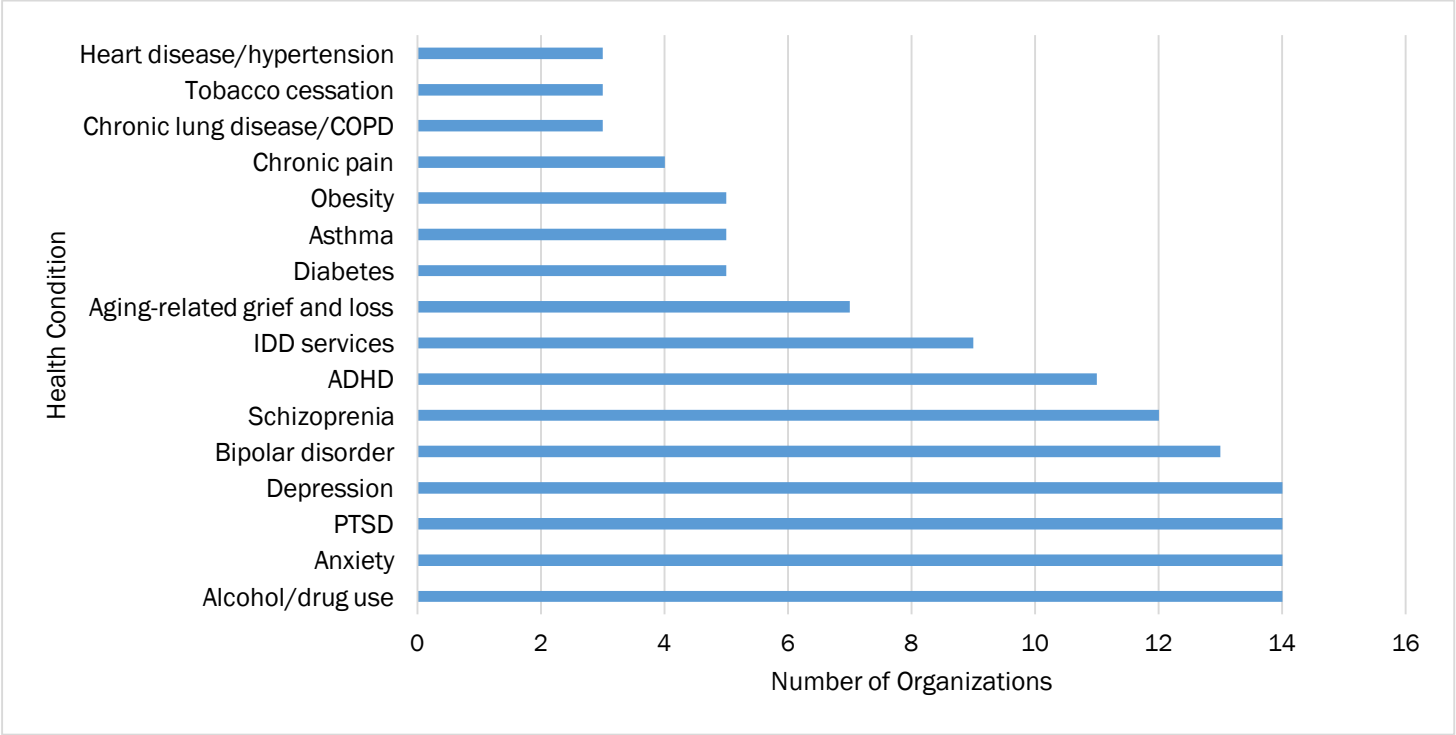
Half (7/14) of the organizations surveyed had implemented some strategies for providing patients with integrated physical and behavioral health care services, while 21% (3/14) were developing planning strategies for providing integrated care or had no plans to provide integrated care at all. Seven percent of the organizations (1/14) had already integrated physical and behavioral health care services and were focusing on maintaining these joint services. Several of the surveyed organizations offer a variety of behavioral health treatment strategies. Approximately 88% (14/16) offer patient-centered care; 88% (14/16) offer referrals to off-site primary care providers; 56% (9/16) offer referrals to off-site behavioral health providers; and 44% (7/16) offer psychiatric medications (Table 2).

Table 2. Behavioral Health Treatment Strategies Offered in Organizations (n=16)

Behavioral Health Treatment Strategy	No.	Percentage
Patient-centered care	14	88%
Referrals to off-site primary care providers	14	88%
Referrals to off-site specialty behavioral health providers	9	56%
Psychiatric medications	7	44%
Medical record that combines physical and mental health	6	38%
Medication-assisted treatment for substance use disorders	5	31%
Co-location of behavioral health providers in primary care setting	5	31%
Psychiatric consultation to primary care staff and specialty behavioral health providers	5	31%
Telehealth/telemedicine	5	31%
A single treatment plan that combines patient's physician and mental health care goals	2	13%
Use of medication algorithms for behavioral health disorders	1	6%

Organizations surveyed in this pilot study identified several health conditions for which they supplied prevention and/or treatment services. Most organizations provided services for alcohol/drug use (88%, 14/16), anxiety (88%, 14/16), depression (88%, 14/16), post-traumatic stress disorder (88%, 14/16), bipolar disorder (81%, 13/16), and schizophrenia (75%, 12/16) (Figure 2). Respondents were then asked to rate the extent to which the community they serve has access to treatment and prevention services. Approximately 63% (10/16) of respondents rated their mental health services as somewhat accessible or very accessible to the community, 56% (9/16) rated their primary care services as somewhat accessible or very accessible, and 56% (9/16) rated their substance use disorder services as somewhat accessible or very accessible.

Figure 2. Health Conditions Treated by Responding Organizations (n=16)



ADHD=Attention Deficit Hyperactivity Disorder; COPD=Chronic Obstructive Pulmonary Disease; IDD=Intellectual and Developmental Disability; PTSD=Post-traumatic Stress Disorder

Workforce Factors Impacting Service Delivery

Barriers to Recruiting and Retaining Behavioral Health Providers

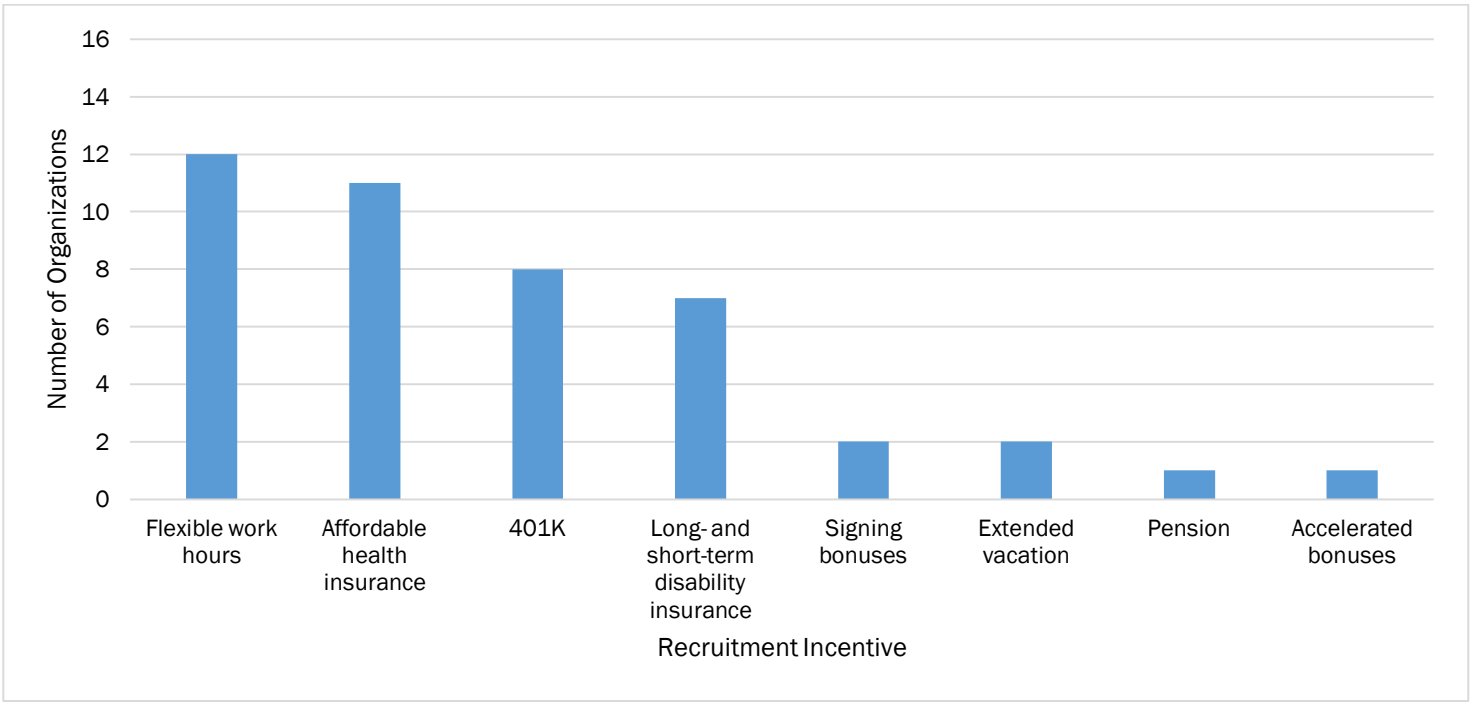
Nearly 70% (11/16) of responding organizations reported that they were trying to fill vacancies for behavioral health provider positions, including clinical social workers (73%, 8/11), case managers (46%, 5/11), addiction counselors (36%, 4/11), psychiatrists (27%, 3/11), and counselors (27%, 3/11). Having an applicant pool that lacks the required licensure or certification was the most commonly reported barrier to filling vacant positions (75%, 12/16), followed by offering non-competitive salaries (69%, 11/16), lack of experience of applicant pool (50%, 8/16), and geographic isolation of the organization (44%, 7/16). In an open-ended question, respondents also noted that a lack of reliable transportation, the exclusion of candidates with criminal convictions, and shortages of psychiatrists and registered nurses who are interested in working in the behavioral health field can be barriers to filling vacant positions.

Best Practices in Recruiting Behavioral Health Providers

When asked to identify incentives their organizations provide to recruit behavioral health providers, 75% of respondents (12/16) reported offering flexible work hours, 69% (11/16) cited affordable health insurance, 50% (8/16) reported offering a 401K plan, and 44% (7/16) reported offering short- and long-term disability insurance. Two or fewer organizations reported offering extended vacation (13%, 2/16), signing

bonuses (13%, 2/16), accelerated bonuses (6%, 1/16), and pension plans (6%, 1/16) as recruitment and retention incentives (Figure 3). Other incentives included referral bonuses, birthday pay, dental and vision insurance coverage, and free life insurance. One representative reported that their organization did not provide any incentives when trying to fill positions.

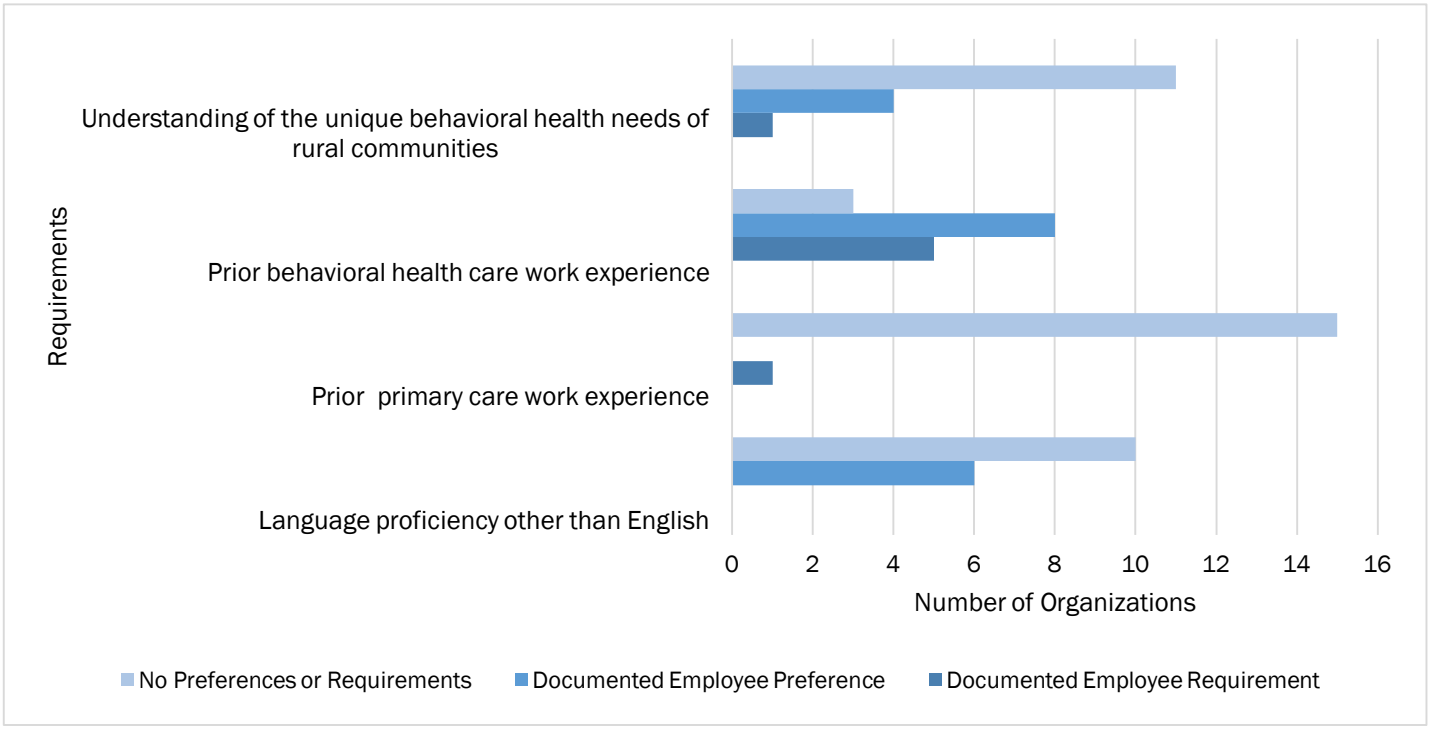
Figure 3. Recruitment Incentives for Filling Vacant Behavioral Health Provider Positions (n=16)



Skills, Training, and Care Coordination of Current Workforce

Respondents reported skills, knowledge, and experiences they prefer or require of their employees. These included language proficiency other than English, prior work experience in behavioral health and/or primary care settings, and an understanding of the unique behavioral health needs or rural communities (Figure 4). Few organizations had documented employee requirements for any skills, knowledge, or experiences. Thirty-one percent of organizations (5/16) required prior experience in a behavioral health care setting and 50% (8/16) preferred prior experience. Further, 38% (6/16) organizations preferred language proficiency other than English of their employees, and 25% (4/16) preferred an understanding of the unique behavioral health needs of rural communities, people of color, and sexual and gender minority groups.

Figure 4. Knowledge, Skills, and Experiences Preferred or Required of Employees (n=16)

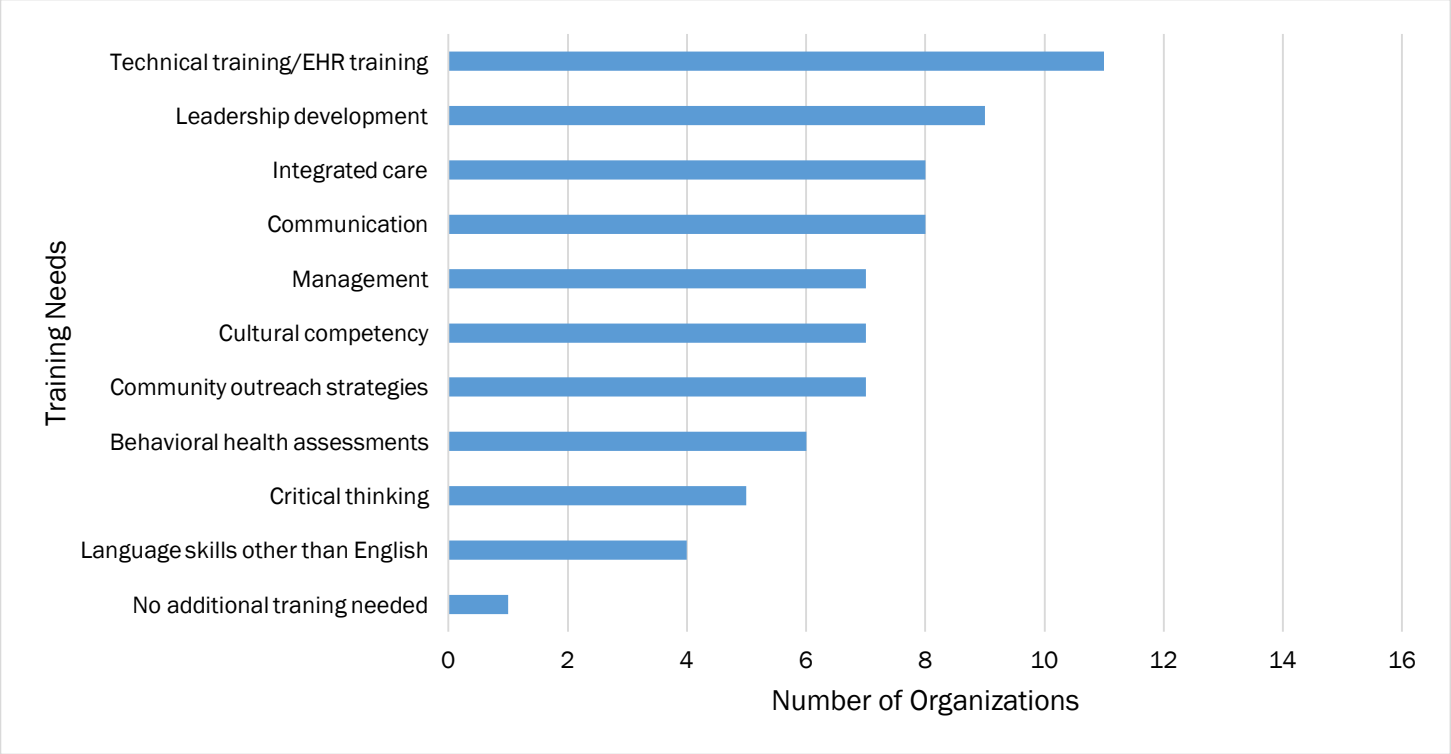


When asked about workforce capacity-building efforts undertaken by their organization, all respondents reported providing on-site training for employees, including competencies in job descriptions, and paying for fees associated with training. Fifteen respondents (94%) reported having annual employee assessments and tracking employee participation in training activities. The majority of respondents also reported allowing use of work hours to participate in training (88%, 14/16), including education and training objectives in performance reviews (88%, 14/16), and providing employees with recognition of training completion (81%, 13/16).

Workforce Development Needs

Respondents most frequently identified technical training or electronic health record training as a behavioral health workforce development need (69%; 11/16). Other knowledge and skill areas in which additional behavioral health staff training is needed include: leadership development (56%; 9/16), integrated care (50%; 8/16), communication (50%; 8/16), management (44%; 7/16), cultural competency (44%; 7/16), community outreach strategies (44%; 7/16), behavioral health assessments (38%; 6/16), critical thinking (31%; 5/16), and language skills other than English (25%; 4/16). One organizational representative indicated that no further training is needed for staff (Figure 5).

Figure 5. Behavioral Health Staff Training Needs (n=16)



EHR=Electronic Health Record

Organizations were asked to identify which occupations would be considered higher and lower priority workforce needs. Priorities were defined as needing more staff, more qualified candidates for open positions, and more competitive salaries for staff, additional staff training, or needing to employ a new occupation type. Organizations identified psychiatrists as the highest priority occupation in terms of workforce development needs (80%; 8/10), followed by clinical social workers (54%; 7/13), addiction counselors (54%; 7/13), social workers (50%; 6/12), and registered nurses (45%; 5/11). Occupations with lower priority workforce development needs included occupational therapists (100%; n=8), psychiatric rehabilitation practitioners (100%; n=6), administration managers (80%; 12/15), counselors (64%; 9/14), case managers (62%; 8/13), and physician assistants (62%; 5/8).

Barriers to Service Delivery

Respondents identified several clinical and workforce barriers their organization faced related to providing behavioral health care services. Chief clinical barriers included: providers' limited training in the treatment of psychiatric and substance use disorders (31%, 5/16); cultural and/or language differences between health care providers and patients (25%, 4/16); and providers' lack of training in evidence-based behavioral health treatments (25%, 4/16). The most commonly reported workforce factors inhibiting behavioral health service delivery were: information-sharing obstacles between primary care and

behavioral health providers (50%, 8/16) and providers' limited time to address both physical and behavioral health concerns (38%, 6/16) (Table 3).

Table 3. Clinical and Workforce Barriers to Providing Behavioral Health Care Services (n=16)

Barriers to Providing Care	No.	Percentage
Clinical Barriers		
Providers' limited training in the treatment of psychiatric and substance use disorders	5	31%
Cultural and/or language differences between health care providers and patients	4	25%
Providers' lack of training in evidence-based behavioral health treatments	4	25%
Providers' stigmatizing attitudes toward behavioral health issues and clients	3	19%
Providers' lack of awareness of evidence-based behavioral health treatments	2	13%
Cultural and/or language differences between primary care and behavioral health providers	1	6%
Workforce Barriers		
Information-sharing obstacles between primary care and behavioral health providers	8	50%
Providers' limited time to address both physical and behavioral health concerns	6	38%
Physical separation of primary care and behavioral health providers	5	31%
Too few clinicians to provide behavioral health services	5	31%
Lack of agreement between primary care and behavioral health care providers over who is responsible for a patient's behavioral health care	4	25%
Providers' lack of population health perspective	3	13%
No capacity to provide care via telehealth/telemedicine	2	13%
Organization's focus is more oriented toward acute (vs. chronic) care	1	6%

CONCLUSIONS

This study was conducted to identify workforce factors that serve as facilitators and barriers to mental health service delivery for underserved populations. Key study findings highlight several workforce development needs. First, provider training should be a priority. Topics of importance noted by respondents included addressing cultural and language barriers between patients and providers, implementing integrated care models, management training, and leadership development. This represents a diverse array of topical areas but may also reflect a need for improved administrative capacity to deliver high-quality services in an integrated manner.

Respondents also reported a need for more qualified candidate pools to fill positions, as well as a need for

recruitment incentives such as flexible work hours or financial incentives to attract providers to rural areas. These findings are consistent with the concern that filling vacant positions with providers of sufficient experience and training continues to be a challenge for the behavioral health workforce overall, but that the problem is often exacerbated in rural communities and specialized recruitment strategies may be necessary to build workforce capacity.

As a pilot study, the small sample size (n=16) impedes our ability to draw generalizable conclusions about the workforce factors impacting service delivery in all HPSAs, MUAs, and MUPs, but generalizability was not the purpose of this preliminary study. The pilot study results provide us with useful information on themes that should be further studied in in future research projects, as workforce development needs in rural and underserved Michigan communities are likely to have some similarity in other communities in need of behavioral health services. A broader regional or national study will help identify policies and programs that can help address workforce capacity challenges such as development of recruitment and retention incentives specifically for communities with vulnerable populations, facilitation of training initiatives for behavioral health providers, and identification of strategies for promoting and supporting integrated care implementation for underserved populations to treat co-occurring disorders and improve access to behavioral health services.

Acknowledgments

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