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Revolutionizing the Behavioral Health Workforce:

A Critical Role for Philanthropy

VREDS PHILANTHROPY

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Executive Summary

For decades, the United States has consistently failed to provide essential mental health and substance use care to Americans. A central reason is that the *people* integral to delivering care are not accessible to the individuals and families when and where they need them.

Poor mental health and mental illnesses, especially when untreated, often co-occur with substance use disorders. In this paper, we refer to these conditions as "behavioral health" and the systems that serve them as "behavioral health systems." A behavioral health "workforce crisis" has been acknowledged in virtually every major assessment of the nation's failing systems, recognizing that without a well-trained and accessible workforce, all efforts at transformation are likely to fail.

Philanthropy is uniquely positioned to identify and accelerate solutions to this urgent problem alongside important ongoing efforts by public officials and other private sector leaders.

At a recent convening hosted by the National Council for Mental Wellbeing (National Council), leaders from government, universities, philanthropy, and civil society convened to share what they are doing to optimize access to behavioral health services through various workforce strategies.

Many ideas and solutions emerged from this meeting, and all are represented by the levers in this framework from the Center for Workforce Solutions, a partnership between the National Council, Health Management Associates, and the College for Behavioral Health Leadership.

Figure 1: Levers of Change

Source: Center for Workforce Solutions (2024) https://www.thenationalcouncil.org/resources/crosswalk-workforce-recommendations

1

A central theme throughout the meeting was that increasing the size of the behavioral health workforce, as it's currently configured, is not likely to increase access to behavioral health services. Long-standing narratives about "national shortages" (in professionals, facilities, etc.) are often built on flawed assumptions modeled in inequitable systems. The data underlying these models are limited and inconsistent. Targets are often built on outdated care models that are sometimes inconsistent with population health needs or best practices. And too often, a "we need more" mentality is unduly influenced by the views of incumbent professional groups. Participants at the convening agreed that a better north star is *equitable access to care*—a goal that centers patients rather than providers. A shift is needed from a shortage frame to an access frame.

2

A second key idea that surfaced is that there are many people sitting on the sidelines who could be brought into the workforce now. Retraining, licensing and credential reform, tele-behavioral health, and interstate compacts are all ways to optimize existing labor sources. They have the added benefit of being able to make an impact within a relatively short, three-to-five-year timeframe.

"A central theme throughout the meeting was that increasing the size of the behavioral health workforce, as it's currently configured, is not likely to increase access to behavioral health services."

3

A third point of discussion was the promising behavioral health service delivery models that include workforce elements like task-shifting. Task-shifting lets all members of a care team practice at the top of their license, unleashing the fullest extent of their training, skills, and judgment. Even more task-shifting occurs with "Behavioral Health Support Specialists"—a term of art from Bipartisan Policy Center for more lightly trained workers like community health workers, navigators, and peers. Smart adjustments like these can boost efficiency, increase retention, and, most importantly, enhance patient outcomes.

4

A fourth focus was the need for sustainable financing and adequate pay—reimbursement that matches actual costs and is in line with similar healthcare services. It is well-documented that behavioral health providers have significantly lower pay than comparable providers. The result is much higher out-of-network use, which creates significant barriers for all people, but especially for marginalized communities. Across all workforce strategies—no matter the setting, model, or type of worker—adequate and sustainable reimbursement is perhaps the most indispensable reform.

Transformed access to effective and dignified care includes many dimensions, along with their respective workforce solutions. It includes care that is timely, equitable, culturally and linguistically competent, accessible, and adequately and sustainably financed. Leaders within the public and private sectors should remain focused on making such services available to all people. A transformed workforce is a critical means to this end.

Summary of Recommendations

Recommendations center on three levers of change along the workforce pipeline: training, licensing & credentialing, and reimbursement & systems. To further close the access gap, philanthropists can prioritize workforce-friendly delivery methods, effective use of support specialists, and digital technology across all three levers. These levers are matrixed against four grantmaking strategies: capacity & program development, research, policy, and impact investment.

LEVERS OF CHANGE

1. **Training:** Educational settings—including high schools, community colleges, medical schools, and post-doctorate programs—will always be an important lever of change. Digital training, second chance programs, and the many additional sites where behavioral health is regularly provided, including FQHCs, CCBHCs, and even primary care, are less obvious, but equally important, sites of intervention.

2. **Licensing and Credentialing:** One shorter-term opportunity is around reducing variability in licensing and credentialing. Philanthropists can help states pursue more flexible licensing approaches, non-onerous requirements, and interstate compacts.

3. **Reimbursement & Systems:** Topline priorities include boosting reimbursement rates for behavioral health providers, addressing historic reimbursement disparities between physical and behavioral health, expanding sites practitioners can bill, and simplifying administrative burdens. Workforce-friendly care models, which optimize the workforce and provide sustainable reimbursement, are clear targets. Value-based payment is also an innovation to nurture and watch.

GRANTMAKING STRATEGIES

1. **Capacity & Program Development:** Gifts to shore up local institutions will continue to come first, especially for place-based funders. From community mental health clinics to academic training institutions to apprenticeship programs—no matter the site or area of the country—it's a good bet that behavioral health has been systematically marginalized and underinvested. By focusing on behavioral health programs, models, and capacity, philanthropists can elevate local institutions and build the field.

2. **Research:** Philanthropists can also help identify more transformational solutions to our broader workforce challenges. More than a century ago, the Carnegie Foundation commissioned Abraham Flexner to crisscross the country and survey the nation's 100-plus academic medical training programs. The resulting "Flexner Report" so convincingly advocated the biomedical model of healthcare training—and indicted its unscientific alternatives—that within months of its publication, half of all medical schools in North America closed. Flexner and his report have been criticized for the ways it excluded and segregated black people from the mainstream of academic medicine and perpetuated disparities. However, his work is still nearly universally regarded as the landmark event that ushered in our modern medical training regime. A research project of similar magnitude could address the inequities Flexner overlooked and help bring health workforce training into the 21st century. In the meantime, research and development are needed in many areas, including curricula, privacy and regulatory conditions for digital health, and broader policy issues.

3. **Policy:** Significant policy change is needed to shift the entrenched accreditation boards and the roughly 50 distinct sets of state laws that govern the licensing of our nation's 14 million care providers. The value of advocacy has been demonstrated again and again whether it is for-profit or non-profit organizations promoting the cause. A study by the National Committee for Responsive Philanthropy found that advocacy provides a return of $115 for every dollar spent. The organization's recent action plan further builds on this finding.[2]

4. **Impact Investment:** Digital technologies have the potential to transform all three levers of change: training, licensing and credentialing, and reimbursement. But regulatory and payment conditions must be favorable for these technologies to flourish.

Recommendations

GRANTMAKING STRATEGY	CHANGE LEVER: Training	CHANGE LEVER: Licensing & Credentialing	CHANGE LEVER: Reimbursement & Systems
Capacity Building	• Time-tested, university-based strategies to prioritize behavioral health • "Culture of training" in a range of clinical settings • Models for training communities	• Program-specific grants to nonprofits upskilling and credentialing support specialists and clinicians	• Build administrative, financial, technological capacity • Implementation support and incentive grants to scale and evolve workforce-friendly delivery models
Research	• National scan of academic training programs • National research and evaluation agenda on behavioral health workforce education and training	• Variability in licensing requirements across all 50 states • Variability in credentialing requirements across all 50 states • National and state data systems to gather and assess essential data	• Models of comprehensive system transformation • Models of state-based value-based purchasing
Policy	• Public-private partnerships • State legislatures to increase behavioral health teaching hospitals, residency, and training spots in state universities • State legislatures to invest in consistent training for support specialists	• Interstate compacts to attract out-of-state practitioners and expand telehealth	• CMS to increase reimbursement for the full array of behavioral health services, workers, and settings • Employers, unions, and states to require and pay for parity • Cross-state dialogue to harness a whole of government approach to behavioral health workforce Improvement • States to increase reimbursement and reduce barriers for support specialists
Impact Investment	• Digital training to prioritize culturally competent care	• Technology that facilitates licensing and credentialing	• Digital supervision and task shifting to improve efficiencies

Background

Major assessments of the nation's mental healthcare system dating back decades, including those from the New Freedom Commission on Mental Health, the National Academies of Science, Engineering, and Medicine (NASEM), and more recently from the U.S. Surgeon General have all documented the country's failure to meet the basic mental healthcare needs of its citizens.[3-5] They have consistently described a "system in shambles" and in need of fundamental transformation.

It comes as no surprise, therefore, that so many Americans find behavioral health professionals to be in short supply in their communities.[6]

Access to equitable mental health services–and the workforce needed to support it–can be understood along many dimensions. These include the many systems, types of workers, and care models that serve patients.

System Factors

System factors encompass a complex array of conditions, systems, settings, and financing. Care is provided across a breadth of health *conditions* covered—from acute episodes to life-long serious and persistent mental illness. Multiple service *systems* are involved: public health, human services, education, healthcare, and the criminal legal system. A range of institutional and com-

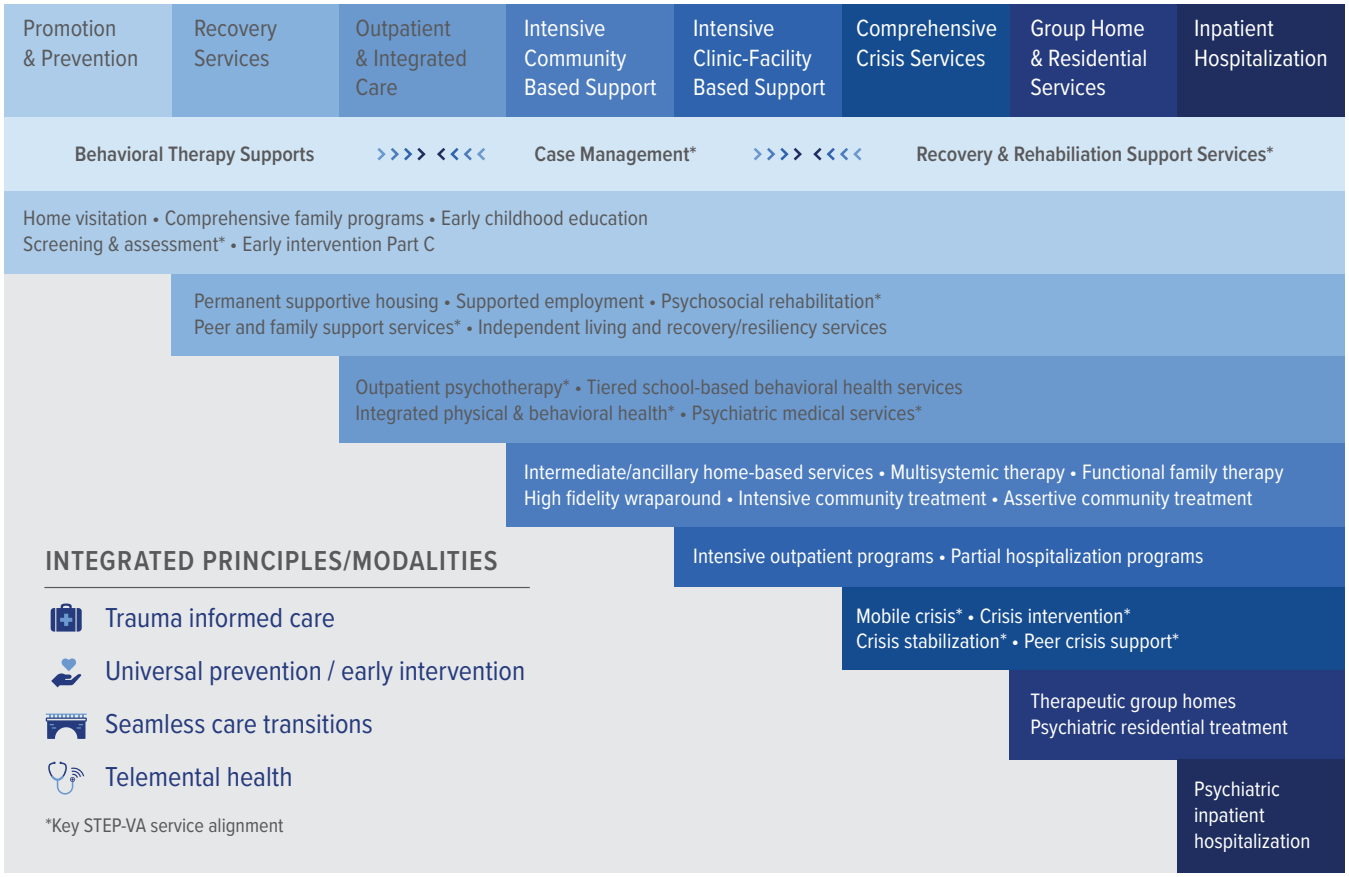

Figure 2: Continuum of Behavioral Health Services Across the Life Span

Source: Virginia Department of Medical Assistance Services, as cited in https://virginiamercury.com/2022/08/15/demand-for-mental-health-services-outpaces-expectations/

munity *sites* also come into play, from clinics, hospitals, and schools to community centers and workplaces. Each site has a mix of public and private insurance coverage and funding at varying stages of evolution (though none as fully evolved as those supporting other forms of health care), and this coverage is almost always inadequate. A visual representation of this complex backdrop from the Virginia Department of Medical Assistance Services is shown on page 7.

Types of Workers

Across and within these systems are the many types of clinical and non-clinical professionals needed. These include a spectrum of highly trained professionals, including psychiatrists and other medical doctors, psychiatric nurse practitioners and nurses, social workers, psychologists, certified peer specialists, and community health workers. Last but not least are people living with poor mental health and their families, who are *de facto* members of the behavioral health workforce and provide an enormous amount of self-care, support, and care for loved ones.[7] As this conceptual model by Advocates for Human Potential illustrates, a well-supported behavioral health workforce system must attend to its infrastructure and *people*.

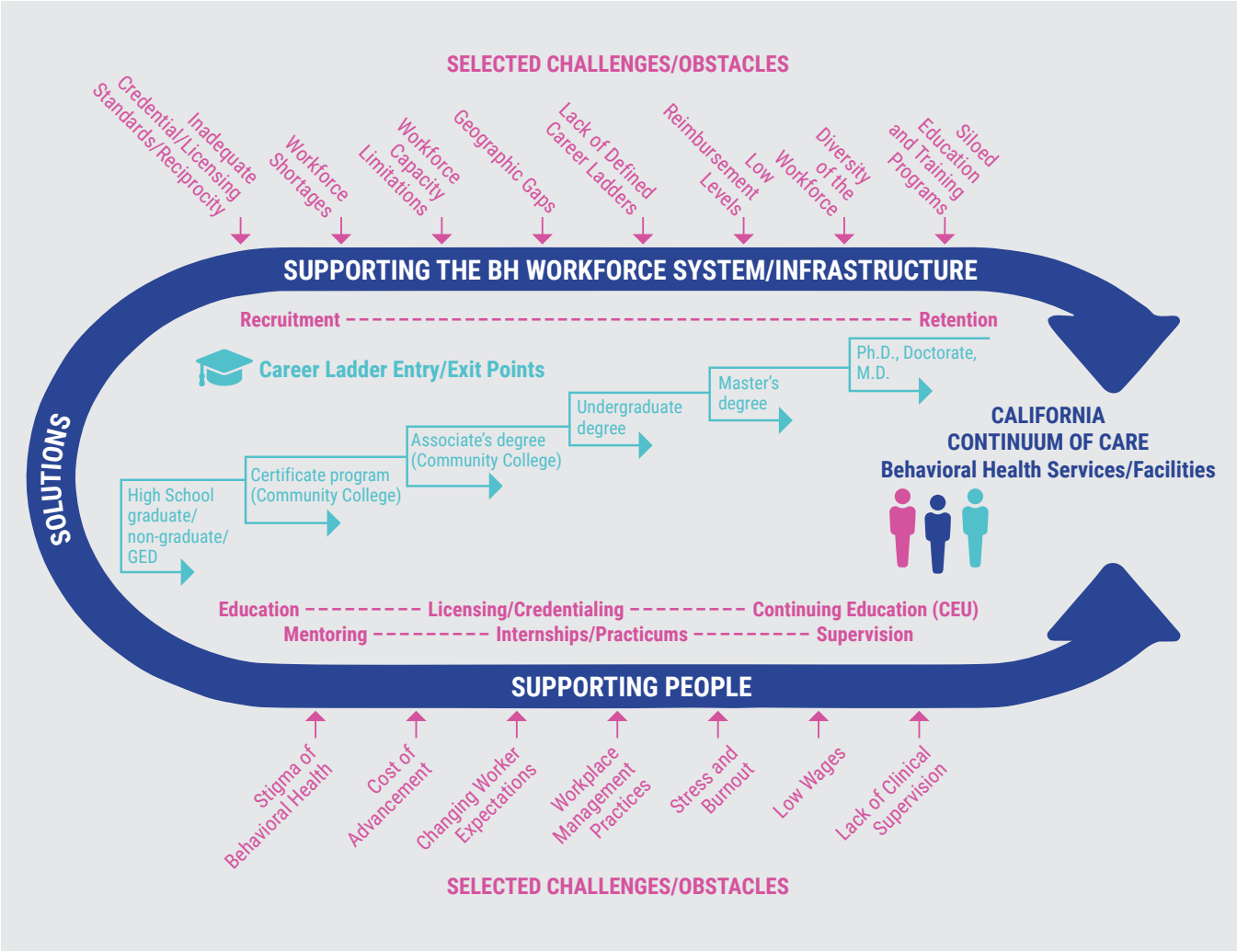

Figure 3: CA Behavioral Health Workforce Development Conceptual Model

Source: https://ilabh.org/files/manual/137/Behavioral%20Health%20Workforce%20Development.pdf

Behavioral Health Support Specialists

Professionals with less formal training, who constitute a significant part of the behavioral health workforce, are widely recognized for their potential to extend it. Support specialists of all kinds—peers, navigators, and community health workers—fall into this category. They bring care to new settings, expand the current workforce, enable each team member to work to the top of practice and reduce disparities.[8] Many states have shown interest in relying less on workers with a significant amount of post-secondary education and more on those with more accessible levels of schooling.[9] In some states, like Washington, they are licensed, and in others, they are more lightly credentialed or not at all.[10] Research has found that trained behavioral health workers with the right mix of personal qualities and familiar backgrounds offer patients significant improvement across a range of settings.[11] A recent report by Rand called for the development of a pipeline for these workers across the broader health system.[12]

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Workforce-Friendly Delivery Models

Various service delivery models bring another dimension. The more workforce-friendly models use approaches such as task-shifting or engagement of non-behavioral health professionals to leverage the time of higher-paid professionals.[13] While they are not workforce strategies per se, these models reflect innovations in how behavioral health workers are deployed and may optimize their reach and effectiveness. Support specialists can be integrated into these workforce-friendly delivery models to further extend efficacy and reach. Mathematica Policy Research prepared "Implications of Behavioral Health Care Models" for Office of the Assistant Secretary for Planning and Evaluation (ASPE) and identified the promising models shown on the next page.[14]

MODEL	POTENTIAL WORKFORCE EFFICIENCIES
Behavioral health (BH) integration models	• Shifts some BH care to primary care providers, which may increase capacity of BH providers
BH mobile applications	• Provides clinical information, which may lead to more efficient treatment and therefore increased capacity to treat clients
Certified Community Behavioral Health Clinics (CCBHCs)	• Increases BH staff salaries, which may allow hiring new and different types of staff, and reduce staff turnover • Redistributes some responsibilities from more costly and highly-trained professionals to less costly staff such as peer specialists and family support workers
Crisis services	• Aligns service delivery with staff qualifications • Helps ensure receipt of appropriate level of care, in least restrictive environment
Hub-and-spoke models for medication-assisted treatment	• Shifts care to lowest level of care needed, which may increase availability of specialists • Expands treatment capacity of community-based providers through mentorship and trainings delivered by specialists
Peer support models	• Redistributes some responsibilities from more costly and trained professionals to more available, less costly peer support
Telebehavioral health models	• Uses technology to increase access to BH providers in communities with BH workforce shortages and address provider maldistribution
Psychiatric and mental health nurse practitioners (PMHNPs)	• Increases treatment capacity through use of professionals trained to provide many of the same services as psychiatrists
Same-day access	• Restructures provider schedules to increase access to services when clients need them, decrease time spent scheduling appointments and conducting outreach, and reduce no-shows

Source: Stefanie Pietras & Allison Wishon, April 2021, "Workforce Implications of Behavioral Health Care Models: Final Report," Mathematica Policy Research Reports cdf225c7db21461aa9d3a9d52, Mathematica Policy Research: https://aspe.hhs.gov/reports/workforce-implications-behavioral-health-care-models-final-report

National and Federal Initiatives

New national and federal initiatives are underway to define the behavioral health workforce crisis and identify solutions. The Substance Abuse and Mental Health Services Administration (SAMHSA) has assembled a technical expert panel for input and is developing a series of playbooks.[16] NASEM is hosting a forum. ASPE at the Department of Health and Human Services released a report. The following agencies also are engaged in important ongoing work.

1. HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Many programs and initiatives of HRSA are aimed at strengthening the behavioral health workforce and connecting skilled health care providers to communities.[15] HRSA supports national research, centers of excellence, and technical assistance relating to the behavioral health workforce; a range of scholarship, loan, and loan repayment programs to individuals; and grants to such organizations as schools, hospitals, and health departments. The latter benefits both professionals and non-clinical professionals in a wide range of fields pertaining to behavioral health. HRSA also support specific groups of workers (such as underrepresented minority students), populations in need of care (such as children, adolescents, and young adults), and specific geographies (such as rural and health professional shortage areas).

2. SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

SAMHSA is charged with leading public health efforts to advance the nation's behavioral health needs. Its strategic plan details workforce strategies, including various fellowship programs, training grants, and career hubs.[17] SAMHSA also supports evidence-based practice resource centers, training and technical assistance centers, national model standards for peer support certification, and grants. Additional focus areas include counseling compacts and regulatory actions to decrease provider restrictions.[18-20]

3.CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

CMS's behavioral health workforce initiatives are undertaken through its influence on two major government programs, Medicare and Medicaid, and through its Center for Medicare and Medicaid Innovation, which innovates in both programs and the Children's Health Insurance Program.[17]

- **Medicare:** CMS sets regulations, manages payment systems, and oversees the administration of Medicare, ensuring beneficiaries receive the services to which they are entitled. Reimbursement rates set by CMS tend to be benchmarks for other payers (commercial and Medicaid), with hospitals typically shifting costs to private payers and negotiating commercial rates around double what Medicare pays.[21-23] Starting in January 2024, more than 400,000 marriage and family therapists and mental health counselors can enroll as Medicare providers and bill independently, which may expand rural access.[24]

- **Medicaid:** Medicaid is the single biggest funder of behavioral health services in the United States (established in 1965 as a federal-state partnership). It's designed and administered by states, while meeting federal requirements, and varies considerably from one state to another.[25] CMS exerts tremendous influence on the behavioral health service system nationally, and many states are responding by increasing reimbursement rates, extending the workforce that can bill for services, reducing administrative burden, and incentivizing provider participation.[26]

- **Center for Medicare Medicaid Innovation (CMMI):** CMMI tests, evaluates, and scales innovative healthcare payment and service delivery models—reducing costs while improving quality. CMMI is pioneering two new models that could be transformative for the workforce — its Innovation in Behavioral Health model and the CCBHC model.[27]

Supply and Provider Demand

SUPPLY

Academic medical centers (including academic nursing, social work, psychiatry, psychology and primary care) will always be targets of philanthropy. Less obvious educational training programs are also important—from apprenticeships to instituting a "culture of training" at community mental health sites. A focus on other supply-side levers will further improve the behavioral health practitioner pipeline. These include the many laws, regulations, and organizations that together determine the number of providers, their required education programs and clinical training, pathways to licensure, credentialing, and entry into the field.

"A statement of values, a strategic plan, research on evidence-based practices, and even regulatory efforts are critical, *but they cannot overcome the reality that what is paid for is what will be provided.*"

PROVIDER DEMAND

Chronic low pay, administrative burden, and limitations on settings workers can bill are all critical factors that influence the interest of professionals in pursuing behavioral health work. As one review of financing in the behavioral health industry observed, "A statement of values, a strategic plan, research on evidence-based practices, and even regulatory efforts are critical, but they cannot overcome the reality that what is paid for is what will be provided. Frequently, what is paid for well or easily, or with a high reimbursement rate, will have more influence on which services are provided and in what manner they are provided than the professional standards or the non-financial actions of system leaders and stakeholders" (emphasis added).[1]

Philanthropic High Points

Philanthropists—independent of the system and relatively immune to its internal conflicts and interests—have long been committed to improving our healthcare workforce.[28] From the "Flexner Report" to the Josiah Macy Jr. Foundation's pioneering gifts for physician assistant program in the 1960s, philanthropists have made transformational impacts.

And they are increasingly centering behavioral health in their giving. Philanthropists support dedicated fellowships for child psychiatrists or psychiatric mental health nurse practitioners, specialized programs to elevate behavioral health specialists, and reforms of the general medicine curricula to integrate mental health. Bound by place, mission, and charter, many local philanthropists are bringing such approaches to their local universities and other training organizations.

Examples of behavioral health workforce philanthropy are noted below. But even with these highpoints, there's still so much more opportunity for investment.

1. CURRICULA REFORM

One holistic reform is interprofessional education, as the Macy Foundation has urged for decades. The Kenan Foundation, for instance, launched a Rural Inter-Professional Health Initiative at the University of North Carolina, through which teams of doctors, nurses, and social workers are trained in rural areas with the hopes they will practice there. Still, others have targeted curricula reform around moral purpose education, fast-tracking learning through "virtual rounds," or integration of psychiatry within all branches of primary care. The New York Community Trust recently funded the National Council to work with ten social work graduate schools to refine their curriculum around opioid use disorder.

2. DEBT RELIEF & FELLOWSHIPS

Others use debt relief and fellowships to better align clinical training with underserved groups, specialties, and geographies.[29] The Meadows Foundation, Lyda Hill Philanthropies, Hackett Family Foundation, and others have supported advocacy and technical assistance through the Meadows Institute for a statewide consortium across the 12 state-funded medical schools in Texas to boost child psychiatry training programs and expand public sector residency training in state universities.

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3. DEDICATED PROGRAMS

The Gordon and Betty Moore Foundation stood up a specialized training program for nurse leaders, and the Ballmer Group created one for behavioral health specialists.[30,31] These specialized programs elevate entry and mid-level professionals and take on makeup and scope of care.

4. BEYOND THE UNIVERSITY

Philanthropists are pursuing training and credentialing of more support specialists through programs at community colleges and high schools.[32,33] A public-private partnership between a family foundation and AmeriCorps recently expanded access to youth peer specialists.[34]

Persistent Challenges

Our ability to expand the workforce is complicated by inconsistent scopes of practice across states, major challenges with payment and reimbursement, and limited training in integrated healthcare. These challenges, coupled with high levels of burnout, prevent behavioral health providers from performing at their full capacity, practicing across state lines or via telehealth, and remaining in the workforce.[35] Workforce deficits are especially acute for children, adolescents, and older adults, and in rural, frontier, and underserved communities.[7]

Underlying all these issues, the data used to monitor progress in the behavioral health workforce is limited and inconsistent. While the behavioral health workforce is broad and spans multiple sectors, most data sources focus on siloed professions or are restricted to a single setting or service system. Further, unlicensed workers cannot be tracked via licensure or graduate data. Nor does data on the behavioral health workforce reveal which client populations are served (e.g., Medicaid clients, adolescents, rural residents). State licensing boards struggle to track meaningful data. These data limitations are further complicated by the fact that there are few standards or benchmarks for knowing what number or mix of clinical and non-clinical professionals are needed in communities of different types and sizes.[36]

> A strong workforce is critical to creating and sustaining robust and integrated behavioral health service systems in this country—a change that is long overdue.

Equitable Access: The Real Goal

Addressing behavioral health workforce challenges is first and foremost about connecting people with the care they need when and where they need it. This care must be available, accessible, affordable, and acceptable to those seeking it. It must also be backed by a sustainably financed system that supports its most critical assets, namely the people who provide the care. High-quality, adequately resourced, and equitable service provision benefits care providers and recipients. A strong workforce is critical to creating and sustaining robust and integrated behavioral health service systems in this country—a change that is long overdue.

Recommendations

Training

CAPACITY & PROGRAM BUILDING

Time-tested, university-based strategies to prioritize behavioral health. Recruitment and admissions policies, curriculum reform, debt relief, fellowships, and dedicated behavioral programs all transform the behavioral health workforce at the source. For decades, philanthropists have been steadily using these strategies to promote interprofessional education, reform curriculum, and build transformational programs. These strategies also better align graduate medical education and residency training with underserved groups, specialties, and geographies.[37] The University of Washington's behavioral health specialist program is one example at the bachelor's level.[38]

"Culture of training" in a range of clinical settings. In settings as diverse as academic medical centers, primary care clinics, FQHCS and CCBHCs, high-performing institutions can use funds to promote systematic continuing education, nurture innovation, attract people in from the sidelines, spur greater collaboration between licensed and unlicensed workers, and meet the needs of people seeking care with respect and dignity.[39] One way to structure giving is a "scholarship fund" to organizations who have current staff who need to finish their licensing requirements or degrees or want to earn their clinical licensure.

Models for training communities. The Alaska BH AIDE model provides culturally relevant training and education for village-based counselors. It also provides education on how to receive payment. Such models are helpful in promoting culturally-competent care.

POLICY

Public-private partnerships. Philanthropists could build on existing fellowship and training programs to fill funding gaps for students at both the undergraduate and graduate levels. For instance, philanthropists could boost efforts by supporting students in Historically Black Colleges and Universities, *Hispanic*-Serving Institutions, or SAMHSA's minority fellowship program with the American Psychiatric Association Foundation. Philanthropists could also support a "Teach for America" type program using placements in the 1400 community-based organizations that make up SAMHSA's National Network to Eliminate Disparities in Behavioral Health. The AmeriCorps Youth Mental Health Corps is another notable example of this type of work.[40]

State legislatures to increase behavioral health teaching hospitals, residency, and training spots in state universities. Add new residency and training spots at state universities for under-resourced areas like child and forensic psychiatrists. Prioritize fellowships for those who go into careers in teaching. Incentivize state universities to incorporate interprofessional education and integrated models of primary care in their medical curricula.

State legislatures to invest in consistent training for support specialists. A behavioral health certification curriculum could be leveraged across the behavioral health continuum, from primary care to community mental health to inpatient care professionals, meeting the needs of mental health centers and inpatient facilities and primary care settings. Such settings are largely staffed by unlicensed professionals whose numbers are often limited by outdated requirements and who generally do not receive relevant training to prepare them to hit the ground running following graduation.

RESEARCH

National scan of academic training programs. Fund a convening and report on the more innovative ways universities are prioritizing behavioral health in their training programs—from bachelor's to post-doctoral levels. Identify ongoing research questions that will improve and inform training and education programs.

IMPACT INVESTMENT

Digital training to prioritize culturally competent care. Technology can proliferate curricula that prioritize the needs of specific groups, ethnicities, and faith traditions—significantly democratizing who can become a behavioral health provider. AI-powered technology is also rapidly becoming more common and accepted, providing clinical insights, simulations, and feedback on how well clinicians are doing on evidence-based practice. Examples include: Eleos, Lyssn, and CogniTrainer.

Licensing and Credentialing

CAPACITY & PROGRAM BUILDING

Program-specific grants to nonprofits upskilling and credentialing support specialists and clinicians. Philanthropists can make targeted grants to develop training, retraining, and apprenticeship programs and certifications, including at local community colleges. Targeted populations may include high school students or "second chance" programs with formerly incarcerated individuals, individuals in recovery, or people displaced from their current jobs. The Healthcare Apprenticeship Consortium is one example[41]. The National Mental Health Workforce Accelerator Program from Kaiser Permanente is a scalable solution that helps diverse post-masters' clinicians earn licensure through placements, supervision, stipends and licensure exam benefits.

POLICY

Interstate compacts to attract out-of-state practitioners and expand telemedicine/telehealth capacity. States should not have to address needs for providers within their borders alone. The Interstate Medical Licensure Compact offers a voluntary, expedited pathway to licensure for qualifying physicians who want to practice in multiple states or more quickly obtain licensure in a new state. Additional compacts to consider include the Professional Counselors Licensure Compact, the Psychology Interjurisdictional Compact, and the Interstate Licensure Compact for Social Work.

RESEARCH

Variability in licensing requirements across all 50 states. Scope of practice varies considerably among non-prescribing mid-level professionals across states, including social workers, counselors, and other providers. Variability in these standards indicates the extent to which they could be reformed.

Variability in credentialing requirements across all 50 states. Credentialing standards also vary among certified uncredentialed, or lightly credentialed, practitioners qualified to provide certain mental and substance use services in community mental health centers and related inpatient or outpatient settings. There is a need to shift from a degree-based approach to a skills-based approach in the way workers are assessed. A foundational study could result in actionable recommendations that are high leverage and fast acting and can benefit all 50 states. The Meadows Institute recently completed a feasibility study in Florida that is now being championed by the Florida Chamber of Commerce.[42]

National and state data systems to gather and assess essential data. These platforms would establish baselines and be a primary resource on workforce challenges, professional development, satisfaction, trends, and best practices.

IMPACT INVESTMENT

Technology that facilitates licensing and credentialing. Philanthropists can make impact investments in entrepreneurs developing innovative low-cost approaches to licensing and credentialing. "First movers" are now actively working to overcome regulatory barriers in their efforts and will help open the field for those to come. For instance, Motivo is helping pre-licensed clinicians access licensed supervision virtually to help meet conditions for licensure.

Reimbursement and Systems

CAPACITY & PROGRAM BUILDING

Build administrative, financial, technological capacity. Philanthropists can continue to build capacity in a variety of settings, including workforce-friendly behavioral health settings like CCBHCs by investing in administrative, technological, and reimbursement capacity building, all of which are rate limiters in moving innovative models and engaging and retaining workers.

Implementation support and incentive grants to scale and evolve workforce-friendly delivery models. Philanthropists can also scale workforce-friendly models and support licensing and credentialing for the workers practicing within these models.

RESEARCH

Models of comprehensive system transformation. Some states are developing a comprehensive road map to increase access to quality care through transforming delivery systems (including multi-payer approaches that included rate increases and the reduction of administrative burdens/regulatory simplification), e.g. Massachusetts.[44] Philanthropists may also support more focused research on how to optimize the team-based workforce (the mix of licensed, unlicensed workforce) in effective delivery of evidence-based, team-based care.

Models of state-based value-based purchasing. The CMMI Innovation in Behavioral Health Model is one promising model, but it will take eight years to unfold. Research is needed on promising value-based payment approaches that provide more flexible funding to behavioral health providers and allow for shared savings. More than half of states are already tying compensation to performance, but with very little overlap in approaches, with some promising efforts in New Hampshire and Pennsylvania. Given that not much attention has been focused in this area, philanthropic support would be particularly meaningful.

POLICY

CMS to increase reimbursement for the full array of behavioral health services, workers, and settings. Behavioral health workers at all levels must have adequate pay that reflects true costs and is in line with comparable types of healthcare services. Federal reimbursement sets the stage for more competitive salary and benefit structures across all payers for employees working in mental health and substance use services.

Cross-state dialogue to harness a whole of government approach to behavioral health workforce improvement. Through a combination of opioid settlement grants, 1115 and other waivers, and block grants, states are finding ways to bolster the workforce (including rate increases, regular calendars for subsequent rate increases, and other strategies). Cross-state learning and adopting of best practices is key to the expansion scalable models.

Employers, unions, and states to require and pay for parity. Employer groups (who pay for half of health benefits), unions, and states all need to require reimbursement parity from their health insurance carriers, and they need to pay for it. One silver lining is the dividends in long-term medical costs that can be earned by investing in mental health and substance use early.[43]

States to increase reimbursement and reduce barriers for support specialists. State Medicaid programs can increase Medicaid reimbursement for community health workers, peer specialists, and navigators ensuring their pay reflects their work and recognizing it as a preventative service. Additionally, they can reduce administrative burdens, paperwork, and unnecessary compliance. One example is allowing support specialists to bill from community settings.

IMPACT INVESTMENT

Digital supervision and task shifting to improve efficiencies. Digital technology can empower all manner of CHWs, peers, specialists, and navigators to bill and obtain supervision from community settings, providing privacy concerns are addressed. One example is technology that empowers support specialists to rapidly screen, assess and appropriately triage individuals on waitlists or in crises.

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