

Health Reform: Health Professional Workforce Workgroup
Friday, November 19, 2010
North Carolina Institute of Medicine, Morrisville
9:00am-12:00pm
Meeting Summary

Attendees:

Workgroup and Steering Committee Members: Tom Bacon (co-chair), Alan Mabe (co-chair), John Price (co-chair), Renee Batts, Regina Dickens, Greg Griggs, Polly Johnson, Dontae Latson, Glenn Potter, Meka Sales, Margaret Sauer, Dennis Sherrod, Sandra Spillman, Marvin Swartz, Stephen Thomas, Helen Wolstenholme

Staff and Interested Persons: Jessica Carpenter, Alisa Debnam, Katie Gaul, Thalia Fuller, Jan King Robinson, Sharon West, Rachel Williams, Berkeley Yorkery

Welcome and Introductions

Thomas J. Bacon, DrPH, Director, NC Area Health Education Centers Program

Alan Mabe, PhD, Senior Vice President for Academic Affairs, General Administration, The University of North Carolina at Chapel Hill

Dr. Mabe welcomed the workgroup to the meeting.

Federal Workforce Planning Grant Task Force

Thomas J. Bacon, DrPH

Dr. Bacon gave an overview of the State Health Care Workforce Planning Grant, funded by the Health Resources and Services Administration Office of Workforce Policy and Performance Management. The grant is to the Cecil B. Sheps Center for Health Services Research and will fund a Workforce Intermediary Committee over nine months to develop a Primary Care Workforce Implementation Plan for North Carolina, which will have recommendations to increase the supply of primary care providers over the next ten years. He summarized how the Workforce Intermediary Committee and the NCIOM Health Professional Workforce workgroup can work together on similar goals without duplicating efforts. His presentation can be found here: [State Health Care Workforce Planning Grant](#).

Selected questions and comments:

- Q: How will you address short-term and long-term needs for educational providers? A: For the long-term, there are expansion programs underway for many major education systems, medical schools, dental schools, pharmacy schools, etc. In the short-term we

will focus on specific interventions to get more out of each dollar and to retain providers in the state.

- In the short-term we should be more concerned with unfilled positions due to retirement and high turnover than with recruitment. How do we fill these current openings and where are opportunities for growth? There should be more recruitment outreach and education on the National Health Service Corps loan repayment for working in shortage areas.
- To address the provider retention issue, there should be a push to get North Carolina medical students to do their residency here since a practitioner is more likely to stay and work in the state he/she does residency.
- The NCIOM workgroup definitely needs to look at scope of practice and find a way to make sure practitioners are working at the top of their ability/education.

Review of Workgroup Plan

Berkeley Yorkery, MPP, Project Director, North Carolina Institute of Medicine

Ms. Yorkery explained the goal of the NCIOM Workforce workgroup is to address short-term (one to four year) health professional workforce needs. The workgroup will identify possible policy strategies to increase recruitment, improve graduation rates, increase retention of current providers, increase recruitment into health professional shortage areas, better serve North Carolina's needs, enhance diversity of the workforce, and expand clinical training capacity. The next three meetings will focus on issues related to mental health providers, primary care and dental providers, and policies affecting deployment of primary health care professionals in patient centered medical homes.

Mental Health Workforce

Marvin S. Swartz, MD, Professor and Head of Psychiatry and Behavioral Services, Division of Social and Community Psychiatry, Duke University Medical Center

Dr. Swartz presented an overview of mental health workforce needs in North Carolina. North Carolina, and the rest of the nation, has a shortage of mental health professionals; especially child psychiatrists. The lack of workforce in mental health is due to difficulties in training and retaining staff, lack of career ladders, marginal wages, and inefficient resources. In 2008 the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services proposed eight recommendations to support, broaden the concept of, and strengthen the workforce; Dr. Swartz reviewed these recommendations with the workgroup. Also in 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA). This act requires insurers that provide coverage for mental health and substance abuse disorders to have equal coverage for both mental health and substance abuse disorders and medical/surgical services. His presentation can be found here: [Mental Health Workforce](#).

Selected questions and comments:

- One barrier to recruitment and retention is that there are currently no clear rules on how to become certified to provide certain services. Clarity on certification requirements is vague across all disciplines in behavioral health. Training requirements are also too unstable, unavailable, or expensive.
 - The current behavioral health system is built on Medicaid; however, Medicaid is not in the business of workforce development and therefore does not have policies on training. We currently have qualified individuals that aren't licensed as well as licensed professionals that aren't qualified. We need qualified licensed professionals.
- Q: Are there models in other countries that do a better job of integrating behavioral health into the health care system? A: Yes. Canada and Great Britain are two examples. Both countries have a more holistic view on health care and therefore mental health was more integrated from the start.
- Q: What is the highest priority out of the Workforce Development Initiative recommendations? A: I believe the highest priority is workforce training. One recommendation is to create a new section in the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MHDDSAS). However, MHDDSAS is very opposed to the idea due to funding issues. It would be possible to clarify training requirements without creating a new section; but we need to have a discussion with licensing boards and Medicaid about this option before we talk to MHDDSAS.
- There has not been a demand for mental health training in physician assistant or nurse practitioner programs because integrated care is a new model and there are not a lot of jobs open that require that kind of training. Graduates do not have a lot of job opportunities that take advantage of any mental health training.

Summary of Workgroup Discussion

After Dr. Swartz's presentation, the workgroup discussed some of the issues raised in his presentation. While the workgroup agreed that the recommendations made by the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services were good recommendations, they focused in on a few of them as being particularly important for meeting North Carolina's mental health needs over the next 1-4 years. The workgroup agreed that the following were important to maintain and expand the mental health workforce to meet the state's short-run needs.

Maintaining or Expanding Access to Mental Health Services

- Keeping Medicaid reimbursement rates for mental health visits high is critical to efforts to maintain or expand access to mental health services for low-income populations.

- Need to develop/strengthen recruitment strategies for mental health professionals.
 - Publicizing the National Health Service Corp loan program for mental health professionals.
 - Look into expanding the definition of mental health provider under the state loan program.
- Continue to strengthen and support integrated care strategies such as co-location.
- Need to increase the numbers of social workers, health techs, substance abuse counselors and other professional and direct support workers to meet the increase in demand for mental health services.
- Keep an eye on new and growing nurse practitioner and physician's assistant programs with a mental health specialty/focus. As integrated care increases, demand for individuals with this type of training will increase. Additionally, this level of provider- who can provide both basic medical care and basic mental health care- are more likely to be able to be financially viable integrated care providers.

Workforce Development and Expansion

- Develop specific training requirements and career pathways for direct care workers and others who provide much of the care for individuals with mental health needs. Educational programs, current professionals, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), the Division of Medical Assistance (DMA), and relevant licensing bodies should be included in these discussions. Service definitions and billing rates (set by DMA), influence the mental health workforce significantly and more needs to be done to ensure that decisions being made about training requirements, service definitions, and billing rates are coordinated so that who can practice, the type of care they can deliver, and their training requirements are clear and help support career pathways for all levels of health professionals working in mental health.
- Currently a significant amount of state and federal funding goes towards possibly inappropriate care models (e.g. overuse of psychotropics) rather than to training the right mix of professionals. Need to analyze current Medicaid data to see where savings could be achieved and reinvested in improving mental health care.

Update on Federal Grants

North Carolina has received a number of Health Services and Services Administration (HRSA) Primary Care Workforce Grants. These grants will finance primary care residency expansion (\$5.5 million), personal and home care aid training (\$578,745), state health workforce development (\$144,595), expansion of physician assistant training (\$3.2 million), and advanced nursing education expansion (\$1.3 million).

Public Comment Period

No further public comments were given.