Community Mental Health Association of Michigan

Addressing Michigan's behavioral healthcare workforce shortage

April 2022 (revised May 2022)

The **"high leverage" recommendations** are boxed, below, and are of two types, both which are recommended to be kicked-off simultaneously, with two different time horizons.

Those items viewed as part of an **overall process change** (longer time horizon) to addressing this issue are boxed and in straight type; those seen as **concrete and discrete steps** (shorter time horizon) that could be taken concurrently to the overall process change, rather than waiting for the completion of this more far-reaching and slower process, are boxed and in italics.

Summary of issue to be addressed

The behavioral health workforce shortage, across all disciplines and job categories, is prolonged and deep. This shortage, being experienced in Michigan and across the country, has hindered the ability of the public and private mental health systems in Michigan to ensure access to care and the proper intensity and duration of that care while also hindering the system's ability to effectively manage the system. Additionally, the ability of these systems to pursue opportunities for system advancement has been significantly harmed by this workforce shortage.

Other resources

This document does not intend to outline all of the dimensions of nor solutions to Michigan's behavioral health workforce shortage. Recently released resources, such as those listed below, on this topic provide additional context for addressing this issue.

- Forging a Path Forward to Strengthen Michigan's Direct Care Workforce (Center for Health Care Strategies; December 2021) https://www.chcs.org/media/Forging-a-Path-Forward-to-Strengthen-Michigans-Direct-Care-Workforce.pdf

- Strengthening the Direct Care Workforce: Scan of State Strategies (Center for Health Care Strategies; December 2021) https://www.chcs.org/media/Strengthening-the-Direct-Care-Workforce-Scan-of-State-Strategies.pdf

- Michigan's Direct Care Workforce: Living Wage and Turnover Cost Analysis (Public Sector Consultants; August 2021) https://www.cmham.org/wp-content/uploads/2022/04/PSCMichigans-Direct-Care-Workforce-Living-Wage-and-Turnover-Cost-Analysis-2-1-2022.pdf

- Behavioral Health Workforce is a National Crisis: Immediate Policy Actions for States (Health Management Associates; October 2021): https://www.healthmanagement.com/wp-content/uploads/HMA-NCMW-Issue-Brief-10-27-21.pdf

- Certified Community Behavioral Health Clinic Workforce and Service Delivery Trends (Behavioral Health Workforce Research Center; National Council for Mental Wellbeing; August 2019) https://www.behavioralhealthworkforce.org/wp-content/uploads/2019/10/NC-CCBHC_Brief-Report.pdf

Approaches to addressing the shortage across the entire behavioral health workforce

Recommendation 1: Cross-sector efforts: Because the behavioral workforce shortage faced by Michigan's CMH, PIHP, and providers is also being faced by Michigan schools (made clearer and more acute by increased, and sorely needed, funding for behavioral health staff within Michigan's schools), any behavioral health workforce plan should be jointly developed and implemented by MDHHS, MDE, and their stakeholders in communities across the state.

Recommendation 2: Reduction in paperwork and administrative burden workforce: A chief barrier to the recruitment and retention of behavioral healthcare staff in the CMH, PIHP, and the providers in their networks are the very high paperwork and administrative-related demands. Persons who have sought careers in health and human services to provide service often express concern and fatigue related to these demands. While some paper and administrative-related demands are expected, the excessive levels of non-value-added demands causes these health and human services professionals to leave the system and, too often, the field.

Needed is an overhaul of the paperwork and administrative-related demands that are currently borne by the state's behavioral healthcare workforce, with the aim of reducing those demands to those with value to the provision of high-quality care.

Concrete recommendations on this front are contained in the paper, "Reducing administrative burden on Michigan's public mental health system (CMHA; April 2022).

Recommendation 3: Promotion campaign underscoring value of behavioral health work: Several years ago, the Section 1009 study group (called together in fulfillment of the requirements of Section 1009 of the MDHHS Budget Bill) issued the 1009 report that provided recommendations to address the recruitment and retention of direct support professionals. While those recommendation, in the main, address the needs of this classification of workers, one of the recommendations would apply to the issue that we discussed**.**

Develop and fund a promotional campaign to build public awareness and appreciation of people with disabilities and those who chose a career to support them.

The campaign should build off the system's mission of inclusion and stigma elimination. MDHHS, the PIHPs, employers, direct support staff, and people with disabilities should participate in the creation and execution of the campaign.

There are numerous successes and positive stories of individuals with disabilities that could be crafted to both educate and change attitudes of community members. There are likewise many individual employees who demonstrate the passion, commitment and resilience which

Approaches to addressing the Direct Support Professional/Direct Care Worker shortage

The approaches to addressing the Direct Support Professional/Direct Care Worker (DSP/DCW) issue were outlined in the Section 1009 report and have been expanded since then, by the Direct Care Worker Coalition, the Impact Alliance, and other coalitions of which CMHA is an active member. attached. These recommendations are summarized below, with those drawn from or based on the recommendations of the Section 1099 report marked with an asterisk:

A. Immediate Actions Needed to Improve DSP/DCW Wages and Benefits:

The Michigan Legislature and Governor need to make additional investments into all the named Medicaid covered supports and services to assure that:

Recommendation 1: Increase the starting wages of DSP/DCW staff to $18 per hour*, not through wage pass throughs that require dollar-specific hourly wage increases, but through increases in the Medicaid and General Fund dollars provided to the state's PIHPs and CMHSPs. This is the recommendation of the statewide Direct Care Worker Coalition, of which CMHA is a core member.*

These funds, retaining their earmark for use to pay DSP/DCW staff, could be used by the state's CMHSPs, PIHPs, and providers to raise starting pay to $18 per hour for all DSP/ DCW staff.

Note that a growing number of stakeholders are calling for a minimum starting wage for all DSPs/DCWs as the mechanism for determining the dollars needed to fund this DCW/DSP wage goal.

The level of this increased funding determined based on the costs of covering all employer costs associated with the increased DSP/DCW wages including FICA, worker's compensation, and other payroll-related costs, as well as overtime.

Recommendation 2*:* ***Permanent increases in the Medicaid capitation and General Fund dollars*** *provided to the state's PIHPs and CMHSPs to* ***fund increases to the entire DSP/DCW wage scale*** *and the* ***wage scale of DSP/DCW supervisors*** *to align with the increased DSP/DCW starting wage.*

Recommendation 3: Paid leave: Direct support staff earn paid leave time at the minimum rate of 1 hour for every 37 hours worked (i.e., 10 days a year for full-time employment).

B. Longer range solutions to address DSP/DCW shortage

Recommendation 4: * **Change background check requirements:** Change Michigan's current laws and policies on criminal background checks to include a "rehabilitation review" similar to those authorized in 17 other states in order to increase the potential pool of applicants for direct support careers. Implementing a review process would allow people with a disqualifying criminal conviction to demonstrate that they no longer represent a threat to people needing supports and services or to their property.

Recommendation 5: * **Provide publicly financed tuition reimbursement** or incentives to direct support workers who are actively studying to become clinicians who serve people with intellectual and

developmental disabilities, mental illness, and substance use disorders in order to increase the number of people interested in doing direct support work. This effort will also improve the frontline skills and broaden the experiences of other health care occupations serving these populations.

Recommendation 6: Support the development of a voluntary **DSP/DCW career pathway and credentialing program** – as outlined by the Impart Alliance, incompass Michigan, MALA, and CMHA. This proposal is outlined in the document, "Immediate Solution to the Direct Care Worker Shortage: Build a Sustainable Training Infrastructure" found at: https://www.cmham.org/wp-content/uploads/2022/04/MI-DCW-Training-Infrastructure-Proposal-10.14.21.pdf

A number of potential sources exist for this training including community colleges and DSP/DCW-specific training organizations. A pay differential could be provided (if funded) for those DSP/DCW staff attaining such credentials.

Approaches to addressing the peer workforce shortage

Recommendation 1: Broaden definition of peer: *For Peer Support Specialist positions, MDHHS currently requires that the individual have a history of participation in services through the public mental health system. This excludes a significant number of otherwise qualified candidates, which is significant now that providers are experiencing deep workforce shortages. Recommended is a change in this requirement to allow persons with histories of serious mental illness, intellectual and developmental disabilities, or substance use disorders become peer support specialists/mentors/recovery coaches, regardless of where and from whom their services and supports were provided.*

Recommendation 2: *Provide funding and earmark to extend a* ***minimum direct care wage of $18 per hour*** *to recovery coaches, peer support specialists, and behavior tech positions.*

Recommendation 3*: Two separate training process exists for Youth Peer Supports Specialist and Certified Peer Support Specialist. However, when Youth Peer Support Specialists reach age 28, they can no longer be peers and must start over in obtaining certification as Peer Support Specialists. Needed is a process to provide* ***shorter training designed to transition Youth Peer Supports Specialists to Peers Support Specialists.***

Recommendation 4: *Allow persons who formerly had a substance use disorder and have* ***attained a defined period of sobriety, even without participating in formal treatment****, to become Peer Recovery Coaches, through an internship/apprenticeship process in addition to training, to become Peer Recovery Coaches.*

Approaches to addressing the clinical workforce shortage

Recommendation 1*:* ***Revise specific regulatory and licensing barriers to recruitment***

= Revise the current Michigan Qualified Mental Health Professional (QMHP) and Children's Mental Health Professional (CMHP) standards to shorten the number of years of experience requirement.

= Allow BA level staff, working as case managers/supports coordinators, to provide a number of the more common Medicaid crisis service encounters.

= Extend Child Mental Health Professional eligibility to Bachelor's level staff – with supervision by fully certified, masters level CMHP staff

- Reduce the number of hours of clinical practice, post graduate school graduation, required for full licensure of behavioral health clinicians (primarily social workers, licensed professional counselors, and psychologist) to reflect experience obtained prior to graduation – via work experience and internships/practicums prior to or while enrolled in graduate school.

***Recommendation 2**: **Establish a Behavioral Health Workforce Student Recruitment Fund** to provide a temporary financial benefit/stipend to 1000 individuals (333 per year) who obtained a bachelor's degree in social work (BSW) and commit to ongoing education in accelerated masters' programs that would award a MSW in three continuous semesters.*

These accelerated MSW programs are already in existence at many universities across Michigan (i.e., EMU, MSU, WSU, WMU, UM). However, program requirements are intense, including 16 – 24 hours per week in an unpaid internship. Given tuition costs, outstanding debt from the BSW program, the need to maintain employment, and the low level of scholarships available, students may opt to forgo ongoing social work education. Providing students with funds that might offset these barriers could quickly accelerate the number of professionals in the field in a short period of time. (Proposal by NASW, Wayne State University School of Social Work, and CMHA)

***Recommendation 3: Create the Behavioral Health Crisis Continuum Workforce Sign-On Bonus**, Akin to what is being developed for first responders and teachers in Michigan, this program would provide a sign-on bonuses of $3000 for social workers, licensed professional counselors, and other behavioral health clinicians entering into a public sector behavioral health (i.e. community mental health, substance abuse programs, crisis intervention, local crisis call centers, mobile crisis care, crisis stabilization, psychiatric emergency services, rapid post-crisis etc.). Through such a program, these clinicians would be required to remain at the employer for a minimum of 3 years.*

Recommendation 4 : Expedite licensing process for LMSWs:

- Use the LMSW testing process as a learning opportunity by providing feedback to the applicant as the questions that they did not answer correctly
- Reduce the wait time to retest (currently 90 days)

***Recommendation 5: Expand federal (National Health Services Corps) and the Michigan State Loan Repayment Program (MSLRP)** to attract psychiatrists, social workers, psychologists, and other clinicians to underserved Michigan communities. While his program is proposed for expansion in the Governor's proposed FY 2023 budget, the expansion is modest and of the magnitude needed to address the behavioral health workforce shortage.*

Expedite the promulgation of the rule that has been requested to align Michigan's ability to pay schedule with that of the federal government – a NHSC requirement.

Recommendation 6: Create a loan repayment program for behavioral health care workers, with a commitment to work in the public mental health system after graduation but **not tied to the federal**

Health Professional Shortage Areas (HPSAs). This requirement, because it is based on only one discipline within the behavioral healthcare workforce, does not reflect the shortage in the broader behavioral health workforce.

Recommendation 7: Provide funding to the system to allow CMHs and providers to provide **tuition reimbursement for BA level employees pursuing their Masters degree in a behavioral health clinical discipline tied to a commitment to work in the public mental health system** - serving as both a recruitment and retention incentive for these employees.

Recommendation 8: *Recognize that increased wages that have been required, over the past year, to attract and retain behavioral health clinicians and administrative staff, and their supervisors, are now the permanent expected wage levels.* ***These increased wage rates must be reflected, permanently, in the Medicaid capitation payments made to the state's PIHPs.***

Recommendation 9: Revise provider qualifications and encounters to leverage scarce staff resources*:*

= Allow ACT crisis encounters to occur outside ACT, conducted by other crisis staff agency wide – thus ensuring ACT crisis capacity

= Align provider qualifications for case management and crisis codes to permit all QMHPs to provide both services

Recommendation 10*: Allow clinical team Leads to participate in the capacity of Supervisor at EBP trainings and/or or eliminate the need for Supervisors to attend additional cohorts if they have already successfully completed a cohort.*

Recommendation 11: Strengthen the hands-on clinical skills taught in graduate behavioral health clinical programs (MSW, MA is Psychology) including: diagnostic skills (both mental health and substance use disorders), knowledge of available community resources (income supports and entitlements), and several evidence-based practices (e.g. CBT, DBT, Motivational Interviewing, etc.)