Maryland's Behavioral Health Workforce Crisis

Challenges and Solutions

Commission to Study the Health Care Workforce Crisis in Maryland | Education and Pathways Advisory Group

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November 2, 2022

Nature of the Unmet Need

- In February 2021, nearly 40% of Marylanders reported symptoms of anxiety or depression, yet nearly a third of those individuals were unable to get needed counseling or therapy[1]
- Over 45 percent of Maryland youth aged 12-17 who have depression did not receive any mental health care in the last year[2]
- An estimated 2,876 Marylanders lost their lives to overdose between April 2020 and April 2021, a rate that ranked 7th highest in the country during that period[3]
- 582 Marylanders lost their lives to suicide in 2020[4]

1 https://www.nami.org/NAMI/media/NAMI-Media/StateFactSheets/MarylandStateFactSheet.pdf
2 https://www.nami.org/NAMI/media/NAMI-Media/StateFactSheets/MarylandStateFactSheet.pdf
3 Keating, Dan; Bernstein, Lenny. (2021, November 17). 100,000 Americans died of drug overdoses in 12 months during the pandemic. Washington Post. https://www.washingtonpost.com/health/2021/11/17/overdose-deaths-pandemic-fentanyl/
4 Maryland Vital Statistics 2020 Annual Report

Suicide Attempt/ Self-Harm - ED Visits

Calendar Year (January-June)	Total Number of Suicide Attempt ED Visits	Percent Change from Prior CY
2018	7,979	
2019	9,200	15.3%
2020	7,264	-21.0%
2021	9,837	35.4%

Percent Change over the Period of January-June of Calendar Year 2018-21 by Age Groups

Age Group	CY 2018-19	CY 2019-20	CY 2020-21	CY 2018-2021
0-17	8.9%	-27.7%	46.3%	15.2%
18-24	12.4%	-16.8%	39.2%	30.1%
25-34	22.8%	-21.9%	30.7%	25.3%
35-54	13.6%	-19.9%	30.1%	18.4%
55-64	22%	-13.5%	23.1%	29.9%
65+	48%	-7.8%	40.%	90.9%

Data Source: Health Services Cost Review Commission and CRISP; Public Health Dashboard, run date September 8, 2021.

Maryland
DEPARTMENT OF HEALTH

Nature of the Unmet Need

"In Maryland, the proportion of psychiatric ER patients staying more than 24 hours has increased at an alarming rate in the past 10 years… In 2010, just 1 percent of **children 12 and younger** with mental health problems stayed in the ER longer than a day. **By 2020, more than 10 percent were getting stuck more than a day – and sometimes weeks.** The percentage of teens aged 13 to 17 staying more than 24 hours also rose sharply, from less than 3 percent to more than 13 percent."

1 Wan, W. (2022, October 20). An autistic teen needed mental health help. He spent weeks in an ER instead. Washington Post. https://www.washingtonpost.com/dc-md-va/2022/10/20/er-mental-health-teens-psychiatric-beds/

Table A3: Psychiatric Emergency Room Services by Race and Gender, FY19

Race/Ethnicity	Total Number Receiving Emergency Room Services		Rate of Utilization Per 1,000 Eligible	Expenditures	
	N	%		Total	Per Child/Young Adult
African-American	5,686	45.1%	19.2	$7,184,713	$1,264
Asian	360	2.9%	9.7	$395,733	$1,099
Caucasian	5,719	45.3%	31.6	$6,176,388	$1,080
Hispanic	119	0.9%	20.0	$151,250	$1,271
Native American	229	1.8%	56.8	$347,930	$1,519
Pacific Islander	24	0.2%	16.5	$18,223	$759
Unknown	559	4.4%	1.8	$367,942	$658
Total	12,613	100%	15.0	$14,642,179	$1,161
Gender					
Female	6,716	53.3%	15.7	$7,321,113	$1,090
Male	5,900	46.8%	14.4	$7,321,067	$1,241
Total	12,613	100%	15.0	$14,642,179	$1,161

Table A4: Residential Treatment Services by Race and Gender, FY19

Race/Ethnicity	Total Number Receiving Residential Treatment Services		Rate of Utilization Per 1,000 Eligible	Expenditures	
	N	%		Total	Per Child/Young Adult
African-American	264	57.3%	0.9	$21,194,511	$80,282
Asian	6	1.3%	0.2	$342,954	$57,159
Caucasian	186	40.4%	1.0	$14,889,739	$80,052
Hispanic	7	1.5%	1.2	$364,732	$52,105
Native American	10	2.2%	2.5	$798,071	$79,807
Pacific Islander	3	0.7%	2.1	$72,971	$24,324
Total	461	100%	0.5	$37,662,978	$81,698
Gender					
Female	134	29.1%	0.3	$10,252,771	$76,513
Male	327	70.9%	0.8	$27,410,206	$83,823
Total	461	100%	.05	$37,662,978	$81,698

Nature of the Workforce Challenges

Designated Health Professional Shortage Areas Statistics

Table 5. Mental Health Care Health Professional Shortage Areas, by State, as of September 30, 2022

Mental Health Care	Total Designations[1]	Geographic Area	Population Group	Facility	Population of Designated HPSAs	Percent of Need Met[2]	Practitioners Needed to Remove Designations[3]
HPSA Total	**6,464**	**1,210**	**770**	**4,484**	**156,827,282**	**27.66 %**	**7,871**
Region 1	**217**	**30**	**20**	**167**	**3,026,988**	**30.27 %**	**154**
Connecticut	44	3	11	30	1,542,562	18.96 %	84
Maine	68	17	2	49	399,337	19.67 %	31
Massachusetts	57	1	6	50	307,807	33.04 %	19
New Hampshire	23	5	0	18	182,854	51.06 %	5
Rhode Island	14	4	1	9	594,428	61.93 %	15
Vermont	11	0	0	11			
Region 2	**291**	**16**	**82**	**193**	**8,233,253**	**23.41 %**	**530**
New Jersey	38	0	0	38	46,452	72.72 %	13
New York	202	11	68	123	6,368,714	18.82 %	411
Puerto Rico	45	1	14	30	1,663,246	15.75 %	96
U.S. Virgin Islands	6	4	0	2	154,841	62.77 %	10
Region 3	**436**	**65**	**104**	**267**	**7,892,163**	**31.04 %**	**474**
Delaware	13	0	5	8	289,347	11.59 %	25
District of Columbia	11	1	1	9	278,686	39.33 %	11
Maryland	63	13	26	24	1,709,025	19.43 %	101
Pennsylvania	133	29	6	98	2,040,721	38.43 %	118
Virginia	106	12	29	65	2,786,158	42.14 %	129
West Virginia	110	10	37	63	788,226	12.99 %	90
Region 4	**974**	**154**	**196**	**624**	**36,056,661**	**26.65 %**	**1,941**
Alabama	73	21	9	43	4,602,101	25.40 %	224
Florida	235	26	47	162	8,703,183	21.00 %	509
Georgia	94	22	11	61	6,040,851	43.17 %	217
Kentucky	131	30	17	84	3,867,642	24.16 %	215
Mississippi	91	16	0	75	3,188,003	39.51 %	188
North Carolina	204	25	80	99	3,917,688	12.96 %	221
South Carolina	73	5	13	55	2,272,722	33.62 %	106
Tennessee	73	9	19	45	3,464,471	16.29 %	261

Nature of the Workforce Challenges

Mental Health Providers

Ratio of population to mental health providers.

The 2022 County Health Rankings used data from 2021 for this measure.

Map | Data | Description | Data Source | Strategies

Mental Health Provider Ratio			
County	# Mental Health Providers	County Value	Z-Score
Allegany	229	310:1	-0.60
Anne Arundel	1,297	450:1	0.33
Baltimore	2,946	280:1	-0.87
Baltimore City	3,199	180:1	-2.55
Calvert	189	490:1	0.50
Caroline	15	2,230:1	1.91
Carroll	400	420:1	0.20
Cecil	232	450:1	0.31
Charles	305	540:1	0.66
Dorchester	86	370:1	-0.10
Frederick	663	400:1	0.08
Garrett	47	610:1	0.86
Harford	577	450:1	0.31
Howard	1,106	300:1	-0.69
Kent	36	530:1	0.64
Montgomery	3,736	280:1	-0.85
Prince George's	1,650	550:1	0.69
Queen Anne's	61	840:1	1.25
Somerset	71	360:1	-0.18
St. Mary's	146	790:1	1.17
Talbot	180	210:1	-2.03
Washington	404	370:1	-0.07
Wicomico	373	280:1	-0.89
Worcester	140	370:1	-0.07

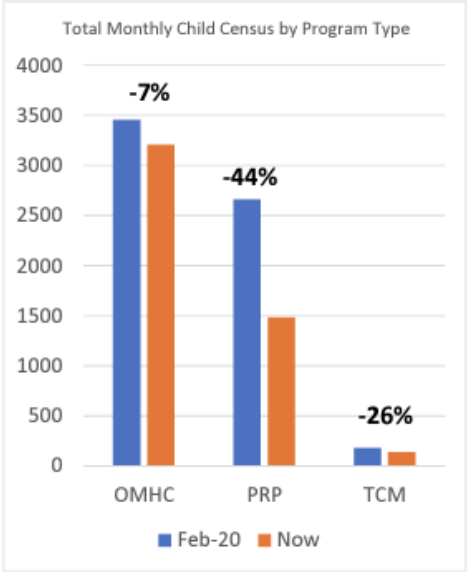
Nature of the Workforce Challenges

Child PBHS Utilization During Pandemic

Issue Brief | September 22, 2021

Despite a pandemic-driven increase in the need for mental health supports for children, providers serving children in the public behavioral health system have reported significant declines in the number of children receiving services.

This factsheet summarizes the total change in monthly census of children receiving program services pre-pandemic and presently. A sample of 13 provider organizations reported the data informing this factsheet.



A. Outpatient Mental Health Treatment

Total decline in monthly child OMHC census (Feb 2020 to Sept 2021): - 7%

- 7 in 10 providers report census declines. Average decline: - 19%
- 3 in 10 providers report census growth. Average growth: + 66%
- 78% have staff vacancies
- 50% have waitlists

B. Psychiatric Rehabilitation Programs for Minors

Total decline in monthly child PRP census (Feb 2020 to present): - 44%

- 92% of providers report census declines; 8% report flat census. Average decline: - 30%
- Note: Two providers cite their census declines as driven by inappropriate Optum denials of authorization requests.
- 83% have staff vacancies; programs without staff vacancies have reduced staff due to reduced service volume.

C. Target Case Management

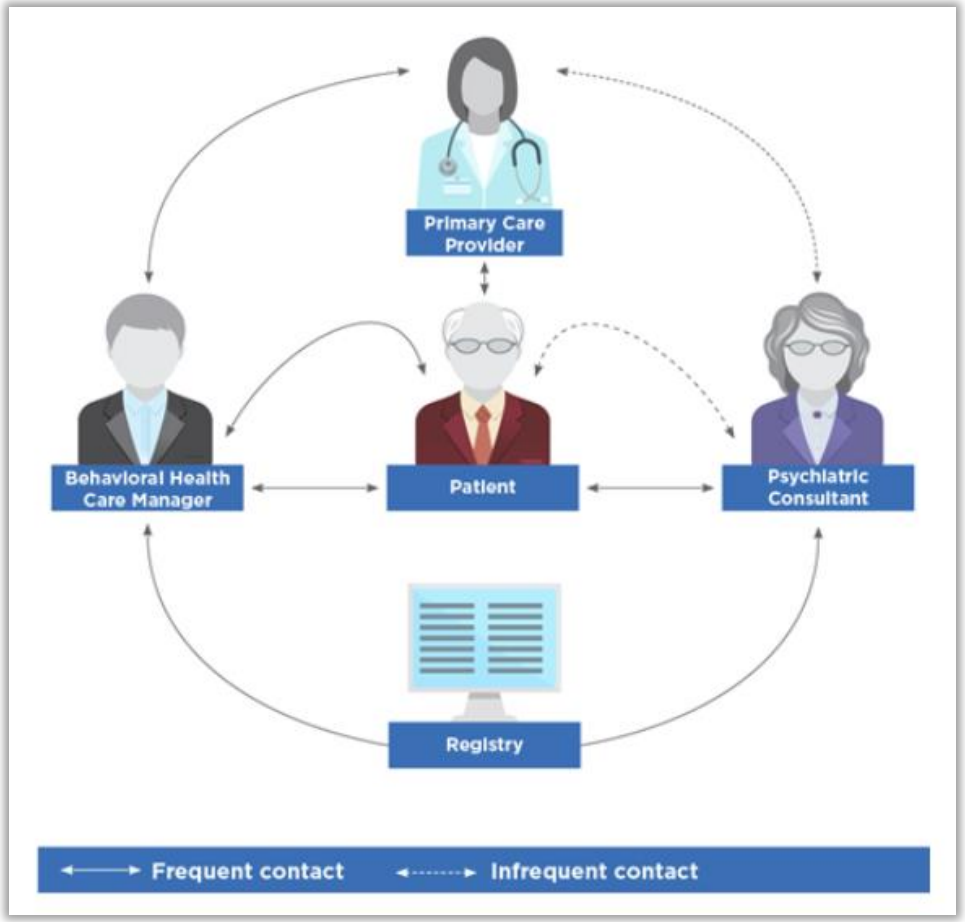
Total decline in monthly child OMHC census (Feb 2020 to Sept 2021): - 26%

- 2 of 2 providers report census declines. Average decline: - 19%
- 50% have staff vacancies
- zero waitlist

Top Five Cited Reasons for Census Decline

- Decline in referrals from traditional sources (schools, PCPs)
- Staff vacancies
- Zoom Fatigue/telehealth reluctance
- Unwilling to do In-person treatment
- Inappropriate denial of authorization request by Optum (PRP only)

Modernize the Workforce



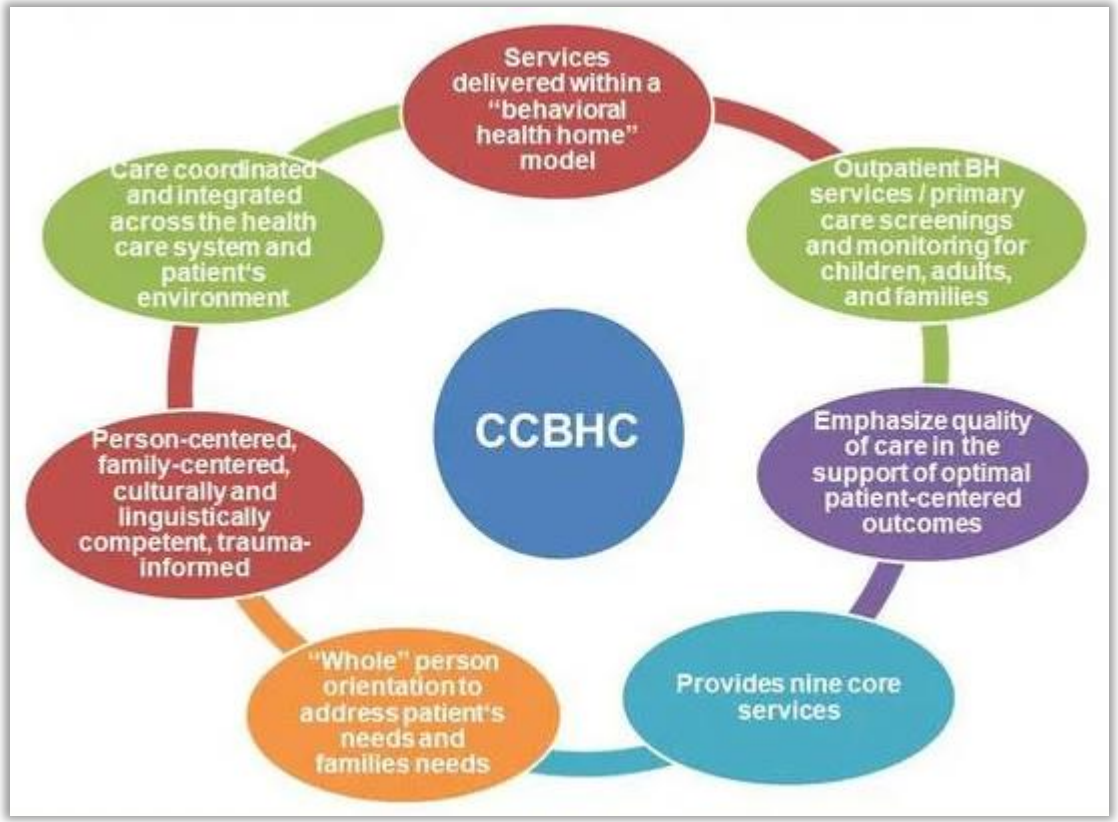
Require Medicaid Reimbursement for the Collaborative Care Model (CoCM)

- CoCM is a validated, evidence-based approach for integrating physical and behavioral health care in primary care settings[1]
- Expands the reach of mental health professionals to more patients
- Saves $6.50 for every $1 invested
- An ongoing Maryland Medicaid pilot has demonstrated "clinically significant improvement" in depression and anxiety symptoms for more than 65 percent of participants[2]
- Commercial health insurers and Medicare are already reimbursing for CoCM in Maryland

1 Unutzer J, Harbin H, Shoenbaum M, Druss B. The Collaborative Care Model: An approach for Integrating Physical and Mental Health Care in Medicaid Health Homes, Health Home Information Resource Center Brief, May 2013.

2 2021 Joint Chairman's Report (p. 113-114) – Collaborative Care Pilot Updates, Maryland Department of Health, January 21, 2022.

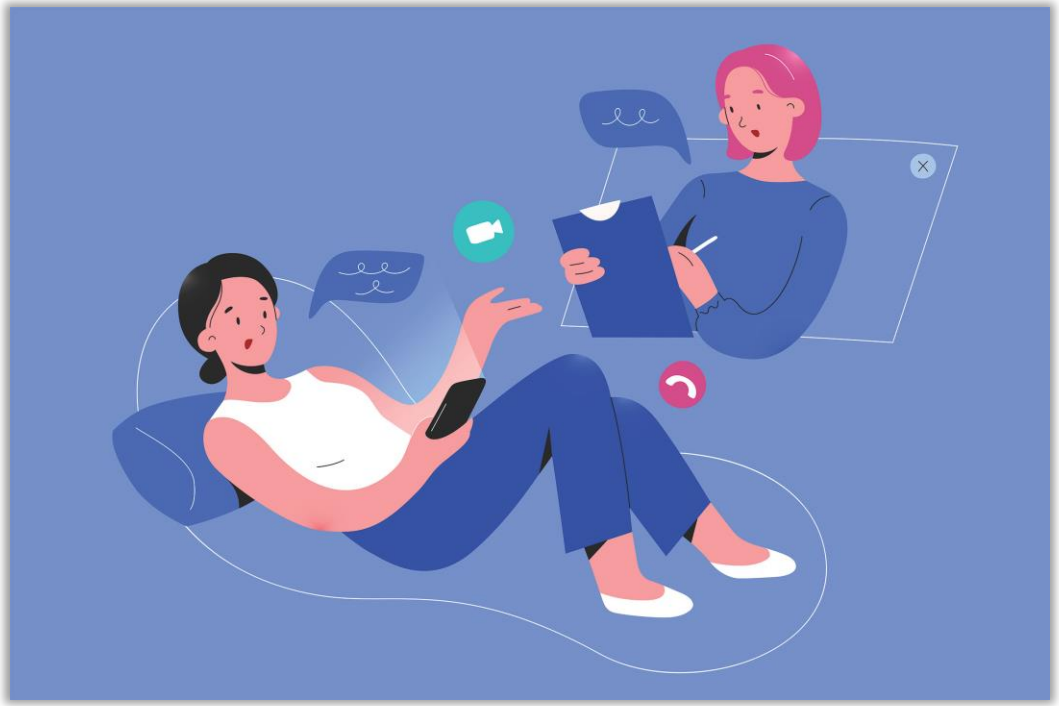
Modernize the Workforce



Sustain and Expand Network of Certified Community Behavioral Health Clinics (CCBHCs)

- CCBHCs are federally designated programs that provide a comprehensive range of outpatient mental health and substance use treatment, care coordination with other providers and services, and connection to other systems and supports
- States that have implemented CCBHCs broadly have seen increased access to care, reductions in emergency department and inpatient utilization, **a mitigation of behavioral health workforce challenges**, higher engagement post discharge from hospitals, improved utilization of medication assisted treatment for opioid use disorders, and improved integration with physical care
- Maryland currently has some CCBHCs, but availability is sparse and grant funding is time-limited

Modernize the Workforce



Maintain and Expand Use of Technology

- *Extend Provisions of Preserve Telehealth Access Act of 2021*
  - Coverage for audio-only telehealth ends June 2023
  - Reimbursement parity for telehealth ends June 2023
- *Require Medicaid Reimbursement for Remote Patient Monitoring*
  - RPM saves staff time normally devoted to medication monitoring and empowers patients to better manage medications on their own
  - Medicaid currently covers RPM services for COPD, congestive heart failure, Diabetes Types 1 and 2, and uncontrolled high blood pressure

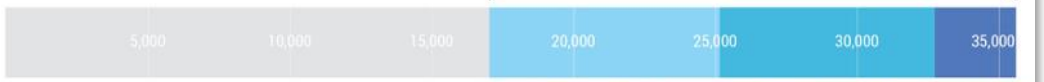
Expand the Workforce

Establish a Behavioral Health Workforce Investment Fund

- States and localities are establishing dedicated funding for pipeline development and retention strategies to support and expand the behavioral health workforce
- Potential fund uses include enhanced training programs, stipends, scholarships, loan repayment and forgiveness, tuition waivers, paid internships, apprenticeship programs, retention subsidies
- Use behavioral health workforce assessment to inform initial and ongoing fund allocation

HOW MANY MORE BEHAVIORAL HEALTH PROFESSIONALS DOES SAN DIEGO NEED?

18,500 more workers needed by 2027



17,000 behavioral health professionals in the current workforce

8,100 more workers needed to meet **today's** demand

7,800 to replace those leaving in next 5 years

2,600 to meet growth in demand by 2027

	2022 Workers	2022 Needed	2027 Needed	# Leaving Profession	Additional Needed 2022-2027
Community Health Worker & Social Service Assistant, including Peer Support Specialist	4,644	6,930	7,588	2,783	5,727
Marriage and Family Therapist	4,443	6,637	7,101	2,111	4,770
Substance Abuse and Behavioral Disorder Counselor	2,566	3,631	4,248	1,270	2,952
Mental Health and Substance Abuse Social Worker	1,283	1,913	2,142	616	1,476
Psychologist (Clinical, Counseling, and School)	1,603	2,401	2,522	533	1,451
Psychiatric Technician	789	1,181	1,334	292	837
Registered Nurse working in BH settings	1,040	1,548	1,641	56	656
Psychiatric Aide	129	192	248	89	208
Psychiatrist	265	396	431	37	204
Psychiatric Mental Health Nurse Practitioner	159	238	297	46	184
Physician's Assistant working in BH settings	28	42	48	8	28
Totals	16,949	25,109	27,600	7,841	18,493

WHAT CAN BE DONE TO ADDRESS THIS SHORTAGE?

Invest in Competitive Compensation

San Diego BH professionals are paid less than other CA counties. **55% of workers surveyed were dissatisfied with pay**.

Pursue Administrative Relief

Streamlining documentation is a top concern for BH professionals. Explore **12 issue areas and 29 opportunities** to reduce administrative requirements.

Build Regional Workforce Training Fund

This report provides a financial framework for a **$128M** down payment to train **4,250** more professionals.

Establish Regional Training Centers of Excellence

Sites would **deliver services**, **expand training and supervision** opportunities, and provide **research** opportunities focused on integrated care, workforce optimization, and training best practices.

Continue Listening to Workers

Input from **1,600 San Diego workers and students** informed this report. Levels of job satisfaction, burnout, intent to leave, and other factors driving career decisions should be surveyed annually to inform implementation and measure progress.

$98M for scholarships, stipends, loan forgiveness, and expanding programs.

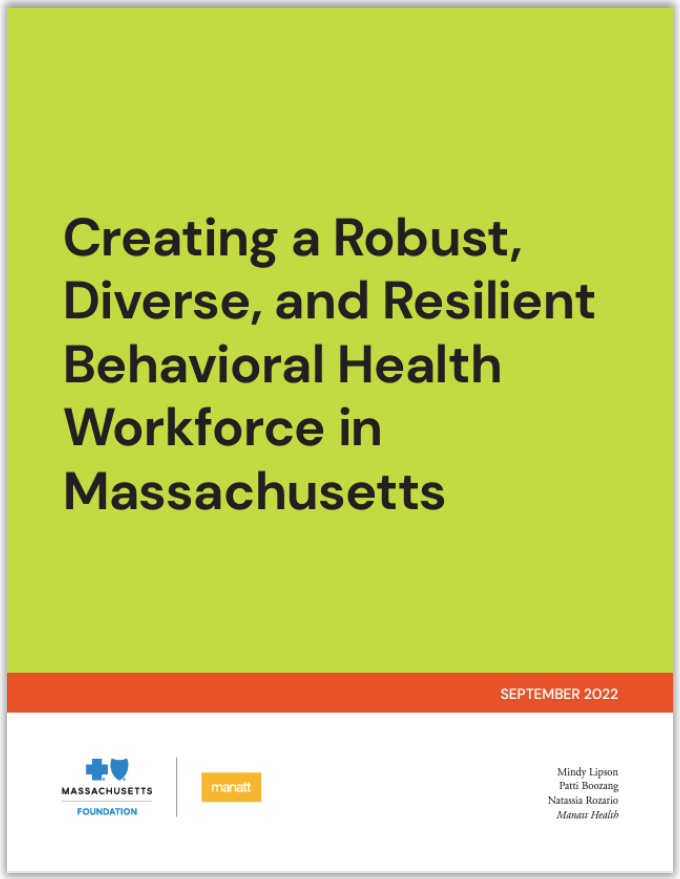
$30M first-in-the nation renewable training fund providing 0% interest loans to students and financing to establish training and supervision programs.

Sample projects for $128M Fund

- **$6M** to recruit, place, certify and provide on-the-job-training for **600 certified peer support specialists**.
- **$3M** for a regional apprenticeship program to train **600 community health workers**.
- **$8.5M** in scholarships and 0% interest loans to recruit, train, place and certify **1,150 substance use disorder counselors**.
- **$1.3M** to establish a **psychiatric technician** program with regional community colleges.
- **$7.8M** for stipends for **260 master of social work students** to complete paid internships in BH settings.
- **$7M** to create **280 new supervision slots** for associate social workers to accrue the 3,000 hours for LCSW licensure.
- **$64M** to train **84 psychiatrists** and **200 psychiatric mental health nurse practitioners** to work in integrated teams in community settings.
- **Loan forgiveness** and **down-payment assistance** in exchange for public service for diverse professionals to build wealth, live and work in San Diego long term.

https://workforce.org/research/addressing-san-diegos-behavioral-workforce-shortage/

Expand the Workforce



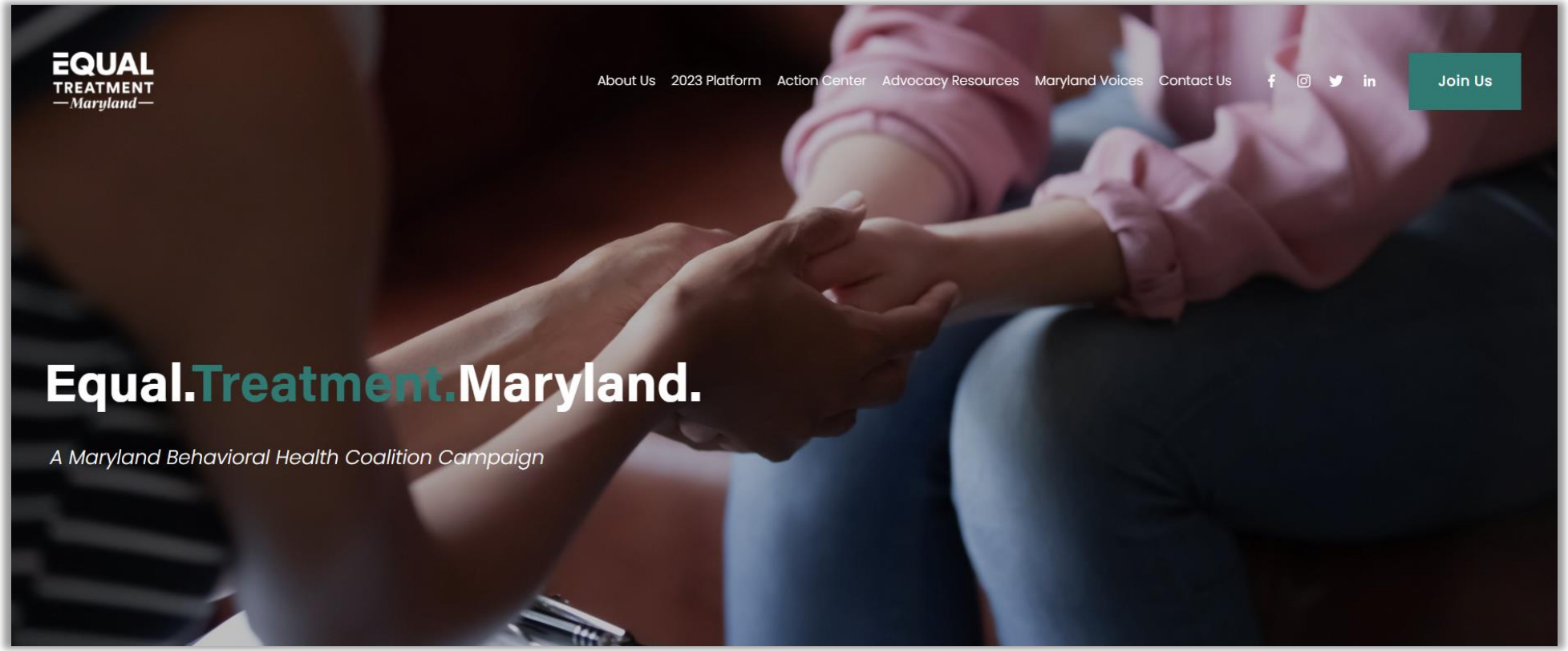
3. RECOMMENDATIONS

Aligned with the imperatives described above, this section details **seven recommendations** for the Commonwealth and its partners to institute policy, programmatic, and budgetary changes that will ultimately help to build a more robust, diverse, and resilient behavioral health workforce. These recommendations are:

1. Conduct a baseline **Workforce Needs Assessment** to better understand the supply of the behavioral health workforce, including demographics, and specific workforce gaps.
2. Establish and maintain a **Behavioral Health Workforce Center** with a charter to improve the supply, distribution, competency, and diversity of the workforce.
3. **Ensure that payment for behavioral health services is equal to payment for similar medical services across all payers** in Massachusetts given the impact of reimbursement on the workforce.
4. Develop and fund a **10-year behavioral health workforce strategy** to grow the behavioral health professional workforce pipeline and address the shortage and maldistribution of providers.
5. Pursue a multipronged campaign to dramatically **expand the paraprofessional workforce (e.g., peers, CHWs, recovery specialists)**, including ensuring that they are paid a living wage, have opportunities for career advancement, and can obtain insurance reimbursement.
6. **Create a system of social supports** for all members of the behavioral health workforce.
7. Fund an **in-depth evaluation of the impact of telehealth on the behavioral health workforce**.

https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2022-09/BH_Workforce_Final.pdf

Equal Treatment Maryland



Questions?