

Identifying Systems-Level Factors That Influence Workforce Capacity and Effectiveness

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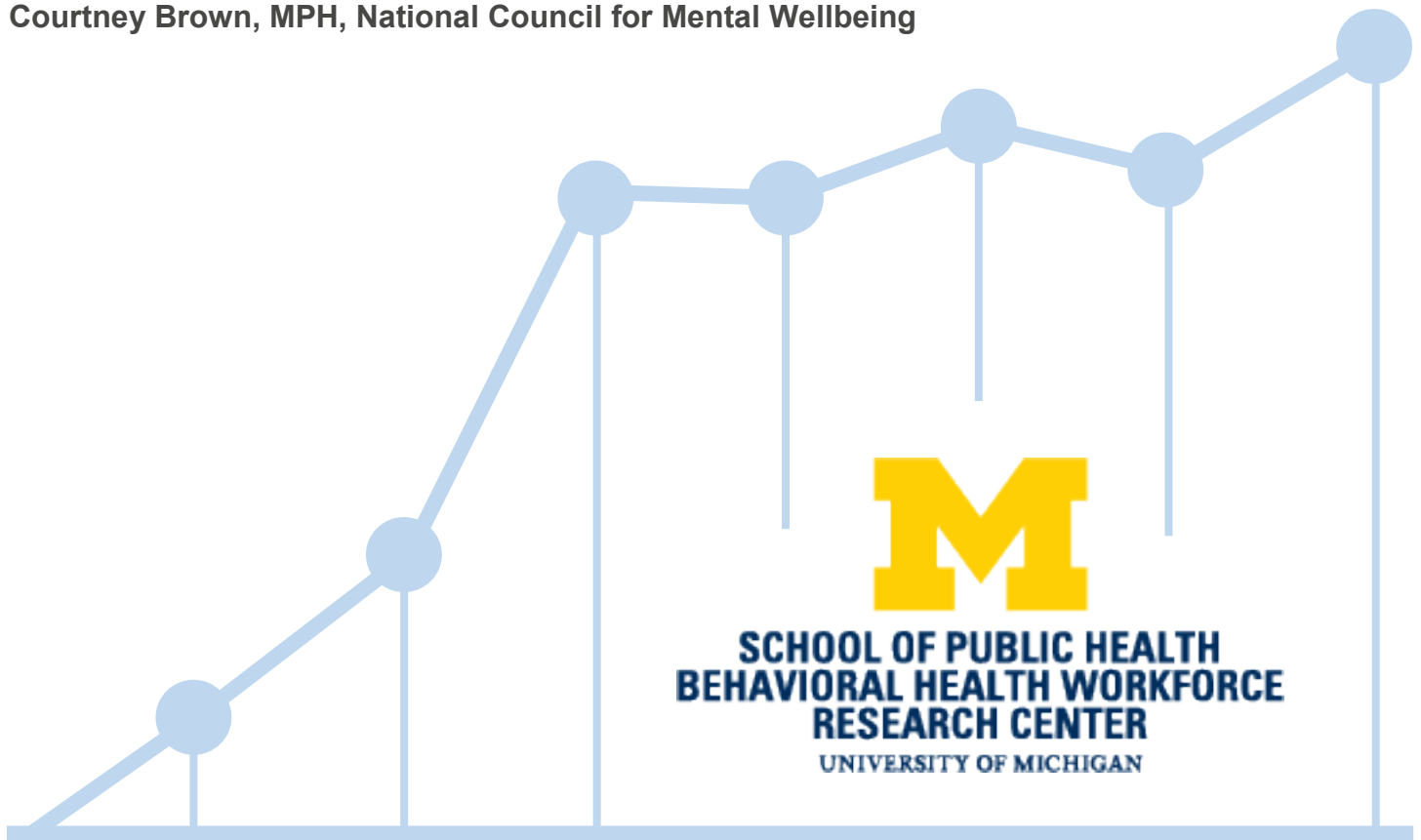
NATIONAL
COUNCIL
*for Mental
Wellbeing*

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Table of Contents

| | |
|---|----|
| Introduction | 4 |
| Methods | 4 |
| Results | 5 |
| Key Findings | 5 |
| Survey Results | 6 |
| Overview of Survey Respondents and Organizations | 6 |
| Factors Impacting Workforce Capacity Pre-COVID-19 | 9 |
| Concerns and Reflections on the Impact of COVID-19 on Organizations | 13 |
| Organizational Response to COVID-19 | 14 |
| Key Informant Interview Results | 14 |
| Overview of Key Informants | 14 |
| Factors Impacting Workforce Capacity Pre-COVID-19 | 15 |
| Organizational Response to COVID-19 | 15 |
| Telebehavioral Health | 15 |
| Workforce Wellness | 16 |
| Hiring | 16 |
| Conclusions and Policy Considerations | 17 |
| References | 18 |

Background

The behavioral health workforce is currently experiencing a shortage of providers across the United States. Estimates by the Health Resources and Services Administration project shortages for all levels of behavioral health professions by 2025, including a deficit of more than 250,000 full time equivalent employees when factoring in unmet need.¹ This workforce shortfall will likely be affected by the COVID-19 pandemic, though it is currently unclear how policy changes and systems-level factors within behavioral health care will impact workforce capacity. The U.S. declared a national emergency in response to the pandemic beginning in March 2020, spurring a rapid transition to virtual health care services such as telebehavioral health.² Regulatory and policy modifications were made by federal and state regulators, allowing provider flexibility in billing and remote service delivery.³⁻⁵ Additionally, the Centers for Medicaid and Medicare Services (CMS) issued temporary waivers and new rules to ensure flexibility in provisions of behavioral health care and to remove practice barriers for the healthcare systems workforce.⁶ Understanding how systems-level factors, including facility characteristics, policies and regulations, population cultures, worker resources, and training opportunities,⁷ affect capacity following these changes will yield insight into the pandemic's impact on service delivery and effectiveness.

The purpose of this study was to gain insight on how a variety of systems-level factors influence behavioral health workforce capacity and impact behavioral health service delivery. Secondly, this study investigates how the COVID-19 pandemic impacted the behavioral health workforce capacity and ability to effectively deliver services.

Regularly assessing the status and interconnectivity of systems factors is critical for identifying how they influence one another, inform behavioral health workforce capacity, and impact behavioral health service delivery. To better understand the impact of the COVID-19 pandemic on behavioral health workforce capacity, the study team investigated systems-level factors and service delivery following state and federal regulatory changes. Results of this study will inform future behavioral health workforce planning efforts, specifically around identifying and removing barriers to maximizing workforce capacity.

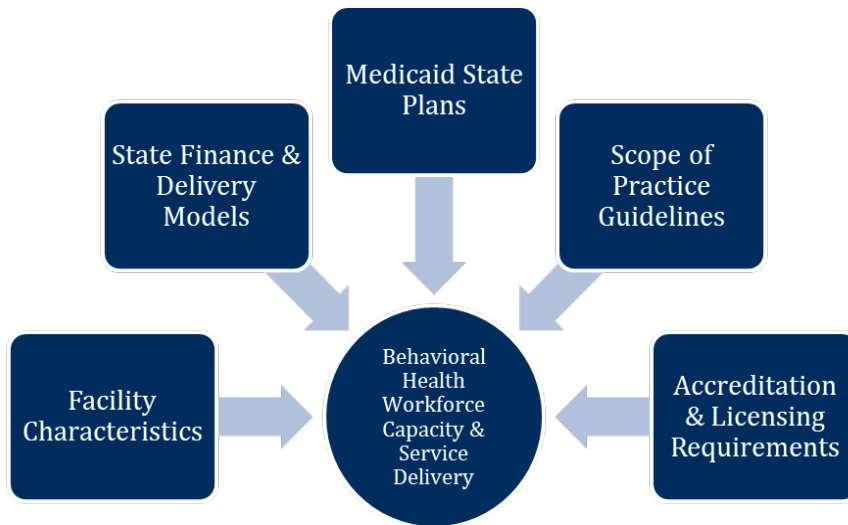
Methods

The National Council for Mental Wellbeing (National Council) research staff, in partnership with the Behavioral Health Workforce Research Center at the University of Michigan School of Public Health, collected quantitative and qualitative data on systems-level factors from behavioral health provider organizations nationwide to address the following research questions:

1. How do the following systems-level factors influence behavioral health workforce capacity (Figure 1)? (*Environmental scan, survey, interviews*)
 - i. Facility characteristics
 - ii. State finance and delivery models (e.g., Health homes, Certified Community Behavioral Health Clinics, Accountable Care Organizations)
 - iii. Other systems-level factors, including Medicaid state plans, scope of practice guidelines, and accreditation and licensing requirements
2. Which systems-level factors impact how the behavioral health workforce effectively delivers services? (*Environmental scan, survey, interviews*)
3. How did the COVID-19 pandemic impact behavioral health workforce capacity and ability to effectively deliver services?

Researchers collected data in two phases: (1) An electronic survey deployed in August 2020 to examine which systems-level factors impact behavioral health services delivery, and (2) key informant interviews completed in October-November 2020. The research team collected quantitative data from a

Figure 1. Systems-level Factors Influencing Behavioral Health Workforce Capacity



convenience sample of behavioral health providers in leadership positions from the National Council using a pilot-tested online survey powered by SurveyMonkey, a secure electronic research platform. Prior to dissemination, the survey was reviewed by Behavioral Health Workforce Research Center experts. Researchers distributed the survey via-email in August 2020 to >50,000 behavioral health stakeholders selected from the National Council's mass communications list. Due to the method of survey distribution, a response rate was not calculated.

The first 350 respondents were offered a \$25 electronic gift card incentive for completing the survey. Participation was voluntary and required approximately 15 minutes for completion. The survey was available online for three weeks, after which quantitative results data were analyzed using Microsoft Excel software.

To gain a qualitative understanding of the pandemic's effect on service delivery and workforce capacity, the study team conducted semi-structured key informant interviews in October-November 2020. Key informants were individuals in leadership positions at behavioral healthcare organizations that provide a range of behavioral health services and either expanded or adopted telebehavioral health due to the COVID-19 pandemic. Interview questions focused on the impact of systems-level factors within organizations that affected service delivery prior to the onset of the pandemic. Study researchers recorded each key informant interview and analyzed findings using Microsoft Excel. Participation in interviews was voluntary and key informants were offered a \$25 gift card incentive for interview completion.

To identify common themes shared across respondents, the research team performed a thematic analysis of survey and interview data. Findings were categorized into three primary domains:

1. Key factors impacting workforce capacity and effectiveness in service delivery;
2. Policy and regulatory factors; and
3. Impact of the COVID-19 pandemic on the behavioral health workforce's adoption and expansion of telebehavioral health

Results

Key Findings

- A total of 215 individuals from all 50 states and Puerto Rico participated in the survey, while 9 organizations from 8 states participated in key informant interviews
- Participants had diversity of organization type, location, subpopulations served, and included representatives from urban, rural and frontier communities
- Staff turnover, financing, and licensing requirements had the greatest negative impact on capacity and ability to effectively deliver services prior to the COVID-19 pandemic

- While scope of practice guidelines in some cases were reported to have a positive impact on an employee's ability to effectively deliver behavioral services prior to the COVID-19 pandemic (especially for mental health counselors and social workers), a majority of responses (57%) indicated that this factor had minimal to no impact across employee type
- Health information technology, including telebehavioral health, had the greatest positive impact on service delivery in response to the COVID-19 pandemic, while other social and economic factors related to accessing and engaging in treatment (e.g., transportation, child care, employment) had the greatest negative impact
- All respondents reported being impacted by the COVID-19 pandemic: 66% reported difficulties hiring; 40% reported financial harm
- A majority of key informants reported benefiting from policy changes that allowed for flexibility in service delivery as organizations implemented new or amended telehealth procedures
- While 59% (or 5 of 9) of key informants expressed plans to increase the use of technology in service delivery or incorporate aspects of telebehavioral health in the long term, others were unsure about expansion due to uncertainty surrounding the timeliness and effectiveness of the COVID-19 vaccine, how the presence of COVID-19 will continue to affect them financially, and how federal and state policies adapt to COVID-19

Survey Results

Overview of Survey Respondents and Organizations

Individuals with leadership roles in private and public behavioral health organizations completed the survey (n=215), with respondents representing agencies that provide behavioral health services across 47 states, the District of Columbia, and Puerto Rico. Delaware, Utah, and Vermont were not represented in survey responses. Response rates varied substantially by survey item and the corresponding rate is listed for each item.

The most common types of organizations represented were those that provide both mental health and substance use disorder services (70%, (66/95)), integrated healthcare services or collaborative care (41%, 39/95)), mental health services (19%, (18/95)), substance use disorder treatment services (6%, (6/95)), and general health care (8%, (8/95)).

More than half of all respondents (54%, (52/96)) were from urban areas with populations of >50,000 people. Approximately one-quarter of respondents (29%, 28/ 96)) were from areas with populations of 2,500-49,999 people. Nine percent of respondents (9/96) reported being from medically underserved areas. Seven percent of respondents (7/96) were from rural areas with a population of <2,500 people, and 5% (5/96) were from Frontier Health Professional Shortage Areas. Approximately 2% of respondents (2/96) were from tribal areas. Half of respondents (52/97) work at organizations that serve <5,000 individuals annually, while 2% (2/97) work at organizations that serve >50,000 persons annually.

Table 1 provides a breakdown of populations served by participating organizations. Survey data indicate that respondents serve a variety of populations, with the highest percentage (96%, 92/96) of organizations serving adults, individuals with low socioeconomic status (92%, 88/96), and individuals with justice involvement (85%, 82/96).

Table 2 provides a distribution of the organizations represented in the study. A variety of service providers and both private and public organizations were represented in the survey data, with 54% (53/98) of respondents employed by mental health clinics and 42% (42/98) by substance use disorder treatment organizations.

| Table 1: Survey Respondent's Populations Served | |
|--|---------------|
| Populations Served | Count n=96 |
| Adults | 92 |
| Individuals with low socioeconomic status | 88 |
| Individuals with justice involvement (individuals currently or formerly involved in the correctional system) | 82 |
| LGBTQ communities | 79 |
| Children | 78 |
| Seniors | 78 |
| Individuals experiencing homelessness | 76 |
| Veterans | 74 |
| Pregnant/postpartum women | 62 |
| Individuals with developmental disabilities | 59 |
| Members of military families | 58 |
| Immigrants | 57 |
| Rural/agricultural populations | 55 |
| American Indian, Native American, or tribal populations | 43 |

| Table 2: Survey Respondent's Organization Type | | | |
|--|---------------|-----------------------|---------------|
| Organization Type | Count n=98 | Organization Type | Count n=98 |
| Mental health clinic | 53 | Rural Health Clinic | 4 |
| Substance use disorder treatment | 42 | Private practice | 4 |
| Social service agency | 17 | State government | 3 |
| Other | 17 | County government | 3 |
| Crisis service center | 13 | Tribal organization | 3 |
| Certified Community Behavioral Health Clinic | 8 | Research organization | 2 |
| Peer organization | 7 | Jail or prison | 2 |
| Hospital (general, psychiatric, or specialty) | 7 | Military | 2 |
| Federally qualified health center | 7 | School/University | 1 |
| Primary care office | 5 | Senior center | 1 |

Respondents reported on types of payers for reimbursement (Figure 2), with almost 90% (86/97) indicating reimbursement by Medicaid, 83% (81/97) receiving self-pay, and 70% (68/97) reimbursed Medicare and commercial insurance. Regarding the 26% (26/97) of respondents that represent the “other” funding category, 45% (44/98) reported receiving state program funding, 27% (26/98) county funding, 18% (18/98) grant funding, and 1% (1/98) tribal funding.

Table 3 summarizes characteristics of participants’ organizations, including: Comprehensive range of health services, accessibility of

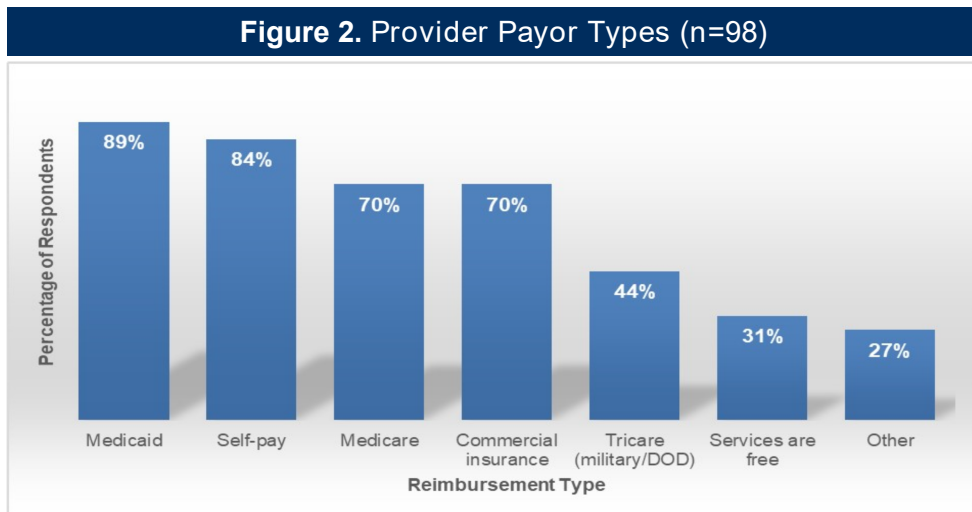


Table 3: Organizational Characteristics

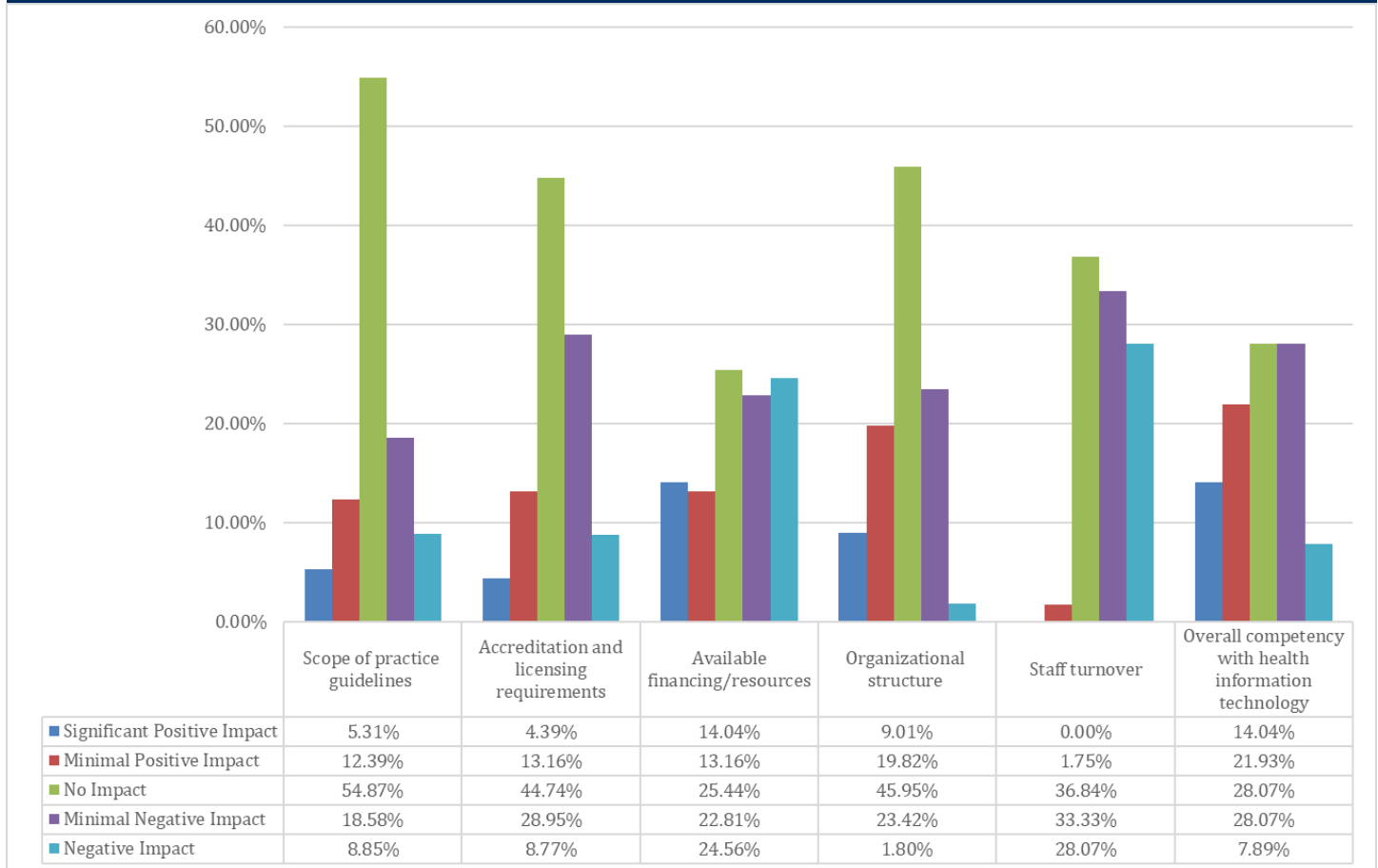
| Organizational Characteristic | Count by response (n=99) | | | | | Total |
|---|--------------------------|-------|----------|-------------------|-----|-------|
| | Strongly Agree | Agree | Disagree | Strongly Disagree | N/A | |
| Person-centeredness: Services are organized around the person, not the disease or the financing. People are partners in their own health care. | 60 | 33 | 2 | 0 | 4 | 99 |
| Quality: Health services of high quality, for example, they are effective, safe, centered on the patient’s needs, and given in a timely fashion. Process and outcome metrics are tracked for quality improvement purposes. | 45 | 45 | 5 | 0 | 4 | 99 |
| Coverage: Services delivery is designed so that all people in a defined target population are covered. | 44 | 39 | 9 | 4 | 3 | 99 |
| Continuity: Service delivery is organized to provide an individual with continuity of care across the network of services, health conditions, levels of care, and over the life cycle. | 43 | 42 | 10 | 1 | 3 | 99 |
| Accessibility: Services are directly and permanently accessible with no undue barriers of cost, language, culture, or geography. | 41 | 38 | 14 | 4 | 2 | 99 |
| Comprehensiveness: A comprehensive range of health services is provided, appropriate to the needs of the target population, including preventive, curative, palliative and rehabilitative services and health promotion activities. | 39 | 35 | 14 | 3 | 8 | 99 |
| Coordination: Local area health service networks are actively coordinated, across types of provider, types of care, and levels of service delivery. Coordination also takes place with other sectors (e.g., social services) and partners (e.g., community organizations). | 33 | 46 | 16 | 1 | 3 | 99 |
| Accountability and Efficiency: Health services are well managed so as to achieve core elements described above with a minimum wastage of resources. | 32 | 43 | 20 | 1 | 2 | 98 |

services, coverage of services provided, continuity of services across a network, quality of services, person-centered services, service coordination, and accountability and efficiency of services.

Factors Impacting Workforce Capacity Pre-COVID-19

To better understand the factors impacting service delivery prior to the COVID-19 pandemic, six systems-level factors were evaluated: overall staff competency, staff turnover, organizational structure, available financing and resources, licensing, and scope of practice guidelines (Figure 3). Of the 115 responses, it was noted that staff turnover, financing, and licensing requirements had the greatest negative impact on capacity and ability to effectively deliver services.

Figure 3. Pre-COVID-19 Impact (n=115)



To better understand how scope of practice guidelines impacted behavioral health services by role, the research team asked respondents how this factor impacted their employees' abilities to effectively deliver services (Table 4).

Survey respondents (n=116) evaluated their daily professional functions to determine the impact of COVID-19 on their staff's ability to effectively deliver services (Table 5). Health information technology, including telebehavioral health, incurred the greatest positive effects on service delivery with 71% (80/113) respondents reporting its impact as significantly or minimally positive. The largest significant negative impact concerned social and economic factors related to treatment access and engagement, including transportation, child care, and employment. Eighty-six percent (98 /116) reported a significant or minimal negative impact in this area.

Table 4: Impact of Scope of Practice Guidelines on Delivery of Behavioral Health Services Before the COVID-19 Pandemic, by Profession

| Profession | Count by response (n=109) | | | | Total |
|---|---------------------------|-----------------|----------------------|------------|-------|
| | Positive Impact | Negative Impact | Minimal to No Impact | Don't Know | |
| Advanced Practice Registered Nurse | 15 | 3 | 36 | 2 | 56 |
| Care Coordinator | 14 | 3 | 34 | 5 | 56 |
| Clinical Social Worker | 24 | 4 | 42 | 6 | 76 |
| Community Health Worker | 7 | 5 | 16 | 4 | 32 |
| In-training Behavioral Health Provider | 10 | 5 | 27 | 5 | 47 |
| Licensed Master Social Worker | 21 | 7 | 31 | 3 | 62 |
| Marriage and Family Therapist | 12 | 6 | 16 | 2 | 36 |
| Master Social Worker | 24 | 10 | 45 | 4 | 83 |
| Mental Health Counselor | 25 | 12 | 39 | 3 | 79 |
| Other | 3 | 4 | 14 | 0 | 21 |
| Peer Support Specialist/Peer Specialist | 10 | 7 | 44 | 5 | 66 |
| Physician | 8 | 0 | 21 | 5 | 34 |
| Physician Assistant | 4 | 1 | 9 | 3 | 17 |
| Practical Nurse or Registered Nurse | 5 | 5 | 31 | 2 | 43 |
| Psychiatrist | 15 | 3 | 35 | 7 | 60 |
| Psychologist | 7 | 3 | 25 | 4 | 39 |
| School Counselor | 1 | 2 | 6 | 0 | 9 |
| Social Worker | 14 | 6 | 34 | 4 | 58 |
| Substance Use Counselor | 19 | 11 | 36 | 3 | 69 |

Table 5: COVID-19's Effect on Workforce Ability to Effectively Deliver Daily Clinical Function Services

| Daily Clinical Service | Impact, count by response (n=116) | | | | | Total |
|---|-----------------------------------|---------|----|---------|------|-------|
| | Most | Minimal | No | Minimal | Most | |
| Use of health information technology, including telehealth | 61 | 19 | 9 | 14 | 10 | 113 |
| Staff safety (e.g., access to personal protective equipment, infection prevention protocols) | 15 | 16 | 17 | 45 | 23 | 116 |
| Ability of patients to engage with health technologies, including telebehavioral health services (e.g., Internet access, technology availability) | 14 | 11 | 7 | 43 | 40 | 115 |
| Mandatory face mask use | 12 | 8 | 25 | 56 | 13 | 114 |
| Workforce training | 9 | 15 | 19 | 39 | 33 | 115 |
| Availability of resources to support adequate workforce (e.g., reserves, community and private philanthropic organization's resources or grants) | 9 | 20 | 24 | 35 | 28 | 116 |
| Substance Abuse and Mental Health Services Administration Emergency Grants to Address Mental and Substance Use Disorders | 7 | 19 | 79 | 4 | 4 | 113 |
| Scope of practice guidelines | 7 | 15 | 45 | 39 | 10 | 116 |
| Accreditation and licensing requirements | 5 | 6 | 77 | 24 | 4 | 116 |
| Daily cash flow | 4 | 7 | 18 | 41 | 42 | 112 |
| Availability of outpatient services (e.g., outpatient day treatment or partial hospitalization) | 4 | 9 | 34 | 47 | 21 | 115 |
| Logistical factors (e.g., space constraints) | 4 | 3 | 14 | 47 | 48 | 116 |
| Availability of ancillary services (e.g., case management) | 3 | 3 | 34 | 52 | 24 | 116 |
| Requirements to implement evidence-based practices | 2 | 8 | 48 | 37 | 17 | 112 |
| Case load management | 2 | 6 | 49 | 49 | 18 | 115 |
| Staff availability (e.g., staff needing to self-isolate owing to their or a family member's risk for COVID-19) | 2 | 14 | 18 | 44 | 37 | 115 |
| Availability of assessment and pre-treatment services (e.g., interim services for clients when immediate admission is not possible) | 2 | 3 | 7 | 63 | 40 | 115 |
| Patient and family engagement (e.g., commitment to and willingness to engage in treatment) | 2 | 11 | 19 | 42 | 41 | 115 |
| Other social and economic factors related to accessing and engaging in treatment (e.g., transportation, child care, employment) | 2 | 7 | 8 | 34 | 64 | 115 |
| Treatment cost (e.g., treatment affordability and health insurance coverage) | 1 | 8 | 62 | 27 | 16 | 114 |
| Availability of resources to maintain pre-COVID-19 staffing levels | 1 | 6 | 26 | 41 | 42 | 116 |
| Availability of residential (non-hospital) services (e.g., residential short-term treatment) | 0 | 2 | 93 | 16 | 3 | 114 |
| Availability of transitional services (e.g., discharge planning, aftercare) | 0 | 1 | 34 | 58 | 20 | 112 |
| Language access factors | 0 | 1 | 43 | 35 | 35 | 114 |
| Mandatory stay-in-place orders | 0 | 7 | 23 | 36 | 49 | 115 |

Respondents also reported on 20 factors that impacted service delivery and workforce capacity following state-level changes to behavioral health service policy and regulations. As shown in Table 6, policy changes had a notable positive impact on services by allowing for increased flexibility in service delivery and reimbursement.

Providers noted their ability to expand and/or implement the use of telebehavioral health via phone, video, or alternate device enabled continuity of care for clients as providers pivoted from in-person to virtual care. Increased state and federal regulations and reimbursement flexibility also had a significant positive impact on workforce capacity. Table 6 reflects the favorable influence of regulatory changes due to COVID-19: Respondents indicated that the changes that had the greatest positive impact were flexibility in the kinds of telehealth authorized during the pandemic (88%, (99 of 113)) and allowing for provision of telehealth services in alternate settings (88%, (100 /113)).

Table 6: Impact of Policy and Regulatory Changes

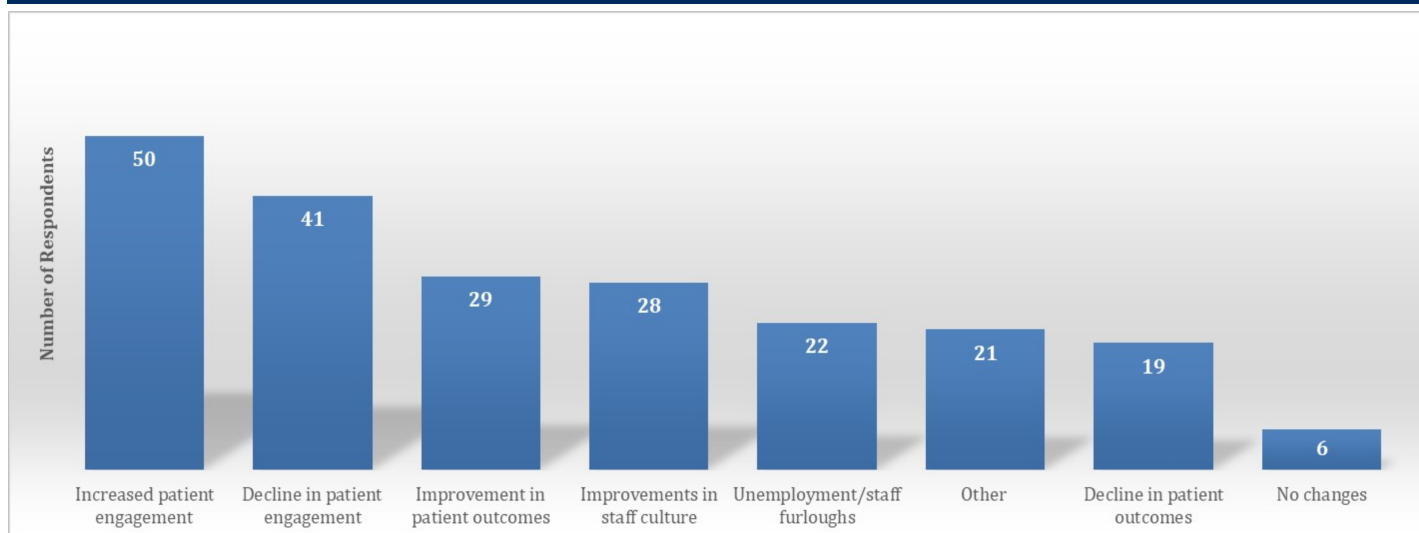
| Daily Clinical Service | Impact, count by response (n=113) | | | | | Total |
|---|-----------------------------------|------------------|-----------|------------------|---------------|-------|
| | Most Positive | Minimal Positive | No Impact | Minimal Negative | Most Negative | |
| Flexibility in the kinds of telehealth authorized during the pandemic | 81 | 18 | 9 | 4 | 1 | 113 |
| Allowing for provision of telehealth services in alternate settings | 79 | 21 | 12 | 1 | 0 | 113 |
| Changes to Medicaid telehealth policies | 80 | 17 | 13 | 2 | 1 | 113 |
| Flexibility related to prescribing using telehealth services | 58 | 25 | 22 | 3 | 0 | 111 |
| State-level policy or regulatory changes | 36 | 42 | 26 | 5 | 3 | 112 |
| Flexibility in state licensure requirements for telehealth | 50 | 32 | 27 | 4 | 0 | 113 |
| Changes to Medicare telehealth policies | 52 | 26 | 28 | 5 | 2 | 113 |
| State initiatives to maintain funding/keep providers whole | 45 | 24 | 30 | 5 | 6 | 110 |
| Paycheck Protection Program | 60 | 15 | 35 | 1 | 1 | 112 |
| Changes to Medicaid State Plan Amendments | 39 | 31 | 35 | 3 | 1 | 109 |
| Changes to federal privacy and confidentiality regulations | 34 | 39 | 36 | 3 | 0 | 112 |
| Changes to private insurance telehealth policies | 35 | 33 | 37 | 4 | 1 | 110 |
| Private insurance reimbursement flexibility | 23 | 42 | 40 | 4 | 3 | 112 |
| Changes to Medicare coverage and payments | 27 | 21 | 50 | 9 | 5 | 112 |
| Public insurance reimbursement flexibility | 26 | 24 | 54 | 4 | 3 | 111 |
| Flexibility in prescribing medications for opioid use disorder | 21 | 22 | 65 | 3 | 0 | 111 |
| U.S. Small Business Association's Economic Injury Disaster Loan Program | 18 | 25 | 67 | 0 | 1 | 111 |
| Section 1115 state waivers | 22 | 17 | 64 | 1 | 1 | 105 |
| Substance Abuse and Mental Health Services Administration grantee flexibility | 14 | 25 | 69 | 0 | 0 | 108 |
| Section 1135 state waivers | 17 | 18 | 73 | 0 | 0 | 108 |

Concerns and Reflections on the Impact of COVID-19 on Organizations

All respondents (n=117) reported being impacted by the COVID-19 pandemic. To better understand the impact of the COVID-19 pandemic, study researchers asked respondents about client outcomes, client engagements, and impact on staffing resulting from pandemic-induced organizational changes (Figure 4). Six percent of respondents (6/99) reported no organizational impact as a result of changes made. In addition, 21 respondents chose “other” impacts that occurred at their organization, which included:

- Declines in staff culture;
- Staff leaving to find other jobs;
- Decreased staff productivity;
- Increased staff burnout;
- Effective prevention of spread of infection;
- Reduced referrals;
- Staff feeling overwhelmed;
- Increases in depression and anxiety among individuals they support; and
- Increased number of deaths of people served

Figure 4. Organizational Impact Post-COVID-19 (n=99)



Respondents were also asked to describe their concerns and reflections regarding COVID-19’s impact on their organizations. Of the 91 respondents that answered this question:

- 40% (36/91) of respondents reported financial harm as a result of the COVID-19 pandemic
- 20% (18/91) reported worse mental health as a result of COVID-19
 - ◇ This includes increased stress and anxiety for staff and clients.
 - ◇ Several organizations reported that their staff were struggling to balance child care and work while working from home.
 - ◇ Several organizations reported that they fear their clients with substance use disorders are returning to use as a result of no in-person mutual aid meetings.
- 12% (11/91) reported staffing concerns as a result of COVID-19; this includes losing staff and having trouble hiring.

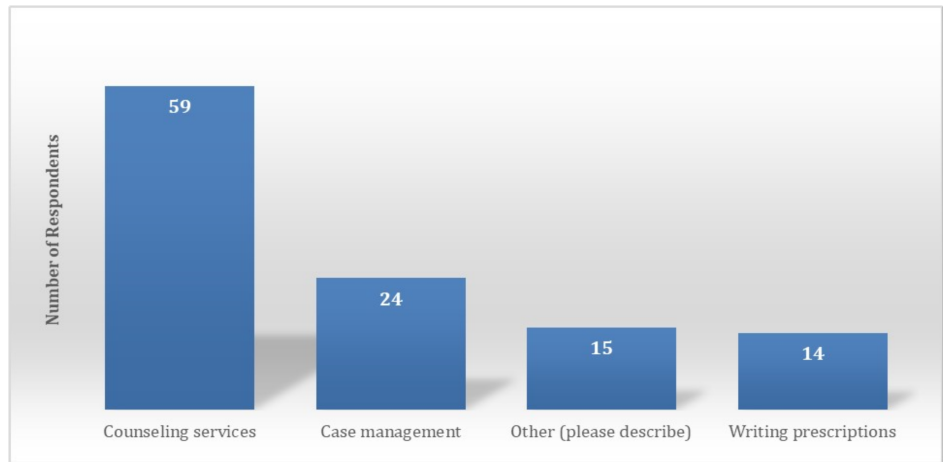
Organizational Response to COVID-19

In order to understand how organizations reacted to the COVID-19 pandemic, respondents were asked to briefly describe how their organization’s plans to improve behavioral health and telebehavioral health service delivery in the next two months have changed owing to the pandemic. Among 92 respondents:

- 9% (8/92) of respondents reported that they currently are, or are transitioning to, more in-person services.
- 60% (55/92) reported that they plan to continue using online/remote services.
- 53% (49/92) reported that they are investing in improving their current telebehavioral health practices through purchasing better equipment and software or increasing employee trainings on how to best utilize telebehavioral health.

Regarding the organizational hiring process, 66% of respondents (66/100) reported their organization was experiencing difficulties with hiring. As shown in Figure 5, hiring difficulties are most greatly affecting counseling services with 89% of respondents (59/66) identifying this area as impacted by hiring challenges.

Figure 5. Areas Impacted by Difficulties in Hiring Sources (n=66)



Key Informant Interview Results

Overview of Key Informants

A total of 9 key informants representing eight states participated in interviews (Table 7). The types of organizations represented by key informants included a Federally Qualified Health Center, a Certified Community Behavioral Health Clinic, a county department of human services, a private independent provider, a large medical center, and community behavioral health organizations. Several organizations reported providing services at more than one location and to more than one type of geographic setting (e.g., rural and urban locations).

Table 7: Key Informant Participants

| State | Role of Key Informant | Primary Types of Geographic Areas Served | Organization Provided Telebehavioral Health Prior to COVID-19? |
|-------|---|--|--|
| MN | Chief Executive Officer | Frontier | No |
| MO | Chief Executive Officer | Urban | Limited |
| CT | President/CEO | Rural | Limited |
| MI | Reimbursement Officer | Urban | Limited |
| NY | Director of Mental Health for Older Adults | Urban | Limited |
| NY | Director, Geriatric Mental Health Initiatives | Urban | No |
| OH | Chief Executive Officer | Rural | No |
| WA | Director of Special Programs | Urban, Suburban, Rural | No |
| IA | Chief Executive Officer | Urban | No |

Factors Impacting Workforce Capacity Pre-COVID-19

To further explore the factors impacting service delivery prior to the COVID-19 pandemic, key informants were asked about the same six systems-level factors evaluated in the study: overall staff competency, staff turnover, organizational structure, available financing and resources, licensing, and scope of practice guidelines.

Several key informants reported that insufficient financing and resources had an impact on workforce capacity, citing issues including an inability to offer staff competitive salaries and Medicaid rates that do not meet the current need. As one informant described:

“A group that has taken a big chunk out of our behavioral health workforce is the managed care companies. They’re able to pay staff much more.”

Key informants also identified staff hiring and competency issues, explaining that it was difficult to find qualified master’s level professionals and those who had expertise in medication assisted treatment and providing services to individuals with serious mental illness.

Impact of COVID-19 Related Policy and Regulatory Changes

A majority of key informants reported benefiting from policy changes that allowed for flexibility in service delivery as organizations implemented new or amended telehealth procedures. New policies allowed for expansion of services for clients, including the use of texting as part of service delivery, the type of platforms allowed, relaxing limits on the number of services clients can receive in a week, and billing approval for expanded telebehavioral health services. One key informant noted:

“Some of the things that were very beneficial, and that I hope move forward is Minnesota had a cap of only three telemedicine services to be provided in a week to a client. All services so that could be primary care and mental health and we’d have no idea that was waived. [...] The other piece was just allowing certain services to be delivered through telemedicine or telephonic and just keeping the broad array of services and disciplines. So even peer services, you know, weren’t eligible before. They are now.”

Organizational Response to COVID-19

Telebehavioral Health

Five of the respondents’ organizations did not use telebehavioral health prior to the onset of the COVID-19 pandemic and 4 offered telebehavioral health for some, but not all, services. Provision of telebehavioral health was a frequently cited as a major change in service delivery in response to the COVID-19 pandemic, with all informants reporting an uptick in telebehavioral health services provided at their organization. More than half of key informants reported shifting to telebehavioral health with a major telephonic component. This transition necessitated additional training for staff on new policies, procedures, and utilization of technology to better support clients in adapting to a telehealth model of care.

Key informant interviewees indicated the shift to telebehavioral health also introduced new challenges to their practice, particularly in rural areas where Internet connectivity is not equal or guaranteed across service areas. Additionally, the availability of proper equipment for clients to access telebehavioral health services was not uniform, which one interviewee reported as a cause of increased no-show rates. However, most key informants indicated a decrease in no-show rates overall. Key informant service delivery experiences include:

“The consumers or patients were at home and they didn’t necessarily have the tools to do the videos. So, the telephonic has had a major impact for us. We

had to use the phone a lot.”

“We did have some of the [telehealth] infrastructure kind of ready to go. But it just changed the timeline on us dramatically.”

“Where people have connectivity it's great, especially if they don't have to drive. They don't have to try to get to a clinic. When there is poor cell service or there is no broadband coverage, or dead zones where we have no connectivity, those folks, that's where we are still doing some face-to-face work because we have people that need to be seen, but they don't have the ability to connect.”

Training in and adapting to new technology was the most commonly reported staff education need. All key informants reported either beginning to offer for the first time or expanding telebehavioral health services at their organization, resulting in an increased staff need for technology and support. Staff also had to modify how they interacted with patients to fit a model that did not include face-to-face interactions. Interviewees reported:

“Learning how to work with patients just verbally was a little bit of a challenge because you can't physically see them in some cases. And then in other cases, we had to set up in-person meetings. We had to set up telehealth in multiple rooms, where before we only may have had it only in one area at each site.”

“Just getting people over the fear of doing it [telehealth], really. It wasn't so much technical training but was walking them through ‘this is what that will look like’ and ‘this is how we do it.’ Now, it's pretty much second nature. But initially, it took a lot of hand holding with people.”

When asked to describe how organizations' five-year plans to improve behavioral health service delivery have changed due to the pandemic, 59% (5/9) of interviewees expressed plans to increase the use of technology in service delivery or incorporate aspects of telebehavioral health in the long term. Thirty-three (3/9) percent expressed uncertainty regarding their organization's five-year plan. Several key informants expressed that organizational plans are dependent on the timeliness and effectiveness of the COVID-19 vaccine, how the presence of COVID-19 will continue to affect them financially, and how federal and state policies adapt to COVID-19.

Workforce Wellness

One key informant reported that their organization has elevated its focus on staff and client mental health by developing stress awareness workshops to help hospitals learn to manage stress among staff. These workshops aim to increase community awareness of the negative effects of stress on health and the availability of mental health services offered through the key informant's agency.

Hiring

Many survey respondents reported difficulties in hiring due to the COVID-19 pandemic. To further explore this, informants were asked to describe challenges that arose due to hiring difficulties. Informants reported difficulties including staff training, difficulty finding or referring clients to a therapist, long wait times for initial psychiatric assessments, cost-prohibitive services, ability to secure placement for individuals to enter treatment centers including on weekends, recruitment and retention of qualified clinicians due to an inability to pay market value, high acuity of client care, and supervision of services. Thirty-three percent (3/9) of key informants reported needing to increase staff to accommodate demand for services, and 22% (2/9) reported that increased revenue had not led to increased hiring and that finding licensed staff to backfill positions was difficult.

Conclusions and Policy Considerations

This study explored systems-level factors that influence behavioral health workforce capacity, effectiveness of service delivery, and the impact of COVID-19 on organizations and providers. Survey and key informant data support a major shift to providing telebehavioral health services in response to the COVID-19 pandemic. Telebehavioral health is a key factor in the ability of organizations to deliver services, as all survey respondents reported feeling impacted by COVID-19 at the time the survey was distributed.

Flexibility in service policy, regulations, and delivery impacted providers' ability to continue serving clients and pivot to supporting individuals remotely as a result of allowance to bill for telebehavioral health services. Respondents reported lower no-show rates and increased engagement when they were able to offer telebehavioral health options ranging from telephonic to video services. More than 50% of key informants reported a rapid shift to virtual supports, a change that was challenging for rural clients who did not uniformly have access to technology. Thus, telephonic support played a large role in the continuation of behavioral health service delivery.

Flexibility in service delivery and billing was a major named factor in continuity of services for 100% of key informants. This finding supports the continuation of policy and regulatory reforms currently in place due to the pandemic in order to help augment staffing shortages, efficiency in service delivery, and facilitation of clients' increased access to and engagement with telebehavioral health.

Education on adapting to new technology was the most commonly reported organizational training need for staff, as the use of telebehavioral health required staff to engage clients differently. Face-to-face meetings were identified as necessary when delivering services to clients with acute needs. Respondents reported the need to develop training not just for their staff but also for individuals they support in learning how to use and access technology, over barriers of consent, and privacy.

Recruitment and retention of staff was another factor that impacted organizations both prior to and during the COVID-19 pandemic. Key informants reported that offering competitive salaries and competing with larger organizations to fill masters-level positions as one of the biggest challenges they experienced.

In addition to staffing shortages and recruitment challenges, staff turnover and burnout had an impact on capacity both before and during the pandemic. Eighty-nine percent of respondents named counseling services as significantly impacted by staffing shortages. One key informant noted the importance of promoting self-care among staff as an effort to reduce burnout. This key informant also provided support to local hospitals by training their staff in how to practice self-care and understanding the link between mental and physical health.

Opportunities for further research on systems-level factors include investigating innovation in service delivery models following the onset of the COVID-19 pandemic, resiliency of the behavioral health workforce, and the perceived quality of telebehavioral health services following the rapid adoption of telebehavioral health.

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