INTEGRATED DELIVERY NETWORKS (IDN) BEHAVIORAL HEALTH WORKFORCE CAPACITY DEVELOPMENT SUMMARY

In the fall of 2020, as New Hampshire's DSRIP waiver was winding down, the Endowment for Health supported seven online focus groups with 38 individuals, including one group with NH Department of Health and Human Services staff and six others (one each with six of the seven regional IDNs). The assessment explored the approaches, strengths, challenges, accomplishments, and lessons learned related to workforce development in each region, as well as identifying the work that remains. Each IDN is unique in its regional characteristics (e.g., size, geography, population, diversity), constellation of partners, and needs within and across partner organizations. Although the assessment highlighted some unique IDN features, it focused on identifying commonalities across IDNs as summarized below.

Approach/structure:

The IDNs dedicated an average of $1.9 million (range: $840k to $3.2m) to workforce development activities, although money spent in other categories (i.e., primary care/behavioral health integration and information technology) also supported workforce development. Each IDN assessed partner needs to inform regional workforce efforts. By participating in the statewide workforce taskforce and sub-committees, each IDN informed state-level workforce activities. Each IDN had a governance structure that made decisions about overall approach; most disseminated funds to partners via RFAs and grants. While attending to common needs within the region, the IDNs built flexible approaches so partners could address institution-specific needs. The IDNs engaged with partners around recruitment, retention, and advancement efforts and employed diverse strategies (e.g., training, bonuses/pay increases, recruiting and moving costs, loan repayment). The IDNs defined "workforce" broadly, including a range of professional and paraprofessional roles.

Strengths:

The behavioral health workforce was described as flexible, creative, responsive, dedicated, and passionate. The DSRIP waiver was said to have supported infrastructure critical to convening multiple partners in each region, including competitors, and forging and strengthening relationships. The waiver supported training and hiring efforts, and led to some improvements in integration, access to behavioral health and substance use treatment services, and some increases in the workforce diversity. The waiver enabled a structure through which the IDNs communicated challenges faced at the local level to the state-level, where policy and systems changes were formulated. The structure also allowed for reporting of state-level activities back to the regional/local level.

Challenges:

Because in NH, Medicaid does not cover some positions (e.g., Community Health Workers, peer recovery coaches) and the rates are lower than in neighboring states, the IDNs struggled to cover critical positions, attract applicants, and retain workers. The pandemic forced many workers to work from home, diverted resources and attention away from other critical community issues, and exacerbated the need for resources, especially among the most vulnerable. Ongoing issues such as alcohol and opioid addiction were coupled with steep increases in anxiety and depression related to isolation, economic fallout, and grief associated with the pandemic. Competition for

workers, particularly those requiring advanced degrees, existed in all regions. However, for some, competition was within the region (i.e., hiring staff away from another organization in the same region), whereas other IDNs competed with organizations in other regions or with those in neighboring states. With the screening for the social determinants of health (SDOH) required as part of the waiver, a flood of patient needs were identified that had to then be addressed. While some improvements in licensing were made, processes remained slow and cumbersome and created barriers to hiring and advancement of workers. While waiver-related data reporting requirements were described as burdensome, the ability to measure the impact of the IDN work remained elusive. Cuts made to the state's Student Loan Repayment Program and the high costs of education created barriers to worker advancement and efforts to build a diverse workforce. Federally Qualified Health Centers and Community Mental Health Centers (CMHCs), which generally cannot pay salaries comparable to those of other organizations, have difficulty retaining workers. Additionally, CMHCs, which often serve as a training ground for those working toward professional licensure, have difficulty retaining workers post-licensure. The focus on productivity (i.e., the number of patient visits seen) limits participation of workers in professional development activities, disadvantages those whose work requires significant travel, and leads to burnout. Competing organizational priorities and the need to institute systems changes related to a single payer created challenges for some organizations. In addition to all of these challenges, it was not clear to IDN staff and participants how the work of the IDNs fit within a longer-term strategy or how accomplishments would be sustained.

Accomplishments:

Improvements were noted in awareness, service delivery, and the culture of care within the regions. At the state-level, some improvements in licensing occurred and the value of non-billable services was better understood. Telehealth significantly improved access to care. The IDNs' work fostered or strengthened inter-organization collaboration, which reduced redundancies when addressing the SDOH. Behavioral health service capacity was improved through skill/knowledge-enhancement, "grow your own" advancement of workers, and hiring of new staff. Many waiver-supported accomplishments will be sustained, including several staff positions, trainings and tools, practice protocols, and technology and communication system improvements.

Left to do:

- Going forward, it will be necessary to demonstrate the collective impact of the workforce to support ongoing engagement of workers and to ward off burnout.
- It will be important to sustain partnerships in the absence of resources for the convener role; continue "boundary spanning" (i.e., supporting positions that work across two or more organizations freely); cultivate a pipeline of workers by introducing behavioral health careers to students in high school or before; and move into emergency and inpatient settings to integrate behavioral health services.
- Continued connection between health care and community organizations that address the SDOH will be critical, as will improvements in funding and models of higher education and sustaining training and capacity building.
- Future work should increase focus on the behavioral health needs of children.

Lessons Learned:

When asked about the lessons the IDNs would share with others interested in their work, participants indicated that, at a state-level, payment reform is critical to cover much needed positions and pay competitive wages; telehealth is essential to expanding services; licensure processes must support hiring and advancement efforts while still serving to protect patients; state-level work should be partner-driven, informed by the IDNs, and communicated back to the regions;

and data reporting should be standardized, based on consensus, feasible, and capable of identifying needs and demonstrating impact. At the regional level, the convener role was critical and should be resourced appropriately; regional governance should focus on simplifying processes and decision-making to get resources into partners' hands quickly; funding should be flexible to allow partners to address their specific workforce needs; and planning for sustainability should happen from the outset. With regard to partners, it is important to cast a wide net and include community partners that address the SDOH. Outreach and securing the right partners (i.e., those with decision-making authority for their organizations) takes time and internal champions are needed to drive change within partner organizations. Given the credential-heavy nature of the work, higher education should be engaged. All partners should have an equal voice and egos should be "checked at the door." Regarding effective workforce strategies, "grow your own" efforts are critical to filling positions given the competition for workers; valuing employees is essential to keeping them (i.e., through pay, advancement opportunities, appreciation, acknowledgement of impact, and good supervision) but using waiver funds to increase salaries for new workers may cause existing workers at lower salaries to become disgruntled. Training should be free, readily available, and easy to access and support priority skill/knowledge development, cross-institutional understanding, licensure, and effective supervision and leadership. Early focus should be paid to creating effective screening for and identification of those most at risk for behavioral health problems and the organizations involved in their care. Such screening, as well as referrals to services, should be easy to access and seamless for patients, staff, and providers.