Presentation Objectives

To describe:

- Washington’s Behavioral Health Workforce Assessment goals and results to-date,
- Workforce-related barriers to accessing and delivering behavioral health services in Washington State, including in rural areas,
- Stakeholders’ recommendations to address behavioral health workforce needs, and which recommendations received notice by state officials.
- Findings of emerging workforce demand changes in Washington.
Washington’s Behavioral Health Workforce Assessment

Funded by Governor Inslee’s federal Workforce Innovation and Opportunity Act (WIOA) discretionary funds

Conducted by:

- University of Washington Center for Health Workforce Studies
  - Susan Skillman, Deputy Director
  - Rachelle McCarty, Research Scientist
- Washington State Workforce Training and Education Coordinating Board
  - Nova Gattman, Legislative Director
- With support from:
  - Agnes Balassa Solutions, LLC
Washington’s Behavioral Health Workforce Assessment - Project Goals

- **Goal 1**: Assess workforce-related barriers to accessing behavioral health services in Washington
- **Goal 2**: Create a recommended action plan to address behavioral health workforce needs
Behavioral Health Workforce Assessment – Required Deliverables

- Phase I report completed November, 2016.
  - Focused on synthesizing data to create actionable recommendations to address behavioral health (BH) workforce needs for the 2017 legislative session
    - Reports at:
      http://www.wtb.wa.gov/behavioralhealthgroup.asp
      https://depts.washington.edu/fammed/chws/studies/wabh/

- Phase II report due December 15, 2017
Behavioral Health Workforce Assessment - Methods

- Conducted stakeholders’ forums and key informant qualitative interviews.
- Reviewed available workforce demand signals from the Health Workforce Sentinel Network.
- Addressed key questions through select analyses of available data and stakeholder expertise.
Stakeholders

- Participation from broad mix of behavioral health stakeholders
- 4 meetings convened in summer/fall 2016

![Behavioral Health Workforce Stakeholders](chart.png)
Key Informants

- Key informants provided 34 telephone interviews and 7 online surveys over seven weeks in Fall 2016

- Represented a broad range of settings and occupations in 19 counties
  - 12 of the counties are largely rural
Phase I Results
Leading Barriers Reported

- Low reimbursement rates (83%)
- Limited availability of quality supervision
- Lack of education, training, and advancement opportunities
- Onerous administrative requirements
Recruitment/Retention Challenges

*Settings*: Rural, residential facilities, and community mental health centers reported greatest challenges

*Rural*: While cost of living may be lower*, recruiting/retaining BH workforce in rural is resource intensive:

- Compensation packages to draw providers to rural areas need to overcome concerns about isolation, lack of continuing education and professional development opportunities, and barriers to conducting research or consulting.
- Filling low-level case manager or front desk positions in rural sites can be just as difficult as hiring licensed practitioners.

*(except in rural areas with a high retiree population or resort regions)*
Recruitment/Retention Challenges

**Occupations in highest demand:** Chemical dependency treatment providers, psychiatrists, and “prescribers” able and trained to provide pharmaceutical treatment for mental health and substance use disorders

**Education and training most needed:**
- Evidence-based practices, and best practices in team-based integrative care
- Too few supervised training sites available
- Need more rural/underserved clinical training opportunities to help new entrants gain competencies for future success in rural practice
The story...

“Community-side, it’s a competition, vultures waiting to land.”

Turnover!

“Across the board, can’t name one [occupation] worse than the others, the problem is so widespread, agencies just cannibalize each other, position open in your agency steals from other providers in the system, not enough to cover for full workforce.”

“Shine a spotlight on the hard work these folks do. Law enforcement and fire and first responders get recognized for public service—behavioral health workers are working with the same folks but are [don’t receive] acknowledgement for the lifesaving work [and], working with violent offenders. Often a social worker is there with law enforcement and not recognized.”
Phase I Recommendations
Recommendation #1
Increase reimbursement rates

- Adjust reimbursement rates to better support competitive recruitment/retention of skilled behavioral health workforce.
- Stakeholder and informants “nearly universal” in agreement that improving reimbursement rates for behavioral health providers was the state’s single most significant lever to address workforce challenges.
  - Informants and stakeholders identified low reimbursement rates as root cause of challenges in recruiting and retaining, and adequately preparing workforce.

“[The work is] mission-driven and people do want to work for that reason but have to pay for their rent.”

“Many child psychiatrists accept cash pay for services and do so because there is enough demand... that they opt out of many insurance plans.”
Recommendation #2
Promote team-based, integrated care

- 2-a. Support the use of/expansion of the Healthier Washington Practice Transformation Hub efforts to promote adoption and training for team-based integrated behavioral health and primary care.
- 2-b. Consider expanding the list of professions eligible to bill as mental health providers.
- 2-c. Train and deploy entry-level providers in both primary care and behavioral health to support health team efforts in community health settings.

“We built our history on the 1 on 1 [provider-patient] relationship and that will always be a foundational piece. [T]he adoption of practice guidelines and evidence-based models and use of data ... our academic institutions have not really taught that as well as they need to.”
Recommendation #3
Increase access to clinical training

- 3-a. Recognize, compensate community-based organizations and the role they play in training new behavioral health professionals/paraprofessionals in their first year of practice.

- 3-b. Increase the ability of behavioral health clinical training sites to accept students/trainees by incentivizing and supporting clinical training sites.

- 3-c. Encourage payers (MCOs/health plans and BHOs) to contract with licensed community behavioral health agencies, as well as individual licensed clinicians.

- 3-d. Increase funding to expand behavioral health education programs and graduate more professionals.
Recommendation #4
Expand workforce to deliver medically assisted behavioral health treatments

- 4-a. Increase primary care providers’ (physicians, ARNPs, PAs, pharmacists) confidence to use their full prescriptive authority for psychiatric medications.

- 4-b. Expand telehealth reimbursement to include any site of origination, as well as consultation.
Recommendation #5

Improve diversity

- 5-a. Improve K-12 behavioral health literacy as a foundation for healthcare careers.

- 5-b. Increase the use of peers and other community-based workers in behavioral health settings.

- 5-c. Expand access to the I-BEST core curriculum, and encourage additional programs that include behavioral health occupations.

“We love having ... students at our clinic but they don’t know anything, they don’t have a behavioral health course, so it takes an enormous amount of time to bring them up to speed, with students sitting in in a fast environment you have to have downtime to go over things with them and you don’t get paid for that time.”
5-d. Reduce care worker turnover, improve diversity by creating career pathways and opportunities for certification of behavioral health and other paraprofessional roles.

5-e. Support continued funding for the state’s health professionals loan repayment program, and consider strategies to expand the program and its applicability to behavioral health occupations.

5-f. Expand the state Work Study program.

“Our clients are made up a diverse group of people, and the business we’re in is working with clients individually to improve their lives, and the therapist needs to understand their culture to do that, it’s part of the pieces that make up a person.”
Recommendations for Further Study in 2017

#6. Increase number of dually certified behavioral healthcare providers.

#7. Address licensing/credentialing barriers.

#8. Increase efficiency of behavioral health workforce by streamlining paperwork/reporting requirements.

“Charting fries people. Clients are in distress, clinicians need to be present and can’t hide behind a computer or clipboard. But if they take organic notes, they spend hours doing charting work on their own time.”
Which Recommendations Received Attention This Legislative Session?

Snapshot as of 6/12/17

#1 Reimbursement:

- Governor’s Budget: Requested raise for inpatient psychiatric payment rate for hospitals.

- House Budget: $50M for a rate increase for Behavioral Health Organizations (BHOs) and psychiatric inpatient provider Medicaid rates.
Which Recommendations Received Attention This Legislative Session?

Reimbursement, cont.

- Proposed HB 1637/SB 5471 – requiring primary care providers’ reimbursement rates in Medicaid to be equal with Medicare rates (did NOT pass)
Which Recommendations Received Attention This Legislative Session?

#2 Promote team based and integrated (behavioral and physical health) care:

- Governor’s budget directs state Health Care Authority to develop a plan for innovative, team-based practice changes
Which Recommendations Received Attention This Legislative Session?

#4-a, 4-b Technology:

- Governor’s budget requested funding for telephone consultation line for primary care providers accessing pain management and medication assisted treatment (MAT) professionals
- SB 5436: Expands the definition of telemedicine origination site to any site of the patient’s choosing (Signed into law)
- Proposed SB 5457 requests telemedicine payment parity beginning Jan 1, 2018 (Did NOT pass)
Which Recommendations Received Attention This Legislative Session?

#8 Streamlining Paperwork:

- HB 1819 – paperwork reduction. Would require Dept. of Social & Health Services to review documentation policies by April 1, 2018
  (Signed into law)
Washington’s Behavioral Health Workforce Assessment

Phase II is underway...
Who is the Behavioral Health Workforce? (traditional)
Who is the Behavioral Health Workforce? (non-traditional)
Examine who is the behavioral health workforce
- Where is behavioral health provided? By whom? New roles?
- Creating snapshots of the supply and distribution of various occupations, including rural/urban distribution

What do we know about the supply of the workforce?
- Education and training pathways
- Skills needed and how to obtain them (new & incumbent)
Washington’s Behavioral Health Workforce Assessment - Phase II

- Describe demand issues
  - Narrative of landscape given available data
  - Signals of emerging demand changes from Washington State’s Health Workforce Sentinel Network
  - Describe detriments of turnover, retention, and incentives (e.g., loan repayment, innovative models)

- Other topics carried forward from Phase I, responding to 2017 legislative actions
Assessing Emerging Changes in Workforce Demand:

Washington State’s Health Workforce Sentinel Network
Washington State’s Health Workforce Sentinel Network

**Industry Sentinels**
- Employer/workforce input:
  - Changes in needed skills and roles
  - New workforce demand signals
  - Review results to identify actionable findings

**Data Hub**
- Data submission via web portal every 4 months (3 times a year)
- Web-based data collection and analysis
- Rapid dissemination on the Workforce Board website:
  - Recent results from industry
  - Trends
  - Relevant health workforce data from other sources

**Education/Training & Policy Stakeholders**
- Information review & dissemination facilitated by the WA Health Workforce Council
- Review and respond to actionable information emerging from the Data Hub and Health Workforce Council:
  - Address emerging skills needs
  - Identify emerging roles
  - Respond to increases and decreases in demand for specific occupations

**Feedback to industry and data/information system**

Funding: Washington State Healthier Washington Initiative (CMMI SIM grant), through Washington’s Health Workforce training and Education Coordinating Board To the U of WA Center for Health Workforce Studies
Sentinel Network Results

- Behavioral-mental health clinic/outpatient mental health and substance abuse clinic
  - *Exceptionally long vacancies:* only about a quarter of BH facilities’ respondents cited NO occupations with prolonged vacancies for an open position (in past 3-4 months).
    - Top 3 consistently mentioned: Mental Health Counselor, Clinical Social Worker, and Substance Abuse and Behavioral Disorder Counselor
    - Also the Top 3 in demand ("In past 3-4 months, did you experience an increase in workforce demand for any occupations?")

- Changes in onboarding priorities
  - More changes reported in BH/MH/SUD facilities than FQHC’s/community clinics or psychiatric/SUC hospitals.
Sentinel Network Results

- **Behavioral-mental health clinic/outpatient mental health and substance abuse clinic (cont’d)**
  - *Changes in training priorities for existing workforce?*
    - Majority say YES.
    - Mental Health Counselors – EHR, evidence-based practices, chemical dependency treatment, integration and care coordination, customer service, keeping up with changing laws/contracts.
    - Substance Abuse and Behavioral Disorder Counselors – same; case management skills
Sentinel Network Results

- Federally qualified health center (FQHC) or community clinic providing free or on sliding fee scale
  
  - *Training Priorities*: customer service, EHR, gathering data (MAs and RNs), SUD treatment (MHC), EHR (physicians).
  
  - *New occupations*: mostly behavioral health workers
    - Wide range of BH occupations, with many of the new roles related to BH integration.
What are the High-level Takeaways from this Assessment so Far?
Takeaways so far:

- Reimbursement and workforce issues are integrally linked
- It’s not just about turning up “the spigot” at initial education
  - TURNOVER and “workforce churn” must be addressed
- Bidirectional integration of behavioral health and physical health care is an important goal
  - But it won’t happen overnight nor in every setting, and we need the BH workforce for all types of facilities
- Question to pursue: How will integration, and related workforce needs, look in rural?
Thank you!

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https://depts.washington.edu/fammed/chws/

http://www.wtb.wa.gov/
Additional Slides (not for presentation)

- Resources for behavioral health workforce planning and development
Retention

Focus on the Addiction and Mental Health Workforce: Increasing Retention For Today and Tomorrow
Presented by NAADAC and SAMHSA

Source:
Retaining the workforce

Once you’ve gone to all of the work to find, interview and hire someone, it’d be nice if they stuck around a while. Yet turnover is a problem for many employers. Here are a few facts about retention and ways to keep your staff happy and working for you for years to come!

84% of workers are looking to leave their jobs

Surprisingly, 89% of employers think workers leave for more money...

...but only 12% of employees do.

Why people leave

- 75% of those who quit, quit their boss – not their job
- 70% of workers aren’t engaged in their work
- 17% leave because of bad management or a bad work environment
- 20% leave because of a bad cultural fit

What can be done about it

- Invest in better management
  - 57% of bosses learned leadership by trial and error on the job
- Create better engagement strategies
  - 90% of companies say it’s important, yet only 25% have a plan
- Provide better coaching
  - The best companies have twice the on-the-job training hours
- Hire internally when you can
  - Outside hires are 61% more likely to be laid off or fired and 21% more likely to leave a job than internal hires

Source: University of Nebraska Medical Center, Behavioral Health Education Center of Nebraska

Retention Toolkit (2015)

https://www.unmc.edu/bhecn/_documents/Retention%20Toolkit.pdf
Research
Looking for more information and best practices on retention? Here are a few resources to get you started:


Loan repayment resources
Federal scholarship and loan repayment programs are available through the National Health Service Corps for behavioral health professionals: http://dhhs.ne.gov/publichealth/Pages/how_orth_loansfed.aspx

The Nebraska Student Loan Program and the Nebraska Loan Repayment Program: http://dhhs.ne.gov/publichealth/Pages/new_orth_loansetete.aspx

Other Toolkits
Building Blocks for Behavioral Health Recruitment and Retention Overview, SAMHSA. http://toolkit.ahpnet.com/


Other Retention Resources
http://www.whenworkworks.org/
http://www.kpcrh.org/
http://www.familiesandwork.org/

Nebraska Resources
Nebraska Office of Rural Health: http://dhhs.ne.gov/publichealth/Pages/new_orth.aspx

Source:
University of Nebraska Medical Center, Behavioral Health Education Center of Nebraska
Retention Toolkit (2015)
Retention Toolkit

Source: University of Nebraska Medical Center, Behavioral Health Education Center of Nebraska

Retention Toolkit (2017)

https://www.unmc.edu/bhecn/workforce/retention.html
Building Blocks for Behavioral Health Recruitment and Retention

Toolkit
Example: Retaining Psychiatrists

- Expand the variety of clinical duties (not just Rx)
- Increase support received from other staff
- Increase team-based training
- Expand use of alternative prescribers
- Reduce demands for documentation
- Greater ability to delegate tasks

Further Resources and Models
Solving the Behavioral Health Workforce Crisis: Award-Winning Tools for Growing your Pipeline of Providers

http://healthworkforcestudies.com/media-events/videos.html
Innovations in Behavioral Health Workforce Education, Training, and Development


Lessons from the Field: Innovations in Behavioral Health Workforce Education, Training, and Development

- Identify cutting-edge education and training strategies to develop practice and leadership skills in interprofessional practice and integration of behavioral health in primary care.

- Learn best practices for the prevention and treatment of children, adolescents, and transitional-age youth, and rural, and other underserved population, who have or are at risk for developing a recognized behavioral health disorder.

- Gain knowledge about strategies to enhance the distribution of behavioral health workforce across rural and underserved populations.
Evidence-Based Practices

Evidence-Based Practices

Welcome to the CEBC:
California Evidence-Based Clearinghouse for Child Welfare

The mission of the California Evidence-Based Clearinghouse for Child Welfare (CEBC) is to advance the effective implementation of evidence-based practices for children and families involved with the child welfare system.

- Searchable database of child welfare related programs.
- Description and information on research evidence for specific programs.
- Guidance on how to make critical decisions regarding selecting and implementing programs.
- Tools and materials to provide support for choosing, implementing and sustaining a program.

Information presented on the CEBC website is considered public information and may be distributed or copied. When using information obtained from the CEBC, we ask that you please use the following acknowledgment: Material/Image/Information obtained from the California Evidence-Based.
Workforce Integration

http://www.integration.samhsa.gov/workforce
Workforce Integration

Continuing Education

Web-Based Certificate in Integrated Behavioral Health and Primary Care

The Certificate in Integrated Behavioral Health and Primary Care (IBHPC) is designed for clinicians -- such as social workers, nurses, care managers, psychologists, and physicians -- who deliver or plan to deliver integrated health services. The program offers three track options so participants can tailor their learning to the populations they serve:

- **Pediatric Track**
  (for those serving children, youth, adolescents, and families in behavioral health, primary care, and other settings)
- **Adult Track**
  (for those serving adult populations presenting with complex needs in physical health, mental health, and substance use)
- **Combined Pediatric and Adult Track**
  (for those interested in the distinct considerations for providing integrated care to both pediatric and adult populations)

The Spring 2017 cohort will begin on March 10, 2017.

Teaching Method

The certificate program in IBHPC is an interactive web-based learning experience. Participants connect from their home or work computer. Each course is a mix of web-based live interactive lectures and pre-recorded self-paced lectures. Throughout all five sessions, participants will have instant access to faculty in real time for comments, questions, and discussions.

Participants require access to high-speed internet and a computer with a camera and microphone. You do not need special skills to participate successfully in a distance-learning environment. We will provide detailed, user-friendly instructions and technical support. We have found user-friendly webcams with microphones for as low as $25.00.

Advisory Board and Faculty

https://ssw.umich.edu/offices/continuing-education/certificate-courses/integrated-behavioral-health-and-primary-care
Workforce Integration

https://aims.uw.edu/resource-library
Medication Assisted Treatment

MAT Myths v Facts
MAT is one of the most effective forms of therapy for substance use disorders but is widely misunderstood. Take a look at our new infographic and separate fact from fiction!

MAT for Opioid Use Disorders Video Interview Series
Click on a video below to watch:
- Going to the MAT with Dr. Williams: An Overview of Medication Assisted Treatment for Opioid Use Disorders
- Going to the MAT with Dr. Williams: Naltrexone
- Going to the MAT with Dr. Williams: Pregnancy and Medication Assisted Treatment
- Going to the MAT with Dr. Williams: Methadone
- Going to the MAT with Dr. Williams: Duration of Medication Assisted Treatment
- Going to the MAT with Dr. Williams: Buprenorphine

https://www.thenationalcouncil.org/mat/
Medication Assisted Treatment

https://www.samhsa.gov/medication-assisted-treatment/qualify-nps-pas-waivers
SBIRT

Clinical Resources

The resources below will help your clinic implement SBIRT

Clinic Tools
Find the WASBIRT-PCI provider card, a clinic flowchart diagram, information on the brief interventions, motivational interviewing, and referral to treatment, as well as links to SBIRT materials to use with patients.

Screening Forms
Find English and Spanish versions of the prescreens and full screens for alcohol (AUDIT), drugs (DAST), depression (PHC9), and anxiety (GAD7).

Training
Find SBIRT trainings being offered throughout the state and online.

Reimbursement
Review the latest information from the Health Care Authority on SBIRT billing and reimbursement instructions. Find links to other relevant SBIRT billing and reimbursement materials.

For Grantee Clinics
For WASBIRT-PCI grantee: quick links to SPAR and Tumbleweed, as well as the latest training manual and the Clinic Flowchart including QPR requirements.

http://www.wasbirt.com/content/clinical-resources
The initiative was met with enthusiasm by supervisors and direct line staff alike. We now have a comprehensive plan to focus on supervisory professional development, which has been endorsed by both senior leadership and middle management staff and communicated to all levels of the agency. This has resulted in a range of very significant outcomes, including increased job satisfaction for supervisors and staff.

Resources

The Yale Program on Supervision provides a range of tools, instruments, forms, competencies, and reference lists for your use. Click on the links to access these resources.

Recommended Books on Supervision
- David Powell provides a list of the best books on supervision, including classic texts, volumes on special topics such as ethics, and discipline specific guides. [download]

Tools for Assessing Supervisors
- This resource identifies the tools that can be used to assess supervisors and the quality of supervision they provide. It includes supervisee assessments of supervision. [download]

Tools for Assessing Supervisees
- This document contains a list of instruments you can access to assess the competencies of direct care staff, counselors, and therapists. It includes generic and discipline specific tools. [download]

Tools for Documenting Clinical Supervision
- Forms to document supervision and informed consent for supervision are included in this resource. [download]

Contracting Agreements for Supervision

http://supervision.yale.edu/resources/index.aspx
Transforming Healthcare Practices Across Washington

Better clinical outcomes, patient satisfaction, lower costs, and greater professional reward.

LEARN ABOUT PRACTICE TRANSFORMATION

http://www.waportal.org/
My practice type is...

BEHAVIORAL HEALTH  PRIMARY CARE

My role...

BACK OFFICE  CARE MANAGERS  EXECUTIVES  NURSES  PATIENTS  PRACTICE MANAGER

PRIMARY CARE PROVIDER (PHYSICIAN, ARNP, OR PA)  PSYCHOLOGIST/MENTAL HEALTH/PSYCHIATRISTS  QI AGENTS

REGIONAL CONNECTORS  SOCIAL WORKERS  SUPPORT STAFF

Filters

Practice Transformation  New Payment Models  Integration of behavioral and physical health  Resource type

Make a selection  Make a selection  Make a selection  Make a selection

Resource type

Integration models  Resources required

22 resources match your criteria

- Defining Behavioral Health and Primary Care Integration
- Collaborative Care Implementation Guide
- A Guide to Integrating Behavioral Health in a Primary Care Setting
Welcome to the Healthier Washington Practice Transformation Support Hub Spring Learning Series

About the Spring Learning Series

The Healthier Washington Practice Transformation Support Hub has partnered with the University of Washington AIMS Center to provide a free spring learning series on Bi-Directional Integration for Behavioral Health Agencies and Primary Care Practices. Led by faculty and staff at the AIMS Center, this series will be broken into tracks that are uniquely tailored to address integration in a behavioral health or primary care setting.

- About the Coaches and Staff
- About the Tracks
- About the Funder

Joining the Learning Series

Registration for the Spring Learning Series is now closed. If you are interested in participating in future training offerings, please send an email to hubaims@uw.edu.

http://www.waportal.org/learningseries
Clinician Burnout in Care for Complex Patients

Resource summary
This article evaluates self-reported clinician burnout and satisfaction in care for complex patients in the Care of Mental, Physical and Substance-Use Syndromes (COMPASS) initiative.

Burnout remains a problem for primary care clinicians and is associated with low job satisfaction and low satisfaction with resources to treat complex patients. A collaborative care model for patients with mental and physical health problems may provide the resources needed to improve the quality of care for these patients.

This resource examines:
- Clinician burnout and satisfaction with resources in caring for complex patients.
- Burnout associated with lower career satisfaction
- Lower satisfaction with resources to treat complex patients
- Clinicians evaluating their ability to treat complex patients.

How did these resources get selected?
Learn about Resource Curation

Tell us about your experience!
Take our quick survey

Tags
Practice Organization, Team Based Care
Transformation Support?
Sign up here
Other Info Available

• Materials on Team-Based Care Models

• MACRA and New Payment Models

• Free on-site coaching
Healthier Washington Practice Transformation Support Hub

- The Hub provides coaching, technical assistance, and tools to help small- to medium-sized practices (20 or fewer providers) and behavioral health agencies with practice transformation.

- Hub resources address needs around integrating physical and behavioral health, promoting clinical-community connections, and transitioning from volume-based to new value-based payment models.

- [https://www.hca.wa.gov/assets/program/Hub-faqs.pdf](https://www.hca.wa.gov/assets/program/Hub-faqs.pdf)
Healthier Washington Practice Transformation Support Hub

Know of a great resource that should be housed on The Portal? Have Questions?

Email portal@uw.edu

The project described was supported by Funding Opportunity Number CMS-1G1-14-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.
Other State Models
Connecticut

- Funded through Mental Health Transformation State Incentive Grant
- To improve access to MH
- In the Resource Center, links and reports
  - http://www.cwcbh.org/resource_center/links_and_reports/
Nebraska

- Established by state legislature in 2009
- To improve access to BH through skilled workforce
- Summaries
  - Webinar: https://www.youtube.com/watch?v=kKbcCBpa_TW&feature=youtu.be
Alaska

- Alaska Health Workforce Coalition
  - Public-Private Partnership
  - Merged with Alaska Mental Health Trust Authority’s Workforce Focus Area and partners
  - Created “Action Agenda 2012 – 2015”
  - Action Agenda 2017 – 2021 currently being drafted

- Summary of Activities:
  - Alaska Training Cooperative
  - Regulatory advocacy
  - Health Career and Technical Education Programs
  - Career Pathways (AHEC)
  - SHARP Support-for-Service incentive programs
Alaska’s SHARP Program

- **Support-for-Service (SfS) Program**
  - Loan Repayment
  - Direct Incentive
    - Better for those who have no loans, mid-to-late term providers
  - Total 254 clinician-contracts across dental, medical, and behavioral health settings

- **SHARP-1 = SLRP**
  - Limitations: Work in HPSAs, only primary care clinicians

- **SHARP-2 = state (SfS) program**
  - Limitations: vulnerable to shortfalls in state revenues
Alaska’s SHARP Program

- SHARP-3 = start (CY’17).
  - Formal announcement of SHARP-3 is planned for this year (CY’17).
  - Funding will principally come from the employers and a consortium of other contributors including private foundations, trade associations, government entities, hospital and community foundations, and other sources.
  - SHARP-3 will not require that clinicians serve in federally designated HPSA locations.

Washington

- Funded through WA DSHS

Evidence Based Practices for Adults

What We Do

First Episode Psychosis (FEP)
Approximately 100,000 adolescents and young adults in the United States experience First Episode Psychosis (FEP) each year (calculated from McGrath, Saha, Chant, et al., 2008). With a peak onset occurring between 15-25 years of age, psychotic disorders such as schizophrenia can derail a young person’s social, academic, and vocational development and initiate a trajectory of accumulating disability.

Cognitive Behavioral Therapy for psychosis (CBTp)
Cognitive Behavioral Therapy for psychosis (CBTp) is an individualized, first-line intervention for adults with schizophrenia and other serious mental illness (Kingdon & Turkington, 2005; Wood et al., 2013). Despite an evidence base that spans more than 20 years, CBT for psychosis is not widely available in community mental health settings in the United States. Nationally, it’s estimated that only 0.1% of all licensed clinicians in the United States are trained in CBTp (Mueser & Noordsy, 2015), and no national standards exist by which to gauge use and proficiency.

Program for Assertive Community Treatment (PACT)

Other Areas of Training and Consultation in Evidence-Based Practice

http://depts.washington.edu/ebpa/projects
Washington

https://www.youtube.com/channel/UCQfrw5zAcXyZzfdEITQF9NA/videos