# Behavioral health workforce strategy

Department of Health Care Access and Information (HCAI)

**SEPTEMBER 17, 2024**

# California will need to grow its behavioral health workforce to reach all Californians

## California's behavioral health workforce is under significant pressure…

- **Workers leaving the field** or choosing to take private pay, driven by **burnout** & **desire for flexibility**
- **Increased burden of physical & behavioral care** after pandemic
- Mix of **staffing shortages & maldistribution** exacerbating challenges
- Existing workforce does not reflect the **diversity of California** in terms of race, ethnicity, and languages spoken
- Professionals experiencing **financial challenges**
- **Longstanding shortages** while demand continues to increase

## … which ultimately limits access to affordable health care for Californians

Shortages & provider challenges result in:

- **Limited availability of behavioral health providers in network,** limiting access for those who can't afford to pay out of pocket
- **Increased costs** passed on from professionals and insurance coverage gaps increasing the real cost paid by consumers
- Compromised **quality of care**, e.g., due to reduced behavioral health professional engagement
- Access further constrained by **geography, ability to pay, & cultural competency**

Non-exhaustive

# HCAI is committed to expanding and diversifying the behavioral health workforce

HCAI enables the expansion and development of a **behavioral health workforce that reflects California's diversity in order to address supply shortages and inequities**, by administering programs and funding and generating actionable data.

A **statewide behavioral health workforce strategy** is essential because no single organization or agency can solve workforce challenges alone.

By uniting with **common goals, actionable data, prioritization, and coordination** across organizations and sectors, we can achieve **greater impact.**

# HCAI is developing a data-driven statewide strategy to address gaps in California's behavioral health workforce

## Purpose

*Support the State to understand and equitably solve the supply/demand gap in behavioral health services & better serve Californians*

## Approach

**Supply & demand modeling: Involves the design, architecture, and build of an analytical tool** that can be continuously improved and expanded based on new and emerging data

**Strategic planning**: A **data-driven** strategy that identifies **innovative and tested best practices** to resolve persistent workforce gaps and inequities, and creates **tailored intervention bundles** to target specific challenge and opportunities

**Stakeholder engagement: Significant stakeholder consultation** and **collaboration with experts inside and outside of government, including health workers;** ongoing validation and refinement of our strategy, shaped by evidence and experience

# Our behavioral health workforce supply and demand model aims to…

- **Quantify** the extent of challenges we know & address future-facing shortages and inequities before they emerge
- Drive **better and more targeted decision-making** for our funds and programs based on the **greatest gaps by role & geography**
- **Identify opportunities for collaboration** with other institutions and partners to solve identified gaps by informing shared priorities
- Track **progress on state equity goals** (e.g., racial and linguistic representation, Medi-Cal acceptance) and **address disparities**
- Position HCAI as a **go-to source** for the health workforce supply and demand; serve as an **exemplar within California and nationwide**

It is important to recognize that **all models have limitations, and no forecast of the future is guaranteed to be fully accurate…**

## … but we've stuck to a few key tenets in our modeling that give us confidence in the results

Our model methodology & assumptions are **informed by existing & well-substantiated approaches to workforce modeling**

We've been **guided by input from a diverse array of experts** (including health workers) to ensure we are grounded in actual practice

Where data were unavailable or imperfect, **we've made reasonable assumptions that we have vetted and tested** with a range of stakeholders

We are **not evaluating the results in a vacuum**, but alongside qualitative input from stakeholders and additional supporting data

***Note: Inputs & assumptions in model are being continuously refined; we have confidence in our initial outputs but specific results may be adjusted over time***

# The behavioral health ecosystem is complex; many different roles provide critical care and support services

Psychiatrist
Clinical Social Worker
Licensed Educational Psychologist
Marriage and Family Therapist
Professional Clinical Counselor
Psychologist
Psychiatric Mental Health Nurse Practitioner
Psychiatric Technician

***Licensed Behavioral Health Clinicians***
*(examples, not exhaustive)*

Peer Personnel
Substance Use Disorder Counselor
Certified Wellness Coach

***Certified Roles***
*(examples, not exhaustive)*

Nurse
Primary care clinician

***Other Medical Roles***
*(examples, not exhaustive)*

Community Health Worker
Residential Mental Health Counselor
School Mental Health Professional
Pharmacist
Mental Health Rehab Specialist
Case Manager
Occupational Therapist
Other Qualified Professionals

***Allied Health Professionals / Other Qualified Professionals***
*(examples, not exhaustive)*

Consist of health care related professions that **provide a range of diagnostic, therapeutic, technical work and support services** distinct from or facilitating that of physicians and other specialists in the health care system; they are **vital in the BH ecosystem** in ensuring client centric care and delivery[1]

***Illustrative, non exhaustive or exclusive (roles can fit into other categories)***

1. "Allied Health Services", National Institute of Health

# We deeply examined 14 roles in our BH supply and demand model – more will be added over time as data becomes available

***Non-prescribing licensed clinicians ("BH-L")***[1]

- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Licensed Professional Clinical Counselor
- Psychologist

***Associate-level clinicians ("BH-A")***[1]

- Associate Clinical Social Worker
- Associate Marriage and Family Therapist
- Associate Professional Clinical Counselor
- Registered Psychological Associate

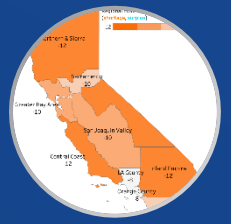
- Licensed Educational Psychologist
- Psychiatrist
- Psychiatric Mental Health Nurse Practitioner (PMHNP)
- Substance Use Disorder Counselor (SUDC)
- Peer Support Specialist (PSS)
- Certified Wellness Coach (WC)

**Note:** The behavioral health professional ecosystem is especially complex, with many additional roles (e.g., MHRS, OTs, other qualified professionals, etc.) playing an important part in the care team & being critical to a well-functioning delivery model

***Given the lack of sufficient data on these roles today, they have not been modeled in this version of the tool; however, these roles will be considered in our strategic interventions and are prioritized on our roadmap for future inclusion & data collection***

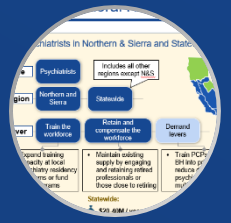
1. In supply/demand modeling, demand for this set of roles has been calculated overall (combined) due to overlapping scopes of practice; supply results remain distinct across each role

# Summary of findings | Behavioral health workforce strategy (1/2)



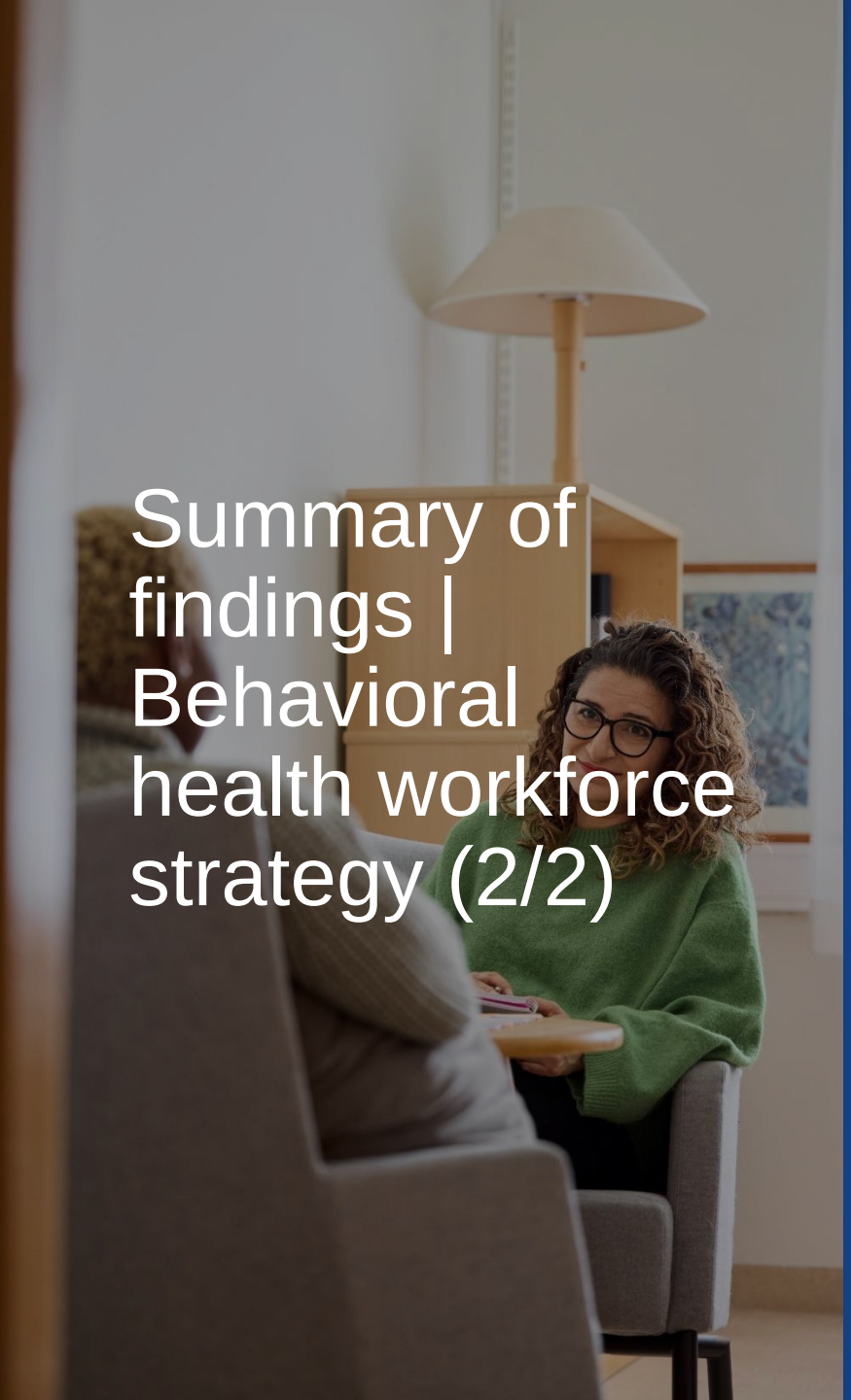
**All behavioral health roles** examined have a **statewide shortage** with highest absolute shortage numbers in **non-prescribing licensed behavioral health clinicians**[1] and most severe shortages in **Northern & Sierra and San Joaquin Valley regions.** There are **racial and linguistic disparities** and **lower access** for certain populations.

Many licensed behavioral health professionals across California are also **unable to work at the top of their license due to a lack of supporting allied health professionals**, for which data is severely lacking *(potential area for HCAI to collect data).*




HCAI should take a **multi-pronged approach to supporting the behavioral health workforce**, including significant investments in **expanding training capacity, clinical supervision opportunities, scaling allied health roles, and retention initiatives,** with a focus on equity to ensure the workforce reflects California's diversity.

1. Includes LMFT, LCSW, LPCC, Psychologist



# Summary of findings | Behavioral health workforce strategy (2/2)

HCAI should continue to **enable data collection and sharing about the behavioral health workforce**, especially as it pertains to allied health roles, and new / emerging roles.

Going forward, **HCAI remains committed to exploring innovative solutions** (e.g., supporting emerging roles) and understanding the important changes happening in behavioral health as professionals and care delivery models shift.

There are also **several interventions outside of HCAI's scope** that will be required to achieve workforce and access goals, such as improving financial incentives, reducing friction and burnout in the workplace, and reassessing educational and training requirements

# Summary | Model findings on **roles**

**All roles affected**: Every behavioral health role examined faces a shortage (supply-demand gap) across the state

**For example:**

- Non-prescribing licensed clinicians[1] face a 37% supply/demand gap statewide, with this gap forecasted to widen
- Associate-level clinicians and psychiatrists both experience a 38% gap; while this gap is forecasted to improve, the gap for psychiatrists is forecasted to worsen
- Substance use disorder counselors face a 18% shortage, with gap forecasted to continue

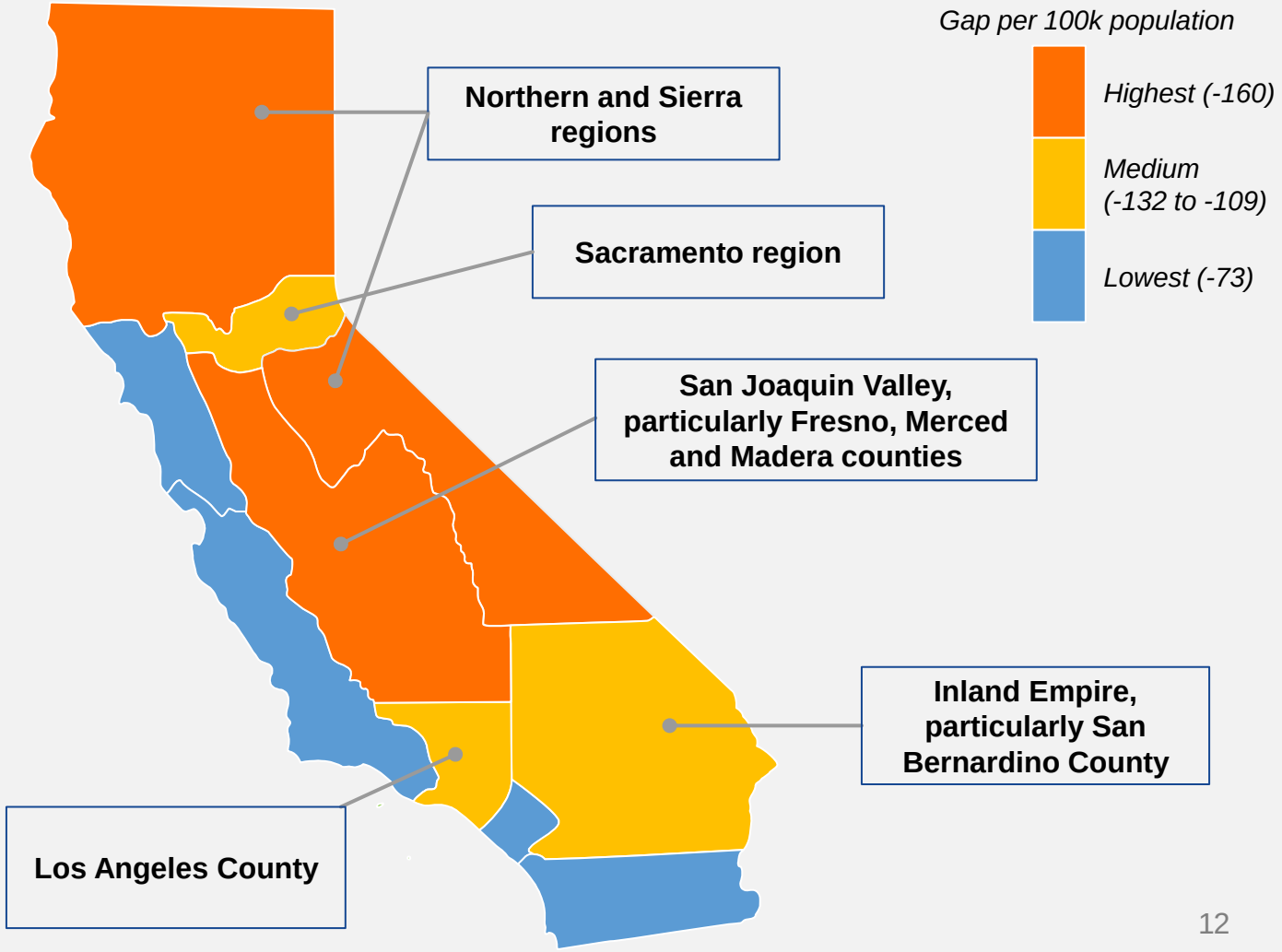
**Data Gaps**: Allied health professionals play critical roles in behavioral health care; however, there is insufficient data to include most of these roles in a supply/demand model, so will be analyzed separately

1. LCSW, LMFT, LPCC, and Psychologist

# Example | How supply/demand model can be used to identify **regional shortages for specific roles**

*All regions & roles have a **behavioral health workforce shortage***

**Example: Non-prescribing licensed clinicians[1] workforce shortage areas**
*(all counties and regions face a behavioral health workforce shortage across roles)*




1. LCSW, LMFT, LPCC, and Psychologist

From the model results, some role x geography combinations had especially severe shortages, while all roles had statewide shortages

We used these combinations to tailor solutions based on shortage drivers and mitigating interventions

**Role / geography combinations with especially severe shortages**

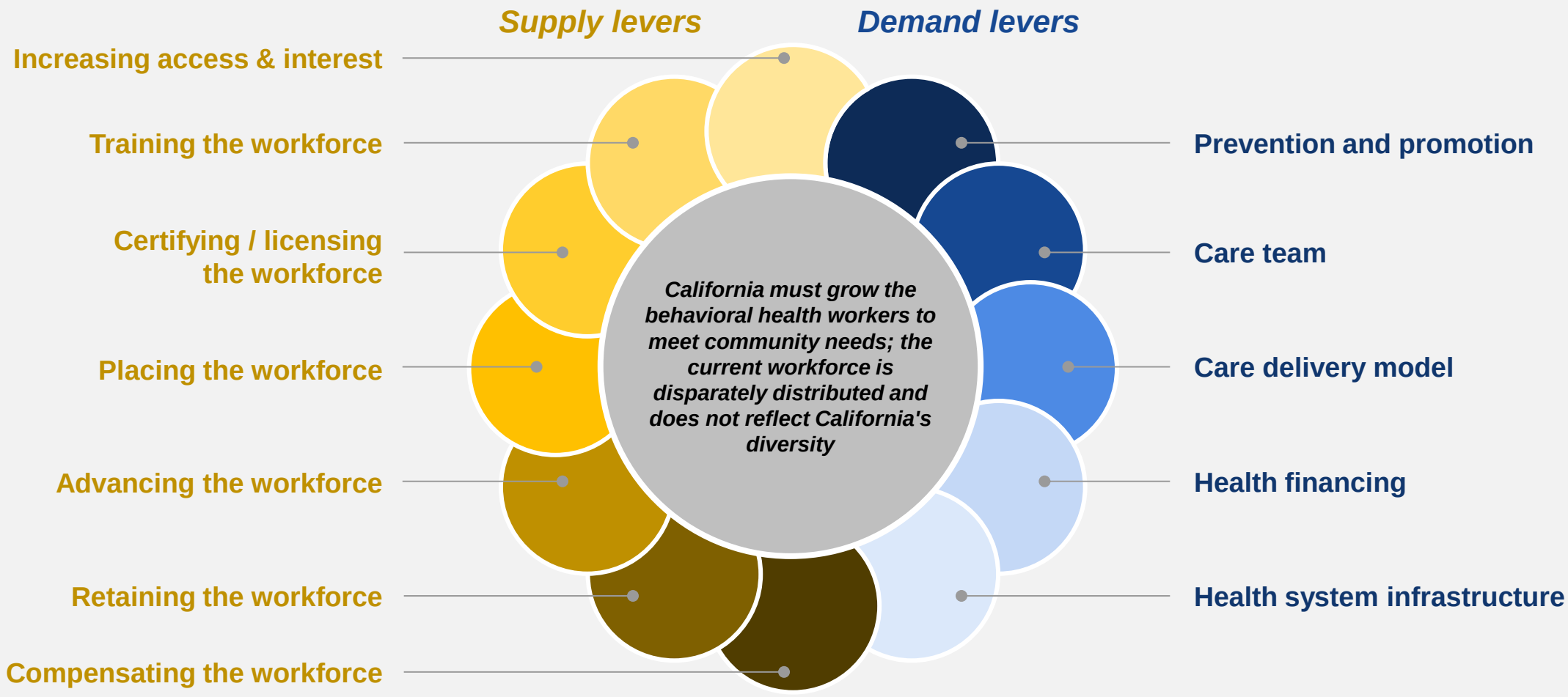
- **Non-prescribing licensed professionals** – *Northern & Sierra regions and San Joaquin Valley*
- **Psychiatrists** - *Northern & Sierra regions*

**Roles with statewide shortages**

- **Psychiatric Mental Health Nurse Practitioners** – *statewide*
- **SUD Counselors** – *statewide*
- **Peer Support Specialist** – *statewide*
- **Non-prescribing licensed professionals** – *remainder of state (Sacramento, Inland Empire, LA County, Greater Bay Area, Central Coast, San Diego Area, Orange County)*
- **Psychiatrists** – *remainder of state (Sacramento, Inland Empire, LA County, Greater Bay Area, Central Coast, San Diego Area, Orange County, and San Joaquin Valley)*

*In addition, while our model did not include them, we are considering the role of other allied health roles as a critical part of the behavioral health ecosystem*

# We engaged with a range of stakeholders to develop **levers that HCAI and others can pull** to address the identified gaps




*Supply levers aim to increase and diversify the health workforce*

*Demand levers aim to optimize demand, by improving workforce utilization*

# HCAI can directly lead or work with others to implement critical state-wide interventions

**Expand educational capacity, particularly in public education institutions and underserved areas**

**Expand clinical supervision –** A significant share of Master's level graduates do not achieve licensure, in part due to lack of clinical supervision opportunities[1]

**Recruit and retain faculty, e.g., through incentives**

**Lower barriers to training –** Through scholarships and non-financial completion supports (e.g., childcare, living accommodation, transportation); potentially linked to service obligations

**Recruit / retain behavioral health professionals in targeted settings –** Through tuition reimbursement, loan repayment with service obligation, or financial incentives to remain long term (e.g., stipends, bonuses)

**Integrate behavioral health into primary care:** PCPs play an extremely critical role in the behavioral health ecosystem, and primary care teams should be trained on how to treat behavioral health conditions, especially in underserved areas

In addition, there are interventions outside of HCAI's scope that may be required to achieve workforce and access goals

Not exhaustive

## Stakeholders identified the following critical interventions:

***Financial incentives***

- Increase **reimbursement rates**
- Improve **compensation for professionals**, and competitive benefits (e.g., living wage, childcare)
- Lower **tuition** to make programs more accessible to low-income students

***Work settings***

- Reduce **professional : client ratios** to reduce burnout
- Where appropriate, increase **usage of telehealth** for professionals and clients[1]
- Offer more **part-time** opportunities and **flexible work schedules**

***Education, training & scope***

- Reduce **administrative barriers** statewide (e.g., streamline billing)
- **Standardize pre-requisites** across schools
- Develop **clear career pathways** (e.g., upskilling from certified to licensed roles) and **stackable credentials**
- Expand **scope of practice** (e.g., expanding PMHNP responsibility)
- Modify **curricula** to allow for more time in the field & prepare trainees to work in safety net settings

1. Telehealth may not always be useful or appropriate based on client needs and other factors

# Next steps

We will continue to refine the model over time to incorporate new data and methodology

We will continue to incorporate input from our behavioral health partners and agencies across the state

We will present additional results at future forums, such as the Health Workforce Education and Training council – next meeting scheduled for November 4 and 5

# We welcome your feedback

If you would like to share feedback on these materials, please email with your input: **behavioralhealthworkforce@hcai.ca.gov**

*We are releasing the state strategy that will guide this investment for public comment and that we expect will be included in next year's budget. That plan can be found at https://hcai.ca.gov/workforce/initiatives/behavioral-health-transformation-proposition-1/*