The Mental Health Workforce Shortage in Texas

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Executive Summary

Nationally, 46.4 percent of adults experience mental illness at least once in their lifetime and 26.2 percent of adults experience mental illness annually. (Hogg Foundation for Mental Health, 2011). In Texas, over 25 percent of surveyed adolescents reported negative emotional states within the previous 12 months and over 20 percent of adults reported poor mental health in the 30 days preceding the survey. Despite this established need, a mental health workforce shortage is evident nationwide.

The 83rd Texas Legislature passed a series of bills to help address the state's mental health infrastructure and payment and delivery systems. Among them was House Bill (H.B.) 1023, which charged the Texas Health and Human Services Commission (HHSC) with making recommendations regarding the state's mental health workforce shortage. HHSC designated the Department of State Health Services (DSHS) with fulfilling H.B. 1023's requirements. Using existing information and data, DSHS conducted a review of the causes and potential solutions for mental health workforce issues across Texas and the nation. The Department conducted a literature review and sought out information from stakeholders, including: the Statewide Health Coordinating Council, mental health care providers, advocacy organizations, and professional organizations. These efforts revealed five possible key themes for state consideration in policymaking:

1. **Increasing the size of the mental health workforce** – At its core, the mental health workforce shortage is driven by factors that affect recruitment and retention of individual practitioners. Chief among these factors, as studies and stakeholders suggest, is that the current payment system fails to provide adequate reimbursements for providers, especially in light of the extensive training necessary for practice. Furthermore, more students may be attracted to the mental health professions by strengthening graduate medical education and by exposing them to opportunities in the mental health field earlier in their education. Finally, maximizing the capacity of the mental health workforce could benefit from expanding roles of providers responsibly within their scope of practice, with appropriate treatment tools available to them.

2. **Improving the distribution of the mental health workforce** – Access to care is differentially distributed across the state. Often, rural and border populations experience greater impacts from the mental health workforce shortage than do urban populations. One approach to consider is increased focus on targeted development and recruitment of rural mental health providers that may be expanded to address these needs. Additionally, the state could consider methods to increase the practice of tele-mental health services.

3. **Improving the diversity of the mental health workforce** – Due to Texas' diverse population, it is important that the workforce include sufficient providers to address the cultural, ethnic, and linguistic needs of the individuals receiving care. Evidence suggests that educational pipeline programs and the state's Joint Admission Medical Program have been successful. The expansion of such programs, aimed at producing mental health providers, is a possible consideration. Additionally, the state may consider policies that encourage international medical graduates to practice in the state, and educational

institutions to equip providers with the necessary tools to treat the state's diverse population.

4. **Supporting innovative educational models** – Recent health care system changes have challenged providers to be more innovative and efficient in their practice. These concepts include team-based care, patient-centered medical homes, and other innovations. The educational system will need to adapt its curriculum, produce more faculty with expertise in these new delivery models, and students with related clinical experience.

5. **Improving data collection and analysis** – Projects aimed at innovative delivery of mental health care have already been initiated as part of the Medicaid 1115 Waiver Delivery System Reform Incentive Payment (DSRIP) program and as a result of Senate Bill 58, 83rd Legislature, authored by Senator Jane Nelson. These projects may shed light on mental health workforce implications and potential scalability. There is also a gap in knowledge about the mental health care needs of the state's population and the actual capacity and productivity of its workforce. Additional data would help inform policymaking decisions.

Introduction

House Bill (H.B.) 1023, 83rd Legislature Regular Session, charged the Health and Human Services Commission (HHSC) with submitting a report to the Legislature providing policy recommendations for addressing Texas' mental health workforce shortage. HHSC subsequently delegated this task to the Department of State Health Services (DSHS). The recommendations included in this report were developed in consultation with programs within DSHS and HHSC, the Statewide Health Coordinating Council, and other nongovernmental entities with expertise in mental health workforce issues.

Background

Nationally, 46.4 percent of adults experience mental illness at least once in their lifetime and 26.2 percent of adults experience mental illness annually. On an annual basis, 5.8 percent of adults in the U.S. experience a serious mental illness[1] (Hogg Foundation for Mental Health, 2011). Moreover, the aging of the U.S. population requires behavioral health service providers with special knowledge and skills (Hoge, et al., 2013).[2]

Nationwide, 39 percent of persons with mental illness and 10.8 percent of persons with substance abuse issues receive needed mental health treatment (Hoge, et al., 2013). A national study conducted by the Center for Studying Health System Change found that 66.8 percent of primary care physicians were unable to refer their patients to high quality mental health specialists. This is a far higher rate of unavailability than those seen for other specialty referrals, nonemergency hospital admissions, or high quality imaging services (between 17 and 34 percent). The study attributed unavailability to either inadequate health insurance coverage or a shortage of mental health providers (Cunningham, 2009).

Workforce-based explanations for a lack of mental health and substance abuse providers at-large generally focus on insufficient numbers of mental health providers, high turnover (a national average of 18.5 percent annually), low compensation, minimal diversity, and the need for accelerated adoption of new evidence-based treatments (Hoge, et al., 2013).

Describing these shortages quantitatively can be problematic as relevant data have not been universally collected and there is no consensus regarding what constitutes adequate supply. However, efforts to describe the mental health workforce shortage should consider both the population's need for mental health services and the number of practitioners available to provide these services (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Finally, despite the Patient Protection and Affordable Care Act's (PPACA) effort at expanding access to medical care, populations living in areas affected by a mental health workforce shortage will likely continue to have insufficient access (Cunningham, 2009). This is in part due to the expectation that PPACA will raise demand for services and thus exacerbate the practitioner shortage (Kirch, Henderson, & Dill, 2012).

As a means of addressing the nation's mental health system problems, President George W. Bush convened the President's New Freedom Commission in 2002. The Commission's 2003 report called for the large scale transformation of the U.S. mental health care system into a consumer-centered system focusing on recovery and delivering excellent care without disparities. Such a transformation demands the vast expansion of the workforce through training and initiatives aimed at the redistribution of duties among providers (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009).

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[1] In this paper, a serious mental illness was defined as one involving a serious attempt at suicide, substantial limitation of work capabilities due to mental or substance disorder, psychosis, bipolar I or II, substance dependence with serious role impairment, a seriously violent impulse control disorder, or any mental disorder resulting in 30+ days of limited capacity in the past year (Kessler, Chiu, Demler, & Walters, 2005).

[2] This report uses the terms 'mental health' and 'behavioral health' synonymously.

Texas' need for mental health services
As noted above, one part of describing a workforce shortage involves demonstrating the needs of the population for mental health services. A standard definition of mental health need is not available locally or nationally.

Children and adolescents
As of February 2014, no reliable statewide survey data on mental health needs existed for children younger than high school age. However, data demonstrate conduct/oppositional defiant disorder (13 percent) and depression (11 percent) were among the most common diagnoses among children receiving services from DSHS' Mental Health and Substance Abuse Division.

Data from the DSHS Texas Youth Risk Behavior Surveillance System's (YRBSS) representative sample of 9th through 12th graders provide a baseline for establishing adolescent need for mental health services in Texas. Results from 2013 indicate that 28.3 percent of Texas' public and charter high school students reported feeling sad or hopeless almost every day for a two week period within the 12 months prior to being surveyed, similar to the national level. The proportion of females (36.8 percent) reporting these feelings was significantly higher than that of males (20.2 percent). Moreover, 16.7 percent of teens reported seriously considering a suicide attempt and 15.1 percent had a plan for how they would commit suicide. Rates for both of these measures were significantly higher among females than males. Finally, 10.1 percent of teens reported attempting suicide in the past year and 3.5 percent of teens had required medical intervention after doing so, with no significant differences between males and females. None of the above measures show any significant differences by race/ethnicity or grade level (Center for Health Statistics, 2013).

Adults
With respect to adults, DSHS' Texas Behavioral Risk Factor Surveillance System (BRFSS) reports that in 2012, 20.4 percent of adults reported having poor mental health for five or more days in the past 30 days. Additionally, the percentage of females (23.4 percent) reporting five or more days of poor mental health was significantly higher than that of males (17.3 percent). Significantly fewer college graduates reported poor mental health for five or more days (13.8 percent) than did those with some college education (21.9 percent), high school graduates (20.8 percent), and those with some high school education (25.7 percent). Likewise, the proportion of people with five or more poor mental health days was lower among those making more than $50,000 annually (14.0 percent) than those making $25,000 to $49,999 (20.0 percent) and those making less than $25,000 (29.2 percent) (Center for Health Statistics, 2012).

Texas' mental health workforce
In addition to patient need, a shortage of providers determines the insufficiency of the mental health workforce[3]. The supply of providers can be conceptualized as being composed of two broad determinants. The first is the entire number of practitioners qualified to serve in mental health and the second is the number of these committed to providing patient care and the

[3] Mental health provider data from DSHS' Health Professions Resource Center appears in Appendix 1. More information on these data can be found at: http://www.dshs.state.tx.us/chs/hprc/health.shtm. Broadly, this report defines the mental health workforce as licensed individuals who primarily provide mental health and substance abuse services. Additionally, this report introduces some data on the state's emerging peer support providers.

percentage of their productive time committed to doing so (Murphy, et al., 2012). The state's shortage of supply is expected to worsen as many of the most skilled practitioners are nearing retirement age. At the same time, the state and the nation's educational institutions are not producing enough new graduates to meet predicted demand. Given the nationwide shortage, it is unlikely that Texas can meet its staffing needs by recruiting practitioners from other states (Thomas, Ellis, Konrad, & Morrissey, 2012) and the extent of the mental health shortage is expected to worsen as the workforce continues to age (Hogg Foundation for Mental Health, 2011).

In addition to a shortage of providers, other sociodemographic factors contribute to the state's inadequate mental health workforce. For example, providers are not distributed evenly across the state resulting in differential access to care by region, especially in rural areas and along the border. Further, the provider workforce does not reflect the state's growing ethnic diversity resulting in the continued need for culturally competent mental health care.

A synthesis of workforce studies has identified five areas that may be targeted (Buerhaus & Retchin, 2013; Hogg Foundation for Mental Health, 2007). First, the state shortage of mental health providers may be addressed through improved employee recruitment and retention and the reorganization of service delivery. Second, there is a chronic maldistribution of the state's workforce requiring greater attention to the needs of rural and border areas. Third, the state's workforce will require greater cultural and linguistic diversity to serve its population. Fourth, the educational curriculum for health professionals should be reevaluated and updated in light of evolving advancements in health care. Fifth, there is currently an insufficient quantity and quality of data at the state and national level to fully inform workforce planning initiatives. A literature review reveals possible policy options for consideration in each of these five areas. The result of this literature follows, and is organized according to each of the five identified themes.

Section 1 – Increasing the size of the mental health workforce

As noted above, studies looking at the widespread and ongoing mental health workforce shortage have been centered on five categories of action. The first and most direct means of addressing the shortage is to increase the number of mental health care providers relative to the population. In this section are five core options that research suggests may improve the recruitment, retention, and deployment of mental health care providers.

Address payment disparities

In a response to DSHS' call for stakeholder recommendations, a consensus emerged among mental health advocacy groups, professional organizations, and health care providers: the payment/reimbursement system for mental health care services is insufficient and serves as a barrier to practice.

Among physicians, national studies have demonstrated that psychiatrists are significantly less likely to accept insurance than other specialty types and that the percentage of psychiatrists accepting insurance declined 17 percent between 2005-2006 and 2009-2010 (Bishop, Press, Keyhani, & Pincus, 2014). A health care staffing firm's 2012 national survey of physicians showed that just 57 percent of adult psychiatrists were then accepting new Medicare patients, lowest among all specialties. Further, just 47 percent of adult psychiatrists were accepting new Medicaid patients, second lowest among all specialties (Jackson Healthcare, 2012). The same report indicated that of physicians leaving the practice of medicine, over half do so for economic reasons. Data from a national survey of physicians listed psychiatrists as the specialty least likely to accept new Medicaid patients and demonstrated that they did so at a rate that was lower at a statistically significant level compared to other specialties (Decker, 2013). In Texas, 33.6 percent of adults with serious and persistent mental illness received services through the community health system, due in part to the shortage of physicians accepting Medicaid (Hogg Foundation for Mental Health, 2011). Studies commonly attribute payment disparities between mental health providers and other practitioners to differential reimbursement structures that fail to account for the increased amount of time that mental health providers spend with patients (Bishop, Press, Keyhani, & Pincus, 2014).

The Texas Medical Association, the Federation of Texas Psychiatry, and the Texas Pediatric Society (TMA, FTP and TPS) jointly authored a letter calling the issue of low reimbursement rates 'the elephant in the room' when addressing the mental health workforce shortage. The Hogg Foundation for Mental Health similarly indicates that without addressing reimbursement rates across mental health provider types 'the shortage is destined to continue and ultimately increase exponentially'. As the Texas Counseling Association (TCA) points out, current reimbursement rates for licensed professional counselors, clinical social workers, marriage and family therapists, psychologists, and psychiatrists often fail to match provider costs when providing individual therapy. This same call is repeated by the National Association of Social Workers – Texas Chapter (NASW/Texas).

Several groups, including TMA, FTP, TPS, TCA, and others, have noted the complex administrative and bureaucratic procedures necessary to manage the reimbursement process. They suggest Texas should streamline its own processes and work to minimize the bureaucratic impacts of federal demands on the state's mental health workforce.

The Statewide Health Coordinating Council (SHCC) intends to consider payment and delivery system innovation in its forthcoming 2015 Update to the State Health Plan, to be presented to the Governor by November 1, 2014.

Expand practice incentives for mental health practitioners

Best practices in recruiting and retaining a workforce of specialists include early exposure to career opportunities in the field and the special populations served; mentoring by behavioral health specialists; training stipends; minority fellowships; loan repayment programs; and the development of career ladders. Paying wages commensurate with the education, experience, and responsibility required of such specialists appears to be a primary factor in the success or failure of recruitment and retention efforts (Hoge, et al., 2013). The Hogg Foundation for Mental Health (2011) has previously recommended that the state work to increase the number of intern sites across professions and address the problems of inadequate pay and reimbursement in the public system. TMA, FTP, and TPS suggest the introduction of a preceptorship program whereby medical students might interact and rotate with doctors in DSHS facilities. Some community mental health centers have also proposed stipend or subsidy programs to realize the potential these programs have in training and employing mental health care providers.

The SHCC has recommended revising the State's Physician Education Loan Repayment Program and Texas Higher Education Coordinating Board (THECB) rules to prioritize loan repayment funds for psychiatrists and primary care practitioners serving in state-supported living centers and state hospitals and those involved in patients' care after transition to community-based care from these facilities. Similarly, TMA, FTP, and TPS have supported expanded loan repayment and forgiveness programs that might be structured to attract psychiatrists to rural and other practice settings with less existing infrastructure and professional support. More broadly, NASW/Texas proposed the establishment of loan forgiveness and tuition reimbursement programs for social workers and all other mental health providers. Likewise, the Texas Hospital Association (THA) has called for incentives to recruit potential mental health professionals at all levels into the field.

Additionally, the SHCC has recommended that DSHS work with THECB and other relevant stakeholders to research and analyze factors discouraging current and future practitioners from selecting psychiatry as their medical specialty. TMA, FTP, and TPS make a similar recommendation, suggesting DSHS employ surveys of medical students and psychiatrists to identify perceived barriers to practice.

Increase higher education funding for mental health fields

Nationwide, the robust expansion of graduate medical education has the most potential to bolster the supply side of the physician workforce strategies, yet the availability of funded residency slots remains a concern (Kirch, Henderson, & Dill, 2012). There has been no substantial increase in the number of graduate medical education residency training positions since the 1997 federal Balanced Budget Act (Kirch, Henderson, & Dill, 2012). Yet more residency positions in psychiatry are needed and their funding needs to be made more secure (Roberts, et al., 2013).

Within Texas, there is a ratio of 13,794.4 Texans per actively licensed psychiatrist. Texas' current workforce of 1,933 psychiatrists will have to grow significantly over the coming years.

As of 2013, the State funded 469 psychiatric resident positions through ten universities across the state. While the number of such positions may require expansion in the future, 105 of these positions were vacant (22.4 percent vacancy rate) as of September 2013. As Texas seeks to improve its practice environment and generate more medical students to the field of psychiatry, TMA, FTP, and TPS recommend continuing to invest in ensuring Texas has the highest quality and most attractive residency programs and facilities.

In addition to reinforcing Texas' mental health residency programs for physicians, stakeholders emphasize continued support for the education of all mental health providers as important. NASW/Texas has drawn attention to the cost of education, the debt burden of mental health care graduates, and the relatively low pay of these providers. The Texas Association of Psychological Associates (TAPA) has also indicated the need to support public education programs.

As a result of federal funding mechanisms, rural community mental health centers often provide a narrow range of services in tightly defined catchment areas (Talbot & Coburn, 2013), but these might be expanded through the targeted use of internships and clerkships.

Initiate early recruitment practices

A review of educational pipeline programs targeted at minority students at an early age found positive outcomes for overall academic performance and enrolling in a health profession (U.S. Department of Health and Human Services, 2009). Locally, the Pathways Project, initiated by the Network of Behavioral Health providers in Houston, is engaged in identifying and implementing mechanisms to attract high school and undergraduate students to the health professions. This process begins with an awareness-building curriculum at the high school level and continues through special educational and experiential opportunities in post-secondary and graduate level educational programs. THA and NASW/Texas support the expansion these types of programs.

Further, research has shown that targeting graduate medical and undergraduate pre-medical students with specialty clerkships and curriculum tracks is effective in recruiting students into residencies of that specialty (Grobler, et al., 2009). As noted above, TMA, FTP, and TPS suggest the introduction of a preceptorship program whereby medical students might interact and rotate with doctors in DSHS facilities.

Responsibly expand the practice capacity of APRNs and other practitioners

Following the Annapolis Framework (SAMHSA's Action Plan on Behavioral Health Workforce Development), expanding the capacities and roles of other health care providers could also help ease the shortage. Research has indicated that existing practitioners may be deployed to more fully use their training and that each profession should be granted a maximum amount of reasonable responsibility. A physician would then provide a leadership role while working as a member of the health care team, with well-specified and defined tasks for each profession (Gorman & Brooks, 2009). For example, research has indicated the increased use of nurse practitioners and physician assistants has great potential to significantly address health care workforce shortages (Kirch, Henderson, & Dill, 2012). Texas has incorporated these approaches, assigning physicians to supervise and delegate to advanced practice nurses and physician assistants serving on the health care team.

Specific to mental health, the SHCC and THA have recommended altering the Texas Administrative Code § 411.472 to allow advanced practice registered nurses (APRNs) in psychiatric hospitals, under physician supervision, to conduct initial psychiatric evaluations and subsequent required patient examinations during the patient's first week of inpatient hospitalization. Consideration may also be given to amending Texas Health and Safety Code §572.0025(f) to allow for APRNs to admit patients into psychiatric hospitals voluntarily. Similarly, Texas lawmakers may consider changes to the Health and Safety Code §576.024 that allow APRNs to order patient restraint or seclusion, as necessary. These amendments would allow APRNs, under the delegation and with the concurrence of the supervising psychiatrist, to work as extenders in psychiatric hospitals in a way that is similar to their roles in other medical settings. Furthermore, this change could ease psychiatrists' workload and allow them to serve more patients, especially in the state hospital systems. Another possible alteration to the Texas Health and Safety Code §574.025 would be to allow APRNs to testify as experts in the field of mental health when requesting an order of protective custody, temporary commitment, extended commitment or court ordered medication.

Another potential opportunity to improve the delivery of substance abuse services is the increased adoption of Person-Centered Recovery Planning and the utilization of laypersons with the lived experience of recovery in the care process. The shifting focus of client-patient interaction is also being addressed through the greater use of unlicensed, certified practitioners like certified peer specialists (Hoge, et al., 2013). Peer specialist and recovery coach efforts may be able to promote better outcomes and reduce costs, and more research about the cost-effectiveness and cost-benefit of peer supports is warranted (Substance Abuse and Mental Health Services Administration, 2012). More than 20 states are now reimbursing certified peer specialists under Medicaid, while another 22 have indicated the intent to do so (Hoge, et al., 2013). Many mental health programs are not taking advantage of these professionals, due in part to limited employer awareness of the positive outcomes associated with their use. The Hogg Foundation for Mental Health (2011) has previously recommended that certified peer specialists be allowed to bill for their services.

TMA, FTP, and TPS support the expanded use of peer specialists as another member of the physician-centered, integrated care team. The Hogg Foundation, DSHS, and ViaHope continue to work together to promote the adoption of peer services in criminal justice facilities, emergency rooms, and community clinics, among other locations.

Section 2 – Improving the distribution of the mental health workforce across Texas

As shown by data on the distribution of health professionals in Texas (see Appendix 1), much of the state, especially rural and border areas, lack suitable levels of mental health professionals. With the changes contained in the Patient Protection and Affordable Care Act (PPACA), the existing health workforce shortage is likely to become more pronounced (Roberts, et al., 2013). Rural communities already lacking mental health professionals and primary care practitioners may find it more difficult to develop the multidisciplinary, integrated service models that may be optimal for people with comorbid conditions. As a potential solution, Talbot & Coburn (2013) have suggested multiple providers form networks that allow them to act as a single underserved site. Previous research on the mental health workforce shortage has shown that ameliorating policies should focus on 1) efforts to recruit health workers to these areas and retain them once they are practicing; and 2) provide the educational, regulatory, financial, personal, and professional support in which these practitioners can thrive (Dolea, Stromont, & Braichet, 2010). Targeted recruitment programs and the expansion of telemedicine and telehealth services are both policy options.

Targeted recruitment

In order to recruit and retain needed health care professionals to underserved areas, stable and rewarding personal and professional environments are necessities (Grobler, et al., 2009). Previous efforts at workforce recruitment have focused on temporary commitments from contracted providers, but research has shown that developing 'home-grown' providers – those who have spent prolonged periods in the community - might be a more sustainable strategy for rural workforce development (Talbot & Coburn, 2013). Specifically, professionals from rural backgrounds or who have served in rural areas in either residence or early in practice are more likely to engage in long-term rural practice. For example, over 2/3 of graduates of the Physician Shortage Area Program in Pennsylvania and Delaware have continued to practice in the same rural area for over a decade. Importantly, this program contains clinical rotations in underserved areas and appropriate educational preparation for rural practice, creating more interest in rural service (Dolea, Stromont, & Braichet, 2010). Further, it has been suggested that the location of university departments and/or teaching clinics in rural areas, the provision of rural clinical experiences for medical students, and rural and scarce skills allowances for practitioners can boost the workforce (Grobler, et al., 2009).

Identify disincentives and barriers to the practice of telemedicine/telehealth[4]

Telepsychiatry and telehealth services offer an important link between underserved areas and the specialists who help promote positive health outcomes. Telepsychiatry has demonstrated diagnostic accuracy and service satisfaction relative to in-person practice (Chung-Do, et al., 2012). Further, telepsychiatry often links urban practitioners to rural populations, allowing specialists, primary care providers, and patients to interact and collaboratively develop treatment

[4] In the final round of stakeholder feedback (August 2014), DSHS received numerous comments pointing to concern with the Drug Enforcement's Administration's enforcement of the federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008 and its potential impacts on the practice of telemedicine. Due to a discrepancy between allowable telemedicine practices under state and federal law, regional DEA agents' strict enforcement of this law is negatively impacting telemedicine programs in East Texas , including those of halfway homes, Local Mental Health Authorities, community centers, and state Delivery System Reform Incentive Payment (DSRIP) Projects.

plans (Chung-Do, et al., 2012). Given this proven efficacy, the expansion of tele-mental health services may prove beneficial in increasing the geographic reach of the mental health workforce.

While current federal and state policy allow for the practice of telehealth and its payment reimbursement, there are very few tele-mental health providers and clients in Texas. The Texas Health and Human Services Commission reported 98 tele-mental health providers serving 9,748 Medicaid clients in 2011. These numbers represented a 113 percent and 128 percent increase from 2009, respectively (Texas Health and Human Services Commission, 2012). Medicaid reimburses for telemedicine services provided by psychiatrists, nurse practitioners, clinical nurse specialists, and physician assistants. Medicaid also reimburses for the telehealth services of psychiatrists, nurse practitioners, clinical nurse specialists, physician assistants, clinical psychologists, clinical social workers, licensed professional counselors, licensed marriage and family therapists, licensed psychologist assistants, and licensed dieticians. Medicare similarly allows reimbursements for telehealth services. Further, Texas Insurance Code, Chapter 1455 currently prohibits the denial of payment on the basis of services having been provided through telehealth technology.

In order to expand the use of telehealth services, other licensing boards might follow the example of the Texas Medical Board by establishing rules for out-of-state practitioners to practice telehealth in Texas. Recently, the Federation of State Medical Boards has been considering the implications of multi-licensing and it is thought that this would aid in access to telemedicine (with certain provisions).

Section 3 – Improving the diversity of the mental health workforce

Those patients with the least established links to the health care system are the first to suffer the effects of health care shortages (Kirch, Henderson, & Dill, 2012). Disparities in education, insurance coverage, and English-language proficiency are linked to difficulties in accessing health services and receiving quality care. These disparities especially impact minorities, and can negatively affect behavioral health. Previous studies have shown that higher percentages of whites in need of mental health services receive those services, while minorities have higher levels of mortality from substance abuse (Hoge, et al., 2013).

Given these outcomes, the low rates of diversity in the mental health workforce should be considered as minority practitioners are more likely to see minority patients than are white practitioners. It has also been shown that health care consumers have better therapeutic relationships and stronger retention rates when using a practitioner of their own race/ethnicity (Hoge, et al., 2013). This lack of cultural and linguistic diversity in the workforce results in a shortage of providers with the knowledge, training, and skills to serve people who speak languages other than English or of racial/ethnic minority populations (Hogg Foundation for Mental Health, 2011).

Targeted recruitment

Studies indicate that increased diversity in the workforce may be achieved through two means. First, efforts to recruit minorities into health professions training programs may be expanded. This effort would require accompanying efforts to improve the educational attainment of minorities at large (Gorman & Brooks, 2009).

A U.S. Department of Health and Human Services review of 24 scientific evaluations of educational pipeline programs found positive outcomes for racial/ethnic minorities and economically disadvantaged students for overall academic performance and enrolling in a health profession (U.S. Department of Health and Human Services, 2009). Key features of these programs include incorporating a range of health professions, a combination of academic support, professional opportunities, and sometimes financial support, and programs targeting students throughout the health education pipeline from kindergarten through 12th grade.

Currently, the Joint Admission Medical Program funded through THECB, supports economically disadvantaged undergraduate students and guarantees them admission to medical schools. Thus far the program has been successful in guiding students into Texas residency programs and producing primary care practitioners for the state. A coalition of mental health advocates and practitioners has supported the expansion of this program with the intent of attracting economically disadvantaged students into psychiatric practice.

Second, psychiatric care in the United States and Texas is and will continue to be dependent upon the services of international medical graduates, who make up nearly 30 percent of the workforce. These workers have diverse backgrounds and sensitivity to the experiences of minorities, including cross-cultural issues, the recognition of and respect for other ethnic groups, and tolerance of non-English language proficiency (Boulet, Cassimatis, & Opalek, 2012). Policy consideration may be given to initiatives that encourage these individuals to practice in the state, especially in underserved areas.

Given Texas' changing demographics, the health professions require the capacity to effectively communicate and interact with their patients. A coalition of mental health advocates and care providers has called for professionals to strive to comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards). Further information on how to implement, advance, and sustain CLAS Standards are available at the website of the Office of Minority Health, U.S. Department of Health and Human Services. TAPA draws attention to the certificate in Psychological Services for Spanish Speaking Populations currently offered by Our Lady of the Lake University in San Antonio as a successful and replicable model for encouraging health professionals to attain the necessary linguistic skills.

The Statewide Health Coordinating Council is legislatively charged to "ensure that health care services and facilities are available to all citizens in an orderly and economical manner". DSHS, in the service of the SHCC, currently collects data on race/ethnicity from the relevant licensing boards. To assess the multilingual competencies of the health workforce, the SHCC recommends that the State allocate the necessary resources and amend the Health and Safety Code, Chapter 105 to direct the Health Professions Council and the Texas Department of Information Resources to collect linguistic proficiency data and provide it to DSHS for analysis. This recommendation is also supported by the Hogg Foundation. Using the newly collected data, DSHS, THECB, and impacted licensure boards would be able to assess the need for greater linguistic and cultural proficiency in the health professions. Remediation of deficiencies might occur through the incentivization of linguistically and culturally competent practice or through the identification and development of linguistically proficient para-professionals.

Section 4 – Supporting innovative educational models

Support integrated health and mental health practices

As the PPACA heightens the shortage of health professionals, leaders in health profession education must respond to this challenge (Kirch, Henderson, & Dill, 2012). Current and projected shortages suggest that the roles and activities of health care workers must likely be reorganized to maximize the productivity of the workforce (Buerhaus & Retchin, 2013). In the area of mental health workforce, this could include expanding the role of the lay workforce, such as certified peer specialists, family partners, and recover coaches (Buerhaus & Retchin, 2013).

One essential attribute of future health workers will be the ability to recognize and employ suitable innovations (Gorman & Brooks, 2009). The utilization of team-based care, collaborative care organizations, and medical homes have been cited as ideal models for improving outcomes and efficiency (Kirch, Henderson, & Dill, 2012). Medical, or health, homes have been presented as an appealing opportunity to offer integrated medical and behavioral health services (Beacham, Kinman, Harris, & Masters, 2011) while also potentially offering social service and housing programs (Mechanic, 2011).

Curriculum changes

Higher education programs and accrediting bodies can meet emerging needs by updating their curriculum (Hoge, et al., 2013). Further, academic medical centers must embrace the innovation imperative and address the projected workforce shortages (Kirch, Henderson, & Dill, 2012). Rather than relying on tradition or incremental change, these efforts should continue to identify and employ 'disruptive innovations' that will spark true workforce growth and increased efficiency (Gorman & Brooks, 2009). It is known that programs will require additional faculty and greater leadership development among existing faculty to achieve the quality of education needed (Kirch, Henderson, & Dill, 2012), but they must also seek to align changing elements of the education system and health system with each other and with patient care needs (Gorman & Brooks, 2009).

Expanded training in clinical settings

Within psychiatry, Roberts, et al., (2013) have suggested additional focus on the psychiatry curriculum and the development of more innovative teaching strategies to attract and prepare new workers. Specifically, these authors recommend expanded psychiatry clerkships and electives for medical students who have not yet chosen a specialty. Further, researchers have recommended that psychiatry residents and fellows receive specific training in telepsychiatry delivery, including such diverse topics as program sustainability, model of health service delivery, program infrastructure development, legal and regulatory issues, administrative strategies, technical applications, quality of service, and clinical outcomes assessment (Chung-Do, et al., 2012). THA supports similar efforts.

With respect to other physician types, it has been estimated that up to 70% of services sought from primary care providers are related to behavioral health conditions (Robinson & Reiter, 2007). Indeed, Texas Medicaid statistics have shown that roughly 66% of behavioral health prescriptions for children were written by physicians not identified as psychiatrists (Becker, King, Shafer, & Thomas, n.d.). Given the role primary care physicians often play in delivering mental health services, the American Academy of Pediatrics has recommended the inclusion of

child psychiatry and developmental-behavioral pediatric training in residency. This suggestion is in response to a study demonstrating that few primary care practitioners feel capable of diagnosing or treating psychopathology in children or adolescents. The Hogg Foundation has recommended ensuring educational requirements are aligned with workforce needs and that primary care physicians, including pediatricians, are comfortable in an integrated health care environment.

It has been suggested that nursing faculty should share and build new curricula for RNs entering psychiatric nursing (Delaney, 2012). For psychologists, a greater concentration of academic training and workplace experience should occur in the clinical psychological setting, including the expansion of rotations for psychologists in the primary care setting (Beacham, Kinman, Harris, & Masters, 2011). Further, doctoral psychology training programs may consider curriculum changes that: maximize the expertise of their faculty; provide greater teaching and supervisory remuneration; maximize the knowledge and skills of their students; and create and expand clinic relationships and affiliations.

Community health centers have been presented as offering an ideal place for psychological training in primary care behavioral health as these efforts would be available to patients with fewest resources and greatest needs (Beacham, Kinman, Harris, & Masters, 2011). 33.6 percent of adults who experienced serious and persistent mental illness received services through the community health system in 2010; this is due in part to the shortage of physicians accepting Medicaid (Hogg Foundation for Mental Health, 2011). As a result of federal funding requirements, rural Community Mental Health Centers often must provide a narrow range of services in tightly defined catchment areas (Talbot & Coburn, 2013), Indeed, mental health advocates and care providers have proposed expanding educational opportunities within public health settings, for example the state hospital system.

Incorporate training on interprofessional collaboration into education of health professionals

As policymakers, industry leaders, and health care professionals seek to better appropriate health resources, the use of collaborative health care teams and patient-centered medical homes has grown[5]. This trend and underlying research has highlighted the benefits of training in interprofessional collaboration, specifically by providing health professions students greater opportunities to interact in their coursework and clinical experiences, as appropriate.

TMA, FTP, and TPS have suggested that as primary care providers are integrated into patient-centered medical homes, they may benefit from additional training on collaborative practice with specialty care providers and on the co-management of mental, physical, and social well-being.

According to the SHCC, the State should increase the availability of collaborative training by appropriating funds and directing the THECB to work with institutions of higher education to monitor and implement evidence-based programs to prepare future providers for practice.

[5] A growing aspect of this approach is the inclusion of pharmacists as part of the health care team, providing collaborative drug therapy management in partnership with physicians. The SHCC's forthcoming 2015 Update to the State Health Plan will contain more information about the role of pharmacists in drug management protocols and how they can be used to expand the efficient delivery of primary and mental health care.

Concurrently, the SHCC recommends that state licensing boards and regulatory agencies examine and amend policies that may deter the full implementation of these efforts, as necessary.

Section 5 – Improving data collection and analysis

Consider potential workforce impacts of Medicaid 1115 waiver DSRIP projects and SB 58 implementation

The Delivery System Reform Incentive Payment Program (DSRIP) has been funded with over $11 billion covering almost 1,500 projects across the state. About 389 of these projects are related to mental health, with many acting to enhance the mental health workforce within specific geographic regions of implementation. Federally-required outcome evaluations do not specifically address how these projects might affect, directly or indirectly, the state's mental health workforce. For this reason, the SHCC and other stakeholders have recommended that HHSC and DSHS evaluate the potential short- and long-term impacts of these projects on the mental health workforce.

Expand data collection and analysis

As noted above, there is a lack of data to define the need for mental health services for the Texas population. Population need is dependent on prevalence of mental health illness, the distribution of risk factors, currently available social services, and other considerations. The main findings of recent systematic reviews on health workforce planning showed that there has been an absence of rigorously designed studies supporting the use of specific interventions addressing the shortage of health professionals (Grobler, et al., 2009; Buykx, Humphreys, Wakerman, & Pashen, 2010). Traditional planning has been insufficient in accounting for population need, models of health care delivery, and workforce productivity. Effective planning must involve the sustained investment on iterative collection of data on each of these elements (Murphy, et al., 2012). Definitions of workforce adequacy must consider population need and the available supply of mental health professionals (Thomas, Ellis, Konrad, & Morrissey, 2012).

Assessment of mental health service needs

The first requirement of assessing the suitability of a health workforce is to understand the needs of the population. Currently, sufficient demand models for Texas' mental health workforce do not exist, especially for small areas. These predictive models should consider the local morbidity of mental illness, mental health service utilization rates for both patients with serious mental illness and the population at-large, and the proportion of mental health needs currently being met by primary care providers (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Such a model is especially important as the U.S. and Texas work to address a chronic lack of health care accessibility (Buerhaus & Retchin, 2013). While the underpinnings of such a model are presented in Appendix 1, the currently available models fail to incorporate data specific to the mental health needs' of the Texas population.

In addition to these more traditional considerations, patient socioeconomic status and cultural and linguistic diversity affect the accessibility and suitability of health care (Terry, Terry, Hoang, & Hannah, 2013). Distinguishing between spatial (geographic) barriers to care and aspatial (social organizational) variables would allow for a more comprehensive description of patient need (Terry, Terry, Hoang, & Hannah, 2013; Wang, 2012). Measurements of shortage should conceptualize access using more nuanced means (Wang, 2012), including the prevalence of mental health disorders (variable by demographics), the extent of need among those in need, the extent to which primary care physicians (PCPs) can meet mental health needs, and finally the

mismatch between the level of need and the services provided (Konrad, Ellis, Thomas, Holzer, & Morrissey, 2009).

Workforce development data

Second, greater consideration of factors affecting workforce development and distribution are needed. More and better data should be collected on the level of service provided for different levels of health and illness and the productivity of providers should be measured (Murphy, et al., 2012). Currently, there is no systematically and uniformly collected nationwide data on the mental health workforce (Hoge, et al., 2013) and data quality in Texas varies by the licensing board and profession. Thus, greater investments on the activity and productivity of health workers are needed to ascertain the effectiveness of staffing levels (Murphy, et al., 2012). Additionally, more extensive and complete minimum data requirements, including race, ethnicity, and languages spoken, when not already collected, would allow a better understanding of provider ability to meet population needs. "Without these statistics, it is challenging to identify a plan for developing the mental health workforce skills and abilities needed to meet the state's increasingly diverse mental health needs" (Hogg Foundation for Mental Health, 2011).

The SHCC has recommended that HHSC and DSHS collect and analyze data from the Department of Criminal Justice, the Juvenile Justice Department, and other relevant agencies as a means of fully defining the state's workforce shortage and designing effective policy solutions. Data from the Department of Family and Protective Services may also appropriate for inclusion in this effort. Specifically, the SHCC calls on the Legislature to provide HHSC and DSHS access to data related to mental health services need and direct these agencies to develop statistical models to measure and predict workforce shortages. TMA, FTP, TPS, the Hogg Foundation, and NASW/Texas also support the expanded collection and analysis of data on mental health need and/or provider supply.

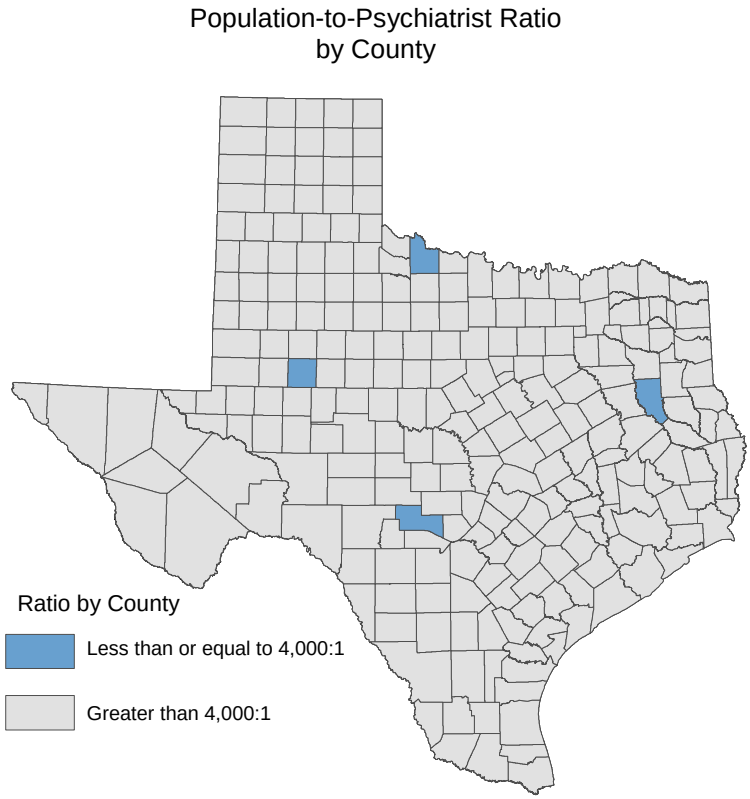
Conclusion

The mental health workforce shortage is a pervasive issue with multiple causes and many potential solutions. In passing House Bill (H.B.) 1023, the 83rd Texas Legislature called on HHSC to provide policy options for its consideration. Research, analysis, and input from mental health providers, advocates, and other stakeholders, revealed five themes for future policymaking efforts: increasing the size of the workforce; improving the distribution of the mental health workforce across Texas; improving the diversity of the mental health workforce; supporting innovative education models; and improving data collection and analysis.

Appendix A: Texas' mental health workforce

Psychiatrists

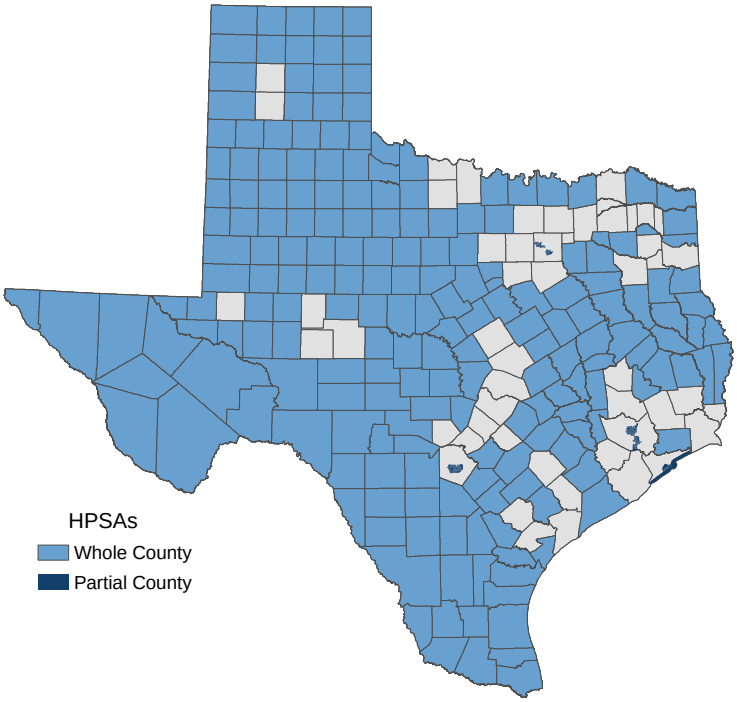
The most common method for measuring health workforce adequacy is to compare the size of the population and the number of health care providers. Cunningham (2009) has noted that the greater the ratio of population to psychiatrists, the less likely that a patient can obtain a quality psychiatric referral. Further, Cunningham suggests that a population-to-psychiatrist ratio of greater than 4,000:1 would likely impact the availability of mental health care, a threshold met by only four counties in Texas.



A statistical model accounting for patient need estimated that a national ratio of persons per psychiatrist not exceeding 3,681:1 was ideal, though provider need specific to Texas was not calculated (Konrad, Ellis, Thomas, Holzer, & Morrissey, 2009).

By comparison to these models which directly consider patient need, the federal Health Resources and Service Administration's (HRSA) threshold for designation of a geographic area as a Health Professional Shortage Area (HPSA) for mental health is a ratio of 30,000 people to one psychiatrist. HPSA designations allow doctors and facilities to receive incentives meant to attract practitioners. In high needs areas (defined by HRSA as areas with high proportions of youth, elderly, low-incomes, or people with alcohol/substance abuse problems) the ratio required for federal designation is 20,000 people to 1 psychiatrist. The Primary Care Office within DSHS currently uses these population-to-psychiatrist measures to apply for mental health HPSA designations.

Counties with Mental Health HPSA Designations



As of September 2014, 206 of Texas' 254 counties had whole or partial county Mental Health HPSAs and 224 counties had whole or partial county designation or at least one site-designated HPSA.[6] Thus using the most lenient federal standard for HPSA designation, the vast majority of Texas counties lack a sufficient workforce of psychiatrists.

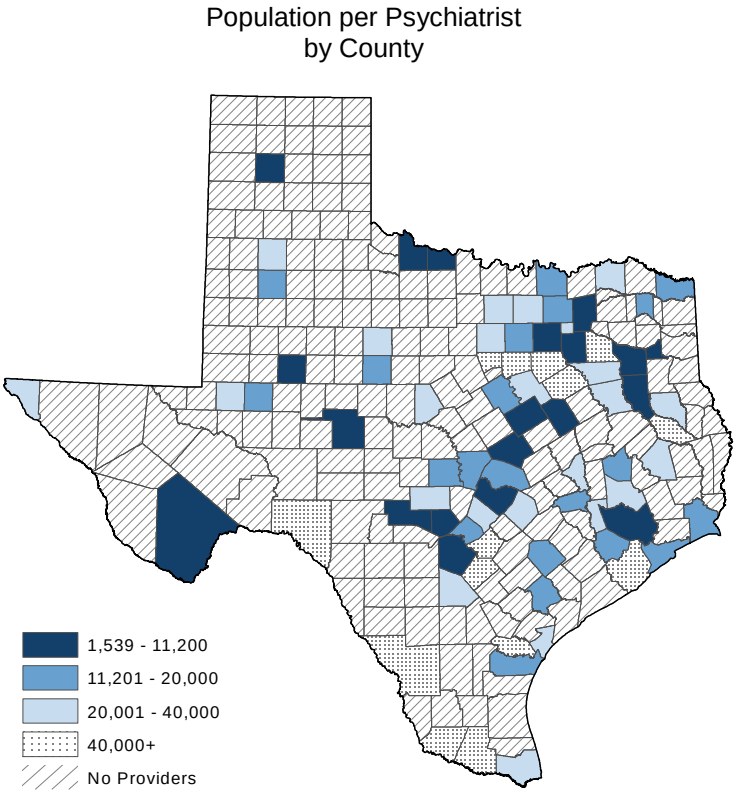
In addition to concern about the total number of psychiatrists, there is also a shortage of pediatric and geriatric psychiatrists. Only six states are considered to have an adequate supply of child and adolescent psychiatrists (Hoge, Stuart, Morris, Flaherty, Paris, & Goplerud, 2013), there is a national shortage of 22,000 child and adolescent psychiatrists and 2,900 geriatric psychiatrists, and only 325 new child psychiatrist graduates are produced nationally each year (Roberts, et al., 2013). The Institute of Medicine concluded that there was a major shortfall for professionals treating the mental health of aged populations. Currently, there are fewer than 1,800 geriatric psychiatrists in the US. By 2030, the national ratio of elderly persons with mental illness or substance abuse issues to geriatric psychiatrists will be 6,000:1 (Hoge, Stuart, Morris, Flaherty, Paris, & Goplerud, 2013).

As of September 2013, 1,933 psychiatrists were actively licensed and offering direct patient care in Texas. Using 2013 population projections,[7] this yields a ratio of 13,794.4 Texans per psychiatrist. However, Texas' five most populous counties (Harris, Dallas, Tarrant, Bexar, and Travis) had roughly 43.4 percent of the population and 63.0 percent of the state's psychiatrists

[6] HPSA site designations allow for a single site, such as a clinic, to benefit from HPSA designation based on either an insufficient number of physicians serving the same population as that site or a disproportionate share of low-income users being provided services at that site.
[7] All population is based on the 2012 projections of the 2013 Texas population offered by the Texas State Data Center: http://txsdc.utsa.edu/Data/TPEPP/Projections/Data.aspx

(9,507:1 ratio) while the remainder of the state had a ratio of 21,081:1. Border and rural areas generally have far fewer psychiatrists per capita.[8]

Geographic Designation	Population per Psychiatrist
Metropolitan, Non-Border	**12,032**
Metropolitan, Border	**29,849**
Non-Metropolitan, Non-Border	**30,219**
Non-Metropolitan, Border	**126,821**
Texas	**13,794**



In 2013, 2,798,583 Texans (10.5 percent of the population) lived in counties with no psychiatrists, while 5,512,060 (20.7 percent) lived in counties eligible for designation under the most utilized federal guidelines as a mental health professional shortage area (ratios of 30,000:1 or higher). By comparison, 99.4 percent of Texans lived in counties with ratios higher than those recommended by the academic literature (Cunningham, 2009; Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009).

[8] Texas' border counties are defined using the 1983 La Paz Agreement. Metropolitan and non-metropolitan counties are defined using the federal Office of Management and Budget's 2013 designations. For an accounting of each county, see Appendix 1.

From 2008 to 2013, there was an average annual growth of 3.64 percent among Texas' active psychiatrists. However because of the state's growing population, the ratio of population to psychiatrists improved by an average of 1.6 percent annually over these five years.

In addition to an overall shortage in 2013, the existing psychiatric workforce differed demographically from the population at-large. The composition of Texas' population was estimated to be 43.4 percent whites, 39.1 percent Hispanics, 11.5 percent African-Americans, and 6.0 percent from other ethnicities. Yet 65.5 percent of the psychiatric workforce was white, with just 5.3 percent African-American and 9.7 percent Hispanic representation. 19.5 percent of the workforce was classified as being of another ethnicity, potentially through their status as an international medical graduate.

Texas faces the additional challenge of an aged psychiatric workforce. Nationwide, psychiatry is one of the top three specialties in terms of the number of practitioners over the age of 55 (Roberts, et al., 2013). Texas' 2013 data indicate that 473 of the state's 1,933 active psychiatrists (24.26 percent) were 65 years of age or older. An additional 532 were between the ages of 55 and 64, meaning that over half of the workforce (51.99 percent) would be 65 or older and of retirement age by 2023.

In 2013, only 681 graduates from US medical schools[9] matched into psychiatric residencies nationwide. This number represented roughly half of the filled psychiatric residencies, with the remainder being filled by international medical graduates (Roberts, et al., 2013). Given this heavy reliance on international psychiatric residents, psychiatric care is expected to maintain reliance on international medical graduates for the foreseeable future (Boulet, Cassimatis, & Opalek, 2012). In 2013, 29.8 percent of Texas psychiatrists reported graduating from a medical school outside of the U.S. with the most prevalent source countries being India (8.4 percent), Pakistan and Mexico (4.0 percent each).[10] Compared with graduates of U.S. and Canadian medical schools, a greater proportion of international medical graduates specialize in primary care, locate in areas of need, and care for poorer patients. Further, international medical graduates are more likely to live in areas with lower median incomes and greater proportions of people living in poverty, providing a gap-filling and safety net role (Boulet, Cassimatis, & Opalek, 2012). Among Texas psychiatrists, international medical graduates are more likely than US-trained practitioners to practice in border areas (8.5 percent vs. 2.7 percent) and slightly less likely to practice in rural areas (4.0 percent vs. 5.2 percent). Among psychiatrists under 40 years of age, international medical graduates are more likely than US-trained practitioners to practice in rural (7.3 percent vs. 3.3 percent) and border (7.3 percent vs. 4.8 percent) areas.

2013 data from the Texas Higher Education Coordinating Board showed that there were 361 psychiatric residencies in the state. In 2008 there were 316, indicating a roughly 3.1 percent average annual growth over the past five years. Among specialties, there were 304 general psychiatric residencies, 53 child and adolescent psychiatry residencies, three addiction psychiatry residencies, and one geriatric psychiatry residency in 2013.

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[9] Graduation from a US or international medical school does not necessarily indicate citizenship or residency status. However, the academic literature does use this measure as a proxy for reliance on foreign-born workers and available data necessitates the use of this measure.

[10] Among all direct patient care physicians in Texas, 25.1 percent graduate from medical schools outside of the US.

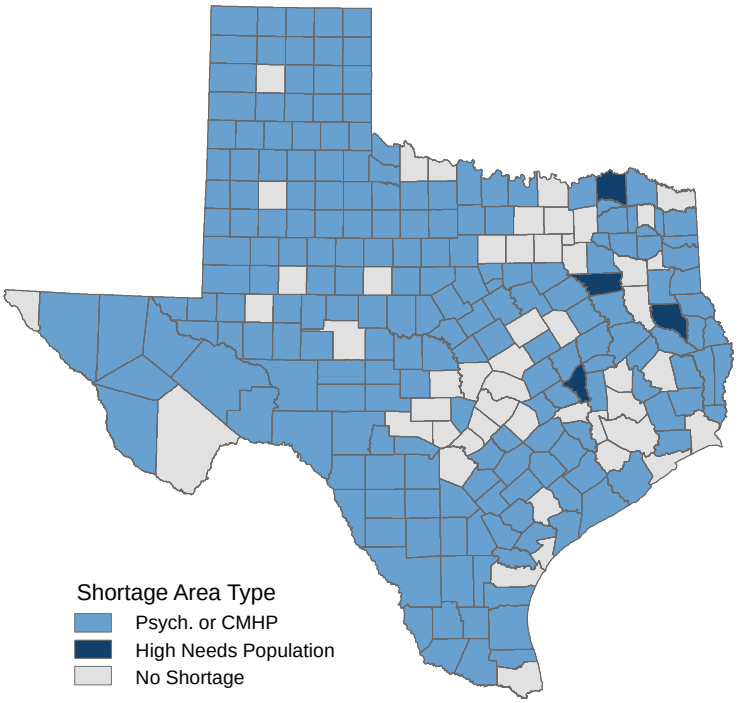
Type of Psychiatric Residency	2008	2013	Percent Change over 5 Years
General	**263**	**304**	**+15.6 %**
Child/Adolescent	**47**	**53**	**+12.8 %**
Addiction	**1**	**3**	**+300 %**
Geriatric	**5**	**1**	**-80 %**
Total	**316**	**361**	**+15.5 %**

Other mental health professions

The federal provider ratios listed above account only for the number of psychiatrists serving a population. However, an alternative federal means for designating shortages in the mental health professions is to consider both psychiatrists and other related occupations, such as clinical psychologists, psychiatric nurses, clinical social workers, licensed professional counselors, and marriage and family therapists (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). The federal HPSA designations including these core mental health providers (CMHP) require a population to CMHP ratio of 9,000:1 including psychiatrists or 6,000:1 CHMP excluding psychiatrists and 20,000:1 for psychiatrists. Incorporating these definitions, 23.3 percent of the 2013 Texas population lived in 199 different counties with mental health workforce shortages.

Finally, areas with greater than 20 percent of their population at or below the federal poverty level, high proportions of underage or geriatric populations, or levels of alcohol/substance abuse in the top quartile of national, state, or regional prevalence may be designated HPSAs with unusually high needs for mental health providers. In these areas, a population to psychiatrist ratio of 20,000:1, a population to CMHP ratio of 6,000:1, or a 4,500:1 population-to-CMHP (excluding psychiatrists) ratio and a 15,000:1 population-to-psychiatrist ratio are eligible for designation. This broader definition drew four more counties into the shortage, resulting in 203 counties and over 6.6 million Texans (24.9 percent) experiencing whole county shortages.

Counties with Psychiatric or CMHP Shortages
(including areas with high needs populations)

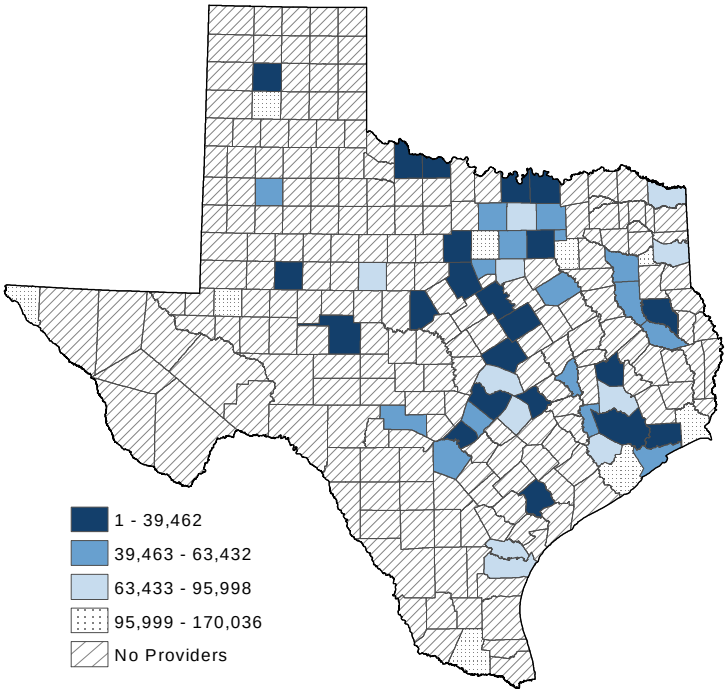


Clinical psychologists

As of September 2013, there were 566 actively licensed psychologists in Texas indicating a clinical specialty. This provided a ratio of 47,111 Texans per clinical psychologist in the state. Over two-thirds (67.84 percent) practiced in Texas' five most populous counties (Harris, Dallas, Tarrant, Bexar, and Travis). These five counties had a combined ratio of 36,236 persons per clinical psychologist while the remainder of Texas had 86,277 persons per clinical psychologist. There were no practicing clinical psychologists in any of the rural border counties.

Geographic Designation	**Population per Clinical Psychologist**
Metropolitan, Non-Border	**40,031**
Metropolitan, Border	**159,193**
Non-Metropolitan, Non-Border	**123,622**
Non-Metropolitan, Border	**-**
Texas	**47,111**

Population per Clinical Psychologist
by County



Data to calculate annual growth rates of clinical psychologists were unavailable, but data did show that 21.0 percent of Texas' clinical psychologists were 65 or older while another 27.2 percent were between 55 and 64 years of age. A sizable proportion of the profession (48.2 percent) will be of retirement age by 2023.

Data for race/ethnicity were not available for clinical psychologists.

Psychologists (All)
HRSA definitions allow for only clinical psychologists to be considered as CMHPs. However, Texas' 2013 total psychology workforce was substantially larger than the clinical subset described above. In fact, there were 7,243 persons eligible to practice under at least one of the state's four license types in 2013. This number includes 3,009 specialists in school psychology, 1,041 licensed psychological associates, and 4,176 licensed psychologists.[11]

Geographic Designation	Population per Psychologist (All)
Metropolitan, Non-Border	**3,190**
Metropolitan, Border	**10,428**
Non-Metropolitan, Non-Border	**7,618**
Non-Metropolitan, Border	**20,024**
Texas	**3,681**

[11] A single practitioner can be licensed under multiple license types.

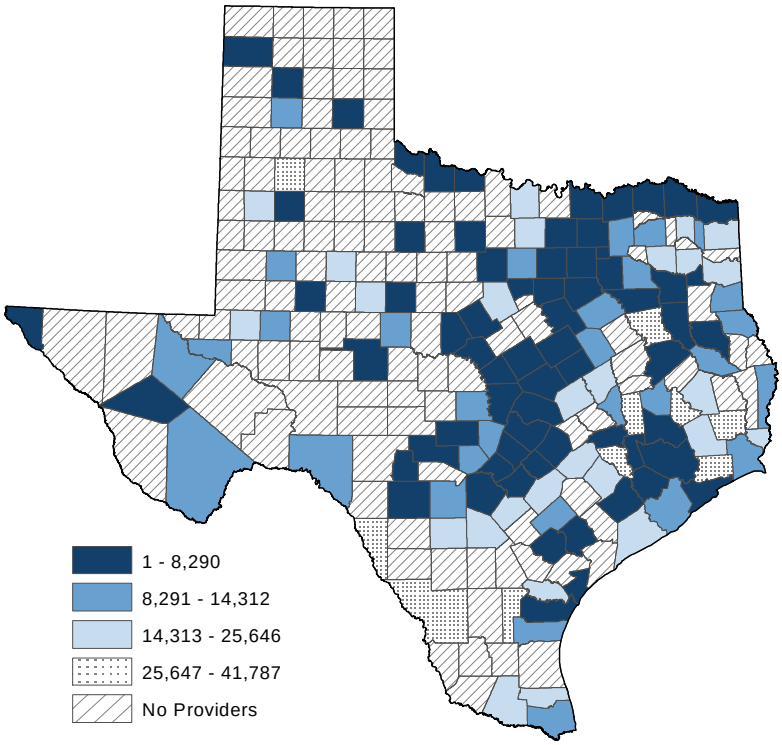
Among those licensed to practice psychology, 16.4 percent were 65 years old or older and 24.7 percent were between 55 and 64 years of age, percentages slightly lower than those of clinical psychologists.

Clinical social workers

Clinical social work is the use of social work knowledge and skills to apply professional theory, knowledge, and methods to restore social, psychosocial, and bio-psychosocial functioning. In September 2013, there were 6,316 licensed clinical social workers in Texas. 4,119 (65.2 percent) of these were in the state's five most populous counties while the remainder were in Texas' other 249 counties, with corresponding population-to-provider ratios of 2,809:1 and 6,870:1, respectively.

Geographic Designation	Population per Clinical Social Worker
Metropolitan, Non-Border	**3,642**
Metropolitan, Border	**9,950**
Non-Metropolitan, Non-Border	**11,056**
Non-Metropolitan, Border	**23,779**
Texas	**6,316**

Population per Clinical Social Worker
by County



The number of clinical social workers in Texas increased at an average annual rate of 4.3 percent from 2008 to 2013, yet the effective annual growth rate was only 2.3 percent when population growth is considered.

In the case of clinical social workers in 2013, 19.1 percent were 65 or older while 29.5 percent were between 55 and 64. Thus, 48.6 percent of clinical social workers will be of retirement age within the following decade. Race/ethnicity data were not available for clinical social workers.

Social workers (All)
HRSA definitions allow for only clinical social workers to be considered as CMHPs. However, Texas' total social worker workforce is also larger than the clinical subset described above. In fact, there were 18,785 social workers in 2013.

Geographic Designation	Population per Social Worker (All)
Metropolitan, Non-Border	**1,300**
Metropolitan, Border	**2,076**
Non-Metropolitan, Non-Border	**2,158**
Non-Metropolitan, Border	**4,476**
Texas	**1,420**

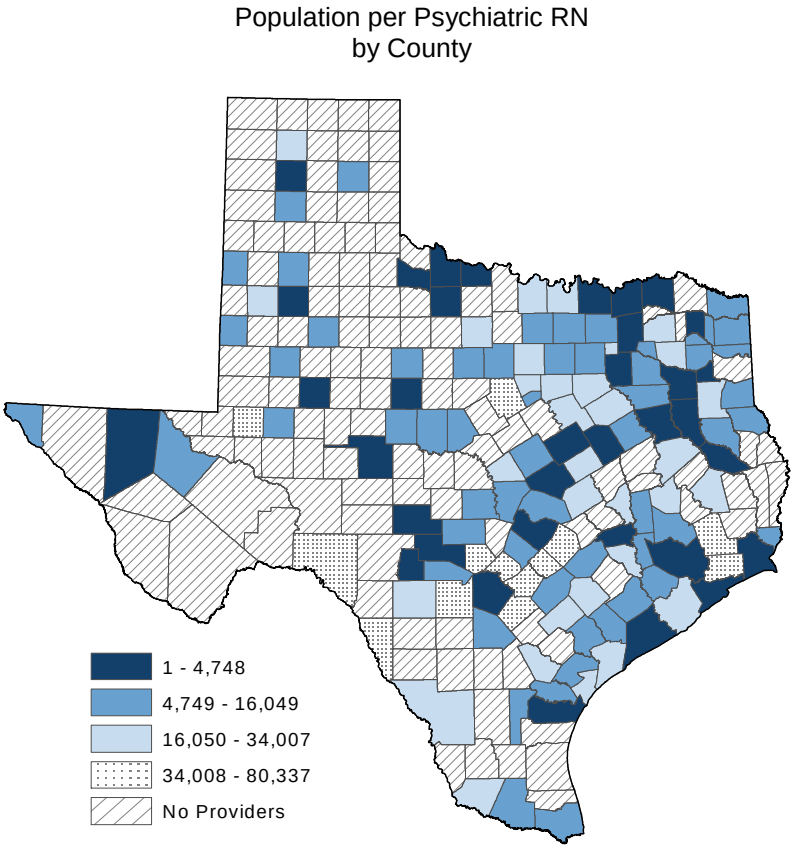
When considering all social workers, 11.3 percent were 65 years old or older and 23.4 percent were between 55 and 64 years of age. These percentages are lower than those of clinical social workers.

Psychiatric nurses
Nationally, there has been a shortage of psychiatric/mental health nurses since the 1980s. The 2004 National Survey Sample of Registered Nurses showed that younger nurses preferred clinical over psychiatric/mental health settings, that fewer total younger nurses were entering the workforce, and that psychiatric/mental health nurses were older than the workforce at large (Delaney, 2012). As of September 2013, there were 188 clinical nurse specialists (CNS) in Texas[12] specializing in psychiatry/mental health. These 188 CNSs would be recognized as CMHPs for mental health HPSA designations. There are an additional 274 nurse practitioners with psychiatric/mental health specialties. There are a total of 5,657 registered nurses (RN), including CNSs and NPs) reporting psychiatric/mental health/substance abuse as their practice specialty.

Geographic Designation	Population per Psychiatric RN
Metropolitan, Non-Border	**4,499**
Metropolitan, Border	**7,003**
Non-Metropolitan, Non-Border	**4,525**
Non-Metropolitan, Border	**47,558**

[12] The Texas Center for Nursing Workforce Studies, housed within DSHS' Center for Health Statistics, conducts ongoing research on the state's nursing workforce shortage. More information on this element can be obtained at www.dshs.tx.us/chs/cnws/.

Geographic Designation	Population per Psychiatric RN
Texas	**4,714**



Among clinical nurse specialists and nurse practitioners specializing in psychiatry or mental health, 52.6 percent were aged 55 or more years and 20.6 percent were already 65 or older. Among all registered nurses with psychiatric specialties, 47.4 percent were 55 or older and 13.5 percent were 65 or older.

The vast majority of clinical nurse specialists and nurse practitioners with a psychiatric focus were white (72.3 percent), with African-American (10.4 percent) and Hispanic (10.0 percent) the next most common categories. Among registered nurses with a psychiatric focus, 60.8 percent reported being white, 18.3 percent reported being African-American, and 10.2 percent reported being Hispanic.

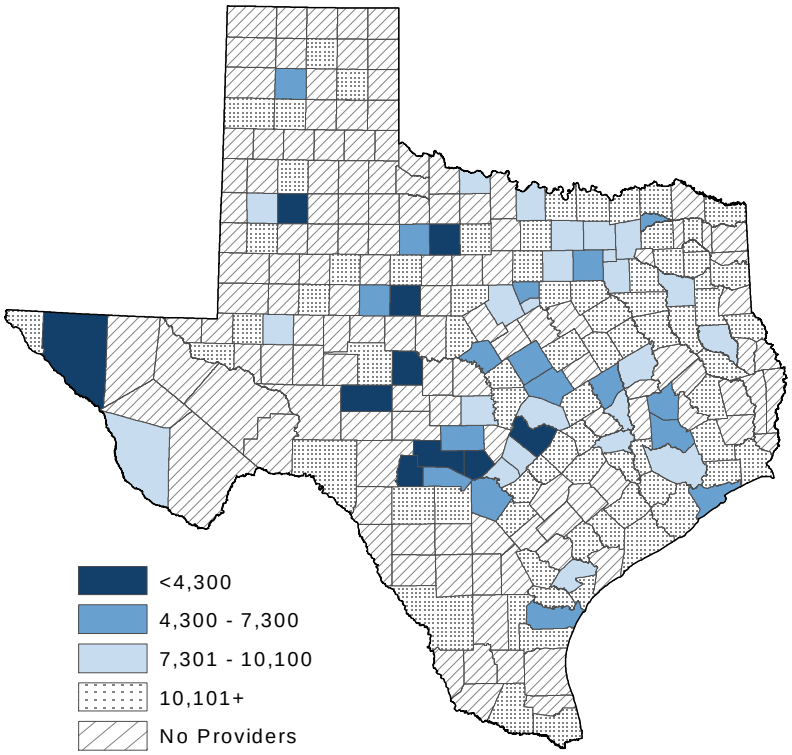
Marriage and family therapists

There were 3,062 marriage and family therapists (MFTs) practicing in Texas as of September 2013, giving a ratio of 8,708.2 persons per MFT. Within the state's five most populous counties the population to MFT ratio was 6,442:1 while it was 11,923:1 in the rest of the state, comprising proportions of 41.35 percent and 58.65 percent, respectively.

Geographic Designation	Population per MFT
Metropolitan, Non-Border	**7,435**

Geographic Designation	Population per MFT
Metropolitan, Border	**32,269**
Non-Metropolitan, Non-Border	**19,998**
Non-Metropolitan, Border	**95,116**
Texas	**8,708**

Population per MFT
By County



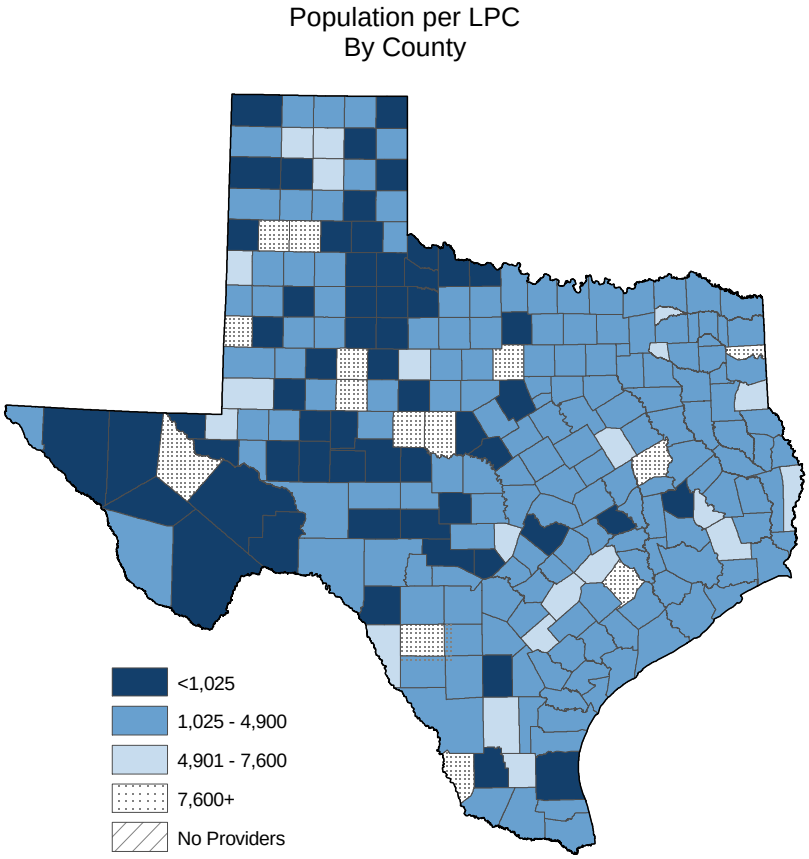
In 2013, 27.7 percent of MFTs were 65 or older and another 31.8 percent were between 55 and 64 years old, meaning that 59.6 percent of the workforce will be of retirement age by 2023. Finally, average annual growth of the MFT workforce in Texas has been 1.8 percent from 2008-2013. Yet when considering population growth, there has been just 0.2 percent average annual growth.

Licensed professional counselors

Licensed professional counselors (LPCs) perform a wide range of counseling services that utilize wide-ranging methods and strategies to help clients achieve mental, emotional, physical, moral, social, educational, spiritual, and/or career development and adjustment (Title 22, Texas Administrative Code, Chapter 681).

In September 2013, there were 18,641 licensed professional counselors (LPCs) in the state, giving a population to provider ratio of 1,430. The five most populous counties had a population to provider ratio of 1,221 while the rest of Texas had a ratio of 1647.1.

Geographic Designation	Population per LPC
Metropolitan, Non-Border	**1,290**
Metropolitan, Border	**2,674**
Non-Metropolitan, Non-Border	**2,190**
Non-Metropolitan, Border	**3,963**
Texas	**1,430**



This field has had average annual growth of 5.47 percent from 2008 to 2013 and yearly growth over 5.5 percent from 2009 to 2013. Moreover, only 14.9 percent of the workforce was over 65 years old and just 22.9 percent was 55 to 64 years of age, meaning just 37.8 percent will be eligible for retirement by 2023.

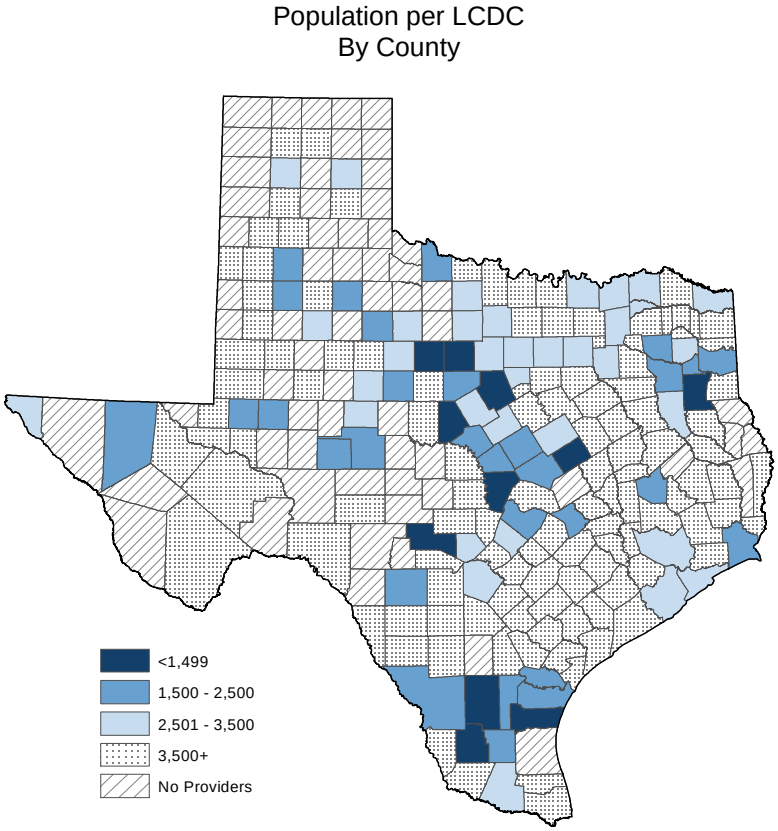
Licensed Chemical Dependency Counselors

Licensed chemical dependency counselors and provide clients with a planned, structured, and organized chemical dependency program designed to initiate and promote a person's chemical-free status or to maintain the person free of illegal drugs (Title 25, Texas Administrative Code, Chapter 140).

There were 8,743 licensed chemical dependency counselors (LCDCs) in Texas in September 2013, with 3,974 of these (45.5 percent) practicing in Texas' five most populous counties. The

corresponding population-to-provider ratios were 2,912 in these most populous counties and 3,165 in the rest of the state.

Geographic Designation	Population per LCDC
Metropolitan, Non-Border	**2,986**
Metropolitan, Border	**3,069**
Non-Metropolitan, Non-Border	**3,421**
Non-Metropolitan, Border	**4,816**
Texas	**3,050**



LCDCs have shown average annual growth of 4.7 percent from 2008 to 2013 with growth above 4.5 percent each year between 2009 and 2013. However, the population-to-LCDC ratio had lower average annual improvement of 2.5 percent over this period. In September 2013, 11.6 percent of the workforce was 65 years of age or older and 25.9 percent was between 55 and 64, totaling 37.5 percent eligible for retirement within ten years.

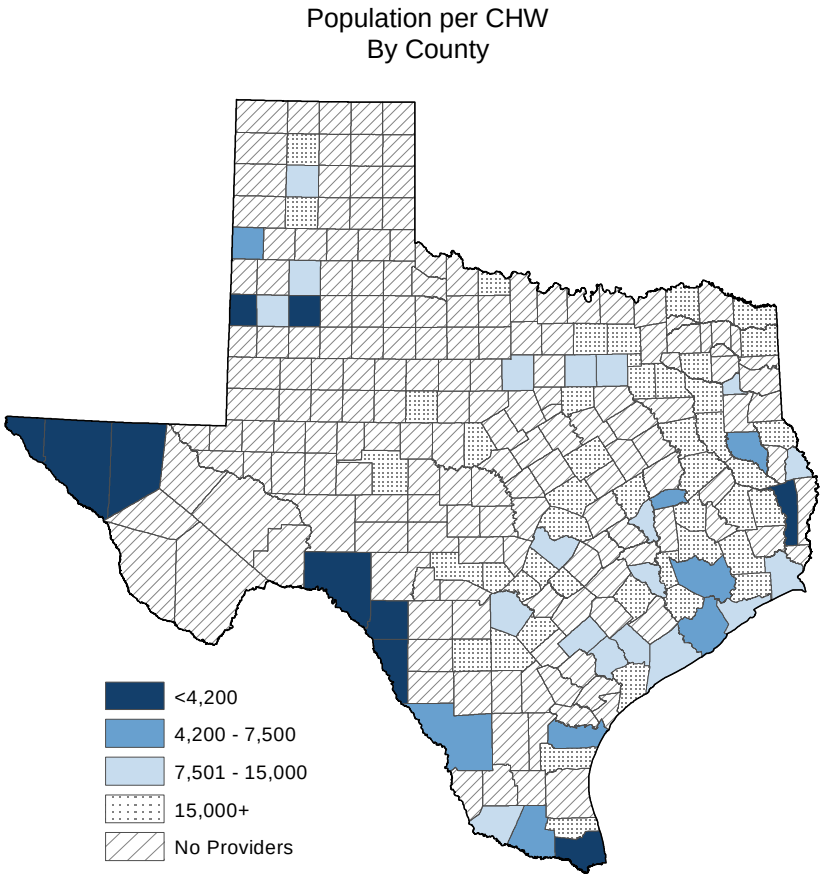
Community health workers/Promotores

Community health workers (CHWs), or *promotores*, are certified by DSHS. These practitioners serve as liaisons between health and social services and community members, helping to bridge ethnic, linguistic, and socioeconomic divides. CHWs help community members access services and build capacity through a variety of activities.[13]

[13] More information on CHW duties and certification can be found at: http://www.dshs.state.tx.us/mch/chw.shtm

In 2013, there were 2,406 certified CHWs in Texas and annual growth was above 20 percent each year from 2009 to 2013. Over this same period, the ratio of population to CHW has improved an average of 22.4 percent

Geographic Designation	Population per CHW
Metropolitan, Non-Border	**11,910**
Metropolitan, Border	**4,805**
Non-Metropolitan, Non-Border	**39,416**
Non-Metropolitan, Border	**6,137**
Texas	**11,083**



Certified peer specialists
A growing national and state trend involves people in recovery from mental illness acting as certified peer specialists (CPS) to provide support to others in treatment. DSHS has helped fund ViaHope, an organization that provides training and certification to CPSs. According to ViaHope, there were 333 CPSs in January 2014 and the organization had conducted 19 total trainings in Austin, Dallas-Fort Worth, San Antonio, Houston and one in East Texas.

Certified family partners
Similar to CPSs, certified family partners (CFP) are parents or guardians experienced in raising a child with mental or emotional issues who are certified to help other parents navigate the system

of care. ViaHope also runs the CFP training and certification program. This program has produced 99 CFPs as of January 2014.

Substance abuse recovery coaches
Serving as a recovery coach (RC) is a form of strengths-based support for persons with substance use disorders or in recovery from alcohol or other drugs and who may also have other mental health issues. These trained individuals offer shared living experiences to assist persons with active addictions as well as persons in recovery.

DSHS' Substance Abuse Program Services program developed the Recovery Coach Training of Trainers curriculum with the assistance of four non-profit organizations. These organizations assist trained individuals in obtaining paid or volunteer positions as RCs in places like treatment centers, hospital emergency rooms, and community and faith-based organizations. Using the DSHS curriculum and funding, these four organizations trained over 100 individuals in Fort Worth, San Antonio, Corpus Christi, and Beaumont. These 100 RC trainers have since trained over 300 individuals as recovery coaches as of February 2014. This ongoing training process provides a supportive workforce for the healthcare industry.

Through DSHS' Substance Abuse Program's Texas Recovery Initiative, RCs have the opportunity to become certified as a Substance Abuse Peer Recovery Support Specialist through the Texas Certification Board of Addiction Professionals (TCBAP) upon meeting TCBAP requirements.

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Appendix C: List of acronyms

BRFSS: Texas Behavioral Risk Factor Surveillance System

CFPs: Certified family partners

CHWs: Community health workers

CLAS Standards: National Standards for Culturally and Linguistically Appropriate Services

CMHP: Core mental health providers

CPSs: Certified peer specialists

DSHS: Department of State Health Services

DSRIP: Medicaid 1115 Waiver Delivery System Reform Incentive Payment Program

FTP: Federation of Texas Psychiatry

HHSC: Health and Human Services Commission

HPSA: Health Professional Shortage Area

HRSA: Health Resources and Service Administration

LCDCs: Licensed chemical dependency counselors

LPCs: Licensed professional counselors

MFTs: Marriage and family therapists

NASW/Texas: National Association of Social Workers – Texas Chapter

PPACA: Patient Protection and Affordable Care Act

RC: Recovery coach

SHCC: Statewide Health Coordinating Council

TAPA: Texas Association of Psychological Associates

TCA: Texas Counseling Association

TCBAP: Texas Certification Board of Addiction Professionals

THA: Texas Hospital Association

THECB: Texas Higher Education Coordinating Board

TMA: Texas Medical Association

TPS: Texas Pediatric Society

YRBSS: Texas Youth Risk Behavior Surveillance System

Appendix D: Stakeholder feedback

In accordance with House Bill (H.B.) 1023, DSHS sought information and data from the Statewide Health Coordinating Council (SHCC) and nongovernmental entities with expertise in mental health workforce issues. Over the course of three periods of stakeholder feedback, DSHS' Health Professions Resource Center and Mental Health and Substance Abuse division solicited information, data, and comments from their stakeholders and other interested parties. In total, dozens of organizations and individuals submitted written feedback via email.

In order to present to the Legislature both the diversity of opinions on these important issues and those areas around which stakeholders coalesce, DSHS invited stakeholder groups the opportunity to have their written feedback published in this appendix. The following groups participated in this portion of the process and their feedback is included on the following pages:

- Statewide Health Coordinating Council
- Child Guidance Center of Texoma
- Children's Hospital Association of Texas
- Coalition for Nurses in Advanced Practice
- Hogg Foundation for Mental Health
- Mental Health America of Greater Houston
- National Association of Social Workers, Texas Chapter
- Texas Association of Psychological Associates
- Texas Council of Community Centers
- Texas Counseling Association
- Texas Hospital Association
- Texas Occupational Therapy Association, Inc.
- Texas Psychological Association

Statewide Health Coordinating Council

P.O. Box 149347 Austin, Texas 78714-9347

Phone: (512) 776-7261
Fax: (512) 776-7344
SHCC@dshs.state.tx.us

7/21/2014

David Lakey, MD
Texas Department of State Health Services
1100 49th St.
Austin, TX 78714

Dear Commissioner Lakey,

The purpose of the Statewide Health Coordinating Council (SHCC) is to ensure health care services and facilities are available to all Texans through health planning activities. Comprised of governor-appointed health care providers, administrators, and consumers, as well as state agency representatives, the SHCC provides the governor and legislature with data, analysis, and policy recommendations through the State Health Plan and the reports of the Health Professions Resource Center.

Broadly, the SHCC envisions a Texas in which all are able to achieve their maximum health potential. In accordance with this vision and in response to the legislative directive of House Bill 1023 (83, Reg.), the SHCC submits to you its policy recommendations for addressing Texas' mental health workforce shortage. Following from the DSHS report, the recommendations are organized around five key approaches aimed at mitigating the shortage: 1) Increasing the size of the mental health workforce; 2) Ensuring equitable patient access to the mental health workforce; 3) Promoting a culturally and linguistically competent mental health workforce; 4) Enhancing the educational curriculum of students of the mental health professions; and 5) Expanding the collection, analysis, and use of data to inform mental health policy decisions and promote the most efficient use of resources.

Please note that while the recommendations attached are specific to the mental health workforce shortage, the SHCC will be addressing payment and delivery aspects of the shortage in its update to the State Health Plan, due to the Governor's office on November 1, 2014. We hope that you find both of these documents useful in planning the state's efforts to improve its mental health system.

Sincerely,

Dr. Mike Ragain
Chair, Statewide Health Coordinating Council

Increasing the size of the mental health workforce

Recommendation 1: The State of Texas must continue to support the education and practice of psychiatrists. Specifically, the State should act through the Texas Higher Education Coordinating Board and the Texas Department of State Health Services to ensure a robust future workforce of psychiatrists by identifying and expanding incentives to practice psychiatry.

Texas' current workforce of 1,933 psychiatrists is insufficient and will have to grow significantly over the coming years. In fiscal year 2014, the State had 469 approved and accredited psychiatric residency positions, but only 365 were filled and received funding. Given the large number of unfilled psychiatric residency positions, any immediate expenditure should be directed at attracting more potential practitioners to the specialty. The Legislature should direct the Texas Department of State Health Services (DSHS) and Texas Higher Education Coordinating Board (THECB) to engage other relevant stakeholders in the research and analysis of factors discouraging current and future practitioners from selecting psychiatry as their medical specialty.

Additionally, the Legislature ought to revise the State's Physician Education Loan Repayment Program (PELRP) (Texas Education Code Title 3 §61.532) to prioritize awards to psychiatrists and primary care physicians serving in state-supported living centers and state hospitals and those involved in patients' care after transition to community-based care from these facilities. The Texas Higher Education Coordinating Board (THECB) should likewise implement rule changes (T.A.C. Title 19 §21.251-21.262) that reflect this prioritization. By dedicating PELRP funds to practitioners in the state's mental health system, the state economically incentivizes new physician selection of mental health specialties, works to address the chronic recruitment and retention issues experienced by the state's public mental health system, and provides improved mental health care to those in the greatest need.

Recommendation 2: The State of Texas should more extensively incorporate advanced practice nurses and physician assistants into its mental health workforce. Specifically, the Legislature should alter Texas Administrative Code Title 25 §411.472 to allow qualified advanced practice nurses and physician assistants to conduct initial and follow-up psychiatric evaluations.

As noted above, there are just 1,933 active and licensed psychiatrists engaged in direct patient care. Roughly half of this number will be of retirement age by 2023. In addition to these psychiatrists, the Texas Board of Nursing (BON) has licensed 388 nurse practitioners and 238 clinical nurse specialists to practice in psychiatric/mental health. These practitioners are currently permitted to perform psychiatric evaluations under BON rules. There are also 90 physician assistants (PAs) currently being supervised by a physician indicating psychiatry or a psychiatric subspecialty as their primary specialization. Texas Medical Board rules (T.A.C. §185.10) should be clarified or revised to expressly permit PAs to perform psychiatric evaluations.

Current Texas regulations (T.A.C. Title 25 § 411.472) require that a physician complete the initial psychiatric evaluation of the patient and see the patient once a day for five of the first seven days of

inpatient hospitalization after the initial psychiatric evaluation. Changing this rule to include advanced practice nurses (APNs) and PAs to conduct psychiatric evaluations, under the delegation and with the concurrence of the supervising psychiatrist, would permit APNs and PAs to work as extenders in hospitals in a way that is similar to their roles in other medical settings. Furthermore, this change would ease psychiatrists' workload and allow them to cover more patients.

Expanding telemedicine and telehealth to ensure an equitably distributed workforce

Recommendation 3: The State of Texas, through the Texas Health and Human Services Commission and Texas Medical Board, should remove barriers to the adoption and practice of telemedicine and telehealth. Specifically, the Legislature should direct HHSC to revise Texas Administrative Code Title 1 Rules §354.1432 and §355.7001 and the Texas Medical Board to revise Texas Administrative Code Title 22 Rule §174.1-174.32.

Current telemedicine and telehealth rules require a new patient to present at an established medical or health site. For certain mental health provider-patient interactions, the use of an established medical/health site may be unnecessary. Moreover, a patient site presenter is required if telemedicine or health services in a provider/patient interaction are not solely limited to mental health. This requirement may serve to impede the expansion of telehealth/telemedicine and thus to limit access to both physical and mental health services. By removing these barriers, the state eases patient burden, allows for the more efficient use of health professionals currently serving as patient site presenters, and empowers the health professional and patient to determine the best course of treatment.

Additionally, the Legislature should allocate funds and direct the Texas Health and Human Services Commission (HHSC) to implement rules allowing for adequate Medicaid reimbursement covering the costs of patient site presenters, when utilized by the provider, and facility use. Under current rules, only the facility fee is reimbursed. This change is intended to encourage the expansion of telemedicine and telehealth services by encouraging facilities to adopt telemedicine/telehealth technologies and incentivizing health professionals to act as patient site presenters.

Promoting a culturally competent workforce

Recommendation 4: The State of Texas should require its relevant licensing boards to collect information on the linguistic competencies of its health professionals. Specifically, the Legislature should amend the Health and Safety Code, §105.003 to require the collection of data on the linguistic proficiencies of licensees of the health professions already impacted by this chapter.

Recommendation 5: The State of Texas should encourage providers to meet relevant ethnic/cultural/linguistic competencies as part of their initial and continuing education.

It is the legislative charge of the Statewide Health Coordinating Council to "ensure that health care services and facilities are available to all citizens in an orderly and economical manner". Recognizing the changing demographics of the Texas population, there is a need in ensuring that health care providers have the capacity to effectively communicate and interact with their patients. DSHS already collects information on race/ethnicity from the relevant licensing boards.

To assess the multilingual competencies of the health workforce, the State should allocate the necessary resources and amend the Health and Safety Code, Chapter 105 to direct the Health Professions Council and the Texas Department of Information Resources to collect linguistic proficiency data for analysis by DSHS. Using the newly and previously collected data, DSHS, THECB, and impacted licensure boards should assess the need for greater linguistic and cultural proficiency in the health professions. Remediation of deficiencies might occur through the incentivization of linguistically and culturally competent practice or through the identification and development of linguistically proficient para-professionals.

Enhancing educational curriculum

Recommendation 6: The State of Texas, through the Texas Higher Education Coordinating Boards, the licensing boards of health professions, and institutions of higher education, should seek to incorporate interprofessional collaborative training as part of the preparation of new health professionals.

As policymakers, industry leaders, and health care professionals seek to better appropriate health resources, the use of collaborative health care teams and patient-centered medical homes has grown. This trend and underlying research have demonstrated a need for greater student preparation in interprofessional collaboration, specifically by providing students of the health professions with greater opportunities to interact in their coursework and clinical experiences, as appropriate.

To increase the availability of collaborative training, the State should appropriate funds and direct the THECB to work with institutions of higher education to identify and implement collaborative practice training programs. Concurrently, state licensing boards and regulatory agencies should amend any policies that may deter the full implementation of these efforts.

Improving data collection and analysis

Recommendation 7: The State of Texas, through the efforts of the Texas Health and Human Services Commission and the Texas Department of State Health Services, and using data from the Texas Department of Criminal Justice, the Texas Juvenile Justice Department, and other relevant agencies, should develop analytical and

statistical models for workforce supply and demand and patient utilization that inform the mental health care needs of the State.

As noted in the DSHS report on the mental health workforce shortage, there is a lack of data to define the Texas population's need for mental health services. Population need is dependent on prevalence of mental health illness, the distribution of risk factors, currently available social services, and other considerations. To fully define the state's workforce shortage and design effective policy solutions, the State should provide HHSC and DSHS access to data related to mental health services need and direct these agencies to develop statistical models to measure and predict workforce shortages.

Recommendation 8: The State of Texas, through the efforts of the Texas Health and Human Services Commission and the Texas Department of State Health Services, should analyze the workforce impacts of the Texas Medicaid 1115 Waiver - Delivery System Reform Incentive Payment Program.

The Delivery System Reform Incentive Payment Program has been funded with over $11,000,000,000 covering almost 1,200 projects across the state. Approximately 400 of these projects are related to mental health, with many acting to enhance the mental health workforce within specific geographic regions of implementation. Federally-required outcome evaluations do not specifically address how these projects might affect, directly or indirectly, the state's mental health workforce. For this reason, the State should direct HHSC and DSHS to evaluate the potential long- and short-term impacts of these projects on the mental health workforce.

Child Guidance Center of Texoma

804 E. Pecan Grove Road
Sherman, TX 75090
Contact: Brenda Hayward, Executive Director 903-893-7768 bhayward@cfgcenter.org

Policy Recommendations for HB 1023

We are a nonprofit outpatient mental healthcare facility that primarily serves poor and working poor families. Over 80% of clients are Medicaid, CHIP or sliding scale. Our service region of Grayson, Fannin and Cooke Counties (Texoma) is suffering a significant mental health professional shortage crisis. Many clinicians are aging out, retiring, relocating or accepting higher paying positions from larger employees or insurance companies in the metroplex. Clinicians are increasingly hard to find who are licensed and qualified to work with children and families living in poverty and experiencing trauma, abuse, neglect and other serious mental health issues. Shortages combined with extensive time delays in getting providers approved to be Medicaid providers and competing with larger for profit and state entities increases the difficulty of hiring and retaining clinical staff. We believe in order to address this workforce crisis much effort needs to be placed on re-examining the career field to provide better opportunities for people who choose the field.

Challenges that greatly impact our agency's ability to function at adequate levels to provide quality mental healthcare include:

1. Finding, hiring and retaining qualified clinical staff
2. Challenges in providing an internship program to "grow therapists" in our region due to lack of payor sources that allow for LPC Interns to be providers
3. Navigating the increased complexity of Medicaid/CHIP managed care processes of adding providers to our group. It is taking 6 to 12 months to add licensed providers to managed care Medicaid.
4. Maintaining sufficient funding to cover the cost of care
5. Meeting the need to be culturally diverse

Recommendations:

1. Increase opportunity for students to enter the field of mental healthcare by offering more scholarships, loan repayment programs and help with securing clinical supervision and sites after graduation.
2. For Loan Repayment programs remove restriction of site having to be providers of ALL 3 Medicare, Medicaid and CHIP…2 out of 3 should be sufficient. The National Health Service Corps requires all 3. We are not a Medicare provider because LPC's are not allowed to be providers for Medicare clients therefore we cannot be an approved site for this great loan forgiveness program.

3. Invest in an improved process for LPC Interns to gain their 3000 hours of internship once they have graduated and need to secure a clinical supervisor and site. This could be done by having the State fund a paid internship program for LPC interns. Sites such as ours could provide FREE clinical supervision and the clients needed for the internship acting as the HOST facility not having to pay for the intern. Currently, we have a small grant from United Way and a local foundation that funds a monthly stipend of $800 per intern. We have 4 interns on the program now. We would like to add more but do not have the funds or supervisors to do so. This is not a lot of money for an LPC Intern to earn while completing their internship. They treat sliding scale clients and provide free services to clients because we cannot bill Medicare or CHIP.

4. Provide an incentive stipend or subsidy program for sites that provide clinical supervision and clients making it worthwhile to have interns involved in care. Supervising interns is time consuming and increases risks. Sites should be compensated for providing the clinical supervision, site, clients, tools, etc. At this time, we cannot bill insurance for interns. Often times we forego payment for them to gain the experience they need. In essence, we are penalized by having interns see clients. This is a major problem for our agency and an even bigger one for private practice clinicians. They are unwilling to be supervisors. If sites could be compensated for clinical supervision then salaries of supervisors could be increased.

5. Reduce the TIME DELAY IN ADDING CLINICIANS TO MEDICAID AND CHIP PLANS. Currently, it is taking over 6 months and up to 12 months to add a provider to Medicaid plans. We have to start with getting a TPI number for state Medicaid and then applying for Amerigroup and Cenpatico Medicaid (which the majority of clients have).
The credentialing process is taking months and during that time the provider cannot see insurance clients. WE CANNOT AFFORD TO PAY A CLINICIAN A SALARY WHILE WE WAIT which results in having to contract with providers while we wait for approval (often times the contractor finds another opportunity like working in a hospital or goes to work for an insurance company). The process is extensive and exhausting and may not yield a good outcome if the provider cannot wait to become approved. This is a serious problem and prevents providers (especially in private practice) from becoming Medicaid providers.

6. Provide payment to Medicaid providers whose population of clients is 50% or more when the Medicaid client does not attend their scheduled appointment. We have an outside appointment reminder service, therapists address the importance of attending sessions at the intake and are required to call the client when they miss. All of this still yields a 25 to 30% no show rate. It would make a big difference if providers could be paid for the time lost in serving this population.

7. Level the playing field by allowing LPC Interns to be Medicaid providers just as LMSW's under clinical supervision are currently in Texas and LPC Interns are in Oklahoma.

8. Level the playing field by allowing LPC's to be Medicare providers

9. Level the playing field by allowing LPCs to bill at the same rate as a psychologist when the same ICD 9 (soon to be 10) code is used for treatment

10. In our region, we have been unsuccessful in hiring a bilingual therapist. Currently, Medicaid does not pay for interpreters for counseling. A phone interpreter service for a 50 minute counseling session can range from $100- $200.00. Insurance companies must reimburse for this type of service in regions that do not have bilingual professionals living in the area.

11. Lobby to increase reimbursement rates so we are able to be competitive in finding, hiring and retaining clinicians. We are greatly challenged to provide quality mental healthcare to poor and working poor clients while striving to be an employer that attracts quality staff. Reimbursement rates do not cover the full cost of care.

Children's Hospital Association of Texas

An Association for the Advancement of Children's Healthcare in Texas

May 21, 2014

Texas Department of State Health Services
Post Office Box 149347
Austin, Texas 78714-9347

Re: "The Mental Health Workforce Shortage in Texas"

To Whom It May Concern:

Thank you for the opportunity to submit comments on the Department of State Health Services' draft report pursuant to House Bill 1023, 83rd Legislature, "The Mental Health Workforce Shortage in Texas."

Medicaid is the single largest payer for mental health services in the United States. Analysis of the availability of mental health professionals to serve this population in Texas is important to examine, particularly for children, who make up about three-fourths of the Medicaid caseload in Texas. For example, the report suggests that a population-to-psychiatrist ratio of more than 4,000 to 1 would likely impact the availability of mental health care. The President and CEO of Driscoll Children's Health Plan (a Medicaid managed care organization) indicates that in South Texas, there are 7 child psychiatrists for 710,000 children.

This presents an almost insurmountable challenge for meeting Medicaid's network adequacy requirements to provide access to a behavioral health specialist within 75 miles and meeting general requirements for Health Maintenance Organizations operating in Texas to provide urgent behavioral health care within 24 hours and routine behavioral health care within 2 weeks. The "Texas Medicaid STAR Program Child Survey Report" for 2011 indicated that only 61% of parents reported their child had good access to behavioral health treatment or counseling.

Inadequate Medicaid reimbursement rates, coupled with growing program complexity, result in declining provider participation in Medicaid. The Texas Medical Association periodically surveys its membership to determine the percentage of physicians accepting new Medicaid patients. Between 2000 and 2012 this percentage dropped

823 Congress Avenue, Suite 1500 • Austin, Texas 78701 • Phone: (512) 320-0910 • Fax: (512) 320-0927

from 67% to 31%. Similar statistics specific to child psychiatrists may not be readily available, but it would be worthwhile for the state to examine the reasons mental health professionals do not enroll as Medicaid providers. The Department of State Health Services and the Health and Human Services Commission should conduct a comprehensive analysis comparing Medicaid reimbursement rates to commercial insurance rates, to other states' Medicaid reimbursement rates, and to the actual cost of providing mental health services.

Finally, through the Medicaid 1115 waiver, funds are being invested in Delivery System Reform Incentive Payment (DSRIP) projects to bolster the mental health workforce. Information on the impact of these projects should be included in the report.

Once again, we appreciate the chance to provide input.

Sincerely,

Bryan P. Sperry
President

BPS:KE:das

AUGUST 26, 2014

DR. DAVID L. LAKEY, COMMISSIONER
DEPARTMENT OF STATE HEALTH SERVICES
1100 WEST 49TH STREET
AUSTIN, TX 78756

Dear Dr. Lakey,

The Board of the Coalition for Nurses in Advanced Practice (CNAP) would like to congratulate you and your staff for the completion of the House Bill 1023 Report. We are particularly pleased with Section 2 of the report dealing with improvements to the distribution of mental health workers in Texas.

As you are aware, the most critical health care professional shortages in Texas are in mental health services. In 2013, 174 out of 254 Texas Counties do not have a single psychiatrist. In Texas, the average number of psychiatrists is 7.3 per 100,000 population. In rural and border urban areas that number drops to 3 or less per 100,000.(http://www.dshs.state.tx.us/chs/hprc/tables/ Psychiatrists, -2013 /)

Psych-Mental Health Nurse Practitioners and Clinical Nurse Specialists are educated to provide care to persons with mental illness. Unlike many other mental health providers, their education includes prescribing the drugs needed to treat these patients. In many cases, these are Controlled Substances, including Schedule II drugs.

Texas law began allowing physicians to delegate prescribing Schedules III-V, Controlled Substances in 2003. Senate Bill 406, that passed in 2013, added Schedule II Controlled Substances for APRNs treating hospice patients and facility-based APRNs caring for hospital inpatients and emergency room patients. APRNs are already permitted to prescribe Schedule II, Controlled Substances in 41 states and Washington, D.C., without these site limitations.

Many patients with mental illness are treated in long-term care as well as outpatient settings when possible. This includes many vulnerable elderly individuals, and people with disabilities, who need the care that APRNs are fully educated to provide. Unfortunately the APRNs' inability in Texas to prescribe or order the Schedule II, Controlled Substances needed by these patients limits the care that is available for these individuals.

We believe statutory changes authorizing APRNs to prescribe and order Schedule II, Controlled Substances would remove a significant barrier to the practice of psych-mental health APRNs, help alleviate the mental health workforce shortage, and most importantly, improve access to mental health care.

Thank you for your work and the work of your staff. If you have any questions about the above or we can be of any service, please do not hesitate to contact us.

Sincerely,

D. John Hubbard

CNAP Public Policy Director

COALITION FOR NURSES IN ADVANCED PRACTICE P. O. Box 86 • Cedar Park, TX 78630 (512) 694-8349
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Hogg Foundation *for* Mental Health

ADVANCING RECOVERY AND WELLNESS IN TEXAS

Policy Recommendations: Addressing the Texas Mental Health Workforce Shortage

People experiencing mental illness can achieve recovery and wellness when appropriate mental health services and supports are available. Through recovery, they can live meaningful, productive lives in their community. Recovery, however, does not happen in isolation. It may require treatment and support from family, friends and mental health professionals such as psychiatrists, licensed professional counselors, social workers, psychologists, psychiatric nurses or advance practice registered nurses, and certified peer-to-peer specialists and community health workers. These professionals have specialized education, training and skills to serve a broad range of mental, behavioral, emotional and psychosocial needs.[1]

The individual and societal benefits of achieving mental wellness are obvious. The economic value of providing appropriate mental health services can be measured in avoided costs to hospitals and criminal justice and juvenile justice systems and improved workplace productivity.[2] The need for mental health services is high. Nationally, 46.4% of adults experience mental illness in their lifetime and 26.2% of adults experience mental illness annually. On an annual basis, 5.8% of adults in the United States experience a serious mental illness.[3] Nationwide, only 39% of persons with mental illness receive needed mental health treatment.[4]

As of November 2013, 207 of Texas' 254 counties in Texas were designated by the federal government as whole or partial Health Professional Shortage Areas for mental health.[5] Factors contributing to the critical shortages include limited education opportunities, high turnover, an aging mental health workforce, insufficient diversity, low compensation and an inadequate reimbursement system.

The following recommendations were presented to the Statewide Health Coordinating Council on February 27, 2014 in response to H.B. 1023 (83rd/Burkett).

Recommendation: Increase Education and Training Opportunities

1. Ensure that all workforce education and training is based on the recovery model of care.
2. Encourage professional curriculum changes in health care service delivery (integrated health care, team-based decision-making, cultural and linguistic competency skill sets)
    a. Increase requirements for mental health training for primary care physicians and pediatricians.
3. Amend certification/licensing requirements for various disciplines to promote needed changes in service delivery.
4. Increase funding for graduate mental health education including psychiatric residency programs, psychiatric nurse practitioner programs, social work/counseling/psychology internship sites, bi-lingual and minority education, and loan repayment.
5. Provide incentives for diversifying the mental health workforce through education and training opportunities such as scholarships, fellowships, internships and mentoring.

Recommendation: Expand Mental Health Peer Support Services

1. Identify and implement changes needed to expand the use of certified peer specialists including but not limited to:
    a. Expand Medicaid reimbursement options for services provided by certified peer specialists.
    b. Revise current peer specialist supervision requirements to expand supervision options to allow Medicaid reimbursement for peer support services in a variety of settings (emergency rooms, inpatient facilities, FQHCs, criminal justice facilities, etc.).
    c. Add peer support services as a Medicaid benefit.
    d. Expand opportunities for consumer operated service providers to offer reimbursable peer support services.

Recommendation: Improve reimbursement for mental health services

1. Increase reimbursement rates for all disciplines
    a. With high demand and low supply, providers can choose to serve those with more resources (private insurance/cash).
2. Increase the number of mental health providers willing to provide services to those receiving Medicaid; consider requirement for providers receiving state funds for education (GME, loan repayment, fellowships, etc.) to serve the Medicaid population.
3. Expand reimbursable services such as consultation, care management, and non-face-to-face service provision to increase access.

Recommendation: Expand Tele-mental health opportunities

1. Analyze best-practices in tele-mental health including what is being done in other states and identify barriers that exist in Texas that limit the expansion of tele-mental health services.
2. Expand the tele-mental health provider base to include certified peer specialists.
3. Identify how tele-mental health is being incorporated into SB 58 integrated care initiatives and 1115 waiver projects; determine if opportunities exist for increasing access to services.
4. Examine reimbursement rules; identify any disincentives that may be limiting tele-mental health service provision.

Recommendation: Expand Integrated Health Care

1. Provide educational opportunities that will:
    a. Increase awareness of integrated health care (benefits, models, opportunities)
    b. Increase mental health training in primary care curriculum
    c. Encourage changes in historic cultures of care (from medical model to recovery-based model).
2. Implement reimbursement changes needed, including reimbursement for:
    a. Care coordination
    b. Consultative services
    c. Team planning
3. Allow provision of flexible services including:
    a. Services provided by non-traditional providers such as peer specialists and community health workers.
    b. WRAP – Wellness and Recovery Action Planning.
    c. Consumer directed services.

Additional workforce considerations:

1. Cultural and linguistic competency
    a. Should permeate all mental health workforce discussions
    b. Collect provider data to include ethnicity and languages spoken.
2. Data collection
    a. Require professional boards to collect data that will aid in identifying specific racial, ethnic, cultural and linguistic workforce shortages
    b. Standardize data collected and reported for all mental health providers
    c. Identify needed data not currently being collected.
3. Geriatric mental health specialists – geriatric psychiatrists almost non-existent.
4. Mental health providers for individuals with intellectual and other developmental disabilities
    a. Few professionals with expertise needed to provide mental health services to this population
    b. Limited consideration of the impact of abuse, neglect and exploitation and the importance of trauma-informed care.

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[1] Texas Statewide Health Coordinating Council, Texas State Health Plan 2011-2016, page 99.
[2] Centers for Disease Control. (n.d.) *Making a Business Case.* Retrieved from http://www.cdc.gov/workplacehealthpromotion/businesscase/
[3] Hogg Foundation for Mental Health. (2011). *Crisis Point: Mental Health Workforce Shortage in Texas.* Austin, TX.
[4] Hoge, M. A., Stuart, G. W., Morris, J., Flaherty, M. T., Paris, M. J., & Goplerud, E. (2013). Mental Health and Addiction Workforce Development: Federal Leadership is Needed to Address the Growing Crisis. *Health Affairs*, *32*(11), 2005-2012.
[5] Texas Department of State Health Services, *The Mental Health Workforce Shortage in Texas*, February, 2014.

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A United Way Agency

May 27, 2014

Commissioner David L. Lakey, MD
Dept. of State Health Services
1100 W. 49th Street
Austin, TX 78756

Dear Dr. Lakey:

Mental Health America of Greater Houston is our area's oldest mental health education and advocacy organization focused on shaping the mental health of people and communities in the areas of children and education, integrated care, chronic illnesses, women, veterans and aging. We actively work to replace misperceptions and misunderstanding about mental illness with compassion and proper treatment; link people to mental health services; provide education and training for key sectors of the community; remove barriers to mental health care by facilitating change in systems and advocate for legislative solutions that address the vast unmet need for public mental health services.

MHAGH would like to thank you for the opportunity to offer comment pursuant to House Bill 1023 from the 83rd Legislative Session regarding mental health workforce shortage in Texas. The draft report offers comprehensive snapshot of current workforce numbers and clearly demonstrates the increased need based on population.

To that end, the comments here listed serve two purposes: a demonstration of factors in our service area highlighting the increased demand for services that should be noted as significant factors, and secondly to mention specific public policies that have contributed to the current workforce situation and recommended adjustments.

The following represents a brief summary of these demands that MHAGH has identified as being important in considering workforce shortage numbers.

<u>1115 Waiver</u>

Within our Regional Healthcare Partnership (RHP), Delivery System Reform Incentive Payment (DSRIP) projects are specifically seeking to increase the number of behavioral health providers in order to increase capacity and access in their regions (as they are across the state). Specifically, there are 41 projects

involved with the expansion of services for behavioral health that will require a significant staffing up of mental health professionals. This increase in demand in a depressed workforce environment is cause for concern for providers looking to expand services given the already limited workforce supply.

ACA Newly Insured Population

As listed in the report, the Patient Protection and Affordable Care Act will add to the strain on a limited mental health workforce with the increasingly insured population because it will "raise demand in services and thus exacerbate the practitioner shortage." It makes sense that the increased number of people covered with health insurance will use more healthcare services, and mental healthcare is no exception.

Dr. Charles Begley with the University of Texas School of Public Health at the University of Texas Health Science Center in Houston notes that our region was predicted to enroll 138,000 persons through the ACA Marketplace. The most resent numbers show that 197,650 enrollments were from Houston (143% of the estimated enrollment goal). This means an additional 60,000 people now have access to insurance coverage and are eligible to receive services. This increase in covered population will not doubt increase mental healthcare demands on an already limited mental health system.

While the Houston situation may be particularly high (27% of the enrollments in Texas were from Houston), it is worth noting that 733,757 enrollments occurred in Texas. In increase in demand for mental health services due to an increasingly eligible population is a statewide problem.

While the concern about mental healthcare workforce shortages can be a challenging public policy problem for lawmakers, there are solutions for lawmakers to consider in bridging the gap.

Expansion of Graduate Medical Education (GME)

Of all policies that lawmakers can consider, increased GME funding is perhaps the single best way to add to the mental health workforce. During the last legislative session, lawmakers increased GME funding by more than 15% by adding more than $65 million in the state's budget.

This wise investment will help to grow the number of providers by increasing the number of residency training slots for graduates who want to specialize in mental health. As well noted, the graduate medical students are likely to remain in practice near the location of their residency.

A continued and expanded effort to train and keep mental health professionals is a long term solution to help increase the supply of care and we encourage legislators to continue that investment.

Expanded Loan Repayment Plans

Physician Education Loan Repayment Program (PELRP) represents an effective way to recruit and retain mental health providers. By offering loan forgiveness, these programs encourage medical students to join the mental health provider workforce.

It was unfortunate that 82nd Legislature cut the funding for PELRP in 2011 so that no new participants were allowed to apply, but lawmakers in the 83rd session soon reversed this policy and re-instated funding to allow new students to participate.

MHAGH believes that this was a wise policy decision by lawmakers and urges the continued funding and expansion of PELRP. In addition to funding, by expanding the eligibility to include psychologists and Licensed Clinical Social Workers (LCSWs), the program could produce a broader pool of practicing mental health providers. This would address the mental health provider shortage in a more comprehensive way, especially in view of the substantial role these additional professional positions play in community based mental health services. By expanding eligibility to include psychologists and LCSWs, the state can provide a direct and diverse incentive for increasing the mental health workforce.

The supply and demand of mental healthcare must be addressed, and the workforce shortage in this field is the first step to increased access. MHAGH believes the increased demand for mental health care professions in the 1115 waiver projects and increasingly insured population through the ACA are demands with a particular local effect. We believe the State of Texas can address these demands by continuing to increase the number of GME residency spots while funding and expanding PELRP to additional mental health fields.

We greatly appreciate the opportunity to offer comment on this report and look forward to helping provide additional assistance going forward. We hope these comments offer a local perspective on statewide challenges but also suggest solutions based on a statewide perspective.

Sincerely,

Mental Health America of Greater Houston

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NASW, TEXAS CHAPTER
National Association of Social Workers

Response and Policy Recommendations to Address Mental Health Workforce Shortage in Texas

National Association of Social Workers/Texas
March 2014

Organizational Background

The National Association of Social Workers/Texas chapter is the premier membership organization for social workers. NASW/Texas advances and promotes the social work profession by advocating on behalf of its 5,500 plus members, so they are better able to serve their clients and communities. NASW/Texas embraces social work values, which celebrate the importance, worth, and dignity of all people. Social work has a history fighting for social justice by serving underserved and underrepresented communities.

After reading the entire report, our organization was dismayed at the lack of serious reference to the abysmally low rates of reimbursement for mental health services as a possible deterrent for mental health professionals who want to serve Texas' most vulnerable populations. Social workers have historically provided services to the most vulnerable and underserved populations, and low reimbursement rates are an enormous deterrent to serving clients in these areas. Our studies have shown that to be the number one reason for lack of participation.

Background on Texas' Mental Health Workforce Shortage

- We agree that a vast portion of the population experiences mental health issues, yet the majority do not receive appropriate or high quality treatment.
- We endorse the recent trend in mental health to move towards resiliency and recovery and away from negative stigmatization and isolation of those with mental illness.
- Early intervention is needed in schools and the criminal justice system in order to address mental health issues before more extreme behaviors and costly consequences can present themselves.
- Early intervention benefits the State and its citizens, as people receive the care they need in their communities, which is a more cost effective approach than treating people in emergency rooms and prisons.
- Emerging research is showing that trauma lies at the root of many behavioral and mental health issues.
- Mental health professionals need to ensure they have training in a variety of evidenced based approaches to treating trauma and trauma related concerns, as well as issues like substance abuse.
- Almost one-third of people who abuse alcohol and half of those who abuse drugs also experience mental illness (National Alliance on Mental Health, 2013). Mental health professionals must be able to identify substance abuse and refer appropriately.

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The Need for Mental Health Services

Children and Adolescents

- While we do not have much data that reflects mental health needs of children, we certainly are aware of the high number of children who experience and/or at risk of poverty and hunger, which places them at risk for community and domestic problems.
- Over a quarter of Texas children live in poverty and are considered food insecure (Center for Public Policy Priorities, 2013). With SNAP benefits being cut, these numbers are expected to grow.
- Texas has the second highest rate of uninsured children in the country at 16% (Center for Public Policy Priorities, 2013).
- School-based early intervention programs for health and mental health can have multiple substantial impacts on children and families.
- As social workers engage with people within their communities and are trained to address the many systems clients encounter (school, health, community, family, legal, etc.), social workers are highly capable of intervening with students and their families.
- The lack of social workers on staff at Texas schools must be addressed, as well as the overwhelming caseloads for the low number of social workers working at schools.
- All professionals that interact with youth need to be educated about risk factors and warning signs of mental health concerns and substance abuse.
- Identifying risk factors and warning signs at their early stages allow for mental health professionals to intervene and provide services before issues escalate into more severe behavioral or criminal issues.
- This will potentially save families, schools, and Texas money and resources.

The Mental Health Workforce

- The number of Americans gaining health insurance or more comprehensive health insurance is expected to grow in 2014 because of the Affordable Care Act (National Alliance on Mental Illness, 2013).
- There will be many uninsured individuals needing mental health services due to the lack of expansion of Medicaid in Texas, and they will resort to more costly acute care in local emergency rooms and jails.
- These factors will place more of a strain on the mental health workforce than before, since more consumers will be accessing care.
- NASW/Texas agrees there are vast shortages among all mental health professions, but as we are a membership organization for social workers, we will focus on issues specific to social work.
    - While the shortages among all mental health professions must be addressed, social workers do have more access to the populations in need than the aforementioned professions.
    - Psychiatrists, psychologists, and psychiatric nurses are not typical providers for individuals and families in need of psychotherapy. In fact, over 60% of the existing mental health care is provided by social workers in the State.

- Social workers with a clinical license (LCSW) do not require referrals in order to file with insurance companies, and they are also authorized to practice independently, which increases accessibility to clients.
- The number of LCSWs in Texas, 6,316, vastly outweighs the number of psychiatrists and clinical psychologists combined, 1,933 and 566, respectively (Texas Department of State Health Services, 2014).
- Even though LCSWs are the only social workers considered to be Certified Mental Health Professionals (CMHPs), licensed social workers have the training to provide valuable services, such as case management. There were 18,785 social workers in Texas in 2013 (Texas Department of State Health Services, 2014).

Policy Recommendations

General Shortage of Mental Health Providers

Incentives for Workers

- If focusing on interstate growth of providers is crucial, then we should be focusing on the schools that produce providers.
- Incentives in the form of stipends, scholarships, loan repayment and loan forgiveness programs must be seriously considered as a way of combating the mental health provider shortage.
- These incentives have been effective in combating workforce shortages for doctors and nurses, and they would also do the same for expanding the number of social workers.
- The average cost of a two-year Master of Social Work program, drawn from a sample of 10 universities nationwide, was $35,000 (Janney, 2014).
- Clinical licensure requires a master's degree, so BSWs must attend a one-year MSW program if they are seeking out a LCSW. Those who do not have a BSW will need to attend a two-year master's degree program to obtain a MSW.
- It takes eight years to become a LCSW, including undergraduate education, graduate education, and two-years of required clinical supervision.
- Becoming a LCSW requires numerous other costs besides educational costs, which can be prohibitive to those working or looking to work in mental health. The national median salary of mental health and substance abuse social workers is $39,980 (United States Bureau of Labor Statistics, 2014).
- With the rising Spanish-speaking population in Texas and the lack of bilingual mental health providers, Texas schools should provide incentives and programs to increase the bilingual mental health workforce. The Hogg Foundation is an excellent resource and model for educating a bilingual workforce.
- Incentives need to be made for LCSWs to work in underserved areas, especially ones with Spanish language proficiency and trainings in specialized therapies.

Expansion of Medical Education

- We promote an expansion of mental health education, not just medical education.

- All practitioners should be educated and adept at providing trauma-informed care, as well as working with difficult populations.

Reconsideration of Scope of Practice and Integrated Care

- Integrated health/mental health teams should be seriously considered as a way to provide for patients' needs comprehensively and in a de-stigmatizing manner.
- We encourage private and public health plans to devise a way to reimburse integrated care practices that encourages this type of care.
- The importance of paying providers in a way that is commensurate with experience, skills, and education cannot be ignored as the number one way to increase the mental health workforce.

Maldistribution of the Mental Health Workforce

- Incentives as a condition of education assistance can be provided for practitioners to work in the underserved counties
- Schools can tailor curricula to meet the needs of their communities, so graduates are able to find work they are qualified to perform locally.
- Providers must be paid enough based on their location, and incentives must be provided for practitioners working in counties in dire need of services.
- Current Medicaid and insurance reimbursement rates are not providing adequate pay for providers across Texas, let alone in areas with high costs of living.
- Jobs with difficult populations or in rural areas must be made more attractive to professionals.
- Jobs where certain certifications or requirements are needed to treat specific populations, such as sex offenders, need to be incentivized as well.
- Social workers can and currently do play a very important role in the medical field, not only with counseling but also with service coordinator/care management.
- Qualified mental health professionals, like social workers, can assist doctors in providing behavioral health services, so medical professionals can focus on providing medical services.
- Social workers excel at helping clients change behaviors, staying on medication and recovery plans, as well as "digging deep" to uncover issues to promote recovery as a preferred outcome for clients.
- Social workers are also trained to work with the geriatric population, and are adept at addressing psychosocial issues among the growing geriatric population in Texas.

Lack of Diversity

- Texas' demographics are changing rapidly, and practitioners need to be able to provide services to those who speak languages other than English, especially Spanish.
- Language proficiency should be emphasized and incentivized in training programs
- Encouraging native speakers and students to enter training programs from a young age, such as in junior high school, will help increase the number of multilingual mental health providers.

- In addition to encouraging language proficiency, there is a need to present mental health professions as interesting, challenging, and financially rewarding careers for students.

Outdated Educational Content and Teaching Methods

- There is a need for language proficiency and integrated practice models, as well as familiarity when addressing trauma, stress, and obsessive-compulsive destructive behaviors.
- Also a need to integrate current mental health knowledge into the curricula of all medical and mental health professionals.

Insufficient Data to Inform Workforce Planning

- We would like to express the need for DSHS to expand its data collection efforts.
- DSHS is charged with collecting demographic information, such as ethnicity and language proficiency, on the groups it licenses, specifically LCSWs, professional counselors, and marriage and family therapists.
- This demographic information would provide a more comprehensive look at the workforce, the diversity of the workforce, and what populations or skills recruitment efforts should focus on.
- Data collection regarding the populations the profession is serving, what health plans they participate in, and other pertinent information would assist in our needs assessments of Texas communities.
- Another way to combat insufficient data is to provide Texas universities with grants to research mental health workforce shortage issues, for example, reimbursement rates, so they can be properly assessed and addressed.

NASW/Texas Recommendations

- Pay LCSWs, LPCs, and LMFTs at 100% Medicaid allowable rate
- Raise the reimbursement rates for all mental health services
- Provide stipends, scholarships, and loan repayment/forgiveness for all mental health providers
- Fund additional slots in medical schools, nursing schools, and schools of social work for more students
- Fund more research in those same schools
- Fund recruitment programs for mental health professionals beginning in junior high school
- Fund retention efforts to keep qualified health professionals in practice
- Teach integrated health and mental health practices in all schools listed above
- Work with organizations such as Mental Health America, National Alliance on Mental Illness, the Hogg Foundation, the Meadows Institute for Mental Health Policy, and teaching universities to reduce the stigma of mental illness/issues so that more people will enter the field and practice with this population.

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NASW, TEXAS CHAPTER
National Association of Social Workers

Revised Response and Recommendations to Address Mental Health Workforce Shortage in Texas

National Association of Social Workers/Texas
August 26, 2014

Overall, NASW/Texas is pleased to see the stakeholder input that was included in the revised HB 2013 report. The mental health workforce shortage in Texas is a complicated issue, and feedback from all types of stakeholders is needed to make a difference. All mental health providers in the state provide valuable services within their scope of practice. We were disappointed to see the report focus mainly on psychiatrists and psychologists, to a lesser extent. Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), and Licensed Marriage and Family Therapists (LMFTs) provide the majority of mental health services in Texas, and are more easily accessible to clients in rural areas than psychiatrists and psychologists. The issues with reimbursement rates and payments that affect psychiatrists and psychologists are issues that affect all providers. With LCSWs, LPCs, and LMFTs being reimbursed through Medicaid and Medicare at considerably lower rates than psychiatrists and psychologists, these providers are experiencing more financial issues than their better paid counterparts.

We recommend the following:

- On page 7, we would like to see a comment which describes the differences in Medicaid and Medicare reimbursement rates for LCSWs, LPCs, and LMFTs compared to psychiatrists and psychologists. Currently, Medicaid reimburses these providers at 70 percent the rate reimbursed to psychiatrists and psychologists for billing the same psychotherapy codes. Medicare's reimbursement rate is 75 percent for these providers.
- On page 8, we would like to see comments regarding the establishment of loan forgiveness and tuition reimbursement programs for social workers and all other providers noted alongside the recommendations for expanding these programs for doctors.
- We would like our citation to be changed to NASW/Texas from NASW-TC.

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TAPA *Representing all Masters-degreed Psychology practitioners in Texas*

Texas Association of Psychological Associates

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August 26, 2014

To: Matt Turner, PhD, MPH
The Department of State Health Services
HPRC@dshs.state.tx.us

Re: Proposed policy recommendations to ameliorate the Mental Health Workforce Shortage in Texas

Dear Dr. Turner:

Thank you for this additional opportunity for input into this important issue.

Following is TAPA's response for inclusion in the Appendix.

If we may work with you further or clarify any of this information, please do not hesitate to contact us.

Betty Dawson, MA, LPA, LSSP
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Licensed Psychological Associates: An Underutilized Resource

Licensed Psychological Associates (LPAs) are strategically positioned to impact the Mental Health shortage in Texas:

- This license exists;
- The training programs exist;
- **There is NO additional cost to the state.**
- Licensed Psychological Associates must have a minimum of a Masters Degree in Psychology and must pass the exams designated by the Texas State Board of Examiners of Psychologists (TSBEP).
- Licensed Psychological Associates have training equivalent to the training of the other masters-degreed mental health practitioners, Licensed Professional Counselors, Licensed Marriage and Family Therapists, and Licensed Masters in Social Work. However, unlike those practitioners, the training of Licensed Psychological Associates is focused in psychology.
- Licensed Psychological Associates have had the same scope of practice as Licensed Psychologists since the original psychology licensing act was passed in 1968, and do so today.
- There are twenty-nine universities, distributed across Texas, with terminal masters programs in psychology. This is significantly more than the number of universities with doctoral programs.

The need for more psychological services exists; Licensed Psychological Associates are qualified to meet that need – and are ready to do so.

Increasing the size of the mental health workforce:

Despite the availability of the twenty-nine training programs at universities across the state which meet or surpass the requirements for licensing as a Licensed Psychological Associate, few students enroll in these programs because of the difficulty finding employment after they are licensed.

The restrictions which require that Licensed Psychological Associates work only in the offices of Licensed Psychologists or where they may be supervised by Licensed Psychologists precludes them from taking many jobs for which they are uniquely qualified. This report states that 65.2% of the Licensed Psychologists in the state reside in the five most populous counties.[1] Therefore, Licensed Psychological Associates are extremely limited in the number of communities where they may provide services.

There are 1,041 psychological associates currently licensed in the state, but they are largely unavailable for services in programs funded by Medicaid, such as community Mental Health centers or waiver programs for Intellectual and Developmental Disability (IDD) services such as Home and Community-based Services (HCS) and Intermediate Care Facilities for Individuals with Intellectual Disabilities ICF/IID). The Medicaid program billing requirements for PhD

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[1] The Mental Health Workforce Shortage in Texas, September, 2014, page 27

supervision make it largely unfeasible for most programs to incur this added expense. Outside urban areas of the state, the lack of PhD psychologist supervisors preclude using this trained workforce.

Prior to the funding shifts to federal sources and to the shift away from providing services through the state hospitals and state schools and into community based alternatives, Licensed Psychological Associates played a significant role in public mental health. Many were employed in the state hospitals and state schools, community mental health centers, state prisons, and the public schools, providing psychological services without supervision.

A provision in the psychology licensing act specifically exempted Licensed Psychological Associates from the supervision requirement when working in the state agencies. Many Licensed Psychological Associates are dually licensed as Licensed Specialists in School Psychology, and may provide the full range of psychological services in the public schools without the supervision of a Licensed Psychologist. Supervision by a Licensed Psychologist is required for Licensed Psychological Associates who work in private practice.

Many states and Canadian provinces allow independent practice for licensed masters-degreed psychology practitioners.

Removing the supervision requirement and allowing Licensed Psychological Associates to take their rightful place among the other masters-degreed mental health providers not only would allow them to work in underserved parts of the states, but also would encourage students to enter the existing training programs.

Improving the distribution of the mental health workforce:

As noted above, the twenty-nine universities with programs that lead to the Licensed Psychological Associate license are widely distributed across the state, and thus, are more available to students who live in more rural or underserved areas. Some are located in border counties. Students who attend one of these universities and who work in these communities are more likely to stay and make their careers in these communities.[2]

Improving the diversity of the mental health workforce:

Also, as noted above, there are more universities with terminal masters degree programs in psychology than those with doctoral programs in psychology. Some of them are historically minority universities. In one innovative program Our Lady of the Lake University in San Antonio offers to graduate students in psychology who are proficient in Spanish the opportunity to obtain the certificate in *Psychological Services for Spanish Speaking Populations* (PSSSP). This program is in existence, and it could be adapted or replicated.

Minority students often have more opportunity to attain a masters degree, than to make the investment of time and money to attain a PhD. Once they have their masters degree, and if they were able to work in the profession of psychology, then there would be more opportunities for them to work toward a specialty credential or a doctorate. Students who have had the opportunity to work in their profession will make more astute students if they choose to pursue additional education or to attain additional degrees, and are more likely to continue in their area of interest in the profession they have chosen.

Supporting innovative educational models:

In addition to the certificate in *Psychological Services for Spanish Speaking Populations* at Our Lady of the Lake University, the programs leading to the Licensed Psychological Associate license often focus on a specialty area in psychology, rather than just in general psychology. Masters programs in psychology teach the use and interpretation of psychological assessment, as well as counseling, neuropsychology, and empirically-based treatments. Almost half

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[2] Talbot and Coburn, 2013, as referenced in Texas Department of State Health Services, "The Mental Health Workforce Shortage in Texas," February, 2014, page 21

[3] TAPA Survey done in 2005.

of the masters programs have programs with a clinical emphasis.[3] Others have programs with an emphasis in areas such as Community Psychology, Family Psychology, Juvenile Forensic Psychology, Health Psychology, Behavior Analysis, and Neuropsychology.[4] These programs are usually two-year programs which go well beyond the coursework required for licensure. The great majority of these programs meet the standards of the Council of Applied Masters Programs in Psychology.[5]

Conclusion

Improving the number, distribution, and diversity of the mental health workforce, and in particular the psychology workforce, could be accomplished easily, and with NO cost to the state. Licensed Psychological Associates are well-qualified, but are underutilized in Texas. The out-dated supervision rules restrict the jobs that Licensed Psychological Associates may take, even though there are many jobs for which they are well-qualified. Because few jobs are available, few students enter the existing training programs. The requirement for supervision add costs to the services provided by Licensed Psychological Associates, and puts them at a disadvantage in competing against the masters-degreed practitioners in the other mental health professions for jobs for which they might be the better candidate.

Removing the requirement that Licensed Psychological Associates be supervised by a Licensed Psychologist will allow these professionals to take their rightful place among the other masters-degreed mental health practitioners. It also would result in the following:

• Licensed Psychological Associates could provide psychological services in small towns and rural communities where there are no Licensed Psychologists. Licensed Specialists in School Psychology who have masters-degrees, but who do not require supervision, provide psychological services in schools and educational co-ops across the state.

• The ability to practice their profession with a masters degree would encourage more students to enter the twenty-nine universities with masters degree programs leading to the Licensed Psychological Associate license, which would also bolster the strength of these programs. Since the the Licensed Specialists in School Psychology have been permitted to work in the public schools without supervision by a Licensed Psychologist, the demand for this masters degree has increased, and the universities have developed additional programs.

• The ability to practice their profession with a masters degree would provide a more accessible path for minority students to provide psychological services. Some of the twenty-nine universities with masters degree programs leading to the Licensed Psychological Associate license are historically minority universities.

• Licensed Psychological Associates are well-qualified to work with psychiatrists and other physicians to assist with assessments of psychological disorders and with counseling for behavioral follow-up and compliance with medication protocols. Removing the supervision requirement would allow them to join medical teams working with mental health disorders. Psychiatrists and physicians are as qualified to provide professional oversight as are Licensed Psychologists.

This model is used in California. According to the California Board of Psychology[6], masters-degreed psychology practitioners may work for psychologists, psychiatrists, psychology clinics and medical corporations.

• Licensed Psychological Associates have worked successfully in the past in public mental health, the state agencies and community mental health centers before funding shifts precluded them from doing so. Removing the supervision requirement would allow them to do so again.

Recommendations

Instruct the Texas State Board of Examiners of Psychology to determine a pathway for Licensed Psychological Associates to practice independently, <u>without</u> the requirement for supervision by Licensed Psychologists.

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[4] TAPA Survey done in 2005.

[5] www.camppsite.org > Standards

[6] www.psychology.ca.gov/applicants/psychassis_inst.shtml

HB 1023 [83(R)] - Mental Health Workforce Shortages Comments

Reasonable description of issues, offers viable solutions

- Reasonable reflection of struggles and barriers experienced in urban, rural/frontier areas.
- Reasonable description of problems and recommendations.
- Addresses many solutions to improving the shortage.
- The language about loan forgiveness will help address shortages, but include other function areas as well.
- Overall a well-documented report.

Challenge to offer competitive wages for MH professionals

- Recruitment and retention of licensed personnel difficult because current rate and funding environment makes it difficult to offer competitive compensation.
- Difficult to attract doctors and other professionals due to lack of funding.

Expand degree options accepted for QMHP credentialing

- State agency imposed requirements for Qualified Mental Health Professionals (QMHP) limits applicant pool since Criminal Justice and Education degrees are not accepted even if services provided under DSHS contract include consumers involved with criminal justice.
- Criminal Justice should be an acceptable major for meeting QMHP requirements.

Possible Solutions

- Tele-health and Tele-medicine are viable alternatives to shortage of physicians, nurses and counselors but implementation barriers remain.
- Peer providers have been a great benefit for Centers and the peer provider involved.
- Increased focus needed in the education system for mental health providers, more educational opportunities and financial help for those interested in the field.
- If the administrative burdens could be lessened, service capacity could be increased.

Workforce Challenges

- Federal DEA regulations require an annual in-person visit – the requirement erodes the efficiency of eliminating travel time for physicians.
- Issues relating to DSHS strict fidelity and training requirements that are cost prohibitive and further impede LMHA ability to recruit and retain providers.
- Attracting psychiatrists is a significant problem.
- Continuing changes in the system affects shortages of mental health workers.

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August 27, 2014

David Lakey, M.D.
Commissioner
Department of State Health Services
PO Box 149347
Austin, TX 78714-9347

Re: Comments on 8/18/2014 Draft Report: The Mental Health Workforce Shortage in Texas

Dear Dr. Lakey:

The Texas Counseling Association appreciates the opportunity to submit additional comments on the latest draft report, "The Mental Health Workforce Shortage in Texas." We appreciate your consideration and inclusion of many of the comments we submitted to Dr. Matt Turner on April 1, 2014 and are included for your reference.

We request a technical correction in Appendix A. Licensed Professional Counselors (LPCs) are licensed by the Texas State Board of Examiners of Professional Counselors as set forth in Chapter 501 of the Texas Occupations Code and not DSHS as referenced on page 30. This licensing board is housed at DSHS, as are the licensing boards for marriage and family therapists and social workers. Each of these mental health professions are regulated by independent licensing boards appointed by the Governor as set forth in their respective chapters of the Texas Occupations Code.

We would ask reconsideration of one of our recommendations. Please amend Section 1 to include the recommendation to expand Medicaid reimbursement to include LPC-Interns and other mental health professionals who work with temporary licenses under supervision. As we stated in our original letter, "including Interns and Associates will also create a pathway to help address the aging out of the current provider groups. Working with Medicaid clients while under supervision, will increase the likelihood that these well qualified mental health professionals will remain in the system as Medicaid providers."

Finally, we feel that the lack of reference to professional school counselors and professional college counselors, especially in Section 2, overlooks valuable resources in improving the distribution of the mental health workforce across Texas. Professional school counselors and professional college counselors are often the primary mental health resources for students and their families – especially in rural and underserved areas of Texas. Expanding your report to include professional school counselors and professional college counselors would provide a more comprehensive overview of the mental health workforce.

Thank you, again, for the opportunity to participate in the process of creating this very important document. Please feel free to call on me if you need additional information.

Sincerely,

Jan Friese

Jan Friese
Executive Director

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April 1, 2014

Matt Turner, PhD, MPH
Health Professions Resource Center
Dept. of State Health Services - Center for Health Statistics
P.O. Box 149347
Austin, TX 78714 – 9347

Dear Dr. Turner:

The Texas Counseling Association is a non-profit membership organization representing more than 7,000 professional counselors working in a variety of settings across Texas. We appreciate the opportunity to provide comments on the Health Profession Resource Center's proposed recommendations relating to the mental health workforce shortage in Texas as directed by HB 1023 (83R).

While TCA certainly agrees that Texas faces a shortage of mental health professionals, we also contend that access to mental health professionals who are qualified to provide services is seriously curtailed by state policies that are unaddressed in this report. These include the Medicaid policies that certify providers, that set reimbursement rates for mental health services and that exclude qualified mental health professional interns and associates. When defining the Mental Health Workforce, it is also critical that Licensed Professional Counselors – who represent the largest group of licensed clinical mental health providers in Texas – be included under Core Mental Health Professions.

Given the data provided in the HPRC report regarding the mental health needs for children and adolescents as well as the reduced rates of poor mental health for individuals with higher levels of education, TCA contends that increased access to both school counselors and professional college counselors is a key strategy in reducing unmet needs for mental health services.

Our specific recommendations to address each of the issues follows:

- Modify enrollment procedures to expedite the certification of mental health Medicaid providers and allow back billing for services provided during the certification process.

The Medicaid credentialing process takes too long. On average it takes more than six months and often as long as 12 months for mental health providers to be added to Medicaid plans. During the credentialing cycle they are not eligible to bill for services they might be providing to Medicaid clients. The procedures are complex and technical assistance is limited. TCA members report that they have been advised by the Medicaid office to bypass the online application process and submit hard copies. Enhancements to the online certification system and expedited processing of provider applications could significantly increase the pool of providers, especially those in private practice, to treat

Medicaid clients. Allowing providers to back bill for services provided during the Medicaid application process would also encourage more providers to participate.

- Establish appropriate Medicaid rates and amend rules to reimburse all providers at the same rate for the same services.

Low Medicaid reimbursement rates and payment policies are a deterrent for participation by mental health providers. Absent a significant rate increase for providers at all levels, efforts to expand the mental health workforce are going to be marginally effective. The current Medicaid reimbursement rate for providing 45 minutes of individual therapy is $68.48 for children and $65.22 for adults. These rates are abysmally low for mental health professionals, who could receive more than double these amounts for a typical fee-for-service visit.

To make matters worse, Licensed Professional Counselors (LPCs), Licensed Clinical Social Workers (LCSWs) and Licensed Marriage and Family Therapists (LMFTs) are paid at only 70% of the Medicaid allowable rate, which translates to $47.94 for children and $45.66 for adults. These providers report that the Medicaid reimbursement equates to less than $10.00 an hour after accounting for office and staffing expenses. Not even the psychiatrists and psychologists who are paid at 100% of the allowable rate recoup their costs.

Many providers who are willing to serve the Medicaid population cannot afford to continue their participation in Medicaid. A growing number of mental health professionals are opting out of networks. They instead use a cash model for their practice further limiting access to services only to those who can afford to personally pay – even in communities where no provider shortage exists.

- Enact rules to allow Licensed Professional Counselor-Interns, Marriage and Family Therapist-Associates and Licensed Clinical Social Worker-Interns to bill Medicaid for services provided under supervision.

LPC-interns, LMFT-Associates and LCSW-Interns have completed a Masters or Doctorate degree, earned practicum experience and passed the Texas license and Jurisprudence examinations. They are provisionally licensed by Texas to deliver mental health services to clients under supervision. Their education and experience are comparable to Psychological Associates and Provisionally Licensed Psychologists who are currently allowed to bill Medicaid for services that they provide under supervision.

Expanding the pool of mental health providers by including LPC-Interns, LMFT-Associates and LCSW-Interns will not only help address the waiting lists for mental health services, but will also help stretch limited Medicaid dollars. It would be appropriate to compensate Interns and Associates at a lower rate than fully licensed professionals since they are working under supervision.

Including Interns and Associates will also create a pathway to help address the aging out of the current provider groups. Working with Medicaid clients while under supervision, will increase the likelihood that these well qualified mental health professionals will remain in the system as Medicaid providers.

- Modify the definition of Core Mental Health Professions to Include Licensed Professional Counselors.

Licensed Professional Counselors are included in statute as authorized independent providers of mental health services under the Texas Medicaid Program, along with psychiatrists, psychologists, LCSWs and MFTs. They are also included as Core Mental Health Providers in the National Health Service Corps Loan Repayment Program and qualify for loan repayment when working in health profession shortage areas.

The licensure requirements for an LPC are as or more rigorous than the other health care professionals included as Core Mental Health Professions. LPCs are required to earn a minimum of a 48-hour master's degree, pass a rigorous license exam as well as the state jurisprudence exam and complete 3,000 hours of post-graduate supervision.

The designation of LPCs in the category of "Other Licensed Mental Health Professions" stems from antiquated federal and state definitions that are more than 40 years old and do not reflect current policy or state law.

Licensed Professional Counselors represent the largest group (3,733) of Medicaid mental health providers as of July 2013. They deliver services in an array of settings, including hospitals, veteran programs, detention centers, mental health centers, college and university settings, jails and managed care facilities to a diverse client population. They are also authorized in statute, as are the other core mental health professionals, to provide independent assessments for protective orders for children, adults and the disabled.

- Enact rules to reduce the student to counselor ratio in elementary and secondary schools.

The report includes data on the unique mental health challenges faced by children and adolescents but overlooks the opportunity for professional school counselors to help address those needs. Including Certified School Counselors as providers is a key strategy to addressing mental health workforce shortage areas across Texas

Professional school counselors in Texas are required to hold at least a master's degree, have two years teaching experience and pass a unique certification exam. When professional school counselors work in districts that implement the Comprehensive Developmental Guidance and Counseling Program endorsed by the Texas Education Agency and enacted in statute, they are able to provide the array of services that address not only a student's education needs but their psycho-social-emotional development and challenges as well. Students who attend schools that implement the comprehensive

developmental guidance and counseling program report that they are more focused, maintain appropriate classroom behavior, feel safe and do better in their classes.

School counselors are strategically positioned and uniquely qualified to identify and address concerns in students early, reducing the number of children and youth who would otherwise require more specialized and costly mental health services if early interventions had not taken place.

Texas schools cite counseling as the most successful strategy to support students' mental health, but high counselor-to-student ratios and assignment of non-counseling related tasks severely limit their ability to provide prevention and early intervention services to students. For example, in 2004, Texas elementary school counselors spent less than a third of their time on behavioral health counseling; high school counselors spent only 12% of time on it (despite the risk for mental illness and suicide spike in adolescence).

Although the Texas Education Agency includes a recommendation of a ratio of 350 students to one counselor, most school districts report significantly higher ratios. In many districts, especially those located in areas currently designated as mental health profession shortage areas, some schools may not even have a single school counselor assigned exclusively to their campus.

Enacting rules that require school districts to reduce the student to school counselor ratio, implement the comprehensive developmental guidance and counseling program, and notify parents if a school counselor is not available full-time at their school would be effective strategies to identify mental health challenges faced by students early enough to provide effective interventions. Using school counselors as the first tier in the mental health system would help to reduce cost and ensure that students receive the services that they need to be successful.

- Enact rules that require institutions of higher education to utilize licensed mental health professionals as college counselors.

A survey by the Association of University and College Counseling Center Directors released in June 2013 found that 95% of College Counseling Center directors report the number of students with a significant psychological problem is a growing concern on their campus. Seventy percent report that the number of students presenting with severe psychological issues has increased in the past year.

There is a clear tie between mental health and college completion and income levels, based on the data included in your report. Included in the increases in college enrollment are large number of returning veterans who bring with them very unique issues and needs.

College counseling centers are often the gateway to identifying the mental health challenges faced by students. Yet, the student to counselor ratios on college campuses is outrageously high. It ranges from 716:1 on campuses with less than 1500 students, to

1940:1 for schools with enrollments of up to 15,000 students, to 2774:1 on campuses with enrollments that exceed 35,000.

In Texas, however, we are seeing an even more disturbing trend – especially in community colleges – to replace well trained and licensed mental health professionals with bachelor level advisors. These individuals are not prepared to identify and develop appropriate treatment plans to address the myriad of psychological needs that our changing college student populations are bringing to their campus.

College counseling centers can function as the gateway to identifying and addressing mental health challenges in our communities. Including them is a key component to appropriately identifying and addressing mental health shortage areas in Texas. Requiring our institutions of higher education to properly staff them with appropriately licensed mental health professionals is key to the success of this effort.

Community college and university counselors should be mental health professionals who are appropriately trained to deal with clients presenting with severe mental health issues so they can help insure they receive the services they need. They are also uniquely qualified to help students identify and resolve issues of anxiety and depression so that they can complete their studies and achieve their career goals. More than 65% of students report that counseling helped their academic performance.

Enacting rules to ensure that college counseling centers are appropriately staffed with licensed mental health professionals is another key strategy in addressing mental health needs, especially in mental health workforce shortage areas in Texas.

Thank you for the opportunity to provide input to this very important study. We are happy to continue to participate as stakeholders in this project and to provide any additional information you may require to support the recommendations included in this letter.

Sincerely,

Jan Friese

Jan Friese
TCA Executive Director

cc: Bret Hendricks, EdD
TCA President

August 29, 2014

TEXAS HOSPITAL ASSOCIATION

David Lakey, M.D.
Commissioner
Texas Department of State Health Services
P.O. Box 149347
Austin, TX 78714-9347

sent via email to:
HPRC@dshs.state.tx.us

Dear Dr. Lakey:

On behalf of its 450 member hospitals generally and on behalf of its Behavioral Health Constituency Council specifically, in addition to its support of an April 1, 2014, letter submitted by a coalition of mental health organizations that include providers, advocates, families, and consumers submitted previously, the Texas Hospital Association offers the following recommendations and comments in response to both the February 2014 draft House Bill 1023 report and the August 2014 draft final House Bill 1023 report prepared by the Texas Department of State Health Services.

The February 2014 HB 1023 report provides background on Texas' mental health workforce shortage from a macro perspective. THA's comments will be more tailored to issues affecting hospitals. Hospitals in general have difficulty recruiting and retaining psychiatrists for inpatient work primarily due to the on-call responsibilities. In addition, many psychiatrists (and psychologists) have transitioned into cash-only private practices due to their reluctance to participate in insurance plans for a variety of reasons, including administrative and regulatory burdens and low reimbursement. The lack of psychiatrists who are willing to perform inpatient hospital services is at a critical level.

Recommendations

1. Regulatory Change: Revise current state regulations to permit advanced practice registered nurses with appropriate competencies to perform psychiatric evaluations and round on inpatient mental health units daily

Texas Board of Nursing rules currently permit advanced practice registered nurses to perform psychiatric evaluations under their scope of practice and collaborative practice agreements. However Texas regulations, specifically 25 T.A.C. § 411.472(f), (g)(1), a copy of which is

attached, require that a physician complete the initial psychiatric evaluation of the patient AND that a physician see the patient once a day for five of the first seven days of inpatient hospitalization after the initial psychiatric evaluation.

Changing this rule would permit APRNs to work as extenders in hospitals in a way that is similar to their roles in other medical settings and specialties. One of the most time-consuming functions in the hospital setting is the completion of the psychiatric evaluation. Permitting an APRN to complete the psychiatric evaluation of a patient with a requirement that the psychiatrist interview the patient and cosign the document within one to two days of the APRN's evaluation would ease the workload on the psychiatrists and still protect patients.

Furthermore, permitting an APRN to see patients within the first five days of inpatient hospitalization will expand the psychiatrist's ability to cover more patients. APRNs work under a collaborative practice agreement, which could be specific enough to ensure that the psychiatrist meets with the patient within 24 hours of admission, weekly, and prior to discharge to ensure appropriate oversight.

Another reason to permit APRNs to fulfill these duties is that not every hospital can afford to pay psychiatrists for on-call services, as many psychiatrists are opting for a quality of life that does not include working on nights and weekends.

2. Operational Change: Require clinics and private practice physicians to provide answering service and call coverage arrangements after normal business hours

Many clinics and private practice physicians shift the burden of screening patients after regular business hours to the hospital emergency department, one of the most expensive sites of care. As a result of this practice, many of the evaluations performed by the emergency departments reveal that a majority of those patients referred have non-emergency conditions related to their inability to refill medications, their inability to get into their psychiatrist's office for an appointment, or are a situational crisis that is easily resolved by listening. Reducing healthcare costs helps everyone, and addressing the after-hours call situation reduces one hospital barrier to physician recruitment.

3. Incentives for Workers: Institute training stipends for psychiatric trainees

THA supports the recommendation that training stipends be paid to psychiatrist trainees, psychologist trainees, and other mental health professional trainees. Given the dire shortage of mental health professionals at all levels, including LCSWs, psychiatric nurse practitioners, and others, any incentive to recruit professionals to this area of practice would be useful.

4. Incentives for Workers: Early exposure to career opportunities in the field and the special populations served

THA also supports the referenced recommendation in the House Bill 1023 reports. One local example of such a program is The Pathways Project developed by the Network of Behavioral Health Providers, a nonprofit agency comprised of the leadership of some 30 Houston area mental health and substance use provider agencies. The Network is in the fifth year of The Pathways Project, a major workforce development initiative that focuses on increasing the number of persons entering one of the many available behavioral health workforce career education tracks. It begins with an awareness-building curriculum at the high school level and continues through special educational and experiential opportunities in post-secondary and graduate level educational programs and seeks to increase the number of individuals who choose careers in mental health and substance use service provision. More information about this project can be found at: http://www.nbhp.org/pathways-project.html.

5. Outdated Educational Content and Teaching Methods: Revise the curriculum to emphasize the value of telemedicine and supporting primary care physicians and pediatricians

THA agrees that emphasizing the value of telemedicine and ensuring that medical students and interns receive appropriate training in the use of telemedicine is important. The curriculum should also ensure that students understand the role of the psychiatrist as supporting other physicians like primary care physicians and pediatricians in addition to having a direct physician-patient role. We understand that the Meadows Mental Health Policy Institute is looking at bringing interested parties together to look at curriculum and other workforce issues.

One recommendation in the February 2014 House Bill 1023 report that THA does not support is the granting of prescriptive authority to psychologists, which is discussed under "Expansion of Scope of Practice and Integrated Care." Psychologists have not had the proper ongoing training or continuing medical education to understand body systems and the psychiatric presentation of medical illness, complicated drug-drug interactions, physical disease states, etc., nor do they have the level of supervision in medical settings for this area of treatment that APRNs and physician assistants have. Additionally, when studies have looked at expanding psychologists' scope of practice to include prescribing to address the *rural* shortage of psychiatrists, as is evidenced by the February 2014 report, there are not enough psychologists in rural areas either. In fact, the February 2014 report indicates no clinical psychologists in rural boarder counties.

Texas law now permits advanced practice registered nurses and physician assistants to prescribe Schedule II controlled substances in hospital-based settings. If this new practice proves to be safe and effective, one option is to expand this prescriptive authority outside of the hospital-based setting. Using telemedicine is another way to better address this issue.

6. Increase funding for crisis intervention and similar training for law enforcement personnel

While members of law enforcement are not typically viewed as part of the "mental health workforce," they have increasingly become the front line for dealing with individuals who have a mental health condition or substance use disorder. Crisis intervention training (CIT) has been shown to improve officers' "knowledge, diverse attitudes about mental illnesses and their treatments, self-efficacy for interacting with someone with psychosis or suicidality, social-distance stigma, de-escalation skills, and referral decisions." *See* American Psychiatric Association's News Release entitled "Crisis Intervention Training for Police Officers Effective in Helping Respond to Individuals with Behavioral Disorders," attached. These studies have also shown that:

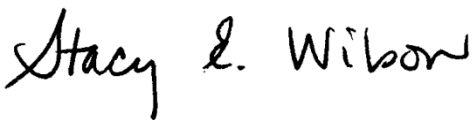
- only 12% of encounters between CIT-trained officers and individuals with a behavioral health issue escalated to the level of physical maneuvers or force;
- officers were significantly more likely to report verbal engagement or negotiation as the highest level of force used; and
- CIT training assisted officers in performing a form of pre-booking jail diversion, thereby reducing the cost of incarceration.

Thus CIT training protects individuals with a mental health condition or substance use disorder, the officer, and the community.

When an officer receives this training, usually a 40-hour course, another officer must cover the shift of the officer in training, and there often is no funding to pay for this coverage. Consequently, additional funding to ensure that officers can receive CIT training when appropriate and desired, whether that funding pays for the officer to attend the training or for coverage of that officer's shift, should be provided by the State. Long-term cost savings in terms of fewer incarcerated individuals and better health outcomes for individuals with mental health conditions or substance use disorders that may reduce recidivism could offset this initial investment.

Thanks again for the opportunity to comment. If you have any questions or need additional information, please let me know.

Sincerely,



Stacy E. Wilson
Associate General Counsel
Texas Hospital Association

TOTA TEXAS OCCUPATIONAL THERAPY ASSOCIATION, INC.
1106 CLAYTON LANE, SUITE 516W • AUSTIN, TEXAS 78723 • PHONE 512-454-TOTA (8682) • FAX 512-450-1777

Dr. David L. Lakey, Commissioner
Department of State Health Services
1100 West 49th Street
Austin, TX 78756

August 27, 2014

Dear Dr. Lakey,

Thank you for this opportunity to comment about the mental health workforce shortage in Texas. The Texas Occupational Therapy Association (TOTA) represents the interest of our members and their patients. TOTA feels that occupational therapists can play an important role in reducing the mental health workforce shortage and improving the functional performance of clients with mental illness.

Since the founding of our profession, occupational therapists have been involved in psychiatry. In 1922, Adolf Meyer, MD, Professor of Psychiatry at John Hopkins University, described the activities of occupational therapists and their patients.[1] Minimum standards for occupational therapy education were established in 1923. Since that time occupational therapy education has had a significant focus on mental health and mental illness. Occupational therapists are trained in the wellness approach to mental health focusing on emotional, environmental, and intellectual elements of mental health. [2]

WWW.TOTA.ORG
ALAMO SOUTH DISTRICT CAPITAL CENTEX DISTRICT GREAT PLAINS WEST DISTRICT GULF COAST EAST DISTRICT RIO GRANDE DISTRICT TRINITY NORTH DISTRICT

Occupational therapists are trained to select and use evaluation tools and interventions that promote mental health and also address physical, sensory, and cognitive functioning affecting our client's ability to participate in daily life.[3] Occupational therapists provide purposeful, goal oriented activities that teach and develop skills in assertiveness, problem solving, medication management, home management, time management, social skills, activities of daily living and wellness. [4]

Occupational therapists' role in mental health has been recognized by the Centers for Medicare and Medicaid (CMS). Effective October 29, 2014, CMS has stated in their conditions of participation that community mental health centers are required to offer occupational therapy services if they wish to bill under Medicare partial hospitalization. [5]

In order to increase the size of the mental health workforce, TOTA recommends that occupational therapists be included as mental health practitioners. Currently there are over 13,000 licensed occupational therapists in the state of Texas. These therapists are trained and ready to assist with the mental health workforce shortage. TOTA agrees with the recommendations to:

- Address payment disparities,
- Expand practice incentives for mental health practitioners,
- Increase higher education funding for mental health fields,
- Initiate early recruitment practices, and

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- Expand the practice capacity of Advanced Practice Register Nurses and other practitioners.

Additionally, TOTA recommends the existing education programs be expanded to include increased laboratory space, increased faculty recruitment and increased faculty salaries.

In order to improve the distribution of the mental health workforce, TOTA recommends that stipends and loan forgiveness programs be developed for those practitioners, other than physicians, who practice in underserved areas of the state.

Thank you for the opportunity to comment. If I can be of further assistance, I can be reached at mary@tota.org or 214-384-8834.

Sincerely,

Mary Hennigan, OTR

Mary Hennigan, OTR, MBA
Executive Director

Notes

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June 24, 2014

David Lakey, MD, Commissioner
Texas Department of State Health Services
PO Box 149347
Austin, Texas 78714-9247

Dear Commissioner Lakey:

On behalf of the Texas Psychological Association (TPA), we appreciate the opportunity to respond to *The Mental Health Workforce in Texas* report commissioned by the Texas Legislature and the reaction by the Texas Medical Association (TMA), the Federation of Texas Psychiatry (FTP) and the Texas Pediatric Society (TPS).

TPA strongly supports the conclusions of the report; specifically, recognition of the great shortage of mental health services and providers in Texas. Our residents unduly suffer from mental health problems that can be effectively treated with evidence-based psychological and medical treatments. By providing these services to our residents Texas will create a healthier and more productive environment for our citizens.

The shortage of licensed psychologists and other mental health providers in Texas certainly exists and increased resources are sorely needed to insure that adequate numbers of professionals choose to train and stay to practice in Texas. The shortage of psychology internship training sites and positions has resulted in a dearth of psychologists in our state. Psychologists who intern in Texas are more likely to set up practice in Texas. The American Psychological Association has created a $3 million grant program to help develop new internship sites for psychologists. TDSHS could certainly benefit by working with Texas agencies to secure some of these grant funds.

The report also rightly recognizes the need to expand the base of appropriately trained providers to prescribe psychotropic medications. Psychologists with specialty training in psychopharmacology have been safely and effectively prescribing psychotropic medications for over 25 years in the Department of Defense, Public Health Service, Indian Health Service,

Louisiana and New Mexico. There are 53 psychologists who have received psychopharmacology training who reside in Texas – many of them licensed to prescribe medications in New Mexico, Louisiana and in the DOD. Significantly, legislatures in Hawaii, Oregon, and recently Illinois have passed legislation authorizing psychologists to prescribe psychotropic medications. The Illinois bill – even now – awaits the approval of the governor. Legislation recently introduced in the U.S. Congress seeks to allow appropriately trained psychologists to prescribe in the VA system. One such bill by Congressman Beto O'Rourke (D-El Paso) in the U.S. House of Representatives addresses the current shortage of prescribing providers in the VA, a shortage that has resulted in well-publicized wait times for our veterans.

Psychologists receive a minimum of 7 years of formal training in diagnosing and treating mental health and substance abuse problems prior to independent licensure. In addition, psychologists must receive an additional two years of formal training in psychopharmacology *after* receiving their doctorates in psychology in order to prescribe psychotropic medications. This specific and targeted training in psychopharmacology far exceeds the general training received by many physicians, dentists, optometrists, or nurse practitioners that currently prescribe medications.

Currently, psychologists with expertise in psychopharmacology regularly consult with primary care physicians and nurse practitioners and make diagnostic and medication recommendations. Psychologists also *teach* physicians how to diagnose mental health problems and how to appropriately use psychotropic medications as part of residency training programs in family medicine, pediatrics and general internal medicine in the State of Texas. If psychologists can recommend medications and teach physicians how to prescribe them, then appropriately trained psychologists should be given the authority to independently prescribe these medications. Patients will benefit greatly by needing to see only one mental health professional for psychotherapy and medication management – one copay, one appointment, one trip, one absence from work.

TMA, FTP, and TPS voiced safety concerns about psychologists independently prescribing psychotropic medications. We are also concerned about patient safety, but the facts are that psychologists have been safely prescribing for over 25 years, have written over 1 million prescriptions and have had no licensing Board actions or lawsuits against prescribing psychologists. TMA similarly voiced concern about the potential for over prescribing by psychologists; however, psychologists see the authority to prescribe as also *the authority to* ***unprescribe.*** Because psychologists are fully trained in behavioral and psychological treatments, unlike our physician and nurse practitioner colleagues, prescribing psychologists in New Mexico, Louisiana and the DOD often take people off of medications and provide psychotherapy instead.

In everyday clinical practice, physicians regularly request psychopharmacology consults from psychologists. Despite the official position offered by the TMA, many physicians welcome the opportunity to have a prescribing psychologist manage their patients with mental health issues. Psychiatrists are experts at the specific medication management of mental health disorders, but wait times as long as 3-6 months for a psychiatric appointment cannot continue. The addition of well-trained prescribing psychologists will remediate this bottleneck. If prescribing psychologists can safely treat the military and citizens in other states, why not in Texas?

Limited access to psychiatrists has been well documented. Psychologists outnumber psychiatrists 3 to 1 in Texas. In 60 rural counties where at least one psychologist provides services for Medicare recipients, no psychiatrists practice. In some counties, psychologists outnumber psychiatrists 7 to 1. With the Affordable Care Act, more insured individuals will be demanding mental health services, further exacerbating these shortages. With media coverage of recent tragic events involving the mentally ill, now is the time for increasing doctoral-level mental health access and extending prescriptive authority to appropriately trained psychologists.

The Texas Psychological Association strongly supports *The Mental Health Workforce in Texas* findings and looks forward to assisting TDSHS in serving the mental health needs of the citizens of Texas by implementing the recommendations contained in it.