RI EOHHS Healthcare Workforce Transformation Committee
BH Practice and Integration Subcommittee Meeting
Meeting Notes: Thursday, 11/3/2016 (3:00 – 4:30 pm)
DLT Conference Room (73-1)

Facilitator: Rick Brooks
Presenter: Susan Storti, Administrator of Opioid Treatment Program Health Homes and Mental Health Policy, The Substance use and Mental Health Leadership Council of RI
Prepared by: Cheryl Wojciechowski
Participants: Kate Prendergast (RIQI), Kathleen Kelly (RIALA), Amy Weinstein (Apprenticeship RI), Sarah Fleury (BCBSRI), Susan Bruce (Optum/UHC), Channavy Chhay (CSEARI), Susanne Campbell (UMass Medical School), Marianne Raimondo (RIC), Ann Detrick (BHDDH/SIM), Mary Dwyer (Community Care RI), Dr. Melissa Jenkins (Brown University), Jim Riley (RIILSN), Brady Dunklee (Apprenticeship RI), Garry Bliss (Integra), Trisha Suggs (BHDDH), Dana Freedman Shara (Planned Parenthood), Judith Fox (BHDDH), Dena Sheehan (BCBSRI), Amy Chirechetti (Optum/UHC), Tonya Glantz (RIC), Katelyn Case (EOHHS), Lisa Ariosto (RIPCPC), Michelle Brophy (BHDDH), Sandra Curtis (EOHHS), Kayla Mudge (HARI).

Agenda Item	Key Discussion Points
Welcome & Introductions	Rick Brooks welcomed participants and provided background on today's subcommittee meeting. The full HWT Committee met on October 7th to begin to plan strategies to transform Rhode Island's healthcare workforce development system. Elizabeth Roberts, Secretary, EOHHS, Nicole Alexander-Scott, MD, MPH, Director, DOH, Rebecca Boss, Acting Director, BHDDH, and Marti Rosenberg, Director, RI SIM Project each spoke to provide a sense of direction and the overarching goals derived from Reinvent MA and SIM. Seven HWT goals were extracted from that meeting: 1. Primary Care 2. Behavioral Health: Practice & Integration 3. Social Determinants of Health/Cultural Competency & Diversity 4. Data Quality, Reporting & HIT 5. Community and Home-Based Care 6. Chronic Disease 7. Dental Care This Behavioral Health: Practice & Integration subcommittee meeting is the second of the seven. The remaining five subcommittees will meet to discuss the other goals through December 1st and the full group will come together again on December 6th to develop concrete workforce development strategies with the likelihood of having the greatest impact and of being accomplished.

Issue Overview (Susan Storti, Administrator of Opioid Treatment Program Health Homes and Mental Health Policy, *The Substance use and Mental Health Leadership Council of RI*)	Susan Storti began by clarifying that the behavioral health (BH) workforce includes everybody, including mental health, substance abuse, and physical health providers. She pointed out several things impacting BH including policy, demands for evidenced based practices, far more complex patients, additional skills/knowledge needed by new graduates, change from functioning in silos, and providers are now charged with delivering the right level care, in the right environment, in the most cost effective manner. She offered what is needed to "re-think the system". BH care should no longer be thought of as being along a continuum but now it should be viewed as more like a circle. We need to address how we are educating the BH workforce and define or clarify the expectations of this workforce. She also highlighted how as we go through healthcare transformation, change will happen on five different levels: 1. Re-shift how services are delivered and the skills needed especially from a life spectrum/continuum perspective. 2. Broaden the concept of" workforce". Should be all inclusive and partner with individual communities to tailor workforce strategies to each community's needs. This includes working with community groups to recruit and train staff. 3. Learn how to work as teams, both internal and external teams. It is important to realize that every discipline is not trained the same way so we must come up with a common language. For example, "drugs" can mean prescriptions or illicit substances – they should be referred to as medications. 4. Look at existing infrastructure to see if it can be used in innovative ways such as developing a mentoring program to cross train the workforce. 5. Think about finding out who's doing what really well and create centers of workforce best practices. Lack of career paths is a retention issue and these centers could facilitate the development of career paths other incentives besides money.
Small Group Discussion of Workforce Strategies	Participants were broken out into small groups. Each group discussed two proposed workforce strategies including: importance, feasibility, how the strategy can be accomplished, potential barriers and possible solutions.
Large Group Discussion of Workforce Strategies	The small groups reported their finding back to the large group as follows: *#1 Train all medical and social service staff to address and address behavioral health conditions.* It is a struggle to provide adequate training to clinical and other staff. The group discussed the tier between PCP and BH professional and how to train that workforce including what resources are available once trained. They also discussed avenues for bridging care between the time a referral is made and when the visit occurs such as "wellness checks". BHDDH recently was awarded a grant to pilot SBIRT in 6 communities. The model includes community health workers (CHW) and the CHWs can test the use of wellness checks. The feds are very interested in seeing sustainability in these grants and SIM is bringing all agencies to the table.

	#2 Increase cultural competence and diversity of BH workforce. The group felt this is a priority and is feasible by taking advantage of a ready cohort of teenagers that are linguistic health navigators for their families. This could be parleyed into a career. *#3 Integrate BH practitioners into primary care setting and train staff to work in care teams where all staff work at the top of their license.* CTC was brought up as a strategy along with looking at models like PACE centers of excellence. The group identified a question that needs to be answered – What would the actual leadership of such a team be. They also identify a barrier – the rules around sharing data and payment. *#4 Provide continuing education to BH professionals on "transformational" issues such as team-based care, care management, social determinants, and alternate payment models.* The group stressed training for all, a culture of ongoing development, train-the-trainer models, on-the-job training, and the need to involve the health insurance commissioner on issues such as APM. *#5 Shift emphasis of health professional training from hospitals to community settings.* Priority for this strategy was set at 4 and feasible at 4. This group questioned "Train for what?", identified the need for onsite supervision, and offered two barriers – funding and reimbursement. *#6 Address shortage of psychiatrists and other behavioral health providers through recruitment and retention initiatives and new models of care.* Priority for this strategy was set at 5 and feasibility at 4. The group suggested telehealth consults with ACOs though acknowledged that changing regulations and funding are barriers. They also suggested reinstituting the URI nurse practitioner program, new code for psychiatry in primary care under Medicare (but there are questions about how to use and what are the requirements), SIM child psychiatry program which includes a Bradley psychiatrist to provide telephone consultation to pediatric primary care). The group also brought up the shortage of Psychiatrists and need for training for PCPs. *#7 Promote behavioral health careers to high schools, unemployed, and entry-level staff.* This group suggested creating a "high school pipeline" by incorporating behavioral healthcare into the career education curriculum. Other suggestions included developing YouTube videos, paid internships for high school students, apprenticeships (peer coaches) that build college credit. *#8 increase training, certification, compensation, job satisfaction, and advancement opportunities of direct care staff to reduce turnover.*

	The group discussed how to support workers in a low paying high stress field. They identified opportunities with mental health parity – licensed mental health counselors aren't as reimbursable as LICSWs and Medicare doesn't pay for BH services. They suggested mapping core competencies and look at pre-nursing and other programs (middle college) to replicate this for MH careers. One barriers is that when staff go for training there are holes in services. *#9 Expand, support, and fund "peer" workforce.* Priority was set at 3-4 and the feasibility was considered high. More outcomes data would be needed to increase the priority level. The group pointed out that Peer Recovery coaches are now being certified. Anchor Recovery provides this type of training and has an on-call Peer Recovery program providing services in hospitals. These workers can be a bridge to physicians and other professional providers. One of the barriers discussed is that there can be a stigma that these workers need to overcome – that they may not be reliable due to their past experience with SA and that they do not have a solid work history. It is important that these workers get into career paths and Apprenticeship RI is building career paths for these types of workers. *#10 Increase use of and training in telemedicine.* Due to the huge shortage of psychiatrists, this group discussed the use of telemedicine to increase access. Some health plans currently offer this as a benefit. In some other states psychologist can prescribe. Therefore a patient could call a psychologist in another state to obtain a prescription until they can access care in this state. Medication adherence apps were also suggested. Potential barriers that were offered were training needed for consumers and Medicaid does not cover telemedicine. The large group also discussed the use of focus groups with consumers in developing the Connecticut healthcare transformation strategy and if this is possible in Rhode Island. It was offered that SBIRT could add consumer engagement questions to their questionnaires. The potential for SIM to engage consumers in each SIM initiative was also discussed.
Next Steps	Rick Brooks thanked participants for their time and input and reminded the group that there will be five other subcommittees throughout November and that the next large HWT Committee meeting will be on December 6th.