Solving the NH Behavioral Health Workforce Crisis

September 2024

A Collaboration Among:

- Attendees of the July 31, 2024 Behavioral Health Workforce Solution Session
- NH Behavioral Health Workforce Center at Dartmouth Health
- NH Community Behavioral Health Association
- HealthForce NH

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Executive Summary

Workforce shortages in New Hampshire's behavioral healthcare sector have reached alarming levels and have stayed at these levels for nearly a decade. Despite heroic efforts from leaders from all sectors, many individuals in NH who are in clear need of behavioral health support are not getting sufficient help. There are many 'bright spots' in NH's quest to improve support for behavioral health statewide.

All efforts have been significantly constrained by shortages of qualified staff.

In July 2024, the NH Behavioral Health Workforce Center at Dartmouth Health, the Community Behavioral Health Association, and HealthForce NH co-hosted the *NH Behavioral Health Solution Session*. Over 100 senior leaders representing diverse perspectives from multiple government agencies, healthcare providers, academic institutions, law enforcement and justice, philanthropy, public health, peer support, workforce development, employment security, staff licensure, and community organizations came together in Plymouth. The **goal of the day was to be clear eyed about the state of the workforce and to get to work on solving it differently**.

This resulting report highlights the findings from the solution session alongside learnings from the NH Behavioral Health Workforce Center at Dartmouth Health and provides a shared path forward.

Part 1 – Prepare a BH labor market that has the gravitational pull to attract and retain highly skilled and qualified BH staff.

- Begin with our strengths and assets both as a state and as a behavioral health system of care.
- Collectively promote NH as the best place to train and work in behavioral healthcare.
- Do the hard work to correct our weaknesses. Right now, it is counter to an individual's economic self-interest to work in a behavioral health career in NH. There is detailed, difficult change work at all levels to correct the fundamentals of revenue and wages and over complexity. This requires finding our shared interests and collaborating to solve each constraint.

Part 2 – Find, attract, prepare, and retain workforce

- Help colleges and universities attract and prepare candidates for NH BH positions
- Help BH Organizations attract and support Peer Paraprofessionals, people in recovery from mental illness and/or substance misuse, and individuals with criminal records as valued members of their teams
- Help BH clinicians return to service from private practice
- Encourage inbound migration of BH workforce / discourage outbound migration
- Utilize telehealth to gain access to more BH staff
- Utilize gig workers for some BH care
- Reduce BH demand by sharing the load with communities and technology

The NH Behavioral Health workforce is in crisis! All of the easy solutions have been tried and exhausted. The remaining work is nuanced, complex, and challenging. There are pathways out of the crisis and all of them require valuing behavioral healthcare as a society and sharing the mission to shore up NH's systems of care. This is shared work requiring leadership from the federal and state governments, from across the entire healthcare value chain, from our partners in philanthropy and advocacy, and from those who educate and engage the public. It is in all of our shared interest to go to work on these actions together and to keep everyone engaged in collaborative problem solving and celebrating progress. The simplest indicators of success will be number of individuals hired into the NH behavioral health labor pool as a whole and the number of staff retained.

Introduction

Workforce shortages in New Hampshire's behavioral healthcare sector have reached alarming levels and have stayed at these levels for nearly a decade. For example: the NH Community Mental Health Centers (CMHCs) provide the state's behavioral health (BH) outpatient safety net and have the mission of keeping individuals in their communities rather than institutional care. Right now, there are 334 open CMHC positions statewide (12% vacancy rate) and an average of 1 in 5 staff turn over every year. The 12-month turnover rate is as high as 1 in 3 in several parts of the state, it takes over 103 days to fill open positions, and turnover is getting worse nearly everywhere. The workforce crisis is clear and it is persistent.

Despite heroic efforts from leaders from all sectors, many individuals in NH who are in clear need of behavioral health support are not getting sufficient help. NH leaders have been actively trying to solve this crisis because they recognize the cascading societal risks that come with under-supported mental health and substance misuse challenges including:

- Increasing deaths of despair from suicide and overdose
- Increasing hospitalizations and Emergency Department boarding
- Increasing behavioral problems at school and home, absenteeism, and school dropout
- Increasing levels of absenteeism from work and decreasing productivity while at work
- Increasing misuse of alcohol, drugs, and opioids
- Increasing levels of disability, unemployment, poverty, and number of uninsured
- Increasing incidents with law enforcement, arrests, court hearings, and incarcerations
- Decreasing lifespans (8.0 to 14.6 life years lost for men and 9.8 to 17.5 life years lost for women with serious mental illness[i])
- Long term impacts including Adverse Childhood Experiences, intergenerational trauma, and generational poverty

There are many 'bright spots' in NH's quest to improve support for behavioral health statewide. To highlight just a few of the bigger programs, NH has launched promising multi-organizational initiatives including: NH Rapid Response and 9-8-8 for crisis care, Mission Zero to eliminate psychiatric boarding in emergency departments, System of Care for Children's Behavioral Health to provide wraparound support for children and families with behavioral health challenges, the NH Integrated Delivery Networks (IDNs) to integrate primary care and behavioral health, and the Certified Community Behavioral Health Center (CCBHC) program to bolster outpatient behavioral healthcare services.

Alongside these large-scale initiatives, NH's philanthropy community, our government leadership and staff, our healthcare organizations, our law enforcement leaders, and our community organizations have all committed significant time, effort, and funding to improve behavioral health across the state.

All efforts have been significantly constrained by shortages of qualified staff.

In July of 2024, over 100 senior leaders representing diverse perspectives from multiple government agencies, healthcare organizations, academic institutions, law enforcement and justice, philanthropy, public health, peer support, workforce development, employment security, staff licensure, and community organizations came together in Plymouth for the *NH Behavioral Health Workforce Solution Session*. The goal of the day was to be clear eyed about the state of the workforce and to get to work on

solving it differently. Cross-sector teams spent the day working through the hardest parts of the workforce challenge. They were asked for 3 things:

1. To bring forward *hard-earned learnings* – which is actual experience gained from trying to solve the workforce crisis to date.
2. To identify *cruxes to overcome* - which are the nuances or details that may not be well understood but that need to be solved to crack the problem.
3. To generate *breakthrough ideas* - which are innovative solutions that learn from the past, overcome the cruxes, and show promise to solve the workforce crisis.

This report highlights the findings from the solution session alongside learnings from the NH Behavioral Health Workforce Center at Dartmouth Health and provides a shared path forward. The body of the report is divided into 2 sections:

- **Part 1 – Prepare a BH labor market that has the gravitational pull to attract and retain highly skilled and qualified BH staff.**
- **Part 2 – Find, attract, prepare, and retain workforce.**

Caveats

The intent of this paper is to [re]sound the alarm regarding an overstressed behavioral health system and its workforce and to spur rapid action, but it is flawed by design and the NH BH Workforce Center team has a few caveats up front:

First, we are standing on the shoulders of giants. For decades there has been a lot of good work in NH led by amazing and dedicated people trying to improve our overall healthcare system – both physical and behavioral health. We all need to honor this work, let others know about it, and then build upon it. While this report does not catalogue all of the past efforts, it intends to respect and complement the value of the good work that has come before and brought us this far!

Second, we all have blind spots. At the Behavioral Health Workforce Solution Session, many participants pointed out that knowledge and expertise has become specialized and siloed. Many participants stated that they have gaps in knowledge about how the healthcare labor markets work. In response, this report attempts to explain the whole system simply and quickly so that we can together locate the big levers for change. This is not a research paper. Since it would take years to accurately describe the complex web that makes up the behavioral health labor market and surrounding systems, we acknowledge that there will be mistakes. (If you do come across errors, please inform the team at the NH Behavioral Health Workforce Center at Dartmouth Health and we will make corrections and maintain a current report.)

Finally, work is already underway but needs awareness building and support. Several of the actions identified in this report are or may be underway. The community of leaders that is working on healthcare workforce wants to know more about the actions, about what you are learning, what additional help you need, and how it's going. Please inform the team at the NH BH Workforce Center at Dartmouth Health of your good work and progress and we will help you spread the word.

Part 1 – Prepare a BH labor market that has the gravitational pull to attract and retain highly skilled and qualified BH staff

A well-prepared labor environment is one that has been intentionally assembled to be *extremely attractive*. The environment not only attracts qualified staff to open positions, it has enough gravity or pull to entice colleges and universities to create and sustain preparatory programs. It has enough gravity to pique the interests of college students preparing for career, high school students choosing a degree program and major, elementary school students learning about careers. The gravity extends to other parts of the economy and entices career changers and pulls at the heartstrings of those who want to serve. The gravity keeps people in their careers, helping them meet their professional aspirations through rewarding and rich career pathways and advancement opportunities. The gravitational pull is stronger than the access and equity barriers that stand before it. The gravitational pull is unbound by state lines.

New Hampshire has an enormous head start with preparing an attractive labor environment. The natural beauty in every region of the state is exceptional, from the vast forests of the north country, to the stark peaks of the White Mountain and Sandwich ranges, to the lakes and rivers in the state's center and west, to the sea. The cultural beauty of the state is compelling, whether you like tiny idyllic villages, college towns, or the rich cultural offerings of small cities. Civic engagement is endemic with both the benefits and costs of leading the national political conversation. And NH is rich in educational institutions with several leading private institutions, the land grant schools, a comprehensive Community College system, and a full spread of public, charter, and private primary and secondary schools.

NH's healthcare leadership is also something to celebrate – markedly so in behavioral healthcare. Beginning 7 decades ago the state was a leader in de-institutionalization. This complete system reform reduced institutional census by 90% over a 40-year period. NH replaced "asylum" care with a complete system of care ranging from inpatient stabilization, to step-down partial hospitalization and intensive outpatient programs, to outpatient community behavioral health, and on to primary prevention and support in community. In this century the innovations have continued. Nearly all major primary care provider organizations have worked with their behavioral health counterparts to begin transition to integrated behavioral health and primary care models. NH has led in the merging of mental healthcare and substance misuse care into "behavioral healthcare." NH is an early pioneer in Peer Support with a formal system of Peer Support Agencies and the employment of Peer Paraprofessionals across many care settings supporting crisis care, recovery, and resilience. NH has a complete system of CMHCs, many of which are undergoing the service delivery and payment reforms of the CCBHC program. And most recently, NH leads in the provision of statewide mobile crisis in tandem with the national launch of 9-8-8. In short, NH is an amazing place to train and to work on the forward frontiers of behavioral healthcare!

So, what is left to do?

There is a lot of clear and relatively uncomplicated work left to do to promote the state's strengths to those who may want to train and work here. Given that there is wide shared interest in this marketing / public relations work, it would be most efficient to collectively promote NH's healthcare system using a *chamber of commerce* model. This report does not detail out the promotional workstream but it can be resourced and led by any number of organizations and/or agencies with professional marketing and public relations expertise.

Action! Collectively invest in the promotion of NH as the best place to train and work in Behavioral Healthcare.

Beyond promotion, there is a lot of nuanced work to do to strengthen the state's current weaknesses in regards to BH workforce attraction and retention, namely:

- Finding revenue to correct staff compensation
- Reducing stress on the current BH system

Finding revenue to correct staff compensation

The flow of revenue for behavioral healthcare is one of the most complicated systems in our economy. If we as a society wish to give one of our behavioral health workers a paycheck and an occasional pay raise, we are up against a morass of complexity. Other parts of the NH labor market (e.g., Real estate, Food and Beverage, Automobiles, Fuel, Manufacturing) adjust wages relatively quickly to market shocks and changing conditions, supply and demand fluctuations, and inflationary pressures. The highly constrained healthcare labor market has not adjusted easily, and over time, this has led to revenue and wages that lag conditions on the ground and are far out of alignment with the rest of the economy.

A highly trained and licensed therapist with a Master's Degree can make more as a semi-skilled laborer at a manufacturing plant. A highly trained certified peer support specialist can double their wage by cleaning rooms in hotels or serving fast food.

Why is revenue correction needed in the first place?

The behavioral health of NH citizens has been impacted by multiple large shocks in recent years. Though there are some bright spots, most indicators of behavioral health have moved negatively over the past decade whether measuring prevalence of mental health illness, reviewing self-disclosure of adolescent wellness, or monitoring deaths of despair suicide and overdose data. There are many big shocks and intermingled changes impacting behavioral health in NH and the most notable include:

- Fentanyl: avg. 437 overdose deaths per year in NH (2019-2023)[ii]
- Global Pandemic: 3,498 deaths and 382,013 reported cases in NH[iii]
- National youth mental health crisis: bullying, harassment, isolation, and maladaptive socialization compounded by smartphones and social media[iv]
- Political polarization and shift toward violence: Poll shows 23% believe we may have to resort to violence[v]
- Gun violence and ongoing threat: According to FBI, 211,853 guns were sold in NH in the past 18 months. 38% of households got a new gun. 41% of NH adults have gun at home.[vi]

- Medicaid expansion and then continuous enrollment wind-down: expansion brought uninsured rate down from 10.5% (pre-expansion) to 5.9% (post expansion). Wind-down removed 25% of Medicaid enrollees.[vii]

In purely economic terms, there has been a large increase in demand for behavioral health services. The simplified economic breakdown of the NH behavioral healthcare labor market is as follows:[viiiix]

1. Demand for BH services has increased markedly
2. Therefore, demand for qualified BH staff has increased
3. At the same time qualified staff are becoming increasingly scarce
4. Inflation has significantly reduced the real value of current wages (e.g., July 2024 prices ~21% more expensive than in Feb 2020)
5. In combination, these labor market conditions have put a great deal of upward pressure on wages for multiple years
6. Revenue for behavioral health staff wages and benefits are highly constrained and the healthcare labor markets do not follow the market-based rules of most of the U.S. economy.
7. Wages have not kept pace for many years. For example, a recent CBHA compensation study of CMHC staff showed that 2021 NH BH wages were off the US median by between 7% and 43% depending on role.
8. At the same time, wages have gone up in other sectors and regions of the country creating incentives for 'economically rational' workers to change careers and/or location.
9. Critical gaps in staffing have opened (e.g., 12% avg. vacancy rate in CMHCs ranging as high as 29%).
10. As staff shortages have persisted and increased, daily work conditions for those who have stayed on have become more challenging leading to more attrition (e.g., 22% avg. annual turnover rate in CMHCs ranging as high as 33%)

Among these worsening labor market conditions, the 2023 NH Medicaid rate increase was historic and a very welcome bright light. But it may have been too little and too late - especially when Medicaid membership declined ~25% under continuous enrollment wind-down and as the uninsured rates compounded. The conditions for a cascading "snowball effect" or "downward spiral" pattern are now firmly established.

Action: Sound the Alarm! NH's Behavioral health labor market is in a downward spiral.

Why hasn't the labor market corrected on its own?

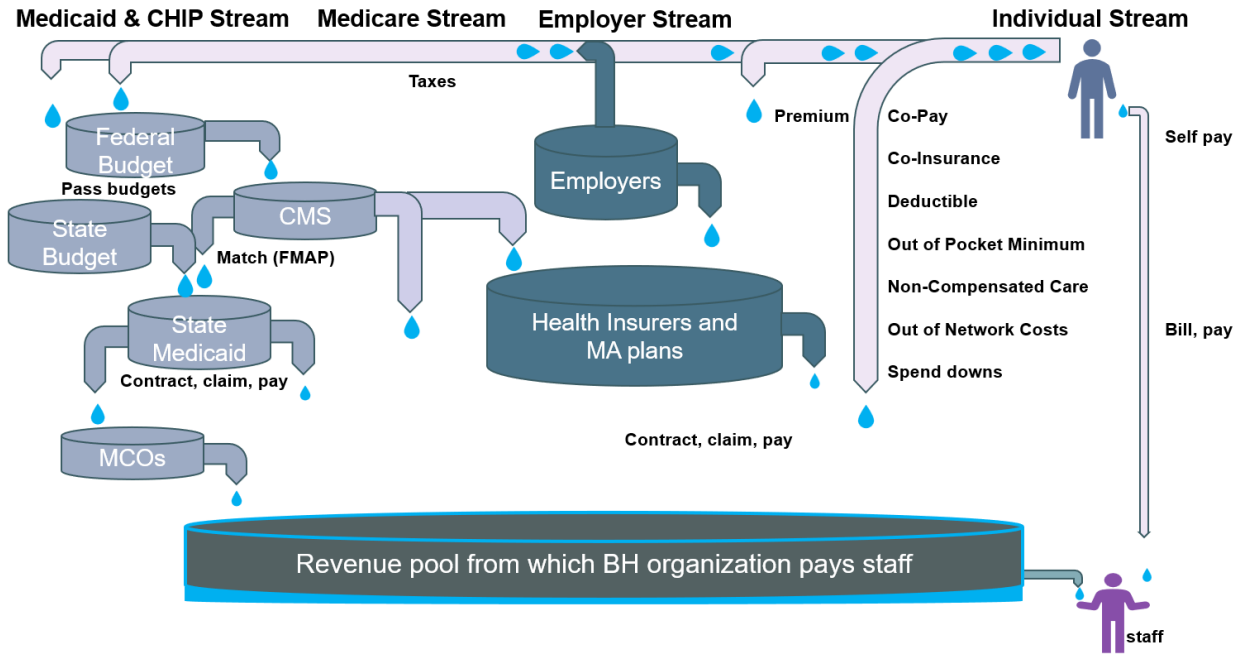
The healthcare labor market acts differently than the market-based systems that are in place with most of the U.S. economy and it is severely constrained by complex revenue flows. If we wish to correct this we have to "follow the money" all the way upstream from staff wages to their sources. This will help us identify potential areas for correction or improvement all along the way. The following section is optional background reading to help explain the complexities of funding flows and their impacts on constraining revenue and wages. For all its complexity, this section is still oversimplified,

omits a lot of details, and is likely flawed. However, it helps accomplish the goal of identifying interventions along the revenue streams for investigation and action.

Optional Background – 'Follow the Money' for Healthcare Wages

Do you remember the 'water cycle' diagram from elementary school where scientists mapped out the journey of a raindrop from a cloud? Below is a similar map that attempts to explain how funding flows from its sources or 'headwaters' to a paycheck for a single behavioral health worker. (We left out evaporation, transpiration, and the little cloud diagrams for now.)

Figure 1: Oversimplified picture of revenue streams for healthcare labor market



Medicaid and CHIP: We'll begin on the upper left-hand side with the 'Medicaid and Children's Health Insurance Program (CHIP)' tributary. This flow is for low-income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income. It is the largest source of revenue for the providers that serve NH children with Serious Emotional Disturbance (SED) and NH adults with serious mental illness (SMI).

The 'headwaters' for this stream start at the federal government and its allocation of taxpayer revenue. This is a routine annual process where the sitting president provides a desired federal budget in line with their administration's vision and priorities. The House of Representatives drafts the budget informed by data from the Government Accountability Office, the Congressional Budget Office, the Office of Management and Budget, and the Treasury Department. Congress debates and then passes (or in some years does not pass) an annual federal budget. The President signs the budget and then oversees its implementation.

Following the Medicaid and CHIP tributary downstream, the Center for Medicare and Medicaid Services (CMS) under the US Department of Health and Human Services (HHS) is responsible for working with each state to distribute the Medicaid and CHIP funds. In the current US system, a state must raise funding to match and draw down Medicaid and CHIP funding. Each year CMS determines the match formula through something called Federal Medical Assistance Percentages (FMAP) aka. Federal Financial Participation in State Assistance Expenditures (FFP). Over the years the Federal Government has passed and implemented laws to 'enhance' the match formula for priority areas such as children's health (under the social security act) and health insurance coverage for the uninsured (under the Affordable Care Act). With these changes *enhanced* match rates are more favorable to states and they can "lever up" more federal funds with state match dollars.

Following the Medicaid and CHIP tributary to the state level, every two years the NH Governor and Legislature pass a budget. The Medicaid and CHIP portion of this budget determines how much federal Medicaid and CHIP funding flows to the state. The combined state and federal revenues are managed by the Medicaid office within the NH Department of Health and Human Services (DHHS). NH Medicaid determines what healthcare services it will pay for and sets actuarial sound rates for these services in consultation with rate setting consultants.

NH Medicaid distributes some funds to behavioral health providers directly and some funds through three managed care organizations (MCOs). The MCOs currently include two non-profits (AmeriHealth Caritas, WellSense) and one for-profit (NH Healthy Families - owned by Centene) which are charged [through their contracts with DHHS] to recruit Medicaid Members and manage their healthcare. MCOs fund their operations with a portion of the Medicaid funds that they manage.

Going further downstream to where revenue meets the care delivery, each NH MCO contracts with each healthcare provider organization to provide services to the Medicaid members they serve. The MCOs pay the behavioral health providers a Fee for Service (FFS) rate for services provided and/or a 'capitated rate,' which is a per member per month amount to support each MCO member. To draw down this rate, the clinicians chart each patient visit in their electronic health records and then the provider organization generates and sends claims to each MCO along with data and information to justify the claim. The MCO processes and accepts / pays or denies their portion of the claims (Individual portion is covered below). The resulting payment is used by provider organizations to run their organizations. The largest portion of operational revenue typically goes to paying staff wages and benefits.

Medicare: Moving to the right in the diagram, we'll go to the Medicare stream next. This flow is for retirement age adults and disabled adults receiving Social Security Disability Insurance. The federal headwaters are the same as for Medicaid. Starting from CMS, Medicare funds flow either directly to providers or through Medicare Advantage (MA) plans. Medicare Advantage plans are health insurance plans that are funded by federal tax funds and managed by private non-profit and for-profit health insurance companies. The MA plans recruit members and manage healthcare payment on their behalf. Each Health Insurer contracts with each provider organization, determines which services they cover and under which conditions, and negotiates rates on behalf of their members.

Going downstream on the Medicare tributary, providers support the behavioral health needs of patients who have Medicare and Medicare Advantage. To be paid, provider organizations negotiate contracts and rates with CMS and with each insurer. Each health insurer has a different way of paying for services, different covered and uncovered services, and different rates. Providers generate and sends claims to

CMS and each Medicare Advantage plan along with data and information to justify the claim. The payer then processes, accepts and pays, or denies their portion of the claim (individual portion is covered below). Resulting revenue is used by provider organizations for operations and to pay their staff.

Employer Stream: Employers pay corporate taxes that support federal government programs and pay state taxes that support state government programs. Employers also provide healthcare coverage to their employees and their families as part of their benefits package – used to attract and retain labor. This flow is for employed individuals and their covered families. Annually, employers select health insurance companies and plans on behalf of their employees and contribute 'tax advantaged' revenue to the health insurance companies. In recent decades many employers have limited annual increases in health insurance contributions which has shifted an ever-growing portion of costs to employees as insurance rates have grown steeply (health insurance premiums for a family increased 47% from 2013-2023).[x]

Going downstream from the employer tributary, the pattern is the same as the Health Insurance/ Medicare Advantage plan part of the Medicare stream above.

Individual Stream: NH Individuals pay federal taxes that support Federal Benefits programs. NH individuals pay state taxes to support state government programs. Since there is no income tax or sales tax in NH, the tax headwaters are severely constrained and draw mainly from meal and room taxes, tobacco excise tax, real estate transaction tax, insurance tax, motor fuel tax, and from state-operated liquor and lottery ticket sales.

Going downstream on the Individual tributary, employed individuals pay health insurance companies for part of their premium through a tax advantaged portion of their paycheck. Alternatively, an individual or small business owner may select a health insurer without their employer using a health insurance exchange. In these cases, the individual pays all of the premium and may receive discounting based on income level.

Going further downstream to where the individual tributary meets care delivery, most individuals pay a portion of healthcare costs on their own whether they are receiving Medicaid, Medicare, or Employer sponsored health insurance. Clinicians chart each patient visit in their electronic health records and then the provider generates and sends claims to each MCO or Health Insurer/ MA Plan along with data and information to justify the claim. The MCO or Health Insurer processes and accepts / pays or denies their portion of the claim and they send an "estimate of benefits" to the provider and the individual to outline their portion of the claim. These costs are opaque and hard for Individuals to predict. They come in the forms of Co-Pay, Co-Insurance, Deductibles, Out of Pocket Minimums, Non-Compensated Care, Out of Network Costs, and Spend down. Individual revenue is also harder to collect than other sources which results in delayed payment and increased write-offs for providers. Like above, the resulting payment is used by provider organizations to pay staff wages and benefits.

Individual Stream – Self Pay: There is one individual revenue stream that stands alone and is orders of magnitude simpler than all the others. The self-pay stream is where an individual pays a healthcare provider for services directly. This stream is used by individuals who can afford to pay directly. In NH's behavioral healthcare system, it is often the only way to access care from a provider who no longer accepts Medicaid, Medicare, and/or Health Insurance.

Government Contracts: The state and federal government provide a wide-range of funding opportunities through many different government agencies. These funds promote specific priorities (e.g., Rural health, Research) and Programs (e.g., Broadband, 9-8-8). The state government and many healthcare organizations apply for, win, and then manage government contracts. The revenue supplements the direct care revenue streams outlined above.

Philanthropy: The last revenue stream is Philanthropy. In this stream a Philanthropy organization donates funding to a healthcare organization in line with its values and priorities.

Left out of this version: There are many parts of the ecosystem left out of this diagram in its current iteration and we'll have to come back to them at a later time. This version excludes flows for active duty and retired US military staff (Department of Defense, Veteran's Administration), flows for Federal Employees Health Benefits Program (FEHB), and flows for Indian Health Services among others.

Points of Intervention along the Revenue Streams to Fund Staff Wages

There are ways to add more revenue to the 'headwaters' and to take the waste and friction out of the revenue streams so that there are sufficient funds to pay workers competitive wages and benefits. The 'upstream' interventions can be accomplished through NH's representative democracy and those who advocate at the federal and state level. The immediate federal intervention point is the federal budget and the specific allocation of funding for behavioral healthcare via CMS (for Medicare, Medicaid, CHIP), via the Substance Abuse and Mental Health Administration (SAMHSA) (for Behavioral Health-specific funding), and via the Health Resources and Services Administration (HRSA) (for rural funding), among others. The immediate state intervention point is the state biennial budget and the specific allocation of funding for federal match via DHHS. The ongoing durable intervention points are through legislation at the federal or state level.

All efforts to increase revenue require that leaders and their public supporters recognize the value in behavioral healthcare. This requires coming to common ground on the existence of treatable behavioral health conditions and the will to responsibly support the needs of NH citizens.

Participants at the BH Workforce Solutions Session came up with the innovative idea of assembling a single non-partisan source of data and information to support leaders as they craft and defend the federal and state budgets and legislation. This effort can build upon the work of CBHA, DHHS, and the Governor's Statewide Oversight Commission on Mental Health Workforce among others. They suggest that this effort could also offer inclusive [not divisive or polarizing] messaging such as "we are all in this together" (meaning The NH Public, NH Legislature, DHHS, MCOs, and Healthcare Providers), "The vitality of the NH BH workforce is tied to the vitality of NH," and "Healthy workforce, healthy lives, healthy NH." Attendees also suggested that businesses may work together to advocate for the best interests of their workers. Attendees suggested NH leverage it's "first in nation" role to elevate the prioritization of behavioral health in national political discussions. [Participants also jokingly suggested that NH could fund BH care by levying a tax on Presidential candidates.]

Action! Curate a single source of data, information, and inclusive messaging regarding the NH BH Labor Market to be used by leaders to align public support and take legislative action.

Action! Allocate sufficient funding for BH in Federal and State budgets and legislation.

Working downstream, there is a giant elephant in the room - the funding of the US healthcare system is in clear need of reform. The most obvious answer to the workforce wage problem is all tied together with the question "why do Americans pay twice as much for healthcare as other wealthy nations?" Large healthcare reforms do occasionally happen and there is some hope for structural correction of the current system that will help resolve both healthcare overspending and the wage gap. In the meantime, there are multiple laws on the federal books that require administrative simplification of the existing system and there are thousands of opportunities to make micro-corrections. This effort can be led at all levels from NH's federal delegation, to those interfacing with the Federal Agencies, to those drafting contracts at DHHS and the MCOs, to those that configure coding, billing and payment systems.

Action! Take every opportunity to simplify the existing healthcare payment system. Seriously consider 'value vs. burden' before adding any additional complexity.

Action! Embrace federal, state, and private payer payment reforms (e.g., Prospective Payment, Bundled Payment, Capitation) and leave behind legacy complexity (e.g., "shadow billing") when transitioning to simpler value-based payment systems.

Working further downstream there are more specific interventions at the intersection of NH Medicaid, the Federal CMS funding flows, and the State budget. The Leadership at NH Medicaid is already adept at maximizing federal funding with constrained state funding. NH differentiate itself on its tax structure with no sales tax, no income tax, and low corporate tax rate. That said, NH does need to raise durable sources of revenue to draw down federal funds. The points of leverage are raising state funds, maximizing enhanced federal funds participation, pursuing statewide grant/waiver opportunities, and rate setting.

Action! Review state matching fund sources for fitness, durability, and sufficiency. Make improvements and add revenue sources where feasible.

Action! Continue to monitor and maximize enhanced federal funds participation opportunities to draw down more federal funding.

Action! Continue to pursue federal grant and waiver opportunities to supplement revenue.

Action! Make market corrections for staff wages through rate setting routines.

Still further downstream there are streamlining opportunities with Managed Care. Periodically, NH may question the role MCOs play in the behavioral healthcare value stream. This could lead to direct Medicaid-to-Provider payment in some areas (e.g., Mobile Crisis) and improved MCO value in others. Ultimately, NH needs to efficiently transfer much more revenue to healthcare staff and any inefficiencies, waste, and excessive administrative overhead along the way should be questioned and reformed.

Participants at the BH Workforce Solutions Session pointed out many current points of *friction* with the MCOs. They included delays in MCO contracting, complex requirements that add administrative burden [and that flows through to clinical staff], and contracting differences between the 3 MCOs. They suggested that MCOs should provide reliable revenue that is sensitive to labor market changes. This could be accomplished with multi-year contracts that provide assurance of future revenue for provision of services (rather than annual contracts with year over year decreases), along with Cost-of-Living Adjustments (COLA) and market adjustments. They suggested that the Providers and MCOs could work together to streamline contracting and create simple, timely, plain language contracts that are consistent across MCOs and Providers. They suggested that the government be made more aware of how the MCOs operate. They suggested that NH align MCO incentives to invest in behavioral healthcare prevention and treatment for their members rather than acute care and long-term support. To do so the state could provide incentives for positive outcomes and penalties for negative outcomes.

Action! Conduct value assessment of MCOs in Behavioral Healthcare and make improvements.

Action! Streamline contracting among 3 MCOs and Provider organizations.

Action! Align MCO incentives with Behavioral Health of their Members.

In a parallel stream, there are opportunities to help the commercial payers who provide Medicare Advantage and/or employer-sponsored health plans to raise and pass through more revenue for behavioral health. Health plans operate largely in the free market and can be responsive to their customers, especially when there is collective pressure to make a change. Health plans respond to revenue, cost, and profit incentives regardless of their tax status and typically prioritize changes that increase their customer base and therefore their access to federal, employer, and individual revenue. They also respond to state laws and rules under the NH Insurance Department so that they can have access to NH's 1.4 million potential customers.

Participants at the BH Workforce Solutions Session detailed out the shortcomings of the commercial payers and behavioral healthcare. First, NH has demonstrated that multi-level care works. This was learned through Medicare reimbursement and through the work of the Integrated Delivery Networks (IDNs). Yet, NH BH Providers often can't provide full range of services to patients on commercial insurance. Insurers often have limits, maximums on available services, and they often only reimburse for certain license types/credentials. The shortage of providers combined with hesitancy to sign on to commercial insurance has created provider panels insufficient to meet need. So, when Patients don't get the care at the appropriate and less expensive level, they escalate to higher levels of care and more expensive services like emergency department visits.

Participants at the BH Workforce Solutions Session suggest that Commercial Insurers recognize that reimbursing multi-level care is better for their members and ultimately reduces overall cost of care for them and their members. They should specifically take down artificial barriers to care and recognize that protecting against overutilization of behavioral healthcare is a waste of resources and counter to the needs of their members. Employers working collectively together along with the NH Insurance Department can influence the decisions of the insurers, raise the standards for care coverage. Participants suggested that BH is perfect for payment simplification and suggested that specific *bundled payments* could be established based on diagnosis and level of care.

Action! Let Health Insurers know that comprehensive multi-level BH care is important to their customers (Employers, Members) and to the state and request plan improvements.

Action! Compel Health Insurers to remove artificial barriers to BH care.

Action! Encourage Health Insurers to embrace payment simplification and value-based payment.

And finally, where the revenue streams meet patient care there are opportunities to help provider organizations find operational efficiencies so they may shift more revenue to support competitive staff wages. Most provider organizations are already very lean out of necessity so there is very little that can be cut from their budgets.

Providers have an opportunity to work with payer partners upstream to simplify and harmonize non-competitive elements of contracts, payment methodologies, state regulation, and reporting requirements. Participants at the BH Workforce Solutions Session pointed out that much of the administrative waste at provider organizations is in response to complexity upstream. This includes administrative burden from managing disparate contracting, service coverage, artificial access to care barriers, coding, billing, claims denial management, prior authorization management, proof of service, and reporting with multiple disparate MCOs, Medicaid, Medicare, commercial insurers, and individuals.

Participants pointed out areas for increased collaboration among Provider organizations which could help with economies of scale. They pointed out recent successes collaborating in the rollout of the NH Rapid Response and 9-8-8 programs. There are multiple opportunities for provider organizations to work closely together and to share services where they are not competing. This could include:

- Staff attraction, recruiting, and training
- Clinical supervision (e.g., current example of cross-organizational clinical supervision for Child and Parent Psychotherapy evidence-based practice)
- Contracting and harmonization of payment reforms
- Multi-organizational career ladders with lateral and upward growth opportunities
- Multi-organizational cross coverage (in person and telehealth) and specialty service sharing (e.g., Deaf and hard of hearing program at Greater Nashua Mental Health)
- Telehealth specialty consultation
- Shared staff (e.g., quality improvement, grant writing)
- Shared technology platforms (e.g., common or similar EHRs)

Action! Provider Organizations work with upstream partners to simplify non-competitive elements of contracts, payment, and reporting requirements – then reduce administrative overhead.

Action! Find and formalize additional shared services among provider organizations for economies of scale/cost and shared expertise.

Continue to stay current with technology to support high quality efficient care delivery. NH Provider organizations are now more than a decade and a half past the last healthcare technology revolution. All sophisticated providers use interconnected electronic health records (EHRs) for care coordination,

charting, billing, and reporting. Tech has brought a lot of improvements to care. Telehealth has opened access to care through remote appointments. Simple text message reminder systems have increased treatment compliance and decreased no shows for appointments. Providing devices (smart phones, tablets) to individuals in need has helped them participate in their own care and access appointments, information, and resources.

Technology has made several giant leaps forward in recent years (e.g., Artificial Intelligence) and can help providers cope with administrative burden. For example, former 'voice to text' technology has been leapfrogged by dictation applications that can complete a large portion of clinician notes while gathering required information for billing and quality reporting.

Medicaid Management Information System (MMIS) is a consistent source of enhanced match federal funding for statewide technology investment in support of Medicaid members.

Action! Continue to invest in technology that improves care provision for individuals, improves work for staff, and improves efficiency and costs for organizations.

Action! Continue to support statewide technology investments using enhanced match federal MMIS funds.

Reduce stress on the current BH system

In parallel with correcting wages, there is work to do to reduce stress on the current BH system. Participants at the BH Workforce Solutions Session were asked to dive deeply into 4 ways to share the load with others:

1. Help PCPs take some burden from CMHCs and Specialty BH Providers
2. Help communities reduce access barriers to work
3. Optimize teams and task share BH services across multi-disciplinary teams
4. Reduce 'charting burden' for clinicians

Help PCPs take some burden from CMHCs and Specialty BH Providers

From 2016 to 2021 NH implemented the integrated care model statewide under the Medicaid 1115 waiver. At its essence, integrated care takes down the silos between primary care and behavioral healthcare and moves toward more holistic care delivered in a coordinated model. In NH, 7 IDNS supported most of the state's largest primary care provider organizations and behavioral health organizations to work together and implement integrated care. In some regions healthcare organizations embedded primary care within mental health agencies and vice versa. The program also led to development of large networks of community organizations who could support basic human needs (e.g., food, housing, utilities, health insurance, financial support, employment) of individuals. The program was large, well-resourced, and advanced the state's capabilities for integrated care tremendously.

Participants in the BH Workforce Solution Session noted that it is important to remember what worked during the waiver, to bring that learning forward, and to continue to incentivize and support the work so it won't stop or be forgotten. During the waiver period, the IDNs supported much of the cross-

organizational work with staff effort and distribution of federal / state funding and this has all fallen away. Still, the value and benefits of the integrated care model is clear and should continue. Some examples include: coordinating care among PCP, BH provider, Community supports; periodically cross-training primary care and behavioral health providers; helping PCPs to prescribe behavioral health medications; and maintaining the community supports networks and referral pathways.

Action! Support and incentivize integrated care as piloted through the Medicaid 1115 waiver.

Help communities reduce access barriers to work

Communities have a large role to play in making NH an attractive place to train, work, and live. Participants in the BH Workforce Solution Session brought forward the hard-earned learning of helping communities provide affordable housing, transportation, childcare, and reducing any other barriers to work. They noted the things that have worked such as assisting with student loan debt and the state loan repayment program (SLRP), providing financial literacy courses, helping families purchase winter tires for safety, and providing affordable healthcare insurance. Affordable housing is a formidable barrier nationwide right now and cited as the largest barrier to work in many NH communities. There are models where staff are provided with housing as part of their employment package and these can be cost-efficient while really helping with attraction and retention.

Going forward, there is mutual benefit for communities to work with provider organizations to attract and retain well-paid professionals and their families.

Action! Work directly with cities, towns, and counties to attract and retain well-paid professionals and their families by reducing barriers to work.

Action! Support statewide and local efforts to increase affordable housing.

Optimize teams and task share BH services across multi-disciplinary teams

In a labor market where some roles are scarce, Provider organizations have an opportunity to deliver services across a team of professionals and paraprofessionals working at the top of their respective roles. NH is a pioneer and leader with including paraprofessionals on multi-disciplinary teams that support individuals. In NH we have formalized multiple paraprofessional roles including Certified Peer Support Specialists, Certified Recovery Support Workers, Community Health Workers, and Resource Specialists among others. Paraprofessionals can share some of the tasks required to support individuals in their treatment and recovery such as staffing crisis lines, co-deploying on crisis teams, supporting Assertive Community Treatment programs, and connecting individuals to support services. Paraprofessionals can be trained more quickly than clinical staff, can be paid competitive but relatively lower wages, and can provide a great deal of value to their clients and teams. For people with their own mental health and substance use experiences this work also promotes and protects their own health and economic stability.

Participants in the BH Workforce Solution Session noted that in order to optimize the work, it's important to have ways to compensate the healthcare team and not just the individual clinician. They noted that it takes a lot of work to implement and maintain high quality cross-disciplinary teams including skilled management, clarity of roles and responsibilities, mutual respect across teams, time for collaboration, and communication of the value of the model to patients and staff alike. They suggested

reimbursement that focuses on the individual holistically, is broader than specific services, and that rewards positive outcomes.

Action! Restructure payment to encourage efficient care delivery by flexible optimized cross-disciplinary teams.

Reduce charting burden for clinicians

Reducing the 'charting burden' for clinical staff will greatly improve working conditions and is one of the most tangible ways to improve staff retention. Clinical staff point to charting burden as one of the most cumbersome and misaligned parts of their role. Rather than the clinical charting (e.g., writing a Subjective, Objective, Assessment and Plan note that is critical to clinical care) clinicians are now required to chart information that is mainly for purposes of billing, prevention of claim denials (and associated rework), and regulation or contract compliance reporting. Charting is uncompensated time and it significantly extends the working day for every healthcare clinician.

Participants in the BH Workforce Solution Session noted that documentation is a big "job dissatisfier," that many documentation platforms and templates are cumbersome, and that the charting processes are least efficient in non-profit organizations. They noted that a good charting process doesn't bring people to the field but it can be a big part of retention.

Participants noted that there is an opportunity to eliminate requirements for data being collected for no clear or valuable reason.

Action! Find and eliminate charting requirements that have low value and high burden.

Part 2 – Find, attract, prepare, and retain workforce

In parallel with preparing an extremely attractive labor environment that is the *"best place to train and work in behavioral health"* – we have to attract and retain staff at all levels. This is not solo work and requires close partnerships among provider organizations and the various educational institutions and many organizations that help prepare individuals for behavioral health roles.

Up front we also have a choice to make with how we think about competition for candidates. Right now, NH organizations are under great stress and have to be very competitive with each other to secure scarce staff. Going forward, we might be better served by working together to collectively recruit for the entire state and to significantly increase the overall candidate pool. Rather than compete with one another we can compete with Massachusetts, Maine, and Vermont who are also moving to recruit more BH staff.

Action! Join forces to attract and retain workforce together for the entire state.

Participants in the BH Workforce Solution Session were asked to dive into some specific areas for more ideas:

1. Help Colleges and Universities attract and prepare candidates for NH BH positions
2. Help BH organizations attract and support Peer Paraprofessionals, people in recovery from mental illness and/or substance misuse, and people with criminal records as valued members of their teams
3. Help BH clinicians return to service from private practice
4. Encourage inbound migration of BH workforce / discourage outbound migration
5. Utilize telehealth to gain access to more BH staff
6. Utilize gig workers for some BH care
7. Reduce BH demand by sharing the load with communities and technology

Help Colleges and Universities attract and prepare candidates for NH BH positions

Work closely with Colleges and Universities to attract more students for BH programs and prepare students for in-demand BH careers. Participants at the BH Workforce Solution Session had lots of prior experience and ideas for how to work with the feeder schools:

- Start early by forming partnerships with colleges, vocational technical programs, and high schools.
- Career pathways are getting stronger with many college course catalogs outlining potential career paths. Making career paths more flexible can help students make changes in line with their interests and learning. Valuing lived experience as much as course completion can open paths to more students. Be specific by articulating clearly the roles you can work in with each career pathway.
- Pay attention to the financial situation of students. Students know that BH does not pay well. Students move to other states after graduation even if they go to college in NH due to pay. For some, paying down school debt is more important than salary.
- Not all colleges have a behavioral health track so there is work to do to create more programs.

- Many students do not know what BH providers do – there is a need for good provider-student two-way communication, sharing success and impact stories, road shows, college class visits by staff, and more teachers in classrooms who also do clinical work.
- There is a gap between skills learned in academia and what's needed in the field that needs to be closed with provider-to-school partnerships, on-the-job training, internships, and other practice/shadowing opportunities.
- Decrease tuition for BH training programs.

Action! Work closely with feeder schools to build student awareness, chart career pathways, teach real world skills, create real opportunities for practice, and reduce financial barriers.

Help BH organizations attract and support Peer Paraprofessionals, people in recovery from mental illness and/or substance misuse, and people with criminal records as valued members of their teams

Behavioral Health peer paraprofessionals, persons in recovery, and those with criminal records can supplement clinical teams. There are many emerging paraprofessional roles in behavioral health and a few under-tapped talent wells to fill them. Peer Support Specialists rely upon lived experience to excel at their work. Recovery Support Workers rely upon their substance misuse recovery experience to help others find their own path. And individuals with criminal records have a wide range of competencies but are hobbled by their legal histories. All paraprofessional roles have a dual mandate – these career paths provide valuable talent –and- protective factors for ongoing recovery/resilience. Employers can successfully engage this workforce if they understand their unique talents and needs, provide supportive training and supervision, and cultivate an accepting multi-disciplinary team environment.

Participants at the BH Workforce Solution Session shared many ideas regarding engagement of paraprofessionals:

- BH paraprofessionals are uniquely empathic to recovery journeys. They can draw upon lived experience and formal training to supplement clinical behavioral health care.
- Training is currently free in many cases. DHHS covers Peer Support Training through the NH Community College System. Peers who are trained within the Peer Support Agencies benefit from career ladders to other organizations and arrive already trained.
- There are stigma and shame barriers still to overcome with paraprofessionals along with role respect from staff with traditional education and training pathways. This requires a lot of training (e.g., formal Recovery Friendly Workplace training), good management, strong attention to multi-role team building, clear boundary setting, and trust building (e.g., treating a paraprofessional as a valued team member, giving them the keys to the building)
- Pay attention to wages, benefits traps, and barriers to entry like criminal background application questions. There are multiple chasms an individual must cross to leave the relative safety of treatment and recovery and move off from safety net benefits to begin working again. Pay needs to be much higher for these roles to make this leap make rational sense.
- Expand evidence-based-practices (EBP) to include peer support. Paraprofessionals are currently included in some clinical EBPs like ACT and early psychosis programs. It would elevate the whole field to make peer support an EBP on its own.

- Build paraprofessional career pathways. These are different than traditional clinical pathways and should pay attention to the unique strengths and goals of each worker, should value lived experience like any other educational credential, and can even provide high value supports like continued recovery resources and criminal record annulment paths.
- Work through current barriers to work for paraprofessionals. These may include work barriers like state, licensing board, and/or payer rules and regulations. They may also include barriers to housing, food, and transportation. Draw on the waiver process first to build a track record of success and then move to change rules where they may be safely modified. Draw on the Critical Time Intervention model for a staged transition to work with support to independence.

Action! Consider paraprofessionals as valuable additions to BH teams and build organizational systems and culture to hire and support non-traditional roles.

Help BH clinicians return to service from private practice

To engage qualified staff immediately, entice providers who have moved to private pay/ private practice to come back to part time or full-time practice with a BH organization that serves Medicaid members. Participants in the BH Workforce Solution Session noted that when clinicians get licensed in community health, they often leave for private practice. They rarely come back in a lateral role and occasionally come back in a supervisory role. This is because the wages can be much higher in private practice and the burden from health insurers is much lower.

There has also been a major disruption in how care is delivered which is drawing licensed therapists away from community practices. Nationally there are now multiple freelance telehealth platforms (think Uber or Lyft for therapists) where providers can work flexible hours from their homes. In a very short time period, many national telehealth platforms have launched and gained large customer bases (e.g., BetterHelp Online, Talkspace) and now Amazon has entered the behavioral health online space with a highly simplified pricing model based on their Prime membership pricing.

To draw people back from private practice and gig work, BH Workforce Solution Session Participants recommended that employers acknowledge and correct for the reasons professionals leave (wages, administrative burden, flexibility, and autonomy). They recommend that organizations showcase the unique benefits of working in community practice like service to community, providing accessible equitable care to those who otherwise could not afford it, and working on a team together. They recommend that employers increase work flexibility (e.g., work from home, schedule) and focus on the benefits that come with employment such as student loan repayment, retirement and vesting, paid time off, professional development and training opportunities, wellness programs, and free and supported access to modern technology (e.g., computer, phone, EHR, telehealth platform). Finally, they cautioned against 'burning bridges' - It is ok when people leave community practice on their own career paths. If we are kind, compassionate, and supportive then professionals may be more likely to come back.

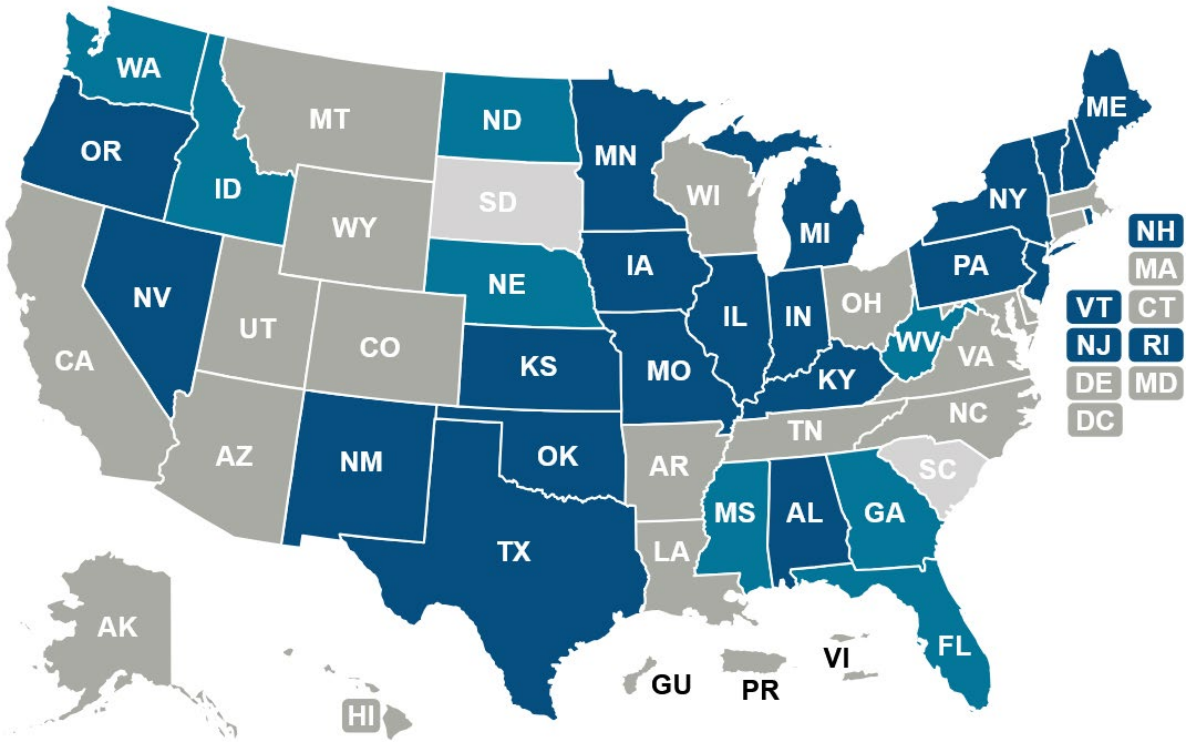
Action! Entice licensed clinicians to return to community practices that serve Medicaid clients by providing highly competitive wages and benefits, insulation from administrative burden, flexibility, autonomy, and a strong culture of community service.

Encourage inbound migration of BH workforce / discourage outbound migration

NH can intentionally set conditions for attracting talent from out of state while defending against talent moving away. NH is competing on a national stage for talent. BH staff are scarce nationwide and states are competing with one another to draw talent to train and work. Most recently, introduction of the CMS Certified Community Behavioral Health Centers (CCBHC) program is helping to raise wages at CMHCs to market competitive levels and this is creating short term wage disparities that are both positive and negative for talent migration at the outpatient community mental health level.

CCBHC has gained traction as a promising model for community-based outpatient care nationwide. On the following map from the National Council, states in dark blue have CCBHCs in Medicaid. States in light blue have independent CCBHC planning efforts. States in tan have planning grants and no CCBHCs in Medicaid yet. States in light tan have no CCBHC activity.

Figure 2: States with CCBHC activity (Map accessed in Sep 2024 from the National Council)[xi]



The CMS CCBHC demonstrations began on the ground in 2015 with planning grants followed by demonstrations beginning in 2017 in 8 states (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, Pennsylvania). Participation in the CCBHC program by outpatient community mental health centers opens an opportunity to make market corrections for wages while setting the foundation for required services under Medicaid [with the hope that private insurance will follow suit]. Since CMHCs are often the training ground for new staff seeking to learn their role and earn licensure, the wage changes are very welcome at one of the main entry points to the field.

Jumping forward to 2024, NH was selected as a demonstration state along with neighboring states Maine, Vermont, and Rhode Island. In NH, Greater Nashua Mental Health Center, Mental Health Center

of Greater Manchester, and West Central Behavioral Health are leading out with the program in 2025. This will help tremendously in attracting staff for their first role in the field and in retaining staff within the CMHCs. Given the staged rollout within NH and among competing states, there will also likely be short term migration toward the CCBHCs. This will be both in state and across state lines for new and existing staff that can travel or change location. The short-term wage differential will cause a period of staffing disparities while CMHCs in each state engage in the new cost model but it is a necessary step to raise all boats once implemented.

Action! CCBHC will cost more so prepare to raise sufficient state funds to match federal funds (35 c. state funding earns $1 total) to support NH CCBHCs demonstration.

Beyond CCBHC, Participants in the BH Workforce Solution Session shared many thoughts and ideas about encouraging migration to NH. They noted that there are many current challenges to overcome including: Staff stepping into a profession that is really difficult and then leaving before completing a degree or post degree training because they need income, organizations burning out from training staff who then go elsewhere, lack of progressing career pathways, the isolation of staff during the winter months, and inter and intraorganizational competition for scarce staff. They noted the *numbers challenge* where need is outpacing pipeline of students. They noted that we are up against population dynamics as the baby boomer generation retires in large numbers and following generations try to fill their shoes.

Participants had many ideas for how to attract and retain talent including: raising wages, requiring volunteerism and community service during training to build deeper connection with local communities, creating more accessible inbound pathways such as streamlined cross-state licensure, credential reciprocity, competency-based licenses, providing flexible working situations (remote days, part-time options, better work/life balance), helping with basic needs (e.g., food, housing, transportation, childcare), creating jobs for following spouses, loan forgiveness and repayment, part time opportunities for formerly retired staff, and clear career pathways from education through job entry and promotion.

They also suggested creating specific recruiting focused on diversity, equity, and inclusion that is aligned with the needs of patients. They suggested training and work opportunities for students who are studying here from other countries and new Americans with foreign experience/certifications.

Finally, they suggested novel 'sweeteners' to bring people to NH such as financial incentives and loan forgiveness (with no strings attached) to move to a community, flexible funding for benefits, and mentoring/advising to find a match between a student/new employee and NH communities.

Action! Create 'fully-loaded' career pathways that meet the needs and goals of BH staff, draw them to NH, and help them to lay down roots and stay.

Action! Create training and work opportunities for foreign students and staff and new Americans.

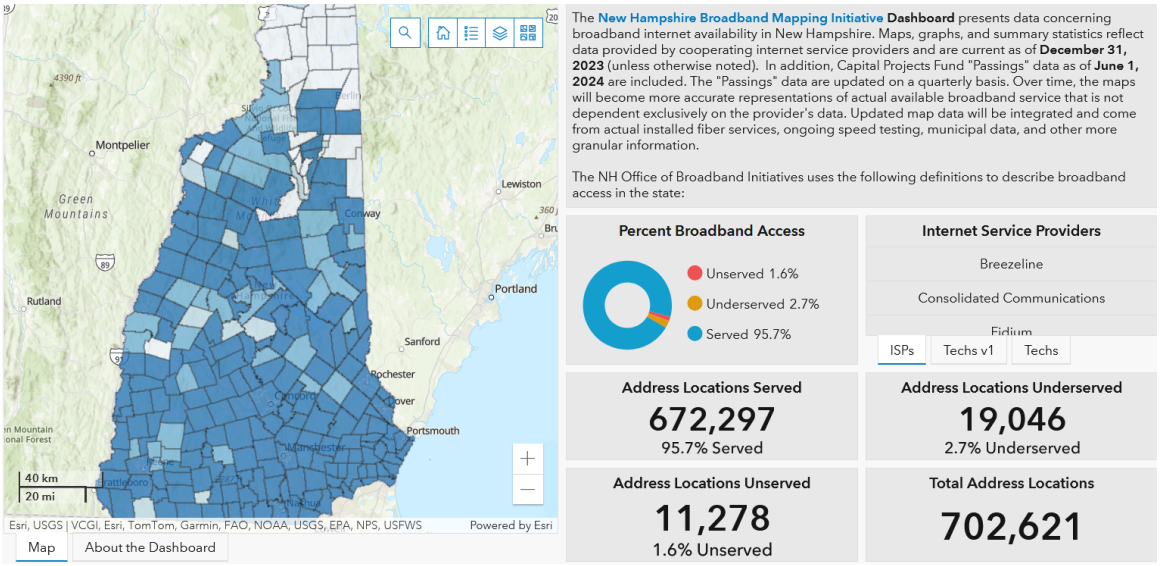
Action! Offer *sweeteners* such as loan forgiveness and financial incentives to draw talent.

Utilize telehealth to gain access to more BH staff

Supplement care with remote staff via telehealth. Much of the care and support in behavioral health is best delivered in-person. In person care may be supplemented with remote options. Delivery of care via telehealth has revolutionized healthcare and behavioral healthcare in particular. Many behavioral health services may be supplemented effectively and securely using remote meeting technology. The Pandemic created urgency for telehealth expansion and reimbursement parity, much of which is still in place as the emergency exceptions expire. Some specific rules, licensure, and reimbursement barriers still complicate telehealth provision across state lines but it has quickly revolutionized remote care and benefited tens of thousands of NH residents.

In parallel, NH has been rapidly deploying affordable broadband statewide which is overcoming former equity, rural, transportation, and technology barriers to care access. NH is a national leader in broadband rollout and now boasts 95.7% of addresses locations served.

Figure 3: NH Broadband Map and Access Dashboard (provided by NH Broadband Mapping Initiative)[xii]



There is now work to do to catch up with this technology and care delivery step change. Healthcare organizations are already adept with domestic (in-state) care delivery via telehealth. This is helping NH providers to reach individuals with access barriers. It's also helping employers offer more flexible hybrid working arrangements to their staff such as work from home remote days. Telehealth has also proven effective for accessing specialized care expertise, for supporting supervision, and for consulting with other providers.

The work left is with finding and solving the remaining licensure, state rule, and payment barriers to cross-state care delivery. This is not trivial as there are deeply embedded systems based on a time when local in-person care was the norm. There are enormous opportunities to scale staffing capacity regionally and nationally if we can modernize our rules to catch up with our technology.

Action! Find and solve the remaining licensure, state rule, and payment barriers to cross-state care delivery via telehealth.

Utilize gig workers for some BH roles

Supplement care teams with temporary staff where it is safe and appropriate for high quality care delivery. The emergence of 'gig work' has changed many industries. Gig or freelance workers value flexibility and independence above other priorities and can be effective in relieving temporary demand pressures on organizations. The industries that have most effectively utilized gig workers have created systems to qualify workers across organizations so that employers can trust that the staff person is qualified and vetted. In healthcare, the leading temporary capacity example is with travel nurses and doctors.

There is an opportunity in NH to identify BH roles that have transferable skills across organizations, have short local ramp-up requirements, that don't require consistent contact with individuals in care, and that can quickly assimilate into local clinical teams (e.g., nurses, medical assistants, some paraprofessional roles). These are appropriate for cross-organizational sharing and temporary work. Gig work is also an entry point for conversion of part time workers to full time roles.

Action! Identify BH roles that are appropriate for *gig workers* and develop infrastructure for qualifying, engaging, supervising, and paying this supplemental workforce.

Share the demand for help with the national therapy platforms. As mentioned earlier, several national platforms have recently emerged powered by BH gig workers (e.g., Better Help, Talkspace). Many therapists are supporting individuals with remote sessions over these platforms and the therapists have a lot of autonomy and flexibility with their work.

There are a few opportunities for NH providers to adjust to the emergence of the national gig work platforms in BH care. Employees that value flexibility and autonomy are drawn to work with the new platforms and sometimes leave their traditional employment. NH employers can understand the attractiveness of this model and emulate the same conditions (flexibility, autonomy) within their organizations. Rather than seeing the national platforms as purely competitive, NH Providers can also recognize that the platforms can take some pressure off from the BH system as a whole at the lower levels of care where individuals are working on prevention, recovery, and resilience-building.

Action! Respond to competition for talent from national therapy platforms by offering current

Action! Consider the national therapy platforms as backup referral options for step down and lower levels of community-based BH care.

Reduce BH demand by sharing the load with communities and technology

It takes a village to keep every child, adolescent, and adult at their best. During the NH 1115 waiver most primary care and behavioral healthcare organizations improved their relationships with community supports organizations. They began screening individuals for unmet basic human needs like food, shelter, utilities, health insurance, childcare, and financial stability. Referral pathways opened up from healthcare to community and in reverse. Community health workers and resource specialists were trained and deployed to support individuals who were unable to navigate complex healthcare and human services. While integrated care models were being deployed across healthcare disciplines, many

communities across the state began providing whole person care with healthcare providers and community organizations working together to support individuals with complex needs.

Though the formal infrastructure of the IDNs has faded away, in most parts of the state the needs screenings have continued in primary and BH care and the referral relationships have remained open with community supports organizations. There continue to be opportunities to see individual and family struggles as opportunities for community members to support those that need extra help in their time of need.

As an example, the NH BH Workforce Center has continued to engage community organizations to share in the support of children and adolescents struggling with mental health and/or substance misuse. We have found that community organizations are seeing the same struggles in school, on the playgrounds, in sports, in after school programs, and in libraries. The professionals in these community organizations have been eager to learn more about behavioral health, ready to collaborate with BH professionals, and willing to share in the support of youth in distress. The *whole community* approach is working with youth and can work with nearly any sub-group within our communities.

Action! Continue to encourage partnerships among primary care, behavioral health, and community organizations to share in support individuals who are struggling.

Consumer technology for behavioral health has advanced quickly. NH Individuals currently use a lot of technology platforms to supplement their care. This includes portals to access their care team, medical records, discharge plans, lab results, scheduling, and billing. It also includes medication and treatment plan adherence apps, patient goals and goal tracking apps, and mindfulness apps. Given the long waitlists for in-person appointments, some provider organizations are pointing individuals to applications to fill the gap prior to treatment and as part of ongoing resilience.

Action! Support individuals to use technology applications as part of their treatment, recovery, and prevention program or as they wait for care.

In Conclusion

The NH Behavioral Health workforce is in crisis. All of the easy solutions have been tried and exhausted. The remaining work is nuanced, complex, and challenging. There are pathways out of the crisis and all of them require valuing behavioral healthcare as a society and sharing the mission to shore up NH's systems of care. This is shared work requiring leadership from the federal and state governments, from across the entire healthcare value chain, from our partners in philanthropy and advocacy, and from those who educate and engage the public. It is in all of our shared interest to go to work on these actions together and to keep everyone engaged in collaborative problem solving and celebrating progress. The simplest indicators of success will be number of individuals hired into the NH behavioral health labor pool as a whole and the number of staff retained.

Acknowledgements

Thank you to the many **leaders who attended the *NH Behavioral Health Solution Session*** in July 2024. The hard work, insights, and breakthrough ideas you volunteered that day provided the raw ingredients for this report.

Thank you to the ***NH Community Behavioral Health Association*** for co-planning and co-hosting the Solution Session. CBHA continues to be the critical gathering agent for behavioral health professionals and their organizations statewide.

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Thank you to the leaders within the ***NH Department of Health and Human Services*** for your tireless work improving NH's behavioral healthcare system and for the many opportunities for public – private collaboration to solve our workforce crisis.

Report Authorship

This report was written by the team at the NH Behavioral Health Workforce Center. Mark Belanger, MBA, was the lead author with support from Barbara Dieckman, MBA, MS, Julie Balaban, MD, and Jacqueline Pogue, MA, MPH.

Appendix A: Listing of Identified Actions

Action	NH Public / Awareness & Advocacy Orgs.	Representatives in Concord & Washington	Gov. Agencies	Health care Payers	Health care Orgs.	Philanthropy & Associations
Collectively invest in the promotion of NH as the best place to train and work in Behavioral Healthcare.	X	X	X		X	X
Sound the Alarm! NH's Behavioral health labor market is in a downward spiral.	X	X	X	X	X	X
Curate a single source of data, information, and inclusive messaging regarding the NH BH Labor Market to be used by leaders to align public support and take legislative action.	X	X	X		X	X
Allocate sufficient funding for BH in Federal and State budgets and legislation.	X	X	X			
Take every opportunity to simplify the existing healthcare payment system. Seriously consider 'value vs. burden' before adding any additional complexity.		X	X	X	X	
Embrace federal, state, and private payer payment reforms (e.g., Prospective Payment, Bundled Payment, Capitation) and leave behind legacy complexity (e.g., "shadow billing") when transitioning to simpler value-based payment systems.		X	X	X	X	
Review state matching fund sources for fitness, durability, and sufficiency. Make improvements and add revenue sources where feasible.	X	X	X			
Continue to monitor and maximize enhanced federal funds participation opportunities to draw down more federal funding.			X			
Continue to pursue federal grant and waiver opportunities to supplement revenue.			X		X	
Make market corrections for staff wages through rate setting routines.			X	X	X	
Conduct value assessment of MCOs in Behavioral Healthcare and make improvements.		X	X	X		
Streamline contracting among 3 MCOs and Provider organizations.			X	X	X	
Align MCO incentives with Behavioral Health of their Members.		X	X	X		
Let Health Insurers know that comprehensive multi-level BH care is important to their customers (Employers, Members) and to the state and request plan improvements.	X	X	X	X	X	
Compel Health Insurers to remove artificial barriers to BH care.	X	X	X	X		
Encourage Health Insurers to embrace payment simplification and value-based payment.	X	X	X	X	X	
Provider Organizations work with upstream partners to simplify non-competitive elements of contracts, payment, and reporting requirements – then reduce administrative overhead.			X	X	X	

Action	NH Public / Awareness & Advocacy Orgs.	Representatives in Concord & Washington	Gov. Agencies	Health care Payers	Health care Orgs.	Philanthropy & Associations
Find and formalize additional shared services among provider organizations for economies of scale/cost and shared expertise.					X	
Continue to invest in technology that improves care provision for individuals, improves work for staff, and improves efficiency and costs for organizations.			X		X	
Continue to support statewide technology investments using enhanced match federal MMIS funds.			X		X	
Support and incentivize integrated care as piloted through the Medicaid 1115 waiver.			X	X	X	
Work directly with cities, towns, and counties to attract and retain well-paid professionals and their families by reducing barriers to work.	X	X	X		X	X
Support statewide and local efforts to increase affordable housing.	X	X	X		X	X
Restructure payment to encourage efficient care delivery by flexible optimized cross-disciplinary teams.			X	X	X	
Find and eliminate charting requirements that have low value high burden.			X	X	X	

Action	NH Public / Awareness & Advocacy Orgs.	Representatives in Concord & Washington	Gov. Agencies	Health care Payers	Health care Orgs.	Philanthropy & Associations
Join forces to attract and retain workforce together for the entire state.	X	X	X		X	X
Work closely with feeder schools to build student awareness, chart career pathways, teach real world skills, create real opportunities for practice, and reduce financial barriers.	X		X		X	X
Consider paraprofessionals as valuable additions to BH teams and build organizational systems and culture to hire and support non-traditional roles.	X	X	X	X	X	X
Entice licensed clinicians to return to community practices that serve Medicaid clients by providing highly competitive wages and benefits, insulation from administrative burden, flexibility, autonomy, and a strong culture of community service.		X	X	X	X	
CCBHC will cost more so prepare to raise sufficient state funds to match federal funds (35 c. state funding earns $1 total) to support NH CCBHCs demonstration.		X	X		X	
Create *fully-loaded* career pathways that meet the needs and goals of BH staff, draw them to NH, and help them to lay down roots and stay.	X		X		X	X
Create training and work opportunities for foreign students and staff and new Americans.	X	X	X		X	
Offer *sweeteners* such as loan forgiveness and financial incentives to draw talent.		X	X		X	X

Action	NH Public / Awareness & Advocacy Orgs.	Representatives in Concord & Washington	Gov. Agencies	Health care Payers	Health care Orgs.	Philanthropy & Associations
Find and solve the remaining licensure, state rule, and payment barriers to cross-state care delivery via telehealth.		X	X	X	X	
Identify BH roles that are appropriate for *gig workers* and develop infrastructure for qualifying, engaging, supervising, and paying this supplemental workforce.			X	X	X	
Respond to competition for talent from national therapy platforms by offering current staff more flexibility and autonomy.					X	
Consider the national therapy platforms as backup referral options for step down and lower levels of community-based BH care.					X	
Continue to encourage partnerships among primary care, behavioral health, and community organizations to share in support individuals who are struggling.	X			X	X	X
Support individuals to use technology applications as part of their treatment, recovery, and prevention program or as they wait for care.	X				X	X

End Notes:

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[iii] Track COVID-19 in NH, New York Times, (data refreshed March 26, 2024) https://www.nytimes.com/interactive/2023/us/new-hampshire-covid-cases.html

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[x] Kaiser Family Foundation, "2023 Employer Health Benefits Survey," Oct 18, 2023 https://www.kff.org/report-section/ehbs-2023-section-1-cost-of-health-insurance/

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