

Creating a Robust, Diverse, and Resilient Behavioral Health Workforce in Massachusetts

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1. INTRODUCTION AND BACKGROUND

The behavioral health workforce in Massachusetts is in crisis. The COVID-19 pandemic has increased the prevalence of behavioral health issues and demand for services, exposing and aggravating the vulnerabilities of Massachusetts' behavioral health workforce and delivery system.¹ Health care, including behavioral health care, has been among the industries hardest hit by the “Great Resignation,” exacerbating workforce shortages that predated the pandemic.² The disproportionate stress that the pandemic is imposing on the health care workforce compounds these issues. These dynamics create an unprecedented call to action for Massachusetts to grow and support a workforce that can meet the pressing demand for behavioral health care in the Commonwealth. This report identifies opportunities to expand Massachusetts' behavioral health workforce, increase its diversity, maximize its potential to meet the needs of all people in the Commonwealth, and strengthen its resilience.³

DEFINITION: Behavioral health includes traditional mental health challenges and substance use disorders (SUD), as well as overall psychological well-being.

See: <https://www.cms.gov/outreach-education/american-indianalaska-native/aian-behavioral-health>.

THE GROWING DEMAND FOR BEHAVIORAL HEALTH SERVICES

Massachusetts has been a national leader in charting a path forward for future behavioral health delivery system reform through initiatives including its Roadmap for Behavioral Health Reform (Roadmap) and Medicaid Section 1115 demonstration (see callout box on page 6).⁴ In addition, the Commonwealth leads among states in many metrics of access to behavioral health services and behavioral health outcomes.⁵

However, amidst these successes, the Commonwealth has grappled with significant and growing demand for behavioral health services among its residents.⁶ Overdoses have been on the rise, with drug-related deaths increasing by 20 percent from 2015 to 2020.⁷ And in Massachusetts, like the rest of the country, many individuals have co-occurring conditions, struggling at once with mental health and substance use disorder (SUD) issues, as well as with physical health issues and social and economic challenges.⁸ The trauma and stress caused by the pandemic has amplified behavioral health care needs in Massachusetts and nationally.⁹ In 2021, over 31 percent of adults in Massachusetts reported symptoms of anxiety or depressive disorder alone, as compared to approximately 21 percent reporting any mental illness in 2018–2019.¹⁰

The pandemic's toll has been particularly harmful on the behavioral health and well-being of people of color.¹¹ In 2020, the Commonwealth's confirmed opioid-related overdose death rate increased by an alarming 69 percent from the previous year for Black non-Hispanic males, which was the highest annual increase of any ethnic or racial group that year.¹² A recent Blue Cross Blue Shield of Massachusetts Foundation (Foundation) report also found that adults in the Commonwealth who identify as a race or ethnicity other than non-Hispanic White and who have lower family incomes represented a disproportionately high number of adults who said they have been in need of behavioral health care during the pandemic.¹³

The pandemic has also had devastating impacts on the behavioral health of children and youth,¹⁴ as highlighted by the U.S. Surgeon General's recent advisory.¹⁵ Currently, in the United States, suicide is the second leading cause of death for individuals between the ages of 10 and 14, and the third leading cause of death for individuals between the ages of 15 and 24.¹⁶ In Massachusetts, nearly half of all youth participating in a recent Department of Public Health survey reported “feeling sad or hopeless almost every day for two weeks or more during the pandemic [to the extent] that they stopped doing some usual activities”—21 percent higher than before the pandemic.¹⁷ These numbers were substantially higher for LGBTQ+ youth, of whom more than three-quarters reported feeling this way.¹⁸ Overall, similar to

“We’re all really worried about behavioral health for kids, both for ongoing issues that have resulted in worse emergency department boarding than ever in my over 20 years working in this field. The delay that happened to the Roadmap as a result of COVID, combined with the COVID impact are both devastating.”

—Interview on March 7, 2022

national data, Massachusetts is seeing that the pandemic is disproportionately impacting the behavioral health of youth of color, youth with disabilities, and youth who are LGBTQ+.¹⁹

THE URGENCY TO BUILD A MORE ROBUST, DIVERSE, AND RESILIENT WORKFORCE

Although it is ranked second among all states in the country on Mental Health America’s measure of access to mental health care,²⁰ there is evidence that serious access deficits still exist in Massachusetts. For example:

- A recent Foundation survey found that more than half (57%) of Massachusetts adults in need of behavioral health care either “had difficulties getting appointments for care when needed or did not obtain any behavioral health care.”²¹
- The Association for Behavioral Healthcare’s recent survey of Massachusetts outpatient providers indicated that 13,797 individuals were on a waitlist to obtain outpatient mental health services at one of the 37 surveyed providers in Fall 2021, with average wait times of 15.3 weeks and 12.7 weeks, respectively, for children/youth and adults to obtain ongoing therapy.²²
- A 2019 Massachusetts Health Policy Commission (HPC) report observed that individuals with “co-occurring disorders may not be getting the care they need in the community,” citing 2016 data that identified co-occurring mental health and SUD co-morbidities in 13 percent of adult inpatient and 4 percent of adult emergency discharges.²³
- Long wait times exist for individuals in need of access to medication assisted treatment (MAT) for SUD as well as for residential treatment services for those with co-occurring disorders. For example, an HPC survey among Massachusetts behavioral health providers providing MAT found that over 25 percent of providers reported wait times of three weeks or greater.²⁴
- During the pandemic, individuals in need of psychiatric care have experienced an uptick in emergency department (ED) boarding—the process of holding patients in the ED after the decision is made to admit the patient due to a lack of inpatient beds.²⁵ The Massachusetts Health and Hospital Association recently reported that in August 2022, there were 540 patients with behavioral health needs boarding across 50 Massachusetts hospitals. Concurrently, from 2021 to 2022, there was a 2.73-fold increase in the number of inpatient beds that were taken offline (i.e., these beds were not available for patient use) solely because of staffing shortages; the number of licensed inpatient beds offline because of staffing shortages increased from 9 percent of beds in February 2021 (208 beds) to 20 percent of beds in August 2022 (568 beds).²⁶
- As of March 2022, the Human Resources and Services Administration (HRSA) identified a total of 57²⁷ Mental Health Professional Shortage Areas (HPSAs) in Massachusetts, indicating a need to improve the geographic distribution of providers.²⁸ A recently released national Behavioral Health Workforce Tracker from George Washington University

DEFINITION: Behavioral health workforce. This report considers the behavioral health workforce to comprise the list of professionals —licensed and unlicensed—that the Substance Abuse and Mental Health Services Administration (SAMHSA) includes as part of its workforce definition, which includes, but is not limited to:

- Psychiatrists
- Psychologists
- Social workers
- Advanced practice psychiatric nurses
- Marriage and family therapists
- Certified prevention specialists
- Addiction counselors
- Mental health/professional counselors
- Psychiatric rehabilitation specialists
- Psychiatric aides and technicians
- Paraprofessionals in psychiatric rehabilitation and addiction recovery fields (e.g., case managers, homeless outreach specialists, or parent aides)
- Peer support specialists
- Recovery coaches

See: <https://www.samhsa.gov/workforce>.

DEFINITION: Distribution of the workforce. This report discusses the distribution of Massachusetts’ behavioral health workforce. A Health Workforce Policies Framework published in *Health Affairs* (described in more detail below and in Appendix A) recommends that as part of assessing distribution, stakeholders should consider “geographic maldistribution of providers, the specialty imbalance, and the need for community-based workers.” In addition to assessing these factors, this report considers whether there is an adequate distribution of specific provider types, as well as the distribution of providers serving populations that have been economically, socially, or culturally marginalized, including communities of color and/or LGBTQ+ communities. This report also considers whether there are whether there are a sufficient number of providers serving other populations with particularly acute needs, such as children and youth.

further underscores there are meaningful differences in the concentration of behavioral health professionals across the Commonwealth. For example, Hampshire County has one provider—either psychiatrist, addiction medicine specialist, psychologist, counselor or therapist—for every 113 persons, whereas Hampden County has one of these providers for every 415 persons—a more than three-fold difference.²⁹

Individuals interviewed for this report also indicate that the Commonwealth faces particular challenges in assuring access to behavioral health care for specific historically underserved communities, including communities of color and LGBTQ+ youth.³⁰ The disproportionate prevalence of behavioral health conditions among these communities underscores the need for Massachusetts to ensure that it has a sufficiently diverse workforce,³¹ as research highlights that concordance between provider and patient racial, ethnic, linguistic, and cultural identities in health care leads to increased trust and better quality of care.³² A demographic profile of Massachusetts' behavioral health workforce does not currently exist; the Commonwealth does not publicly report data on the distribution and composition of members of its behavioral health workforce by race, ethnicity, linguistic/cultural identities, or sexual orientation and gender identity (SOGI). However, Massachusetts and national data on the overall health and behavioral health workforces suggest that there are likely racial, ethnic, or cultural asymmetries between the behavioral health workforce and those needing care.³³ For example, a recent Massachusetts HPC survey among Massachusetts behavioral health facilities treating SUD and mental health found that 34 percent of respondents identified a shortage of clinicians able to treat patients who do not speak English “as a moderate to extreme barrier to care.”³⁴ A recent national study focused on psychiatry also highlights the lack of diversity in the behavioral health workforce; the study found that underrepresented minorities (e.g., Black, Latino, or Native American people) comprise only 10.4 percent of practicing psychiatrists in the United States, while representing 32.6 percent of the U.S. population.³⁵

The pandemic has not only intensified demand for behavioral health services, but also exacerbated these workforce challenges. Massachusetts' behavioral health workforce has seen increased attrition during the pandemic as a result of retirements and people leaving the field; additional losses are anticipated with the “graying” of the behavioral health workforce as many providers are at or approaching retirement age.³⁶ More clinicians are leaving mental health clinics than there are new clinicians entering.³⁷ A survey by the Association for Behavioral Healthcare found that in 2021, “for every 10 master’s-prepared clinicians hired, approximately 13 master’s-prepared clinicians left their positions.”³⁸

MASSACHUSETTS EFFORTS TO GROW AND SUSTAIN THE BEHAVIORAL HEALTH WORKFORCE

Massachusetts has recognized the urgency to grow and sustain its behavioral health workforce to meet the needs of its residents, especially those who have been economically, socially, or culturally marginalized. The Commonwealth's [Delivery System Reform Incentive Payment program](#) (DSRIP) authorized under the MassHealth Section 1115 [demonstration](#) has made building and training the behavioral health workforce one of its key priorities for statewide investments. Under DSRIP, the Commonwealth has:

- Invested heavily in loan repayment programs to recruit and retain behavioral health professionals
- Offered training [programs](#) to build the competency of the paraprofessional workforce (e.g., peers, community health workers (CHWs), CHW supervisors, recovery coach supervisors)

Massachusetts' [Roadmap](#)—a blueprint for transforming Massachusetts's behavioral health delivery system—proposes several initiatives to grow, address maldistribution in, and build resilience in the behavioral health workforce, including:

- Loan repayment incentives for practitioners with “diverse cultural, racial, ethnic, and linguistic backgrounds and competence”
- Expansion of coverage of peers for mental health and addiction
- Efforts to enhance behavioral health provider participation in insurance such as by reducing administrative burdens, providing targeted rate increases to help recruit and retain qualified staff at Community Behavioral Health Centers (CBHCs) and integrated primary care practices, and expanding insurance reimbursement for telehealth
- Training programs to build the skills and competencies of behavioral health practitioners
- Enhanced certification standards for peers and CHWs

The above examples highlight just some of the specific workforce initiatives that Massachusetts has undertaken to build a more robust, diverse, and resilient behavioral health workforce, and additional examples of Massachusetts-driven behavioral health workforce initiatives are integrated throughout this report. However, recent data make clear that while these efforts should be applauded, they are not enough to combat the current behavioral health workforce crisis, and additional action is needed.

A CALL TO ACTION

It is incumbent upon the Commonwealth to build a robust, diverse, and resilient workforce that meets the needs of its population. The urgency to act in this moment is not only fueled by a growing behavioral health crisis but also by an unprecedented moment of collective understanding of what it means to be impacted by a behavioral health condition.³⁹ The worsening behavioral health crisis, coupled with a softening of the stigma surrounding behavioral health conditions over the past few years, has opened up new policy and funding opportunities and galvanized new and powerful political will at the local, state, and national levels. **There is no better time for Massachusetts to invest in the behavioral health workforce.**

PROJECT GOALS AND METHODOLOGY

The Foundation engaged Manatt Health to develop a report that identifies opportunities to maintain, expand, and increase diversity in Massachusetts' behavioral health workforce to maximize the workforce's potential to meet the needs of all people in the Commonwealth and build its resilience.

To meet this goal, Manatt Health:

- Conducted interviews with Massachusetts stakeholders and national experts, which included provider association representatives, academics, and state officials with experience in behavioral health, workforce development, and/or diversity, equity, and inclusion issues. A complete list of stakeholders interviewed is included in the Acknowledgements section. When conducting interviews for this report, the Manatt Health team shared the “Health Workforce Policies Framework” (the Framework) published in a recent *Health Affairs* article by Angela Beck, formerly the director of the University of Michigan's Behavioral Health Workforce Research Center, and other health care workforce experts. The Framework describes four pillars to “reshape the workforce”: production, distribution, maximizing potential, and resiliency.⁴⁰ In reviewing the Framework, the team encouraged interviewees to take a broad view of the factors that influence the state of the behavioral health workforce. Additional details about the Framework and these pillars can be found in Appendix A.
- Conducted a literature review of peer-reviewed articles; reports by university research centers, leading health care foundations, and industry associations that have prioritized behavioral health workforce and equity; resources from federal agencies; and websites for state departments of mental health/SUD and Medicaid agencies.
- Developed an inventory of different behavioral health workforce programs in Massachusetts and across the country.⁴¹ Examples from the inventory are highlighted in callout boxes throughout the report and in Appendix B.
- Developed recommendations informed by the interviews, literature review, and inventory of behavioral health workforce programs to augment the Commonwealth's current behavioral health workforce initiatives. The recommendations in this report aim to address each of the Framework's four pillars (described in more detail in Appendix A), recognizing that they are all critical to building a more robust, diverse, and resilient workforce.

2. IMPERATIVES FOR CREATING A ROBUST, DIVERSE, AND RESILIENT BEHAVIORAL HEALTH WORKFORCE

Creating a more robust, diverse, and resilient behavioral health workforce in Massachusetts is an ambitious but achievable task. It will require strong leadership, financial investment for the long-term, a multiyear commitment by a broad array of stakeholders, and an understanding that progress will be incremental. To achieve this vision, the Commonwealth must meet **four imperatives** that are crucial for advancing the recommendations described in this report.

- 1. Addressing the behavioral health workforce crisis, including rallying public and private sector commitment to responding to the crisis, should be a key priority for the incoming governor and Legislature.** Addressing the crisis requires sustained, strong leadership to mobilize and coordinate resources across sectors and take action to meet short-term, intermediate, and long-term goals that build on initiatives such as Massachusetts’ “Roadmap for Behavioral Health Reform” or the vision introduced in the Foundation’s report “Ready for Reform: Behavioral Health Care in Massachusetts.”⁴²
- 2. Tackling behavioral health workforce challenges requires shared commitment and responsibility across stakeholders, including the Massachusetts and federal governments, providers, payers, academic institutions, large employers, and community-based organizations, among others, over the next 10 years.** The Commonwealth is fortunate to have a deep bench of stakeholders who are committed to advancing behavioral health delivery system transformation and building a more robust workforce. Within the Massachusetts government alone, the Executive Office of Health and Human Services (EOHHS), the Executive Office of Labor and Workforce Development (EOLWD), and the Executive Office of Housing and Economic Development, Office of Consumer Affairs, and Division of Insurance, in addition to the Legislature, all have key roles to play in creating a more robust behavioral health workforce. To ensure enduring progress, it is vital to continue to build consensus among stakeholders to take action in effectuating changes needed to reshape and grow the behavioral health workforce.
- 3. A larger proportion of Massachusetts health care spending should be infused into the behavioral health delivery system, and in particular, toward community-based behavioral health care.** While stakeholders interviewed indicate that the Massachusetts health care system as a whole is sufficiently funded, they note a need to redirect existing funding to the behavioral health delivery system, and in particular, to community-based providers delivering outpatient care, to support greater investment in the behavioral health workforce.⁴³ Inadequate funding for the behavioral health delivery system has far-reaching implications for the workforce across different settings (e.g., community-based settings, inpatient settings, etc.): low reimbursement rates mean that salaries are persistently low; low salaries temper interest in the field and inhibit retention; and unfunded training responsibilities create an additional burden adding to burnout.⁴⁴ In line with recommendations from the Association for Behavioral Healthcare,⁴⁵ Massachusetts policymakers and the incoming governor have the ability to make strides toward addressing this issue by coalescing to support a plan to require increased spending on behavioral health. For example, the Baker-Polito Administration proposed legislation, An Act Investing in the Future of Our Health (S.2774), that would require a 30 percent increase in spending on primary care and behavioral health services over a three-year period, with the possibility of continued increases over additional years.⁴⁶ However, it will ultimately take several years to right size spending on behavioral health and grow behavioral health infrastructure to meet the Commonwealth’s needs.
- 4. Advancing equity must be central to all efforts to address the behavioral health workforce crisis.** Massachusetts’ efforts to embed equity in all efforts to address the behavioral health workforce should focus on two key policy priorities. First, Massachusetts must prioritize workforce diversity across the continuum of provider types, including among licensed professionals and paraprofessionals, with a focus on racial, ethnic, linguistic, and cultural diversity as well as gender and sexual diversity. The Commonwealth needs better data to aid in understanding the demographic profile of its behavioral health workforce and how the current workforce maps to the demographics and needs of Massachusetts residents.⁴⁷ Second, Massachusetts should seek to build the workforce in rural areas and communities that have been historically marginalized.

3. RECOMMENDATIONS

Aligned with the imperatives described above, this section details **seven recommendations** for the Commonwealth and its partners to institute policy, programmatic, and budgetary changes that will ultimately help to build a more robust, diverse, and resilient behavioral health workforce. These recommendations are:

1. Conduct a baseline **Workforce Needs Assessment** to better understand the supply of the behavioral health workforce, including demographics, and specific workforce gaps.
2. Establish and maintain a **Behavioral Health Workforce Center** with a charter to improve the supply, distribution, competency, and diversity of the workforce.
3. **Ensure that payment for behavioral health services is equal to payment for similar medical services across all payers** in Massachusetts given the impact of reimbursement on the workforce.
4. Develop and fund a **10-year behavioral health workforce strategy** to grow the behavioral health professional workforce pipeline and address the shortage and maldistribution of providers.
5. Pursue a multipronged campaign to dramatically **expand the paraprofessional workforce (e.g., peers, CHWs, recovery specialists)**, including ensuring that they are paid a living wage, have opportunities for career advancement, and can obtain insurance reimbursement.
6. **Create a system of social supports** for all members of the behavioral health workforce.
7. Fund an **in-depth evaluation of the impact of telehealth on the behavioral health workforce**.

For each recommendation, this report describes the problem it aims to address; efforts stakeholders in the Commonwealth have implemented to address the problem to date; examples from around the country of potential programmatic or policy solutions to address this problem; and actionable steps the Commonwealth and its partners can take to implement the recommendation. We also denote whether the recommendation would be implemented in the short-term (one to two years), medium-term (three to five years), or over the long-term (greater than five years).

RECOMMENDATION 1:

Conduct a baseline Workforce Needs Assessment to better understand the supply of the behavioral health workforce, including demographics, and specific workforce gaps.

[Short-term]

The Commonwealth currently does not comprehensively collect data on the supply of its behavioral health workforce. While the Massachusetts Department of Public Health publishes a Health Professions Data Series that identifies trends and patterns—including overall supply by health care provider type as well as demographic information (race/ethnicity, language spoken, gender) and distribution across geographic and clinical settings—these data do not include behavioral health professionals.⁴⁸ National data sources provide information on the supply of the behavioral health workforce in Massachusetts, but these sources are also limited (e.g., lacking data on provider demographics and on paraprofessionals).⁴⁹

“Policies should be based on workforce data. We need investment in research and evaluation to identify gaps and guide solutions.”

—Interview on March 18, 2022

Stakeholders highlight the lack of data as a barrier to understanding and addressing the behavioral health workforce crisis in Massachusetts. The Association for Behavioral Healthcare has recommended that “the Commonwealth should implement a behavioral health workforce data collection and planning strategy” to address these gaps.⁵⁰ In addition, several interviewees for this report note that without these data, it is challenging to appropriately target workforce

policies and programs, such as identifying which geographic areas to focus on for recruitment efforts or which provider types to focus on for retention strategies.⁵¹ And relatedly, without data on the demographic characteristics of the workforce, it is nearly impossible to develop targeted strategies to improve diversity and advance health equity.⁵²

Several other states have conducted or contracted with vendors to conduct a comprehensive behavioral health workforce needs assessment, providing information on the size, racial, ethnic, and cultural composition of the behavioral health workforce, the distribution of the workforce, and the associated demands on the behavioral health delivery system. To tackle the behavioral health workforce crisis, Massachusetts should conduct a baseline Workforce Needs Assessment to better understand the supply of its behavioral health workforce, including demographics and specific workforce gaps.

MASSACHUSETTS EFFORTS TO DATE

Efforts to collect data on Massachusetts' behavioral health workforce have been limited.

- In February 2022, the Association for Behavioral Healthcare released a workforce survey, which collected data on current challenges related to recruitment, vacancies, and access to outpatient mental health services.⁵³
- Pursuant to Chapter 52 of the Acts of 2016, HPC published the 2019 report “Co-Occurring Disorders Care in Massachusetts: A Report on the Statewide Availability of Health Care Providers Serving Patients with Co-Occurring Substance Use Disorder and Mental Illness,” which provides summary level data on the capacity and availability of clinicians in Massachusetts to treat individuals with co-occurring mental health and substance use disorders.⁵⁴
- Under the “ARPA bill” (Chapter 102 of the Acts of 2021), which appropriates federal funding from the American Rescue Plan Act (ARPA) and state funding to address the health and economic impacts of COVID-19, Massachusetts has earmarked \$100,000 for a report on the health care workforce to be conducted by the HPC that will focus on the factors contributing to workforce shortages in the primary and behavioral health care systems.⁵⁵
- Chapter 77 of the Acts of 2022, An Act Establishing the Behavioral Health Trust Fund and the Behavioral Health Advisory Commission, requires the establishment of a Behavioral Health Advisory Commission, which is to conduct an assessment that identifies current behavioral health workforce challenges, including but not limited to challenges related to building the pipeline, emerging workforce needs, and recruitment and retention strategies. Based on the assessment’s findings, the Commission is to advise on how dollars from a new Behavioral Health Trust Fund may be allocated to “[address] barriers to the delivery of an equitable, culturally-competent, affordable and clinically-appropriate continuum of behavioral health care and services.”⁵⁶
- On August 10, 2022, Governor Charlie Baker signed Chapter 177 of the Acts of 2022, An Act Addressing Barriers to Care for Mental Health, into law. This legislation includes a provision requiring HPC to conduct a statewide pediatric behavioral health assessment to inform future policymaking. Part of the assessment requires an “analysis of the

EXAMPLE FROM THE FIELD

In 2022, the George Washington University Fitzhugh Mullan Institute for Health Workforce Equity launched a [Behavioral Health Workforce Tracker](#), which provides an interactive national map to visualize the geographic distribution of the behavioral health workforce by provider type, including psychiatrists, addiction medicine specialists, psychologists, counselors, therapists, primary care physicians, advanced practice providers, and other physicians. For behavioral health prescribers, the tracker allows data to be examined by insurance acceptance status (e.g., Medicaid, Medicare, private insurance), providers who are treating SMI, and those who are DATA 2000-waivered (i.e., authorized to prescribe outpatient buprenorphine) and who are actually providing buprenorphine for opioid addiction. Prescribers include psychiatrists, addiction medicine specialists, primary care physicians, advanced practice providers, and other physicians. In addition, to illustrate state variations in the robustness of behavioral health workforce, the tracker produces customizable state maps that may be drilled down to the county level to display more local variations.

The map relies primarily on two sources of data: 1) IQVIA Xponent, which provides detailed prescriber data on behavioral health medications prescribed by psychiatrists, addiction medicine specialists, primary care physicians, advanced practice providers, and other physicians; and 2) state licensure data, to identify psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists.

capacity of the pediatric behavioral health workforce to respond to the acute behavioral health needs of children and adolescents across the Commonwealth.”⁵⁷

- In 2022, the George Washington University Fitzhugh Mullan Institute for Health Workforce Equity launched a Behavioral Health Workforce Tracker, which provides an interactive national map to visualize the geographic distribution of the behavioral health workforce.⁵⁸ The tracker includes specific Massachusetts level data that may be drilled down to the county level to view variations in size of the population per provider and by provider type. For behavioral health prescribers, data may be examined by distribution of the workforce by payer types, those treating serious mental illness (SMI), and those who are DATA 2000-waivered (authorized to prescribe outpatient buprenorphine to treat opioid addiction). For more details, see the *Example from the Field* on page 10.

RECOMMENDATIONS

It is essential that the Commonwealth conduct a baseline behavioral health Workforce Needs Assessment, similar to what has been conducted by other states, like Oregon and Washington (see callout boxes), to describe the capacity, composition, and distribution of the licensed professional and paraprofessional behavioral health workforce in Massachusetts. This assessment should account for how the workforce relates to the behavioral health needs of the population with a focus on addressing the shortage and maldistribution of providers and advancing health equity. The Commonwealth may be able to leverage some of the work conducted by the Behavioral Health Advisory Commission described above. Ideally, the Behavioral Health Workforce Center (Workforce Center), which is described below in Recommendation 2, would be able to conduct the baseline Workforce Needs Assessment, but given the urgency of the task, it is unlikely that the Workforce Center will be established in time to design and implement the assessment. Certainly, the Workforce Center could update and evolve the Workforce Needs Assessment in future years, as it should be conducted periodically.

As part of the process for the initial Workforce Needs Assessment, the Commonwealth could consider convening a workgroup to provide input on assessment design, consult on methodology and analysis, validate findings, and advise on actionable steps and recommendations. The workgroup would comprise government leadership—including from EOHHS, EOLWD, and the Department of Education (DOE)—academic institutions, community colleges, and representation from providers, hospitals, plans, community-based organizations, schools, and consumer organizations with expertise and experience in behavioral health and workforce issues, as well as representation from communities of color, LGBTQ+ communities, and other communities that have been economically, socially, and/or culturally marginalized.

The initial Workforce Needs Assessment should use both quantitative and qualitative methods to present the current landscape of the behavioral health workforce in Massachusetts, which will augment existing data collection efforts, including the work conducted by the Behavioral Health Advisory Commission (described above), as well as national data initiatives that quantify states’ behavioral health workforces, including HRSA HPSA data⁵⁹ and George Washington University’s recently released Behavioral Health Workforce Tracker⁶⁰ (see *Example from the Field* on page 10). Specifically, the assessment would include the following information:

EXAMPLE FROM THE FIELD

In 2016, Washington State’s Governor Inslee [directed](#) the State’s Workforce Training and Education Coordinating Board (Workforce Board) to conduct an evaluation to “establish a baseline for behavioral health workforce shortages and provide a plan for improving how [Washington State] coordinate[s] the right services for patients.” In response to the Governor’s request, the Workforce Board established a project team that included the University of Washington Center for Health Workforce Studies (UW CHWS), which produced a comprehensive [report](#) to “describe the supply, demand, and distribution of the behavioral health workforce”; “assess the range of barriers to creating a more robust workforce,” such as recruitment and retention, skills training, credentialing, licensing and related policy issues, and paperwork and documentation burdens; and propose solutions. The report also details workforce implications of shifts in payment methodologies and other types of policies on workforce demands, technical skills needed in the workforce, and lessons learned from behavioral and physical health integration.

The report required an 18-month-long process incorporating qualitative and quantitative data collection and analysis. In terms of qualitative data, the report relied on a total of 189 stakeholders and informants from a wide range of health care-related organizations; quantitative data came from state agencies, including certification boards.

- Counts and distribution of providers by provider type and employment status (e.g., practicing vs. non-practicing, full-time vs. part-time status)
- Descriptive features of the workforce in terms of demographics (e.g., race/ethnicity, SOGI, and age)
- Prevalence and/or risk of behavioral health conditions across the Commonwealth in terms of race/ethnicity, SOGI, and age; among populations with socio-economic challenges; and among populations with other social risk factors (e.g., homelessness and justice-involved)
- Distribution of providers by employment status as compared to the needs of the Massachusetts population (e.g., prevalence of mental health conditions and SUD). To this end, Massachusetts should consider using a provider-to-prevalence or provider-to-need ratio, such as the one Oregon has developed (see callout box). For further understanding of the extent to which the workforce aligns with need, Massachusetts can stratify this analysis by provider demographics and need among underserved populations (e.g., children and youth, people of color, LGBTQ+ individuals, people with disabilities).
- Underlying causes behind challenges to recruitment, retention, distribution, and diversity of the behavioral health workforce
- Current licensure policies and any barriers that they present
- Impact of COVID-19, telehealth, and other payment/policy shifts on behavioral health providers

DEFINITION: Provider-to-prevalence ratio, or provider-to-need ratio. In some of its [behavioral health workforce reports](#), Oregon uses a provider-to-prevalence ratio, also called a provider-to-need ratio (PNR), to quantify the number of providers with certain qualifications as compared to the prevalence of people with specified conditions needing that provider's expertise. For example, Oregon has calculated a PNR for number of licensed addiction providers and licensed addiction prescribers per 10,000 Oregonians in need of services (i.e., those ages 12+ with a history of alcohol use disorder in the past year), and is able to compare PNRs across regions of the state to understand where workforce gaps are largest according to need. The Eugene S. Farley, Jr. Health Policy Center, which conducted one of Oregon's workforce assessments, indicates that "PNRs provide a more specific estimate of supply against demand to indicate regional maldistribution with more accuracy."

The process for developing the Workforce Needs Assessment must involve close collaboration with the Commonwealth and entities asked to contribute data to identify approaches for systematic data collection and which data sources are most appropriate. To that end, the University of Michigan Behavioral Health Workforce Research Center published a report on the minimum data set needed to help address questions related to behavioral health workforce supply and distribution.⁶¹ These data elements, listed in Table 1 below,⁶² may serve as a guide for information to include in the initial Workforce Needs Assessment. Recognizing that this list is extensive and that collecting and reporting some data elements will require additional planning, the Commonwealth may designate some data elements to be part of ongoing monitoring and evaluation efforts to be conducted by the Behavioral Health Workforce Center, described below in Recommendation 2, instead of being included in the initial Workforce Needs Assessment.

EXAMPLE FROM THE FIELD

Oregon has conducted several different assessments of its behavioral health workforce, giving it rich information to draw upon in developing future workforce strategies. These efforts include:

- A biennial health workforce assessment that is mandated by the [Legislature](#) and includes data on the behavioral health workforce. The most recent 2021 [report](#) describes overall behavioral health workforce trends, including the distribution of providers across the state, placing emphasis on underrepresentation of people of color in all licensed behavioral health occupations and noting the impacts of telehealth on the workforce during the COVID-19 pandemic.
- A 2019 behavioral health workforce needs assessment, "[An Analysis of Oregon's Behavioral Health Workforce: Addressing the Capacity of Licensed and Unlicensed Providers to Meet Population Needs](#)." This report describes the counts and distribution of providers by provider type; their descriptive features in terms of race/ethnicity, gender, and age; the rate of behavioral health conditions across the state in terms of race/ethnicity, gender, and age, and how the distribution of providers relates to the needs of the Oregon population through a provider-to-prevalence ratio. Various state agencies contributed data sources for the report, including health profession licensing boards.
- A 2022 [study](#) mandated by the [Legislature, described in more detail in Recommendation 3](#), to provide recommendations to the Oregon Health Authority and State Legislature on how to increase wages for behavioral health providers. The study involved key informant interviews with providers, administrative and policy leaders, and others with knowledge of the behavioral health delivery system, as well as focus groups with behavioral health consumers and providers, and meetings with organizations in the state.

TABLE 1. SUMMARY OF MINIMUM DATA SET (MDS) ELEMENTS FOR BEHAVIORAL HEALTH WORKFORCE

MDS THEME	DATA ELEMENTS
Demographics	<ul style="list-style-type: none"> • Name • Age • Race/ethnicity • Sexual orientation gender identity (SOGI) • Place of birth and residence • Military/veteran status • Language skills
Licensure and Certification	<ul style="list-style-type: none"> • Type of job-related licenses held • Type of job-related certificates held • National Provider Identification number • State identification/registration number
Education and Training	<ul style="list-style-type: none"> • Degrees obtained and years of completion • Field of study/specialty • Completion of other educational programs (e.g., internships) • Current enrollment in degree program
Occupation and Area of Practice	<ul style="list-style-type: none"> • Primary occupation • Area of practice* (indicating special areas of focus—e.g., children and adolescent health,* SMI,** addiction**)
Prescriber Data**	<ul style="list-style-type: none"> • Prescriber data on treating behavioral health issues (e.g., providers prescribing medication for depression, medication assisted treatment, psychosis, anxiety, bipolar disorder, other SMI, and other behavioral health conditions)** • DATA 2000-waivered prescribers (denoting those who are actually prescribing buprenorphine)**
Practice Characteristics	<ul style="list-style-type: none"> • Employment status • Number of current employment positions • Number of hours and weeks worked per week/year in clinical practice • Employment arrangement • Use of telehealth • Employer practice setting • Hours per week spent on activities (e.g., clinical supervision, diagnosis) • Clinical or patient care provision • Acceptance of insurance and insurance types (Medicaid, Medicare, private, out of pocket)* • Employment plans

* Elements with one asterisk are either additions or modifications to the original data elements published by the University of Michigan Behavioral Health Workforce Research Center.

** Elements with two asterisks may be available through the George Washington Behavioral Health Workforce Tracker.⁶³

RECOMMENDATION 2:

Establish and maintain a Behavioral Health Workforce Center with a charter to improve the supply, distribution, competency, and diversity of the workforce. [Medium-term]

Today, expertise on behavioral health workforce issues is diffuse across the Commonwealth. No one entity is responsible for monitoring the state of the behavioral health workforce in Massachusetts; identifying gaps and challenges across communities and provider types; using data to craft solutions to identified gaps; or evaluating the impacts of investments in addressing workforce challenges. As a result, the Commonwealth is not able to monitor trends, accurately describe disparities in workforce representation, or understand the demand for services. These challenges not only hinder the Commonwealth's ability to design and support the implementation of interventions responding to the most pressing behavioral health needs of its population,⁶⁴ but also impede its ability to advance health equity at large.⁶⁵

"Based on our Center's workforce survey of providers, we can align our programs and figure out where we can intervene. We have invested in rural areas and created career pathways based on data tracking where students are going after graduation."

—Interview on April 6, 2022

The Commonwealth should **establish a Behavioral Health Workforce Center** (the Workforce Center) that seeks to improve the supply, distribution, competency, and diversity of the behavioral health workforce. The main functions of the Workforce Center would be to: (1) serve as the Commonwealth's primary data hub on behavioral health workforce data; (2) set the behavioral health workforce research and evaluation agenda for the Commonwealth; and (3) act as a centralized resource for technical assistance and training and identification and dissemination of best practices for the behavioral health workforce. The need to establish a workforce center has been identified by the Massachusetts Legislature, which had bills H.1346/S.2814⁶⁶ under consideration during the 2021/2022 legislative session, to establish such a center, detailed below.

MASSACHUSETTS EFFORTS TO DATE

The Commonwealth has begun to undertake efforts that would jumpstart the establishment of the Workforce Center, and there are organizations in Massachusetts that currently conduct some of the activities that could be included as part of the Workforce Center's charge.

- The Massachusetts Legislature proposed legislation in 2021/2022, H.1346/S.2814, An Act Establishing a Behavioral Health Workforce Center of Excellence (COE), which would establish a center at an institution of higher education to "gather data and research to advise policy leaders on how to address the current crisis in behavioral health workforce across the Commonwealth."⁶⁷
- William James College hosts the Center for Workforce Development, which has received several federal HRSA grants to provide training, scholarships, and professional development focused on behavioral health, with special focus on building the diversity of the behavioral health workforce.⁶⁸ In 2021, Massachusetts passed the "ARPA bill" that allocated \$500,000 to William James College to develop a behavioral health workforce development center focused on retaining and developing a "culturally diverse, experienced, behavioral health workforce that cares for underserved communities" and training education experts, including teachers and administrators "to create inclusive, behaviorally healthy school environments that foster psychological health, social development, diversity and inclusion for children."⁶⁹
- In 2021, the UMass Chan Medical School completed an interim evaluation of Massachusetts' Section 1115 demonstration, including its DSRIP program, which encompassed several workforce initiatives (e.g., recruitment, technical assistance, and training programs). Overall, the evaluation recommended that the Commonwealth should continue to invest in loan repayment and workforce training programs to "facilitate building the supply of providers in workforce areas facing the greatest need."⁷⁰

RECOMMENDATIONS

To further augment programs initiated under the Roadmap, the Commonwealth has several options for establishing and funding the Workforce Center including through a state agency or at an academic institution with expertise in behavioral health and health workforce research.

The Workforce Center could be modeled after Nebraska's Behavioral Health Education Center of Nebraska (BHECN) (see callout box) in terms of purpose and specific functions. The overall mission of the Workforce Center would be to improve the supply, distribution, competency, and diversity of the behavioral health workforce throughout the Commonwealth. Specific functions of the Workforce Center would include:

- **Act as the Commonwealth's behavioral health workforce data hub and monitor, analyze, and report on behavioral health workforce trends.** As the Commonwealth's main behavioral health workforce data hub, the Workforce Center would collect data from a diverse set of sources, including licensing boards and other state entities that are essential to inform current and future trends in the workforce supply and demand for services, disaggregated to the extent possible by race, ethnicity, SOGI, and geographic distribution. For example, the Workforce Center could collaborate with licensing boards to require the collection of demographic data (e.g., race, ethnicity, SOGI), which is often challenging to obtain, as part of the provider licensure renewal process; a similar type of strategy has recently been implemented by states such as Washington and Indiana.⁷¹ In addition to collecting existing administrative data from state and national sources, the Workforce Center would collect and generate its own data on workforce trends, such as through survey administration.

As the Commonwealth's behavioral health workforce data hub, the Workforce Center would be responsible for monitoring, analyzing, and reporting on trends in the supply, distribution, and diversity of the Commonwealth's behavioral health workforce, identifying areas of unmet need among specific populations where there are workforce gaps (e.g., children/youth, specific racial or ethnic groups, individuals with co-occurring mental health conditions and SUD, etc.). This monitoring function would build upon the baseline Workforce Needs Assessment that is described above in Recommendation 1.

- **Set and update a research and evaluation agenda.** The Workforce Center would be responsible for setting a research and evaluation agenda that informs future behavioral health workforce strategy and is responsive to areas where there are pressing policy and/or program needs, such as addressing urgent needs related to children and youth, and the impact of telebehavioral health on the workforce, as described in Recommendation 7. This work may include convening expert workgroups to develop recommendations on top priorities. The Workforce Center would conduct or contract with partners to conduct research that supports market need and evaluates the impact of behavioral health workforce interventions.

EXAMPLE FROM THE FIELD

In 2009, the Nebraska Legislature established [the Behavioral Health Education Center of Nebraska \(BHECN\)](#) via Revised Statute [71-830](#) to address behavioral health workforce shortages in the state. Since then, the Legislature has allocated an annual appropriation to BHECN. BHECN serves several functions, including:

- **Conducting analysis of the behavioral health workforce:** BHECN monitors and reports on workforce trends, including trends in the overall supply and distribution of the workforce, as well as trends in the aging and diversity (racial/ethnic composition) of the workforce by provider type; compares Nebraska's workforce supply density to that of the United States; and publishes a [Nebraska Behavioral Health Workforce Dashboard](#) that maps provider count by county from 2010 to 2020.
- **Developing behavioral health regional education and training sites:** BHECN is developing six regional sites to foster workforce development opportunities at the local level.
- **Funding residencies and other training programs:** BHECN funds two psychiatry residents per year, who are trained in interprofessional and telehealth services in rural and underserved settings. BHECN also helps to fund training of other members of the behavioral health workforce.
- **Supporting interprofessional development opportunities:** BHECN fosters interprofessional opportunities such as conferences to disseminate workforce education materials that are focused on improving patient outcomes.
- **Cultivating networks:** BHECN convenes networks of individuals, committees, partners, and champions that help to mobilize support and funding to advance its mission.

- **Act as a centralized resource for technical assistance and training and identification and dissemination of best practices on the behavioral health workforce.** The Workforce Center would coalesce expertise on behavioral health workforce throughout the Commonwealth—through both direct hiring of experts and partnerships with EOHHS, EOLWD, DOE, academic institutions, and behavioral health provider organizations—to provide technical assistance and training to and convene stakeholders invested in building a more robust and diverse behavioral health workforce in Massachusetts. These activities would include:

- **Identifying best practices to build the capacity of the behavioral health workforce.** The Workforce Center would be able to leverage its role as a data hub and its partnerships with key stakeholders across the Commonwealth to identify best practices in real time to build the capacity of the behavioral health workforce with an eye towards equity.

- **Providing data-informed technical assistance.** With a rich base of information at its fingertips, the Workforce Center would be able to provide data- and best practice-informed technical assistance to entities such as universities, community colleges, and behavioral health provider organizations on investments they could make to create a more resilient workforce. For example, the Workforce Center could provide technical assistance and trainings to behavioral health provider organizations and members of the workforce themselves on best practices in creating a more supportive work environment for people of color, promoting the integration of the paraprofessional workforce among clinical teams, and addressing burnout. Additionally, the Workforce Center would be able to advise educational institutions on the behavioral health workforce needed for the future, by position, geography, and demographic data (e.g., race, ethnicity, SOGI), to inform the development of programs to build the pipeline.

- **Convening key stakeholders to share best practices and create professional networks across the behavioral health workforce.** The Workforce Center should also have the capabilities to convene key stakeholders in Massachusetts’ behavioral health workforce—including behavioral health professionals and paraprofessionals, behavioral health provider organizations, academic institutions, and advocates, to design and implement a range of virtual and in-person convenings to share best practices and lessons learned in the field. In this role, the Workforce Center could host conferences; institute experiential learning in community-based settings; create forums for individual and group peer-to-peer and expert consultation; conduct webinars; and facilitate learning collaboratives.

- **Serve as a resource to funders, including the Commonwealth and foundations, and national policy and research entities committed to strengthening behavioral health workforce policies.** Leveraging its robust data resources, research and evaluation findings, and insights from its technical assistance arm, the Workforce Center may serve as a valuable resource to funders looking to understand where to invest funding to grow the behavioral health workforce, such as funding to pilot and test new interventions and to sustain interventions that have demonstrated success in growing and/or improving retention in the workforce. In addition, the Workforce Center may supply data and analysis to national policy and research entities that seek to shape national and state policies to grow and sustain the behavioral health workforce, which in turn, may contribute to new federal policy and funding opportunities for Massachusetts and other states.

EXAMPLE FROM THE FIELD

In 2021, the Illinois Legislature [funded and established](#) the [Illinois Behavioral Health Workforce Education Center](#) to address the behavioral health workforce crisis in the state. The center uses a “hub and spoke” model, with one anchor higher education institution (Southern University of Illinois) in partnership with other institutions, to research, identify, and evaluate interventions to close the workforce gaps in the state. To give the Behavioral Health Workforce Education Center a head start in getting up and running, the Legislature previously had [formed](#) a Behavioral Health Workforce Education Center Task Force, consisting of the Department of Human Services – Division of Mental Health, Board of Higher Education, and academic institutions. The taskforce produced a [report](#) to the Legislature on behavioral health data, shortages, and evidence-based models or practices.

The Workforce Center could be governed by a steering committee with composition similar to that of the Workforce Needs Assessment workgroup, described in Recommendation 1, including interdisciplinary state government leadership (e.g., EOHHS, EOLWD, DOE), academic institutions including community colleges, and representation from

providers, hospitals, payers, community-based organizations, schools, consumer organizations with expertise and experience in behavioral health and workforce issues, as well as representation from communities of color, LGBTQ+, and other communities that have been economically, socially, and/or culturally marginalized. In addition to providing oversight, the steering committee would help set Workforce Center priorities, design and advance its research and evaluation agenda, foster partnerships among key stakeholders, and coordinate with other workforce monitoring initiatives in the Commonwealth. This type of stakeholder engagement is critical to the success of the Workforce Center, as Massachusetts has several academic institutions and other nongovernmental entities with deep expertise and experience on behavioral health workforce issues.

RECOMMENDATION 3:

Ensure that payment for behavioral health services is equal to payment for similar medical services across all payers in Massachusetts given the impact of reimbursement on the workforce. [Short-term]

As summarized by the Centers for Medicare and Medicaid Services (CMS), the federal Mental Health Parity and Addiction Equity Act (MHPAEA)⁷² “generally prevents group health plans and health insurance payers that provide mental health or SUD benefits from imposing less favorable quantitative—including reimbursement—and qualitative treatment limitations on those benefits than on medical/surgical benefits.”⁷³ Despite MHPAEA requirements, insurance reimbursement rates are often low for covered behavioral health services compared to similar physical health services. A Milliman study found that in 2017, commercial insurers in Massachusetts provided reimbursement for primary care office visits that *was almost 60 percent higher* than reimbursement for behavioral health office visits.⁷⁴ And, in 2020, the Massachusetts Attorney General found that three health insurers operating in the Commonwealth had violated MHPAEA by paying lower rates for behavioral health services as compared to similar physical health services.⁷⁵

Insufficient reimbursement of behavioral health services creates a cascade of downstream consequences for the behavioral health system and its workforce. Low reimbursement rates across all payer types for behavioral health services “trickle down” to lower salaried positions across the field, deterring people from pursuing a career in behavioral health.⁷⁶ Among those who decide to enter the behavioral health workforce, low salaries make it difficult for professionals and paraprofessionals to pay off student loans and live comfortably, creating barriers to retention, particularly in community-based settings.⁷⁷ In addition, low insurance reimbursement rates may incentivize many behavioral health professionals to forgo participation in insurance networks.⁷⁸ Interviewees and reports from other states indicate that the reality that many behavioral health professionals can earn more money at hospitals, in private practice, or by forgoing participation in insurance networks makes it more difficult for community-based behavioral health provider organizations to attract and retain workers.⁷⁹ This problem is likely magnified in the current environment of behavioral health workforce shortages across both inpatient and community-based settings. Accordingly,

MENTAL HEALTH PARITY

When deployed effectively, mental health parity requirements can help bolster the behavioral health workforce by ensuring that behavioral services are covered by insurance, that consumers are able to access the services, and providers are reimbursed sufficiently. MHPAEA requires payers to cover a range of behavioral health services provided by a sufficient behavioral health network and prohibits payers from imposing utilization review policies that are stricter than those imposed for other medical services. The effectiveness of MHPAEA is directly tied to the state’s enforcement of its requirements.

Today, MHPAEA requirements do not [apply](#) to the Medicare program and non-federal governmental plans that are self-insured (e.g., state-sponsored plans for teachers). These insurers have the ability to impose limitations on behavioral health services, including caps on visits, annual or lifetime coverage, and reimbursement, that are stricter than those in place for other medical services. The proposed FY2023 [President’s Budget](#) seeks to close this loophole so that MHPAEA requirements apply more broadly. States are responsible for overseeing compliance with MHPAEA for plans that they regulate; the federal government oversees compliance with MHPAEA for plans subject to the Employee Retirement Income Security Act (ERISA) and federally sponsored plans (e.g., plans for federal employees). (Note that MHPAEA [applies](#) to Medicaid managed care plans, Medicaid alternative benefit plan coverage, and the Children’s Health Insurance Program.)

the Association for Behavioral Healthcare’s February 2022 survey of community-based providers in Massachusetts concluded that “reimbursement is the most important retention factor.”⁸⁰

Improving reimbursement for behavioral health services will incentivize the expansion, retention, and resiliency of the behavioral health workforce. In line with these goals, **the Commonwealth should take further action to ensure that payment for behavioral health services is equal to payment for similar medical services across all payers in Massachusetts.**

MASSACHUSETTS EFFORTS TO DATE

The Commonwealth has grown its efforts to ensure that payment rates are equitable across behavioral health services and other medical services. For example:

- Leveraging ARPA funds, MassHealth required managed care entities and Program of All-Inclusive Care for the Elderly (PACE) organizations to increase rates by 10 percent through June 2022 for a wide range of behavioral health services, including, but not limited to, outpatient mental health services, partial hospitalization, programs of assertive community treatment, recovery coaching, SUD clinic services, and structured outpatient addiction programs.⁸¹
- An Act Addressing Barriers to Care for Mental Health (Chapter 177 of the Acts of 2022), requires payment parity for primary care and licensed mental health practitioner evaluation and management office visits.⁸²
- In FY2019, Massachusetts increased state funding for Department of Mental Health and Department of Public Health-provided behavioral health services by 20 percent.⁸³
- Anticipating the potential passage of An Act Investing in the Future of Our Health (S.2774) which was introduced in the 2021/2022 legislative session but was not passed, and which would require a 30 percent increase in spending on primary care and behavioral health care, the Center for Health Information and Analysis (CHIA) has conducted an analysis to determine the baseline proportion of spending on these services.⁸⁴
- Related to MHPAEA enforcement, the Massachusetts Division of Insurance conducts yearly Market Conduct Examinations and publishes reports on carriers, including assessments on compliance with parity requirements.⁸⁵ As noted above, in 2020, the Massachusetts Attorney General identified that three insurers were in violation of MHPAEA requirements related to their methodology for establishing reimbursement rates for behavioral health services, and reached a settlement with those plans requiring them to amend their methodologies so that they “are comparable to, and applied no more stringently than, the methodology and processes used for establishing [medical/surgical] Provider reimbursement rates.”⁸⁶

RECOMMENDATIONS

Policymakers in the Commonwealth should identify a path toward **requiring payment parity for behavioral health services** for insurance products that the Division of Insurance regulates. Although MHPAEA requires reimbursement for behavioral health services to be on par with similar services for other medical conditions, reimbursement for behavioral health services has remained low when benchmarked against other medical services.⁸⁷ An explicit and stand-alone state legislative requirement for payers to match their reimbursement for behavioral health services to similar services for other conditions will likely lead to increases in reimbursement rates for behavioral health services across the board.

EXAMPLE FROM THE FIELD

In 2021, Oregon’s legislature passed [HB2086](#), which required the Oregon Health Authority to conduct a study and develop a report on Medicaid rates for behavioral health services, with a specific focus on how they compared to rates for physical health services. The legislature required the report to include recommendations on how to ensure that behavioral health providers—including peers and family support specialists—are paid a living wage and how to promote “more equitable wages between physical health care workers and behavioral health care workers.” The [report](#) was released in February 2022; among other analyses, it compares:

- Wages for behavioral health providers as compared to physical health providers,
- Medicaid rates for physical health, behavioral health, and specialty services against Medicare rates, and
- Reimbursement for select Current Procedural Terminology (CPT) codes when performed by physical health versus behavioral health providers.

As a first step to moving toward payment parity for behavioral health with other medical services, the Commonwealth could conduct or commission (through CHIA, HPC, or an academic institution) a comprehensive analysis of provider payment rates against comparable medical services among state-regulated commercial plans. This analysis would also promote transparency and improve plan accountability for managing behavioral health services. Massachusetts legislators could also expand on the recently passed Act Addressing Barriers to Care for Mental Health, which requires payment parity for physical health and behavioral health services that use evaluation and management codes, to all levels of care such as, for example, partial hospitalization services and other more intensive behavioral health services. Similar federal legislation, the Strengthen Kids' Mental Health Now Act of 2022, has been introduced to require that Medicaid pay at least the same amount as Medicare for a broad range of pediatric mental health and SUD services.⁸⁸

Additionally, Massachusetts should continue to strengthen its oversight of insurer compliance with MHPAEA. Without strong accountability and oversight, parity can exist on paper but not in reality. Massachusetts is responsible for oversight of state-regulated payer compliance with MHPAEA; however, with multiple insurers found to be in violation in 2020, it suggests there is a need in Massachusetts, like other states across the country, for more continuous, consistent enforcement.⁸⁹ Massachusetts can strengthen its oversight and payer compliance through a combination of heightened performance review, including a regular review of plan reimbursement policies related to MHPAEA, technical assistance and education for payers regarding MHPAEA requirements, and enforcement action in cases of noncompliance such as fines and corrective action plans.⁹⁰

RECOMMENDATION 4:

Develop and fund a 10-year behavioral health workforce strategy to grow the behavioral health professional workforce pipeline and address the shortage and maldistribution of providers. [Medium- to long-term]

Stakeholders interviewed noted (and data validates) that many behavioral health professionals in the Commonwealth are reaching retirement age, exacerbating shortages in an already stretched workforce.⁹¹ At the same time, not enough young people in Massachusetts and other states are entering the behavioral health workforce because of a lack of awareness or interest in the field, stigma, and/or low pay.⁹² Salaries for behavioral health professionals remain persistently low. For example, the U.S. Bureau of Labor Statistics reports that in 2021, annual mean wages for Massachusetts mental health and substance use disorder social workers; substance abuse, behavioral disorder, and mental health counselors; and marriage and family therapists were between \$53,000 and \$56,000 per year, well below the Commonwealth's \$72,940 annual

"We have short-term workforce allocation solutions. What are the long-term strategies to bring people into the workforce and then allocate them appropriately?"

—Interview on March 2, 2022

mean wage for all occupations.⁹³ And there are sharp salary disparities across settings. In 2019–2020, on average, hospitals paid almost 38 percent more than behavioral health agencies to individuals with the same degree. For example, the mean salary at hospitals for licensed independent clinical social workers (LICSWs) was \$78,270 versus \$58,781 at behavioral health agencies, and for psychologists, it was \$104,125 at hospitals as compared to \$78,603 at behavioral health agencies.⁹⁴

Filling gaps in the professional behavioral health workforce will take time. Many professional-level positions (e.g., LICSWs, psychologists) take years of schooling and training, during which an individual may not be paid or paid little for working close to full time.⁹⁵ For example, to become a licensed mental health counselor in Massachusetts, a student must complete a 100-hour practicum prior to completing a 600-hour clinical field internship.⁹⁶ Post-degree, the same individual must complete an additional 3,360 hours of training.⁹⁷ A 2020 national survey found that on average, individuals pursuing a master's degree in social work took on \$49,000 in debt to complete their degree, in addition to having an average of an additional \$17,000 in debt from prior education.⁹⁸ Black/African American individuals

faced 47 percent more debt for social work education than White individuals; Hispanics had 10 percent more debt than non-Hispanics.⁹⁹ Accordingly, between the cost of tuition and training requirements, professional training and degree programs may be prohibitively expensive to people looking to enter the field, serving as a barrier especially for individuals who may be from socioeconomically, racially, ethnically, or culturally marginalized communities due to historic policies that have impacted wealth accumulation and income, impeding greater diversity in the workforce.¹⁰⁰

In addition, stakeholders interviewed note that Massachusetts' current behavioral health workforce is not appropriately distributed across settings and modalities (e.g., inpatient, community-based outpatient, telebehavioral health, state agencies), geographic areas, and populations (e.g., children/youth vs. adults), meaning that the workforce may not be aligned with where there are the greatest needs.¹⁰¹ For example, as noted earlier in this report, there are currently dire shortages at community-based provider organizations.¹⁰² Stakeholders attribute this shortage to a variety of factors, including the ability of hospitals and state agencies to pay higher salaries and the shift of a critical mass of providers from working in community-based settings to environments like digital health start-ups because of opportunities for higher pay and better work-life balance, as discussed further in Recommendation 7.¹⁰³ At the same time, hospitals are also struggling with workforce shortages; in January 2022, one major Massachusetts hospital system indicated that it could not staff up to one-sixth of its inpatient psychiatric beds, rendering them unusable.¹⁰⁴ These challenges are amplified for providers in rural areas of the Commonwealth.¹⁰⁵ And finally, interviewees raise that there is insufficient diversity in the behavioral health workforce to meet the needs of Massachusetts residents.¹⁰⁶ As noted throughout this report, quantitative data on the maldistribution of workforce is limited, making it difficult to assess the scale of these gaps.

Addressing these shortages requires a long-term and well-resourced plan. Specifically, **the Commonwealth should act now to develop and fund a 10-year strategy to grow the behavioral health workforce pipeline and address the shortage and maldistribution of providers.**

MASSACHUSETTS EFFORTS TO DATE

The Commonwealth and stakeholders have undertaken a number of significant efforts to grow and address the shortage and maldistribution of the Massachusetts behavioral health professional workforce. For example:

- Under the “ARPA bill” (Chapter 102 of the Acts of 2021), enacted in late 2021, the Legislature allocated \$110 million for a loan repayment program administered by EOHHHS for the full range of behavioral health professionals (licensed and unlicensed), including psychiatrists, psychologists, master’s-level clinicians, and inpatient psychiatric mental health nurse practitioners. The program is required to “prioritize the recruitment and retention of a culturally, ethnically and linguistically diverse workforce,” and to be eligible for the program, an individual must commit to working in a community-based or inpatient psychiatric setting for four years. The act also requires the Health Policy Commission to release a report on strategies for workforce development, such as scholarships, mentorship programs, and loan forgiveness, across health care professions.¹⁰⁷
- An Act Establishing the Behavioral Health Trust Fund and the Behavioral Health Advisory Commission (Chapter 77 of the Acts of 2022) requires the Behavioral Health Advisory Commission to determine “the feasibility of grant, scholarship and other pipeline development programs that mitigate the financial burden of entering and progressing up the behavioral health workforce pipeline” for the full range of both professional and paraprofessional positions. The act also directs the Commission to identify strategies to promote retention.¹⁰⁸

EXAMPLE FROM THE FIELD

In 2016, the Oregon Health Authority convened a diverse group of stakeholders called the [Behavioral Health Collaborative](#), which published [recommendations](#) designed to “help transform Oregon’s behavioral health delivery system from one that is fragmented and unable to serve everyone in need to one that is integrated and providing better health and better care at a lower cost.” The Collaborative made several recommendations related to strengthening the behavioral health workforce, including but not limited to: performing an analysis of the types and areas where there are workforce shortages; cultivating a culturally and linguistically appropriate workforce; developing trainings to bolster the competencies of the licensed and unlicensed workforce; and implementing new recruiting and retention strategies (e.g., establishing a central, statewide recruitment strategy, collaborating with universities and community colleges).

- Under DSRIP, Massachusetts has invested in student loan repayment for psychiatrists, psychologists, licensed behavioral health professionals, and nurse practitioners working in community-based settings, including special funding designated for those working at Community Mental Health Centers.¹⁰⁹ Preliminary data show that these efforts have been successful in promoting provider retention in community-based settings; in its December 2021 Section 1115 demonstration renewal application, MassHealth reported that over 94 percent of behavioral health providers who received funding for loan repayment in 2018 and 2019 continued to work in community-based settings.¹¹⁰
- In its Section 1115 demonstration renewal application, which is under review by the federal government, Massachusetts proposes continuing to invest in loan repayment, specifically targeted toward licensed behavioral health clinicians, master’s-prepared clinicians less than a year away from licensure, psychiatrists, and nurse practitioners with prescribing privileges. As a condition of loan repayment, licensed behavioral health clinicians and master’s-prepared clinicians would be required to work for four years in community-based settings where a substantial portion of patients are enrolled in MassHealth, while psychiatrists and nurse practitioners would be required to maintain a patient panel where at least 40 percent of their patients are covered by MassHealth or uninsured.¹¹¹
- William James College is a grantee for the HRSA-funded Behavioral Health Workforce Education and Training program through which it recruits, provides stipends to, and trains graduate students from underrepresented backgrounds who are in Doctor of Psychology, counseling, and school psychology programs to serve children, adolescents, and transitional age youth in team-based, community-based settings.¹¹²

RECOMMENDATIONS

To further build upon the work started by the Roadmap, the Commonwealth—including EOHHS and EOLWD—should collaborate to develop a comprehensive and well-resourced 10-year strategy for growing its behavioral health professional workforce, with an explicit focus on increasing: racial, ethnic, cultural, LGBTQ+, and language diversity in the workforce; providers who practice in underserved areas of the Commonwealth; providers working with children/youth; and providers who work in community-based settings. The strategy should be data-informed, focused on building the workforce in positions, geographic areas, and communities where there is an identified need. This strategy will require robust and long-term financial investment to build the pipeline. In addition to state budget appropriations, the Commonwealth can explore partnerships with employers, universities, and provider organizations and federal funding opportunities, such as HRSA grants, to help fund these investments. Specific components of a 10-year behavioral health workforce strategy include:

- **Encouraging interest in the field.** Programs that encourage interest in behavioral health professions among high school and college students are essential to building a workforce pipeline. In other states, Area Health Education Centers (AHECs) and state universities are key partners in these efforts, and the Commonwealth can identify opportunities to partner with these organizations to develop programs that expose teens and young adults to the field. For example, AHECs in Montana offer a series of “Heads Up Behavioral Health Camps” across the state to expose high school students to careers in behavioral health. Activities include discussions with a range of behavioral health professions, mental health first aid certification, and training on suicide and anti-bullying.¹¹³
- **Providing financial incentives to build the pipeline.** As part of redirecting health care spending in the Commonwealth toward behavioral health, Massachusetts should institute financial incentives to achieve the following goals:
 - **Reduce barriers to entry and the financial burden of training.** The expense and time associated with the education and training required to become a behavioral health professional present significant barriers to entering the field. Working with universities and other partners, including large provider systems and health insurers, EOHHS can develop new scholarship programs for incoming undergraduate and graduate students to pursue the education required to become behavioral health professionals. These efforts should prioritize targeted scholarship programs for historically marginalized populations to encourage their entrance into the field, augmenting initiatives funded by SAMHSA and HRSA (see callout box). Additionally, recognizing that people may not

pursue careers as behavioral health professionals because they cannot afford to work unpaid during training, these partnerships can include initiatives to pay students who are completing internships and fieldwork, such as university stipends, insurance reimbursement, or salaried arrangements.

- **Continue to monitor existing strategies to address the maldistribution of providers.** Longer-term efforts to grow the behavioral health workforce should address the maldistribution of providers across areas of the Commonwealth and between institutional and community-based settings, recognizing that workforce shortages in institutional settings also need to be addressed. As it is doing today, the Commonwealth should continue to use financial incentives, including scholarship programs and loan repayment programs targeted to licensed, master's-prepared, and unlicensed professionals, to induce behavioral health providers to practice in rural, economically marginalized, or other underserved areas or to focus on populations with particularly great needs (e.g., children/youth). The new Workforce Center (see Recommendation 2) should continuously monitor the distribution of behavioral health providers across the Commonwealth to pinpoint workforce gaps, including where there is a need for additional providers from particular racial, ethnic, cultural, or other marginalized backgrounds and where there is a need for providers with certain degrees (e.g., LICSWs, advanced practice registered nurses), and target future scholarship and loan repayment initiatives accordingly.

EXAMPLES FROM THE FIELD

FEDERAL PROGRAMS FOCUSED ON BUILDING AND RETAINING A DIVERSE HEALTH CARE WORKFORCE

- **SAMHSA's Minority Fellowship Program (MFP):** In 1973, SAMHSA launched the [Minority Fellowship Program](#) (MFP), focused on encouraging members of diverse racial and ethnic groups to join the behavioral health workforce. Initially, the program focused on doctoral professionals, but in 2014, the program expanded to increase the number of “culturally-competent master's-level behavioral health professionals specifically focused on youth ages 16–25” and master's-level addiction counselors. Each year, the program accepts 200 fellows (master's-level or post-graduate students) and provides **financial support as well as mentorship and professional development opportunities**. MFP works with the American Association for Marriage and Family Therapy, American Nurses Association, American Psychiatric Association, American Psychological Association, Council on Social Work Education, NAADAC: The Association for Addiction Professionals, and National Board for Certified Counselors and Affiliates.
- **Area Health Education Centers (AHEC):** Established in 1971 by Congress, the [AHEC](#) program was intended to “recruit, train and retain a health professions workforce committed to underserved populations.” The AHEC program leverages community-academic partnerships to address local needs while also developing the health care workforce, focusing on **exposure, education, and training opportunities**. A sample initiative is the AHEC Scholars program, which offers graduate health professional students experiential education opportunities in rural and underserved areas; the curriculum includes topics such as behavioral health integration, cultural competency, and social drivers of health. Currently, there are over 300 AHECs across the country. In Massachusetts, there are AHECs [located](#) in the Berkshires, Boston, Cape Cod, Central Massachusetts, and the Merrimack Valley, which undertake a range of functions related to workforce development. For example, the [Berkshire AHEC](#) provides continuing education and professional development opportunities on a range of topics including mental health and SUD issues and has collaborated with Massachusetts Department of Public Health to address local public health challenges such as overdoses and youth suicide.
- **HRSA Initiatives:** HRSA has funded and implemented several initiatives focused on enhancing and supporting the diversity of the health care workforce, including the behavioral health workforce. These initiatives currently include:
 - The [Centers of Excellence](#) Program (2022–2027) provides grants to academic institutions in behavioral health, schools of medicine, and schools of osteopathic medicine “to **recruit, train, and retain under-represented minority students and faculty** at health professions schools.” Some Center of Excellence grantees provided financial support to students and all of these grantees worked towards “improving information resources, clinical education, curricula, and cultural competence as they relate to minority health issues and social determinants of health.”
 - The [Health Careers Opportunity Program](#) (2018–2023) provides grants to graduate programs in behavioral health, schools of medicine, and schools of osteopathic medicine to focus on: 1) promoting the **recruitment** of qualified individuals from economically or educationally disadvantaged backgrounds into health professions, including allied health programs; 2) **improving retention, matriculation and graduation** rates by implementing tailored enrichment programs designed to address the academic and social needs of economically or educationally disadvantaged students; and 3) providing opportunities for **community-based health professions training** in primary care settings, emphasizing experiences in rural and underserved communities.” In Massachusetts, [Mount Wachusett Community College](#) received one of these grants.
 - [Scholarships for Disadvantaged Students](#) (2020–2025) **provide grants** to eligible health professions and nursing schools to create scholarship programs of up to \$40,000 per student focused toward students from “disadvantaged backgrounds.” In Massachusetts, [William James College](#) received a grant to provide these scholarships.

RECOMMENDATION 5:

Pursue a multipronged campaign to dramatically expand the paraprofessional workforce (e.g., peers, CHWs, recovery specialists), including ensuring that they are paid a living wage, have opportunities for career advancement, and can obtain insurance reimbursement.

[Medium-term]

Paraprofessionals are critical members of the behavioral health workforce.¹¹⁴ In Massachusetts, these professionals include peer recovery coaches, certified (mental health) peer specialists, CHWs, recovery support navigators, and recovery specialists.¹¹⁵ When integrated as part of a clinical care team, paraprofessionals may serve as an important bridge between clinician and patient, translating information, building trust, and connecting the patient to community-based resources.¹¹⁶ They also can occupy a variety of roles, allowing for task-sharing and for professionals to practice at the top of their license.¹¹⁷

As demonstrated during the pandemic, the paraprofessional workforce is also critical to advancing equity, as members of this workforce typically belong to communities they serve and are able to identify and share experiences with their patients and clients with regard to race, ethnicity, culture, and language.¹¹⁸ This workforce has a unique ability to quickly forge trust among communities who experience a lack of trust in the health care system.¹¹⁹ There has been interest in how to leverage this workforce to provide psychosocial support, especially among populations who experience mistrust of the health care system and grapple with socioeconomic and cultural factors adversely impacting their health.¹²⁰ For all of these reasons, there is a growing need to expand this component of the behavioral health workforce.

Despite the increasing evidence of the importance of paraprofessionals in improving outcomes,¹²¹ there are various national and Commonwealth-specific structural barriers to expanding this workforce, which taken together, make paraprofessionals in the behavioral health workforce vulnerable to low job-satisfaction and attrition.¹²²

- **Paraprofessionals have challenging jobs yet often do not make a living wage.**¹²³ The Massachusetts Association of Community Health Workers reports that CHWs in Massachusetts receive “considerably lower pay than those occupations requiring a similar skillset.”¹²⁴ Although some CHWs lack college experience, the requisite skills for their job is comparable to many occupations requiring college degrees or more advanced degrees and training.¹²⁵ In 2021, the mean hourly wage in Massachusetts was \$24.00 for CHWs (annual mean wage for CHWs was \$49,920), which was approximately 31 percent lower than the mean hourly wage for all occupations in Massachusetts (\$35.07) (annual mean wage for all occupations was \$72,900).¹²⁶ For comparison, the Massachusetts Institute of Technology’s Living Wage Calculator indicates that as of 2022, the living hourly wage in Massachusetts is \$21.88 for an adult with no children, \$44.23 for a household with one adult and one child, and \$43.77 for a household with two adults and two children.¹²⁷
- **Services provided by the paraprofessional workforce may not be reimbursable by MassHealth, Medicare, or commercial insurers** and instead rely on grant funding,¹²⁸ which may discourage scaling of this workforce and limit access to the services they provide.¹²⁹
- **The paraprofessional workforce may feel job dissatisfaction.** Research shows that members of this workforce, especially peers, are vulnerable to microaggressions and other forms of discrimination from the non-CHW/peer members of the team.¹³⁰ Clinicians, especially those used to practicing in more medical models, do not always grasp the role the paraprofessional workforce can play on care teams, leading paraprofessional members of the team to feel a lack of clarity in their work, a sense of not being fully integrated as part of the team, and a sense of isolation and burnout.¹³¹
- **There are limited career pathways for advancement within the profession.**¹³²

“When you talk about a more diverse workforce, we need to talk about those with lived experience. How do we create paths for peer supports to become LCSWs or psychologists?”

—Interview on March 3, 2022

It is incumbent upon the Commonwealth to address these challenges and **expand and support the paraprofessional workforce.**

MASSACHUSETTS EFFORTS TO DATE

Massachusetts' efforts in recent years to build out its paraprofessional behavioral health workforce, particularly in MassHealth, lay the groundwork for additional efforts in this area:

- Under Massachusetts' DSRIP program, MassHealth supported the growth of the paraprofessional workforce, namely CHWs, recovery coaches, and peer specialists. It invested in the creation of Medicaid Accountable Care Organizations (ACOs), which have had the flexibility to hire CHWs and other paraprofessionals as part of their efforts to improve outcomes and decrease total cost of care.¹³³ Additionally, the Commonwealth invested DSRIP funds in workforce development priorities, which included training CHWs, recovery coaches, and peer specialists along with their supervisors.¹³⁴ The interim evaluation of the 2017–2022 1115 demonstration period overall recommended continuing these types of workforce investments.¹³⁵
- Although MassHealth pays for services provided by most types of behavioral health paraprofessionals, including peer recovery coaches, recovery support navigators, and certified peer specialists,¹³⁶ the state's Roadmap proposed to expand MassHealth coverage and work with commercial insurers to expand coverage for recovery coaches and certified mental health peer specialists.¹³⁷
- Massachusetts is investing in integrated team-based models—most notably, the Community Behavioral Health Center (CBHC) initiative—that include the paraprofessional workforce as care coordinators and outreach workers. CBHCs are intended to function as community-based entry points for timely assessment and linkage to behavioral health care treatment,¹³⁸ and are similar to the federally Certified Community Behavioral Health Clinics,¹³⁹ which continue to be the subject of increased federal investment.¹⁴⁰ In February 2022, EOHHS released a request for proposals (RFP) to develop a network of CBHCs across the Commonwealth, and in July 2022, 25 providers were designated as CBHCs. The initiative will launch on January 1, 2023.¹⁴¹ Stakeholders are optimistic about CBHCs' promise to provide a sustainable payment stream and support the employment of paraprofessionals since the rate buildup assumes that care coordinators and outreach workers will play a meaningful role in the model and be paid a livable wage.¹⁴²
- Massachusetts has established a Board of Certification for CHWs within the Massachusetts Department of Public Health, which seeks to open new opportunities for individuals to become CHWs and set standards so that CHWs consistently deliver high quality services.¹⁴³
- Holyoke Community College received an HRSA Opioid-Impacted Family Support Program grant¹⁴⁴ to establish the Community Health Worker Apprenticeship Program,¹⁴⁵ which is a two-year program for CHWs that begins with free pre-apprenticeship training courses and culminates with a paid registered apprenticeship at the Behavioral Health Network, which is a regional behavioral health provider in Western Massachusetts.

RECOMMENDATIONS

The Commonwealth has the opportunity to employ a number of strategies to invest in growing and supporting the behavioral health paraprofessional workforce. Specifically, the Commonwealth should:

- **Gather data on the supply, distribution, and diversity of the behavioral health paraprofessional workforce.** The baseline Workforce Needs Assessment described in Recommendation 1 should assess the size, geographic distribution, and racial, ethnic, or cultural composition of the paraprofessional workforce. In addition, the Workforce Center should continue to monitor the supply, distribution, and diversity of this workforce.
- **Support financial sustainability of the behavioral health paraprofessional workforce.** As recommended under the Roadmap, the Commonwealth should continue efforts to pursue commercial coverage of services provided by the paraprofessional workforce, acknowledging that services provided by members of this workforce have the potential to benefit Massachusetts residents beyond those covered by MassHealth. While MassHealth provides fairly robust coverage of behavioral health paraprofessionals today, stakeholders interviewed note that there is a gap in insurance

funding for CHWs, who are primarily funded through grant opportunities, such as those that have been made available during the COVID-19 pandemic.¹⁴⁶ Similar to other states like Oregon¹⁴⁷ and California,¹⁴⁸ Massachusetts should submit a state plan amendment to CMS to cover services delivered by CHWs, which would likely permit provider organizations to pay this workforce higher salaries. Additionally, given their critical importance to the behavioral health delivery system, the Commonwealth should work with the Legislature to pass a wage add-on to increase MassHealth rates for provider organizations that agree to pay employed paraprofessionals a living wage.¹⁴⁹

- **Continue to integrate the paraprofessional workforce into clinical teams.** As noted above, failure to integrate paraprofessionals into clinical teams is associated with burnout and attrition.¹⁵⁰ Paraprofessionals are also most impactful when fully integrated into clinical teams.¹⁵¹ Specific ways to promote the integration of the paraprofessional workforce into clinical teams include offering ongoing training to paraprofessionals on how they may apply their unique skillset to build trust with communities to augment the clinical services provided by a team; offering ongoing trainings to supervisors and organizational leaders to better integrate paraprofessionals into the team and to help paraprofessionals manage workloads and navigate complex client interactions; and implementing strategies to increase the visibility and participation of CHWs on teams, such as by including paraprofessionals in huddles, staff meetings and decision-making.¹⁵² The Commonwealth's forthcoming launch of the CBHC model¹⁵³ offers a new opportunity to identify best practices for integrating paraprofessionals into clinical teams, and more broadly, the Workforce Center should incorporate this topic into its research agenda.
- **Bolster the paraprofessional pipeline.** It is critical for the Commonwealth to collaborate with the Workforce Center as well as other academic institutions, community colleges, and community-based organizations to develop and implement a comprehensive recruitment strategy that emphasizes low-barrier hiring practices and incorporates best practices, such as hiring individuals from nontraditional settings and leveraging community-based organizations for assistance in recruitment.¹⁵⁴ Massachusetts should also consider partnering with community colleges on recruitment and training programs for paraprofessionals, considering initiatives similar to the associate's degree program established in Missouri that is described in the callout box.
- **Support career advancement opportunities for the paraprofessional workforce.** To retain the paraprofessional workforce, it is critical that the Commonwealth collaborate with the Workforce Center as well as other academic institutions and community-based organizations to develop career advancement opportunities that integrate best practices for the paraprofessional workforce and allow for professional development and advancement within and outside of the profession.¹⁵⁵

EXAMPLE FROM THE FIELD

Missouri State University–West Plains is establishing a [two-year associate degree program](#) in community behavioral health support with a local junior/technical college for community behavioral health support specialist positions. Traditionally, these positions have been held by individuals with a bachelor's degree; however, given the urgent need, the Missouri Department of Mental Health has approved students with this associate degree to be hired, allowing them to enter into the field. The university, in partnership with the Missouri Behavioral Health Coalition and several southern Missouri behavioral health care providers, will develop and deliver the program and provide clinical placements.

RECOMMENDATION 6:

Create a system of social supports for all members of the behavioral health workforce.

[Medium-term]

On May 22, 2022, Surgeon General Vivek Murthy issued an advisory¹⁵⁶ warning of rising health care workforce burnout and noted that the “Nation’s health depends on the well-being of our health workforce. Confronting the long-standing drivers of burnout among our health workers must be a top national priority...”¹⁵⁷

Even before the pandemic, the overall U.S. health care workforce has been experiencing “crisis levels” of burnout, according to the National Academy of Medicine.¹⁵⁸ The workforce has faced mounting anxiety and exhaustion as members navigate an intense environment that is overly stressed by heightened administrative burdens and constantly shifting with new technologies, updated regulations, and increased merger and acquisition activity.¹⁵⁹ Compounding this stress has been decades of inadequate funding in public health and social services alongside growing income gaps and racial, ethnic, and cultural disparities.¹⁶⁰ Especially in community-based settings in under-resourced neighborhoods, this dynamic has imposed increasing stress upon the workforce.¹⁶¹ As described in the Surgeon General’s Advisory, “This gap between health workers’ desire to contribute more to their patients’ health and social security, and their ability to do so in practice, seeds and compounds their sense of moral distress and burnout.”¹⁶²

DEFINITION: Burnout is “an occupational syndrome resulting from chronic workplace stress due to an imbalance between job demands and resources. It is characterized by having at least one of the following feelings when thinking about one’s job: emotional exhaustion, feeling detached from and cynical about work, and reduced professional efficacy.”

See: <https://www.hhs.gov/surgeongeneral/priorities/health-worker-burnout/index.html>.

Specific to behavioral health, studies have found that 21 to 67 percent of this workforce experienced burnout prior to the pandemic.¹⁶³ Similar to its impact on the rest of the health care¹⁶⁴ and public health workforce,¹⁶⁵ the pandemic has amplified the stress on the behavioral health workforce.¹⁶⁶ Specifically, it has increased the prevalence and acuity of individuals with behavioral health conditions, leading to the behavioral health workforce carrying heavier and more intense caseloads while also coping with their own losses, loneliness, caregiving and child care challenges, and other pandemic-related stress that the rest of society has faced.¹⁶⁷ All of these factors may be compounded for behavioral health professionals and paraprofessionals who are people of color or LGBTQ+, especially if they face discrimination in the workplace.¹⁶⁸ This buildup of burnout creates significant challenges to retention and may have wide-ranging and long-lasting adverse impacts, including poor physical and behavioral health outcomes for the workforce; lower quality care; and patient dissatisfaction.¹⁶⁹

“We need to address the mental health needs of providers. Who is caring for the caregivers?”

—Interview on March 10, 2022

The federal government has made building resilience among the health care workforce a priority.¹⁷⁰ In March 2022, the federal government enacted the Dr. Lorna Breen Health Care Provider Protection Act of 2022, which authorizes the Department of Health and Human Services to award grants to hospitals, professional medical associations, and other health care entities to promote behavioral health services and supports for frontline healthcare workers and advances a campaign to prevent suicide among frontline health workers.¹⁷¹ And in early 2022, HRSA awarded \$103 million in Healthcare Workforce Resiliency Training (HWRT) Program grants to academic institutions, provider organizations, and other entities to support evidence-informed planning, development, and training in health profession activities to reduce burnout and suicide, and promote resiliency among the workforce in the face of long-term stressors and health impacts amid the COVID-19 pandemic.¹⁷² However, this federal investment is limited considering the level of need, and similar efforts specifically focusing on the behavioral health workforce have not been undertaken.

Strengthening the resiliency of the behavioral health workforce and preventing further burnout and attrition requires partners across the Commonwealth to coalesce and create a system of social supports for all members of the behavioral health workforce.

MASSACHUSETTS EFFORTS TO DATE

The Commonwealth and select stakeholders have introduced efforts to increase resiliency among all health care workers amid COVID-19, including:

- Under An Act Establishing the Behavioral Health Trust Fund and the Behavioral Health Advisory Commission (Chapter 77 of the Acts of 2022), the Behavioral Health Advisory Commission is required to assess “the availability of trauma-informed supports and services for behavioral health practitioners and related staff.”¹⁷³ An Act Addressing Barriers to Care for Mental Health (Chapter 177 of the Acts of 2022) further directs the Commission to consider funding “evidence-based or evidence-informed programs dedicated to improving the behavioral health, mental wellness and resiliency of health care professionals,” for behavioral health providers and provider associations.¹⁷⁴
- The Massachusetts League of Community Health Centers was awarded more than \$2.9 million in funding through an HRSA Promoting Resilience and Mental Health Among Health Professional Workforce grant.¹⁷⁵ Focusing on rural and medically underserved communities, the purpose of these awards is to help “establish a culture of wellness among the health workforce and ... support training efforts that build resiliency for those at the beginning of their health careers.”
- Massachusetts General Hospital funded and developed a training program on resilience and prevention for frontline healthcare workers.¹⁷⁶ This course builds an understanding of resilience and teaches techniques on mindfulness, coping with uncertainty, and practicing self-compassion.

RECOMMENDATIONS

The Commonwealth should collaborate with partners, including the new Workforce Center, behavioral health provider organizations, universities, and unions, to implement a systemic and multipronged approach to building a more resilient workforce. Although many programs aimed at reducing burnout focus on the individual, such as by offering resources on self-care, meditation, or exercise,¹⁷⁷ research shows that taking a system-level approach that combines sustained person-level and organization-directed interventions has longer lasting positive effects.¹⁷⁸ In the Commonwealth, specific elements of this system-level approach to addressing burnout should include:

- **Leveraging the Workforce Center to provide training to professionals and paraprofessionals on building resilience and to create opportunities for peer support and mentorship.** One of the envisioned roles of the new Workforce Center is to be a centralized training and convening entity for the Commonwealth. In this role, the Workforce Center should consider offering trainings to:
 - **Behavioral health provider organizations** on how to create a more supportive workplace that prioritizes well-being and makes all employees feel valued. Topics could include improving supervision, recognizing and addressing burnout, and creating a supportive and inclusive workplace for workforce members from communities of color, who are LGBTQ+, and other communities that have been economically, socially, and/or culturally marginalized (e.g., via investment in governance and leadership, policies and practices, and workforce training that promote diversity, equity, and inclusion).¹⁷⁹
 - **Members of the workforce** on how to improve their own resiliency, addressing topics such as prioritizing self-care and managing vicarious trauma. Participants could earn continuing education credits for participating in these trainings.

In addition, the Workforce Center could act as a convening body that creates communities of peer practice and mentorship groups for members of the workforce to share experiences and create connections and mentorship relationships to provide new sources of supports. These communities should include ones focused on licensed professionals and paraprofessionals who are from communities that have been economically, socially, and/or culturally marginalized.

- **Creating a set of recommendations for behavioral health provider organizations to prevent burnout.** The Workforce Center could convene an expert working group to identify best practices in preventing burnout and develop a set of actionable recommendations to disseminate and deliver trainings to provider organizations. Example recommendations could include those focused on individual provider coping mechanisms and those promoting organizational change (e.g., creating and adhering to realistic provider-to-client ratios¹⁸⁰ and promoting interdisciplinary teams¹⁸¹).

- **Investing in crisis support for the behavioral health workforce.** The Commonwealth should leverage state funds as well as federal grant dollars, such as SAMHSA dollars, to provide crisis support to the behavioral health workforce to address the ongoing and residual trauma caused by the COVID-19 pandemic. Similar to the efforts of New Jersey’s Department of Human Services (see callout box), the Commonwealth could partner with a network of providers in crisis counseling to provide a variety of supports—including to behavioral health providers specifically and health care providers generally.

- **Providing financial incentives to address the behavioral health workforce’s social, mental health, and wellness needs.** In the Association for Behavioral Healthcare’s recent survey of outpatient providers in Massachusetts, 92 percent of respondents indicated that improved employee benefits would meaningfully impact retention.¹⁸² The pandemic has highlighted the role that social supports, such as reliable child care, have on workers’ abilities to do their jobs effectively.¹⁸³ As an enticement to employers, the Massachusetts Legislature could provide tax credits to employers that offer a standard set of no-cost mental health and wellness benefits for their employees. Child care is a particularly acute barrier to recruitment, retention, and advancement for women, who represent a majority of the behavioral health workforce, experience inequities in pay and leadership roles, and are disproportionately affected by a lack of child care.¹⁸⁴ Nationally in 2021, women represented more than 70 percent of school and other psychologists, more than 75 percent of mental health counselors, and about 69 percent of SUD and behavioral health counselors.¹⁸⁵ A recent national survey reports that over one-quarter of women became unemployed during the pandemic due solely to lack of child care.¹⁸⁶ As a result, child care support could have a wide-reaching impact on stabilizing the workforce. In addition to the transportation supports funded through the Commonwealth’s HCBS Spending Plan for the HCBS workforce, the Legislature should support child care tax credits or stipends for members of the behavioral health workforce to encourage retention. For example, the Oregon Health Authority has provided \$8 million in direct child care stipends to hundreds of behavioral health providers.¹⁸⁷

EXAMPLE FROM THE FIELD

Earlier in the COVID-19 pandemic, the New Jersey Department of Human Services launched a crisis counseling helpline—the [HEAL NJ Healthcare Workers COVID Hope & Healing Helpline](#) for frontline health workers and responders—and leveraged the expertise of the Division of Mental Health and Addiction, Disaster and Terrorism Branch, which has historically provided crisis support to communities and first responders in the aftermath of traumatic events (e.g., federal disaster, terrorism, mass shootings) to provide a suite of [crisis supports](#) to communities and the health care workforce to address the trauma associated with COVID-19, including telehealth crisis counseling, virtual support groups, and wellness webinars. These initiatives were supported with federal funds from the Federal Emergency Management Agency (FEMA) and SAMHSA.

RECOMMENDATION 7:

Fund an in-depth evaluation of the impact of telehealth on the behavioral health workforce.
[Short-term]

Telehealth has rapidly proliferated over the past two years, ensuring a level of continued access to behavioral services during the height of the pandemic.¹⁸⁸ Nationally, less than one percent of behavioral health services were delivered via telehealth prior to March 2020; by August 2021, 36 percent of behavioral health services were delivered via telehealth.¹⁸⁹ Massachusetts has evolved its telehealth policies accordingly, and in December 2020, the Legislature passed a law, signed by the governor in January 2021, requiring that state-regulated commercial health plans and public health

plans pay for behavioral health services delivered via telehealth at parity with in-person services, assuming telehealth is a clinically appropriate modality for the service.¹⁹⁰

Because of the urgent and exponential expansion of telebehavioral health, more research is needed on its broad implications for access, costs, consumers, and the workforce.¹⁹¹ According to stakeholders interviewed and research to date, telebehavioral health has meaningfully increased access to behavioral health services by expanding the total number of providers available, expanding access for people who live in underserved areas.¹⁹² Across disciplines, telehealth may also offer opportunities for people to see a provider of their same race, ethnicity, or gender or sexual identity.¹⁹³ In addition, early research shows that behavioral health services delivered via telehealth are as effective as in-person care for certain conditions, such as anxiety, depression, and post-traumatic stress disorder.¹⁹⁴

Interviewees also noted that expansion of telehealth has created new challenges related to the behavioral health workforce.¹⁹⁵ Similar to in other fields, many behavioral health professionals prefer working remotely because of the flexibility it offers and have chosen to continue practicing virtually as in-person care has resumed. Interviewees and some research indicate that this shift has reduced the number of providers available to provide certain services that may be more appropriately performed in person, such as family therapy, and for populations that prefer or may benefit from obtaining services in person, such as children and families or people with schizophrenia.¹⁹⁶ Additionally, the expansion of telehealth has resulted in some providers leaving community-based settings to work in private practice where they can deliver all or most services remotely—serving lower acuity populations—or for digital health start-ups, exacerbating existing workforce shortages at community-based provider organizations.¹⁹⁷

"It has been difficult to get clinicians to come back to working in clinics. The behavioral health workforce is overwhelmingly women with child care and other caregiving responsibilities, so working from home via telehealth makes more sense for their lives. People are making the decision that they want to work from home, and if clinics cannot provide that, they establish independent practices."

—Interview on March 2, 2022

Since the workforce implications of the telebehavioral health expansion are just emerging, **the time is now for the Commonwealth to fund an in-depth evaluation of the impact of telehealth on the behavioral health workforce and identify strategies to mitigate any unintended workforce consequences of the increase in telehealth.**

MASSACHUSETTS EFFORTS TO DATE

The Commonwealth has begun to undertake more intensive efforts to understand the impact of telehealth, although there has been limited focus to date on how it impacts the behavioral health workforce. For example:

- The state contracted with UMass Chan Medical School's Commonwealth Medicine to evaluate MassHealth telebehavioral health services during the pandemic. Among other recommendations, this evaluation suggested maintaining parity in payment for in-person and telehealth visits and reimbursement for telephone sessions as well as adding compensation for the time it takes a provider to teach a person receiving services to use the required technology.¹⁹⁸
- In November 2020, HPC published the Telemedicine Pilot Investment Program Evaluation Report, which assessed four HPC-funded pilot sites' use of telemedicine to address behavioral health access challenges in high-need populations.¹⁹⁹
- In 2020, the Community Care Cooperative and the Massachusetts League of Community Health Centers founded the FQHC Telehealth Consortium to build centralized capacity and training for FQHCs to shift to providing more services through telehealth during the pandemic. The Consortium includes 35 FQHCs—95 percent of FQHCs in the Commonwealth—that serve 700,000 patients.²⁰⁰ As part of its work, the Consortium will be conducting an evaluation on the impact of telehealth at FQHCs across the Commonwealth.

RECOMMENDATIONS

Consistent with Recommendations 1 and 2, the Commonwealth requires data to better understand telehealth's impact on the behavioral health workforce. As a first step, the Commonwealth should contract with a vendor—which may be the Workforce Center or another organization coordinating with the Workforce Center—to conduct an independent evaluation that answers the following research questions about the impact of telebehavioral health.

RESEARCH QUESTIONS

- To what extent is telehealth increasing the number of behavioral health professionals available to serve the Massachusetts population?
- How is telehealth changing the demographics, including race, ethnicity, sexual identity, and gender diversity, of providers available?
- Does having telehealth as an option improve recruitment into the field?
- How does the availability of telehealth impact the mix of services that the behavioral health workforce is providing? Which services are critical to provide in-person versus virtually?
- How does the availability of telehealth impact the needs of patients served by the behavioral health workforce? Which populations are served more effectively in person?
- To what extent does telehealth mitigate behavioral health workforce shortages in underserved areas of the Commonwealth?
- How does telehealth impact the distribution of the workforce among institutional settings, community-based settings, private practice, and digital health start-ups?
- To what extent does having telehealth as an option increase resilience and prevent behavioral health professionals from leaving the field?

Based on the findings of the evaluation, the Workforce Center should convene stakeholders to identify strategies to incentivize the recruitment and retention of behavioral health professionals for services, geographic areas, and populations that are determined to be more effectively delivered through in-person services. This evaluation should inform the 10-year strategy to grow the behavioral health professional workforce pipeline and address the maldistribution of providers (Recommendation 4).

4. CONCLUSION

There is no more urgent time than now for Massachusetts to build a robust, diverse, and resilient behavioral health workforce that meets the growing needs of its population. Although Massachusetts has been a national leader in behavioral health, it has struggled—even prior to the pandemic—to meet the behavioral health needs of its residents, especially for those who have been socially, racially, ethnically, economically, or otherwise marginalized.

But in the face of this crisis, there is opportunity for transformation. The behavioral health crisis has not only generated tremendous demand for services, but also kindled a profound collective understanding of what it means to struggle with a behavioral health condition. These dynamics—the coupling of heightened demand and softened stigma—create an unprecedented call to action for Massachusetts to invest as it has never before in its behavioral health workforce.

In recent years, Massachusetts has prioritized growing and sustaining its behavioral health workforce, including through the Roadmap for Behavioral Health Reform and initiatives funded by DSRIP under the MassHealth Section 1115 demonstration. This report identifies opportunities to augment these efforts. Drawing upon examples from around the country, the report provides imperatives and seven concrete recommendations for the Commonwealth that will require strong leadership, a robust data infrastructure, sustained financial investment, a commitment to equity, deep stakeholder engagement, and an understanding that progress will be incremental. Through these efforts, the Commonwealth has the potential to emerge with a robust, diverse, and resilient workforce that not only is able to meet the behavioral health needs of today but will also promote the behavioral health and well-being of generations to come.

APPENDIX A. FRAMEWORK FOR BEHAVIORAL HEALTH WORKFORCE POLICIES

“The Health Workforce Policies Framework” published in a recent *Health Affairs* article by health care workforce researchers Angela Beck, Joanne Spetz, Patricia Pittman, Bianca K. Frogner, Erin P. Fraher, Jean Moore, David Armstrong, and Peter I. Buerhaus describes four pillars to “reshape the workforce”: production, distribution, maximizing potential, and resiliency. For purposes of this paper, “The Health Workforce Policies Framework” has been adapted to focus specifically on the behavioral health workforce as well as on policies to increase the diversity of the behavioral health workforce. When conducting interviews for this report, the Manatt Health team shared this framework to encourage interviewees to take a broad view of the factors that influence the state of the behavioral health workforce. In addition, the adapted framework served as a useful organizing and conceptual tool to develop an inventory of workforce programs in Massachusetts and across the country; examples of which are highlighted in the callout boxes in the paper and elaborated upon further in Appendix B. The recommendations in this report aim to address each of the four pillars, recognizing that they are all critical to building a more robust, diverse, and resilient workforce.

Production refers to policies and programs to better align the number and type of workers to the population’s needs, including a consideration of how workers are recruited, trained, and retrained during their careers. These policies and programs include, but are not limited to, apprenticeships, residency and other field training programs, pipeline programs, scholarships, and loan repayment opportunities. Production includes a focus on increasing the diversity of the workforce to ensure representation of racially, ethnically, socially, or otherwise marginalized communities. For more examples, see *Appendix B: Examples of Programs Focused on Recruiting and Retaining the Behavioral Health Workforce*.

Distribution refers to policies and programs that address the maldistribution of providers, not only in terms of geography, but also in terms of specific communities that lack adequate access to behavioral health services, including those who have been economically, socially, or culturally marginalized. Distribution policies include initiatives to expand telehealth and specific recruitment strategies that are specifically focused on increasing supply in areas where there are workforce shortages and among specific communities that have historically lacked access to behavioral health care.



Resilience refers to policies and programs that promote workforce resilience, advance safer working conditions, and support the mental health and well-being of all health care workers to counter burnout and attrition, especially among providers from communities who have been economically, socially, culturally, or racially marginalized. The issue of resilience is particularly important given the heightened stress and emotional toll associated with the pandemic.

Maximizing potential refers to policies and programs designed to leverage the scope and reach of the behavioral health workforce. These policies and programs include promoting behavioral health and primary care integration, and flexibility in regulations related to billing, scope of practice, and interstate mobility of licensure.

Source: “Investing In A 21st Century Health Workforce: A Call For Accountability,” *Health Affairs*. September 15, 2021. Available at <https://www.healthaffairs.org/doi/10.1377/forefront.20210913.133585/full/>.

APPENDIX B. EXAMPLES OF PROGRAMS FOCUSED ON RECRUITING AND RETAINING THE BEHAVIORAL HEALTH WORKFORCE

This appendix includes examples of the types of programs in Massachusetts and across the country focused on recruiting and retaining the behavioral health workforce, including those that specifically focus on ways to recruit and retain providers from communities that are underrepresented. It does not provide an exhaustive list of behavioral health workforce programs but provides a sample of leading efforts across the country. It is categorized by different program types as they apply specifically to behavioral health paraprofessionals and to behavioral health professionals, as well as those that apply to both paraprofessionals and professionals. Programs that do not focus specifically on the behavioral health workforce are noted with an asterisk (*). Those programs that specifically focus on building racial/ethnic diversity are denoted with an orange star (★). Please note that in general, implementing programs that are focused on increasing the number of paraprofessionals is recognized as a strategy to enhance the diversity of the behavioral workforce given that paraprofessionals often share the same ethnicity, language, socioeconomic status, and life experiences with the community members they serve.²⁰¹

TYPE OF PROGRAM	MASSACHUSETTS INITIATIVES	OTHER LEADING EXAMPLES
Behavioral Health Paraprofessionals include, but are not limited to, peer recovery coaches, certified (mental health) peer specialists, community health workers (CHWs), recovery support navigators, and recovery specialists. ²⁰²		
<p>Certification and training programs for new paraprofessionals Provide certification and training to new paraprofessionals who may have no formal background in the field. It is important to note that while certification could lead to increased recognition and proliferation of CHWs and peers, there are also concerns that certification could create barriers to entry because of its cost and/or linguistic challenges (e.g., certification exams may be costly and not be in a person's native language).²⁰³</p>	<ul style="list-style-type: none"> The Board of Certification for Community Health Workers within the Massachusetts Department of Public Health implements a voluntary certification program for CHWs.²⁰⁴ To be certified, an individual either has to meet work experience and/or training requirements.^{*205} Under its DSRIP program, MassHealth has provided funding to training programs to build and enhance competencies of CHWs and peer specialists employed by participating DSRIP organizations (e.g., ACOs and community-based provider organizations).²⁰⁶ Completion of these trainings meets the requirements for CHW certification.^{*207} 	<ul style="list-style-type: none"> Many states have set up certification programs for CHWs and/or peers.²⁰⁸ These programs share common features including training requirements and requirements to work a certain number of hours over a period of time.²⁰⁹ In most states, certification is voluntary, but in an increasing number of states, certification is required for Medicaid reimbursement (e.g., MN,²¹⁰ OR,²¹¹ RI,²¹² TX²¹³).* States are innovating around different CHW and peer certification and training models. For example, Missouri State University–West Plains, in collaboration with other state and local partners, established an associate degree program in community behavioral health support at a local junior/technical college for individuals to become community behavioral health support specialists.²¹⁴

* Programs that do not focus specifically on the behavioral health workforce are noted with an asterisk.

★ Programs that specifically focus on building racial/ethnic diversity are denoted with an orange star.

TYPE OF PROGRAM	MASSACHUSETTS INITIATIVES	OTHER LEADING EXAMPLES
<p>Training programs for existing paraprofessionals and supervisors</p> <p>Provide training to support building the capacity and professional advancement of paraprofessionals. These types of programs may support long-term retention of this workforce.²¹⁵</p>	<ul style="list-style-type: none"> • Under its DSRIP program, MassHealth has invested in the design and delivery of a training curriculum for CHW supervisors and recovery coach supervisors focused on building their capacity to provide more responsive and informed supervision of their teams.^{*216} • William James College is a recipient of the Health Resources & Services Administration (HRSA) Behavioral Health Workforce and Education Training (BHWET) Program for Paraprofessionals (see right hand column for more details), which offers paid stipends and tuition to individuals who complete a program that includes CHW certification training, professional development, and a year-long field education experience in a health center in an underserved community.²¹⁷ William James College launched this program in January 2022 and has thus far recruited 20 CHWs.²¹⁸ 	<ul style="list-style-type: none"> • The Penn Center for Community Health Workers developed the IMPaCT CHW program to support CHWs, supervisors, as well as program directors, on a wide spectrum of best practices on the design and implementation of CHW interventions, including recruiting, hiring, training, and clinical integration of CHWs as part of health care teams.²¹⁹ The IMPaCT program is the most widely disseminated CHW program in the country, having undergone several randomized control trials demonstrating improved patient outcomes, and is currently being replicated across 18 states.^{*220} • In California, the Community Health Workers/Promotores Academy at Loma Linda University's San Manuel Gateway College has developed a comprehensive training model for CHWs at various skill levels and their supervisors.²²¹ End of program evaluations for this training program show a 99 percent job placement rate within six to nine months of completion of training.^{*222} • The HRSA BHWET Program has supported several initiatives to improve the quality of behavioral health clinical training and education and increase the number of behavioral health paraprofessionals and professionals (see below section for an example of BHWET Professional Program).²²³ The most recent BHWET award for paraprofessionals allocated \$24.3 million to state licensed nonprofit and for-profit organizations to design and scale community-based training to enhance the supply and distribution of the paraprofessional workforce.²²⁴ A BHWET program evaluation showed that between 2014 and 2019, the BHWET program supported the training of 16,472 paraprofessionals as well as graduate level social workers, psychologists, school and clinical counselors, psychiatric nurse practitioners, marriage and family therapists, and behavioral health paraprofessionals.²²⁵

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TYPE OF PROGRAM	MASSACHUSETTS INITIATIVES	OTHER LEADING EXAMPLES
<p>Behavioral Health Professionals (including psychiatry residency programs) Implement psychiatry residency programs at academic medical institutions and training programs for other graduate behavioral health students at academic institutions, provider organizations, and community-based organizations. These programs increase the supply of the behavioral health workforce in the short-term because participants provide care while they train.²²⁶ They may also increase the supply in the long-term as individuals are more likely to practice in areas similar to where they trained.²²⁷</p>	<ul style="list-style-type: none"> ★ In addition to receiving funding for the BHWET Program for Paraprofessionals, William James College received funding from HRSA's BHWET Program for Professionals in 2021 to design and scale paid-for experiential training opportunities, field placements and internships for graduate level students in behavioral health disciplines to work with vulnerable populations, particularly children, adolescents, and transitional-aged youth at risk for behavioral health disorders.²²⁸ William James College's BHWET Program for Professionals is expected to launch in the second half of 2022 and will provide stipends to its graduate students enrolled in master's and doctoral programs in clinical, counseling, and school psychology programs.²²⁹ The program is focused on recruiting and retaining students from diverse backgrounds.²³⁰ • The Massachusetts League of Community Health Centers is piloting a Psychiatric Mental Health Nurse Practitioner Fellowship Program (PMHNP), providing funding for up to 10 fellows (\$55,000 each) at community health centers.²³¹ Two community health centers—the East Boston Neighborhood Health Center and the Lowell Community Health Center—received awards, including \$35,000 each in flexible spending funds. The program aims to attract psychiatric mental health nurse practitioners to practice at community health centers, while simultaneously strengthening community health centers' ability to manage psychiatric conditions.²³² PMHNP is funded by a grant from the Massachusetts Department of Public Health, which was part of a state appropriation from the FY2021 state budget to enhance "behavioral health outreach, access, and support."²³³ 	<ul style="list-style-type: none"> • The most recent 2021 HRSA BHWET award for Professionals allocated \$44.2 million in grants to accredited academic institutions or accredited professional training programs with the goal of enhancing the supply and geographic distribution of behavioral health professionals.²³⁴ ★ Established in 1974, the SAMHSA's Minority Fellowship Program (MFP) focuses on encouraging members of diverse racial and ethnic groups to join the behavioral health workforce by providing funding to behavioral health professional associations, including the American Association for Marriage and Family Therapy; the American Nurses Association; the American Psychiatric Association; the American Psychological Association; the Council on Social Work Education; NAADAC: The Association for Addiction Professionals; and the National Board for Certified Counselors and Affiliates.²³⁵ These health professional associations in turn offer stipends as well as mentorship and professional development opportunities to individuals pursuing doctoral-level and master's-level programs in various fields (e.g., marriage and family therapy, nursing, professional counseling, psychiatry, psychology, social work, and addiction treatment), and they are committed to improving behavioral health outcomes for minority communities.²³⁶ Every year, 200 MFP fellows are awarded.²³⁷ ★ Several psychiatry residency programs encourage diverse applicants and actively seek to promote learning environments that foster equity, diversity, and inclusion in recruitment and retention, training and education, clinical services, and research.²³⁸ ★ The UCLA International Medical Graduate Program is a pre-residency program that recruits medical graduates from Latin American medical schools who are already residing in and are seeking to be licensed and practice in the United States.²³⁹ The program provides clinical rotation experience as well as mentorship and preparation for the U.S. Medical Licensing Examination.²⁴⁰ Students in the program must agree to pursue a family medicine residency in California and continue to practice in a medically underserved community in California for at least 2 years. In 2018, the program had placed 128 graduates into family residency programs in California.*²⁴¹

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TYPE OF PROGRAM	MASSACHUSETTS INITIATIVES	OTHER LEADING EXAMPLES
<p>Scholarships Pay for tuition for undergraduate or graduate school students and thereby mitigate the financial stress that can be overwhelming and discouraging, especially for those who are economically disadvantaged.</p> <p>Some of these scholarship programs, such as the HRSA National Health Service Corps, are tied to service conditions (i.e., scholarship recipient must practice in an underserved area for a certain period of time). These service-contingent scholarships increase the supply in the short-term while the provider is fulfilling the service requirement of their scholarship. Evidence is mixed as to whether these programs have a long-term impact on increasing supply.²⁴²</p>	<ul style="list-style-type: none"> ★ William James College is a recipient of the HRSA Scholarships for Disadvantaged Students (SDS) program to enhance diversity in the behavioral health workforce.²⁴³ Through this funding, since July 2020, William James College has awarded 40 scholarships annually (\$32,500 each) to students enrolled in its Clinical PsyD Program and Counseling Program who are from “disadvantaged backgrounds,”²⁴⁴ including first-generation college graduates and members of underrepresented minority communities, and who express commitment to serving in primary care settings or medically underserved areas.²⁴⁵ • The Massachusetts Department of Public Health’s Primary Care Office provides assistance to potential National Health Service Corps (NHSC) sites, which support federal scholarships and loan repayment programs (see next column for more details).^{*246} 	<ul style="list-style-type: none"> ★ Established in 1990, the HRSA SDS program seeks to enhance diversity among health professionals by providing funding to health professional and nursing schools to provide scholarships to students from “disadvantaged backgrounds” who are in need of financial assistance.²⁴⁷ Between academic years 2014 to 2019, 12,356 students received scholarships; approximately 60 percent were underrepresented minorities, 93 percent of those who completed the program graduated, and nearly half of those who provided post-employment data served in medically underserved communities a year after graduation.²⁴⁸ Between 2016 and 2019, approximately a quarter of scholarships were awarded in the field of behavioral health.²⁴⁹ For the 2020 SDS program, HRSA allocated \$48.2 million.^{*250} • Colorado has established the Colorado Health Service Corps Scholarship Program for Addiction Counselors, which provides scholarships (up to \$5,000) to individuals who are in the process of becoming a licensed certified addiction technician, certified addiction specialist, or a licensed addiction counselor.²⁵¹ Scholarships may be used towards the costs of tuition related to licensure training.²⁵² • HRSA’s NHSC aims to increase workforce supply in health professional shortages areas (HPSA) through a scholarship and loan repayment program (see below for details on the loan repayment program).²⁵³ Under the NHSC scholarship program, HRSA offers scholarships to health professional graduate students who must meet several eligibility requirements, including being (1) a U.S. citizen or U.S. national, eligible for federal employment; and (2) enrolled or accepted as a full-time student pursuing a health profession career, including but not limited to, physicians, nurses, and nurse practitioners, in an accredited school or program. In return for receiving the scholarship, the recipient must commit to working in an underserved community at an NHSC approved site (including behavioral and mental health sites) for a minimum of two years of service.²⁵⁴ The most recent NHSC national data (FY2021) show that 54 to 63 percent of NHSC scholarship recipients remained at their NHSC service site one to two years after completion of the program and 80 percent of those who fulfilled their commitment between FY2012 and FY2020 continue to practice in a HPSA.^{*255}

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TYPE OF PROGRAM	MASSACHUSETTS INITIATIVES	OTHER LEADING EXAMPLES
<p>Visa waivers Provide visa waivers to foreign medical graduates in exchange for service in medically underserved areas. These programs have the potential to increase supply as well as enhance diversity, as they recruit physicians from other countries. However, limited evaluation data on these programs reports mixed results on retention and job satisfaction.²⁵⁶</p>	<p>★ Massachusetts' Conrad-30/J-1 Visa Waiver Program, like many other states' Conrad-30/J-1 Visa Programs, supports employment requests for J-1 visas for physicians in sites that serve the state's medically underserved populations.^{*257}</p>	<p>★ The federal Conrad-30 Waiver Program allows states to each recruit 30 J-1 foreign medical graduates to apply for a waiver of the two-year foreign residence requirement upon completion of the J-1 exchange visitor program.²⁵⁸ The program seeks to "address the shortage of qualified doctors in medically underserved areas."²⁵⁹ Although there are federal requirements around program implementation, each state has flexibility around application rules and guidelines.^{*260}</p> <p>★ A 2010 study of Washington State's Conrad-30 program found:</p> <ul style="list-style-type: none"> – Over half (55 percent) stayed with their J-1 employer for a median of 23 months longer than required and continued to work at practices focused on underserved populations for an average of 34 consecutive months after fulfilling their commitments. – After completing their term with their J-1 employers, 74 percent of physicians who served in rural areas moved to urban areas and 57 percent remained in the state. – Although most participants expressed satisfaction with the program, 38 percent "felt their employers should have showed them more respect."^{*261} <p>★ A 2021 study on the Conrad-30 program in Delaware reported that:</p> <ul style="list-style-type: none"> – Forty-six percent of physicians in the state's HPSAs are recruited through the Conrad-30 Waiver Program.^{*262}

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TYPE OF PROGRAM	MASSACHUSETTS INITIATIVES	OTHER LEADING EXAMPLES
<p>All Behavioral Health Providers: This category includes a mix of programs focused on behavioral health professionals and paraprofessionals.</p>		
<p>Pipeline programs Seek to generate interest, provide exposure, and prepare students early in their academic journey to pursue careers in health care (including behavioral health). These programs increase supply of the workforce in the long-term. Research suggests that pipeline programs focused on underrepresented minorities that implement a variety of strategies (e.g., financial support, social support, mentoring) are successful at increasing the diversity of the workforce.²⁶³</p>	<ul style="list-style-type: none"> ★ Mount Wachusett Community College (MWCC) established the Health Careers Opportunity Program (HCOP) Catalyst High School, which is funded by the HRSA HCOP grant (see next column) and is a year-long program for high school seniors who are interested in health care.²⁶⁴ The high school exposes them to careers in allied health and behavioral health fields while also providing them opportunities to enroll in courses at MWCC for college credit and potentially earn a scholarship to attend MWCC.*²⁶⁵ ★ University of Massachusetts (UMass) Chan Medical School Baccalaureate MD (BaccMD) Pathway Program recruits sophomore students at UMass undergraduate campuses who are underrepresented minorities, including those who are either from ethnically and racially marginalized backgrounds, economically disadvantaged, or first generation college students, and offers provisional acceptance to the T.H. Chan School of Medicine at UMass Chan Medical School.²⁶⁶ The program provides mentorship through the medical school admission process and aims to enhance test-taking, interview, and problem-solving skills and competencies to secure admission and academic achievement while in medical school.*²⁶⁷ 	<ul style="list-style-type: none"> ★ Established in 1972, the HRSA HCOP is a pipeline program, which provides funding to educational institutions and seeks to improve recruitment, matriculation, and graduation rates of individuals from “disadvantaged backgrounds” into health professions when they are early in their academic journey.²⁶⁸ HCOP supports collaborations across the country among K-12 schools, colleges, health professional graduate schools, and other academic programs with the goal of making students from disadvantaged communities more competitive applicants for health profession schools.²⁶⁹ Between FY2015 and FY2020, HRSA HCOP awards resulted in training 19,984 students; over 70 percent of individuals who participated in HCOP activities were underrepresented minorities.*²⁷⁰ • The Area Health Education Center of Montana established a Heads Up Behavioral Health Camp for high school students to explore careers and learn skills in behavioral health by hearing from local professionals from a range of occupations (e.g., social work, psychiatry, psychology).²⁷¹ Students also have the opportunity to gain a Youth Mental Health First Aid certificate and receive training to serve as peer supports in their communities.²⁷² • The Nebraska Behavioral Health Workforce Center has collaborated with state and local partners to launch a number of initiatives to build the pipeline of mental health professionals, focusing on high school students.²⁷³ <ul style="list-style-type: none"> – The Frontier Areas Mental Health Camp and Ambassador Program is a free week-long camp in the rural and tribal areas of Nebraska that encourages high school students to pursue careers as psychologists, social workers, substance use counselors, and other behavioral health professionals and offers college-credit classes in behavioral health as well as mentorship after the camp ends.²⁷⁴ – The Virtual Mentor Network provides individualized mentorship opportunities for high school students by connecting them with psychology and psychiatry professionals.²⁷⁵

(continued)

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TYPE OF PROGRAM	MASSACHUSETTS INITIATIVES	OTHER LEADING EXAMPLES
<p>Pipeline programs (continued)</p>		<ul style="list-style-type: none"> ★ In 2020, the University of New Mexico Health Sciences Center collaborated with the University of New Mexico Office for Community Health Academy, Central New Mexico Community College, and Health Leadership High School, to design and implement the Community Health Worker Pilot Apprenticeship Program with the goal of enabling high school students, particularly students of color from low-income neighborhoods who are interested in the health care field, to receive both a high school diploma and a CHW certificate simultaneously.²⁷⁶ ★ The University of California (UC) Postbaccalaureate Consortium is a collaboration among postbaccalaureate premedical programs at the Schools of Medicine at UC Davis, UC Irvine, UC Los Angeles, and UC San Francisco that recruits students from underrepresented and economically disadvantaged backgrounds who are either re-applying to medical school after not being previously admitted or are applying to medical school for the first time.²⁷⁷ The program provides mentorship and rigorous academic, testing, and interviewing preparation with the goal of helping make these students more competitive applicants. Over the years, the program has been successful in increasing the number of underrepresented students entering medical school, with over 90 percent of its postbaccalaureate students matriculating into medical school.^{*278} ★ University of California Programs in Medical Education (UC PRIME) is a pipeline initiative focused on increasing the number of medical students pursuing careers in underserved areas.²⁷⁹ The program augments standard medical education with additional curricula to address the needs of populations who are underserved. For example, there are UC PRIME programs focused on the Latino community; African, Black, and Caribbean communities; rural areas; and Native populations.²⁸⁰ The program also provides dedicated faculty mentorship to its students.²⁸¹ Employing focused recruitment strategies and supplemental admission criteria, the program encourages students from underserved communities to pursue a medical degree.²⁸² Approximately 64 percent of program participants are from underrepresented backgrounds.^{*283}

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TYPE OF PROGRAM	MASSACHUSETTS INITIATIVES	OTHER LEADING EXAMPLES
<p>Apprenticeships Help individuals learn a trade or job under supervision of someone with expertise. The U.S. Department of Labor recognizes the apprenticeship model to be an effective strategy to build competencies and address workforce shortages.²⁸⁴ The focus, however, has traditionally been in the areas of construction and trade.²⁸⁵ In the behavioral health workforce, and health care workforce more broadly, apprenticeships are emerging as a mechanism to train paraprofessionals and professionals.</p>	<ul style="list-style-type: none"> Holyoke Community College has used a grant from the HRSA Opioid-Impacted Family Support Program,²⁸⁶ which funds training programs for paraprofessionals to provide services to children whose parents are impacted by substance use disorders (SUDs), to set up the CHW Apprenticeship Program.²⁸⁷ The CHW Apprenticeship Program is a two-year program that begins with free pre-apprenticeship training courses and culminates with a paid apprenticeship at Behavioral Health Network, a regional behavioral health provider in Western Massachusetts.²⁸⁸ 	<ul style="list-style-type: none"> In Rhode Island, a local workforce organization, Building Futures, in partnership with the Rhode Island Department of Labor and Training Office of Apprenticeships, established a paid apprenticeship program with funding received in 2018 from the U.S. Department of Labor's National Health Emergency (NHE) Dislocated Worker Demonstration Grant to Address the Opioid Crisis.²⁸⁹ The apprenticeship program provides on-the-job training that meets state requirements to become a certified CHW or dually certified CHW-peer recovery specialist at community-based organizations (CBOs).²⁹⁰ As of October 2021, the program has enrolled 43 CHW apprentices and 53 dual CHW-peer recovery specialist apprentices, and has expanded from two employers to nine employers sponsoring apprenticeships.^{*291} The Alabama Office of Apprenticeship, which is part of the Alabama Department of Commerce, in partnership with Alabama A&M University, recently launched an apprenticeship program for Master of Social Work (MSW) students that trains second year MSW students as apprentices working in behavioral health agencies.²⁹² HRSA recently launched a \$226.5 million grant initiative, the Community Health Worker Training Program, which provides grants to various entities, (e.g., health professions schools, nonprofits) to build the pipeline of CHWs through apprenticeship programs.^{*293}

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TYPE OF PROGRAM	MASSACHUSETTS INITIATIVES	OTHER LEADING EXAMPLES
<p>Loan repayment programs Help licensed behavioral health professionals as well as paraprofessionals repay educational loans. Loan repayment is often tied to service commitments in underserved communities, which can increase supply of the workforce in the location of the service commitment in the short-term, but data is mixed on whether these programs lead to long-term retention.²⁹⁴</p>	<ul style="list-style-type: none"> Through its DSRIP program, MassHealth invested approximately over \$5 million in various loan repayment initiatives to recruit different types of behavioral health professionals to commit to work in community-based primary care and behavioral health settings, ACOs, and other community-based organizations, for periods of time, ranging from 18 months to four years.²⁹⁵ The award amount ranged (\$7,500-\$50,000), depending on the provider type and the duration of service.²⁹⁶ Providers eligible for loan repayment included physicians (including psychiatrists), psychologists, registered nurses, licensed practical nurses, advanced practice registered nurses, psychiatric clinical nurse specialists, nurse practitioners, physician assistants, licensed independent social workers, licensed clinical social workers, licensed mental health counselors, licensed marriage and family therapists, licensed alcohol and drug counselors, care coordinators, and master's-prepared unlicensed behavioral health providers.²⁹⁷ Preliminary evaluation findings report that 94 percent of primary care and behavioral health providers who received a loan repayment in 2018-2019, and 98 percent of master's-prepared behavioral health provider recipients in 2018 continue to practice in community-based settings.²⁹⁸ Under Massachusetts' 1115 demonstration extension application, Massachusetts has requested to establish two behavioral health-focused loan repayment programs that seek to engage approximately 90 providers per year for four years with a focus on "clinicians with cultural and linguistic backgrounds."²⁹⁹ The first program would provide \$50,000 in loan repayments for licensed behavioral health clinicians and master's-level-prepared clinicians intending to be licensed within one year of the award. Participants must commit to working in a community-based setting with a significant number of MassHealth members for at least four years.³⁰⁰ The second program would provide up to \$300,000 in student loan repayment for psychiatrists or nurse practitioners who commit to working at an organization with a panel that is at least 40 percent MassHealth or uninsured members for four years.³⁰¹ <p style="text-align: right;"><i>(continued)</i></p>	<ul style="list-style-type: none"> HRSA's Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR LRP) repays educational loans for various eligible disciplines, including but not limited to, physicians, physician assistants, nurse practitioners, clinical support staff, and behavioral health paraprofessionals working full-time SUD treatment jobs for six years at a STAR LRP-approved treatment facility.³⁰² The Ohio Department of Health SUD Professional Loan Repayment program provides loan repayment to clinicians who commit to practice for two years at sites that accept Medicare/Medicaid, accommodate clients regardless of ability to pay, are located in an HPSA, and also experience a high burden of clients with SUD. Clinicians may receive up to \$25,000 annually towards loan repayment.³⁰³ Under the NHSC Program (mentioned above), HRSA offers a loan repayment program to providers who are U.S. citizens or U.S. nationals; participate (or are eligible to participate) in the Medicare, Medicaid, and the Children's Health Insurance Program; are fully trained and licensed to practice in an NHSC-eligible primary care medical, dental, or mental/behavioral health discipline with qualified student loan debt; and are working at an NHSC-approved site for at least two years.³⁰⁴ For behavioral health, the following disciplines and specialties are eligible: physicians/psychiatrists, health service psychologists, licensed clinical social workers, marriage and family therapists, licensed professional counselors, nurse practitioners, and physician assistants. The most recent NHSC data (FY2021) shows that 43 to 44 percent of NHSC loan repayment recipients remained at their NHSC service site one to two years after completion of the program and 81 percent of those who fulfilled their commitment between FY2012 and FY2020 continue to practice in an HPSA.^{*305}

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TYPE OF PROGRAM	MASSACHUSETTS INITIATIVES	OTHER LEADING EXAMPLES
<p>Loan repayment programs <i>(continued)</i></p>	<ul style="list-style-type: none"> The Massachusetts Department of Higher Education offers loan repayment awards for health professionals, including mental health professionals, up to \$50,000 in return for serving two years full-time in an underserved community (e.g., HPSA).³⁰⁶ To be eligible, an individual must be licensed to practice in Massachusetts in an eligible discipline (including, but not limited to, primary care physician, nurse practitioner, advanced practice nurse, psychiatric nurse specialist, physician assistant, clinical or counseling psychologist, clinical social worker, mental health counselor, professional counselor, and marriage family therapist). The individual must also have unpaid professional student loans and cannot participate in other state or federal loan repayment programs.^{*307} 	
<p>Other recruitment and retention initiatives focused on enhancing the diversity of the behavioral health workforce</p>	<ul style="list-style-type: none"> ★ William James College was allocated \$500,000 in Massachusetts' 2021 American Rescue Plan Act (ARPA) bill (Chapter 102 of the Acts of 2021), from federal COVID-19 dollars and state surplus funds to develop a behavioral health workforce development center focused on retaining and developing a "culturally diverse, experienced, behavioral health workforce that cares for underserved communities."³⁰⁸ 	<ul style="list-style-type: none"> ★ In 2021, Oregon (via HB2949) invested \$60 million to increase the recruitment and retention of providers in the behavioral health care workforce with associate's, bachelor's, master's, or doctoral degrees or other credentials who are people of color, tribal members, or residents of rural areas in the state and who can provide culturally responsive behavioral health services.³⁰⁹ Financial incentives include tuition assistance and scholarships for undergraduate and graduate students, loan forgiveness, housing assistance, childcare and tax subsidies, grants for graduate students to complete supervision to obtain licensure, and bonuses for supervising clinicians.³¹⁰ ★ HRSA's Centers of Excellence Program provides grants to designated health professions schools that either are historically black colleges or schools with a high enrollment of Hispanic students, Native American students, or other underrepresented minorities.³¹¹ Grant funding can be used to support various initiatives, including establishing, strengthening, or expanding programs to enhance the academic performance of students who are underrepresented minorities attending the school; and improving the capacity of such schools to train, recruit, and retain underrepresented minority students and faculty including the provision of scholarships, stipends, and fellowships.^{*312}

* Programs that do not focus specifically on the behavioral health workforce are noted with an asterisk.

★ Programs that specifically focus on building racial/ethnic diversity are denoted with an orange star.

TYPE OF PROGRAM	MASSACHUSETTS INITIATIVES	OTHER LEADING EXAMPLES
<p>Programs that promote resilience and retention</p> <p>Seek to combat burn-out and vicarious trauma as well as provide additional social support to providers, all of which help promote workforce resilience and retention.³¹³</p>	<p>Addressing burnout and promoting behavioral health and well-being</p> <ul style="list-style-type: none"> The Massachusetts League of Community Health Centers was awarded a \$2.9 million HRSA Promoting Resilience and Mental Health Among Health Professional Workforce Program (see right-hand column for more details), which seeks to reduce burnout and promote mental health among the health care workforce.^{*314} Massachusetts General Hospital developed a training program on Resilience and Prevention for frontline health care workers that teaches techniques on mindfulness, coping with uncertainty, and practicing self-compassion.^{*315} <p>Providing other social supports</p> <ul style="list-style-type: none"> Under its ARPA Home & Community Based Services (HCBS) Spending Plan, Massachusetts has proposed establishing programs for HCBS and behavioral health direct care and support workers requiring childcare or transportation.³¹⁶ 	<p>Addressing burnout and promoting behavioral health and well-being</p> <ul style="list-style-type: none"> HRSA provided \$103 million in ARPA funding to address burnout and promote behavioral health in the health workforce through two grant programs: Promoting Resilience and Mental Health Among Health Professional Workforce Program³¹⁷ and the Health and Public Safety Workforce Resiliency Training Program.³¹⁸ Funding for these grant programs went to academic institutions, hospitals/health systems, health care providers associations, and FQHCs, among other types of organizations.^{*319} Early in the COVID-19 pandemic, the New Jersey Department of Human Services launched a crisis counseling helpline—the HEAL NJ Healthcare Workers COVID Hope & Healing Helpline—for frontline health workers and responders.³²⁰ The helpline sought to address the trauma associated with COVID-19 among the health workforce by linking them to crisis supports, including telehealth crisis counseling, virtual support groups, and wellness webinars.³²¹ The Federal Emergency Management Agency (FEMA) and SAMHSA provided financial support for the helpline.^{*322} The Healing, Education, Resilience & Opportunity for New York’s Frontline Workforce (HERO-NY) provided a train-the-trainer wellness series to meet the mental health and wellness needs of frontline health care workers as they responded to COVID-19.³²³ The series underscored the importance of resilience and coping strategies.³²⁴ HERO-NY was offered in partnership with the U.S. Department of Defense, Uniformed Services University of Health Sciences, U.S. Department of Veterans Affairs, New York City Health + Hospitals, New York City Department of Health and Mental Hygiene, and the Fire Department of the City of New York.^{*325} The University of Nebraska Behavioral Health Workforce Center (BHECN) created the BHECN Serenity Project—offering free online yoga, meditation, and wellness sessions to behavioral health and other frontline health care providers.³²⁶ <p>Providing other social supports</p> <ul style="list-style-type: none"> The Oregon Health Authority has provided \$8 million in direct childcare stipends to hundreds of behavioral health providers.³²⁷

* Programs that do not focus specifically on the behavioral health workforce are noted with an asterisk.

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- 1) **Statewide Investment (SWI) 1a: MassHealth’s Student Loan Repayment Program** aimed to decrease the shortage of primary care providers and licensed behavioral health professionals in community-based primary care and behavioral health settings (\$2.5 million allocation over two years; required four-year commitment in exchange for loan repayment award; \$50,000 award for primary care physicians, psychiatrists, and psychologists, and up to \$30,000 for advanced practice registered nurses, psychiatric clinical nurse specialists, nurse practitioners, physician assistants, licensed independent clinical social workers, licensed certified social workers, licensed mental health counselors, licensed marriage and family therapists, licensed alcohol and drug counselors 1, and master’s-prepared unlicensed behavioral health providers);
 - 2) **SWI 1b: MassHealth’s Behavioral Health Workforce Development Program** aimed to reduce shortage of behavioral health providers practicing in community-based behavioral health settings (\$1.29 million allocation over two years; required four-year commitment in exchange for loan repayment award; award is \$30,000 over two years for licensed independent clinical social workers, licensed certified social workers, licensed mental health counselors, licensed marriage and family therapists, and licensed alcohol and drug counselors 1, and master’s-prepared unlicensed behavioral health professionals);
 - 3) **SWI 1c: MassHealth’s Community Partner (CP) Recruitment Incentive Program** aimed to recruit/retain care coordinators and registered nurses/licensed practical nurses in MassHealth Behavioral Health and Long Term Services and Supports Community Partner Program (\$907,500 total allocation; required 18-month commitment from care coordinators and four-year commitments from registered nurses and licensed practical nurses in exchange for loan repayment award; \$7,500 award for care coordinators and \$30,000 award for registered nurses and licensed practical nurses);

- 4) **SWI 3b: MassHealth’s Community Mental Health Center (CMHC) Behavioral Health Recruitment Fund** aimed to increase the number of psychiatrists and nurse practitioners with prescribing privileges at community mental health centers via recruitment packages that consists of loan repayment and funding for special projects (\$800,000 total allocation over one year; required four-year commitments from nurse practitioners and psychiatrists in exchange for recruitment package; the recruitment package for psychiatrists is \$150,000 over two years (maximum of \$50,000 towards loan repayment and a maximum of \$50,000 per year for a special project) and \$110,000 for nurse practitioners over two years (maximum of \$30,000 towards loan repayment and \$40,000 per year for a special project).

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