Strengthening Our Core: Investing in Workforce to Develop a Sustainable System

Jennifer Bright:

Good morning. I'm Jennifer Bright. I'm the president of Momentum Health Strategies. I'm wearing a lot of hats today. The other hat, just full disclosure, is I'm currently the board chair of Mental Health America, an organization that I worked for a few years ago.

I'm really happy to be here with you. We've heard the first panel was a phenomenal reminder of the topic that we're going to be tackling, which is it's about workforce. That's really an important backbone of our ability to envision a future like Sarah challenged us this morning. I'm really pleased to be able to guide a conversation with some really awesome panelists, so let me just briefly tell you who is joining me on stage, and then we'll dive in.

First, we're going to hear from Marley Doyle, who is the executive director for the Behavioral Health Education Center in Nebraska, which is associated with the University of Nebraska Medical System. Next, we're going to be talking with Keris Jan Myrick, who is a board member and policy liaison for the National Peer Support Workers Association and I'm also happy to say is a fellow board member for MHA. Next, we're going to hear and talk with Drew Bertagnolli, who is the national director for Mindset Behavioral Health Services and a clinical psychologist at One Mind... I'm sorry.... One Medical, and last but never least, Dr. Russ Petrella who is currently a senior advisor with McKinsey, but also has had a former experience in running Beacon and brings a lot of experience. All of these folks bring some terrific experience to this conversation this morning.

I want to start actually with Russ just to do some framing, given the numerous hats you've worn in the mental health space over the years, to talk a little bit about the edges of this problem that we call workforce because, as we've already heard in the first panel, there's a lot of dimensions to this. Maybe you could just take a few minutes to draw the edges a little bit for the audience, and then we can dive into some of the topics.

Russ Petrella:

Thanks, Jennifer. Let me put this all in context. I'm a clinical psychologist. I've spent 40-plus years working on mental-health-related issues, ran a couple of companies and spent a lot of my time trying to recruit mental health professionals. The situation as of right now is that it's a complex supply-and-demand issue. You've got a taste of that in the earlier discussion. The demand now for mental health professionals, and in this I'm talking about psychologists, psychiatrists, social workers, counselors, peer support, all the support people, crisis workers, et cetera, the entire group of people who provide services and support for mental health, there's just not enough of them. It's that simple.

Why? Because the demand now is greater than ever. The demand has to do with, one, is that there are more people seeking mental health services. The pandemic certainly kicked some of that off. I bet there's not a person in this room who during the pandemic, when it was at its height, wasn't anxious at some times or depressed at some times, and a lot of that has carried over. Also, there's a pandemic of need of services for youth. Youth right now are struggling with a variety of issues. There's been a reduction, and this is somewhat debatable, but since I've been working, there has been a reduction in stigma in terms of mental health services. People are more willing to talk about services, more willing to reach out for services, more willing to get services, particularly younger folks, which I think is a good thing.

Mental health services is typically a one-on-one game. That means that, in order to receive services, typically, there's diagnosis involved, there's treatment involved, there's follow-up, there are support services. There's a variety of services. You heard about crisis services. You need people to do all

of those roles. The supply right now of mental health professionals of all types, there is over a third of the country that does not meet the standard for what most professionals agree is enough mental health providers to provide services to individuals. Some of it is a geographic issue. If you look at, for example, the population of psychiatrists in New York, the state, the psychiatrists, there are 612 per 100,000 people. They, typically, talk in terms of that. If you go to Idaho, for example, there's one psychiatrist for 100,000 people. You get the same kinds of things in the Northeast. It's permeated with mental health professionals.

That's not the only thing that is impacting this. There's clearly economic issues. We heard about that this morning. What I found interesting is that, I had already written down my same example, nationally, the average pay rate for an individual doing mental health counseling is about 32... excuse me... 42, $43,000 a year, which is roughly $21 an hour.

I live outside of New York. I went to my local grocery store, Stop & Shop. At the entrance to the store, there was, "Summer jobs available." Cashier is $21 an hour. What was mentioned earlier is what is more stressful? Scanning groceries, where they don't do anything anymore, they scan, they certainly don't bag, scanning groceries or dealing with someone in crisis, dealing with someone who's depressed and it clearly takes a toll? There's clearly burnout that goes on for mental health professionals, and that has impacted it.

What I wanted to do is touch on how does this actually impact the client? That was touched on earlier. As a clinician, my view is that individuals who reach out for help, call a crisis line, try to schedule an appointment, they've either made a decision themselves or sometimes are urged to this decision by family and friends that you need to get someone, you need to talk to someone. It's typically the way it's framed.

There's really a moment when people are willing to make that call, when they're willing to say, "Maybe I need help," and that moment is sometimes fleeting. If you call a mental health professional's office, and they say, "Sure. We can see you. How is six weeks from now? Late next month?" and what happens, this is very common in mental health, is there's a lot of no-shows for these first appointments because what was ever bothering someone, whatever was on their mind at the time and they felt ready to talk about it, it goes away. They think, "Really, I feel a little bit better. Maybe I don't need it." The problem is is that mental health problems frequently tend to get worse over time, and you miss that moment where people were willing to get help.

The shortage of professionals means there's wait lists. There's shortages of program spots, slots where people need a certain kind of program and there's not enough people to supply those services. The travel distance, if you're in Idaho and there's one or two or three psychiatrists in the whole state, that's a major burden. It's an economic burden also. The fact that patients continue to suffer, and I use that word continue to suffer from whatever issues they're dealing with because there's not enough professionals out there to offer them assistance is, to me, a great embarrassment for all of us and for this country.

The group of folks here are going to talk about some solutions, some novel solutions, some ways to make the pool of professionals bigger, to increase the capacity of the individuals who are already out there, to get people to not drop out from being a mental health professional because of economics at times. Like someone said earlier, it's a lot less stressful to work at Starbucks than it is to be a crisis counselor.

How do we avoid people dropping out of the field and how do recruit new people into the field and pay them in a way that is fair and equitable and get the right people so that the right services at the right time is the key to the whole thing? That's my big picture. This is a crisis in the field. As there's more

awareness and stigma is reduced, the demand is going to get greater, and I think one of our biggest challenges is going to be how do we solve this.

Jen?

Jennifer Bright:

Thanks, Russ.

Well, if you're a visual person, he just drew a picture of Mount Everest for all of us. I think, when you think about the enormity, the scale, it's not too farfetched of a visual image, but we also know that getting to the summit is a team sport, and it's going to require everybody having a role. There's going to be specialized equipment involved, and we might have to hold our breath for a little bit until we actually reach the summit.

Thinking forward towards solutions, Marley, I wanted to turn attention to you. One of the things that Russ said at the end of his remarks was that we need to come up with new solutions and strategies for how to recruit and retain and create that team that's really going to create the workforce of the future. Can you talk to us a little bit about your work and your model and what some of the lessons that you've learned along the way and what you think some of our audience members can take away to apply in their work?

Marley Doyle:

Absolutely. I thank everybody that is attending today for caring about this issue and the shared wisdom of the panel. I wanted to just talk a little bit today about something that Nebraska is doing to try to solve this issue. Of course, none of these things are one-size-fits-all and none of these things are just a one thing that can help the whole issue. That's just a big caveat, but what Nebraska has decided to do is to invest in behavioral health workforce. We have a huge shortage much like every state, but especially rural states. Currently, 88 of our 93 counties are designated is behavioral health professional shortage areas, so we have a huge need, and how did we solve it?

Well, one thing we've done is we went to our state to try to address it through a policy. What we did is proposed that the state help support a center, a behavioral health workforce development center that would be dedicated to the recruitment and retention of behavioral health professionals. Luckily, the state supported it. That was in 2009, and we are now a line item on the state's budget. Since the inception in 2009, we've seen a 38% increase in the behavioral health workforce, which is pretty profound considering that most other states in our surrounding area have seen a decrease. We can't take credit fully because we don't know that. Beacon's work is the sole reason, but we certainly can't ignore it either.

I wanted to describe some of the programs and things that we've done that have been successes over the years. One of the efforts that we did early on was exposing students to behavioral health careers as an option. We got into high schools. There's a program that we have called High School Alliance in which students can apply and become part of. It's a program where they get exposed to all different health careers, and behavioral health is one of those. We do lots of career panels.

In rural Nebraska, we have something called Farm Camp which is not actually farming, but it goes with the area. What we do is we bring high school students in to stay at one of the state colleges for the week. They receive college credit, and they learn about neuroanatomy. They have exposure to mentors. They learn about the different career options. It's a really, really neat program. They get college credit at the same time, and then they can come back and be camp counselors the next year so

you have this development of a pathway. That's just some of the examples of what we do from a recruitment perspective.

We also feel like it's very important to create training opportunities. It's one thing if you have students that are interested in behavioral health careers, but how do you get them to go into and study graduate programs and then create opportunities that they can actually use their training? We support training opportunities all across the state. We're particularly interested in developing rural training opportunities because, if students can train in the areas they are from, they're much more likely to practice there.

What we have found, and this isn't unique to Nebraska, but what we have found is that most of our programs are in the urban areas on the Eastern side of the state. Students come. They train there and then they stay. Then we have this disparity of urban and rural providers, so what we've done a lot of work on over the past decade is trying to create more rural training opportunities with the schools and programs that exist there so the students can actually train there, stay there and become part of the community that they live in and represent.

Then the last piece of what we do is retention. Retention efforts, of course, are important. We provide free continuing education for all the licensed behavioral healthcare providers. We help support licensure fees. We do a lot of work with mentorship, networking and training on resiliency, wellbeing. Those are just some examples of the major buckets that we do, and then we're always looking forward. These are the programs that we do, but we've gone back and gotten additional state funding to support trainees in correctional settings. We have a separate bill for that. We have a separate bill to support psychologists and training opportunities particularly in rural areas.

Most recently, we went back and amended our statute and got increased funding to diversify and expand the definition of a behavioral health provider so we can really tackle this from a global perspective. We were also able to receive ARPA funding, and we are going to use that to create, again, more training opportunities, a tele-behavioral health network that will cover the entirety of the state to assure that everybody in Nebraska has access to tele-behavioral health services among other things.

I think the point is is that this has been a really unique way to address the problem that has required a lot of relationships and support from our state legislators. We're very fortunate that they have prioritized this. I think it's very progressive of them to do so, but it's a good model. It's relatively cheap from a state perspective, but has a great impact. I think it's just a model to look at and think about especially if you live in a state that has a lot of disparities.

Jennifer Bright:

Marley, thank you for those examples. I think, oftentimes, for those of us that are Washington, DC-based, we often think about what are the federal policy issues we need to talk about, but I think what you're raising is that, much like 988 has devolved to the states to make decisions, same thing for this workforce development, it's got to be a bottom-up approach because it has to be relevant to the state you're in, for example, the rural-urban issues that you raised. Thank you for raising those.

I know all of us in the room were really struck and moved by the powerful story that Andrea shared with us this morning. Isn't it wonderful that she is then turning around and providing aid, offering her services and her support to others, which I think is even more powerful? That leads me to talk to you, Keris, and have you share your experience about the power of peer-provided services. What's its value? Where do we see the evidence, and why do we need to up the investment in this area?

Keris Jan Myrick:

Sure. Thank you for having me and being able to talk about the peer support workforce. I think a lot of people are very interested in it. Yet, we haven't seen a lot of growth over the years. Peer support workers are, of course, people with lived experience of mental health or substance-use conditions who are trained to provide support to other folks who are going through similar conditions. I mean, imagine what it's like to go through anything, and what you do is you talk to somebody who's been through it if you're going through a divorce or you've broken your arm and it's your first time in a cast. Who knows what it feels like to be in a cast but the person who's been in the cast? They'll tell you, "Yeah, the best way to itch it is this way, not that way." I think of peer support analogous again for people with mental health conditions.

Peer supporters have been billing Medicaid since 1999, with Georgia being the first state to have Medicaid billable services. Medicaid is the largest funder of peer services. Yet, in a 2016 study, there are only 25,300-some-odd peers across the nation. I live in Los Angeles County of California, and that county has 10 million people. All of these peer supporters that are across the United States wouldn't even come to near the number that we need for a county in a state. We still need to do more work, but let's talk a little bit about the evidence of peer support because, a lot of times, people feel like there's not enough evidence or there needs to be more evidence or more research. Of course, there always needs to be more research, but the current research evidence that we understand about peer support is that it reduces cost, especially cost of high-cost services. It reduces the number of ER visits. It actually helps people not just engage in treatment, but be activated in their treatment.

There's a difference between engagement, "I've shown up," to being activated, "I'm participating in," and that's what peer supports can help with. They also help with reducing, I mean increasing tenure in the community because of increasing community inclusion, reducing stigma and increasing hope. Those are just a couple of things that peer supporters do. They're also parent and family supporters. For parent and family supporters, they can who are helping other parents and/or family members who have a loved one with mental illness. That's a smaller evidence space and, in that evidence space, we're finding that it increases the confidence of parents and family members being able to support their loved one in understanding how to navigate systems.

The other thing I think that's important especially when you're talking about 988 and crisis and crisis system reform is that it's reported that between 11 and 50% of people who had previously attempted suicide do not follow through with treatment or go to appointments or things like that. When you talk to somebody who's been through a similar experience, you're more likely to follow through and carry through, especially if you have that person who might support you to first navigate what is a very complicated, not one system, but several systems. That's the other value of peer supporters is that they're exquisite in navigating systems because they've been through it themselves.

I will add, too, what is critically important especially as a person with lived experience who's been given a diagnosis of a mental health condition, that would be me, is not just having any old peer supporter, but having someone who looks like me, who's gone through the same, maybe, racial discrimination and other things that I've been through when I'm trying to understand and distinguish between what things are related to discrimination, gas lighting I would call it maybe if other people understood it that way, versus what are things that are really having to do with my mental health condition.

I actually didn't believe myself that recovery was possible. I was rolling around inpatient, in locked facilities and all of this for many years until I actually said, "I need to meet somebody who looks like me who's been through the same situation that I've been through." Once I met that person who's a peer supporter, Ms. Jackie McKinney from Philadelphia, it was just like a lightning bolt went off in my head about what the possibilities were. That's the power of peer support. I was able to finish my

master's degree, well, two master's degree, and one day that seal will be off the end of my name for the Ph.D. One day.

I think the things that we need to think about and why we're struggling with advancing peer support is that the wages are very low. I think, just to your point, peers are making anywhere between maybe $15 an hour and up. What we found in a wage study, so there's only one wage study that I know about that, and I do a lot of peer research, just so you know, but in 2016, I think, that study was done that, the other part about the wages, many peers reported that it's the wages that are keeping them back because they're too low and they don't want to continue in the workforce. What we also found was that there was a disparity between wages that were earned by women versus wages that were earned by men. It's a $4,000-a-year difference lower for women. The very issues that are happening throughout the nation with wage disparity or salary disparity for male and female is also happening in the peer workforce.

When we look at wages, the other thing we need to do is look at rates, especially rates and rate formulation within Medicaid or those billable or fee-for-service. Those vary just widely, I don't even understand it, from 1.96 per 15-minute all the way to $26-and-something for 15 minutes for the very same service. That's the variability from state to state. Wages and the formulation, I mean, rates and the formulation also can contribute to what wages are earned. I think we need to have a much better understanding about what are the formulations and for CMS to help us have this better understanding of what are the different rates for the different codes by state that peers are billing on, what kind of recommendations or guidance can they provide to states about ensuring that those rates, seeing how those rates contribute to wage in order for the wages to be higher for peers.

The other area that we need help in is, I've told you, there are 25,300-some-odd peers throughout the country as of 2016. We don't know exactly where all of these peers are. Is there a shortage in rural areas? Are there more in urban areas? By the way, what do these peers look like? We do not have an understanding of the demographics of the peer workforce either.

Lastly, I think there could be more use of and understanding peers in the crisis space. Even though stigma has reduced, there's still a lot of stigma within our own mental health provider agencies. When we're trying to encourage and use peers in ED and crisis settings, many people do not want to use peers. They have a lot of fear about can peers actually provide this work? Will peers be safe? We're the actual people who are in the hospital before, so we get it. We know what it's like when we want to maybe have a moment of violence because we're frustrated. We understand that and usually can diffuse that quicker than somebody else. However, people are more concerned about keeping the peer safe versus using the peer to help, to reduce a lot of things that are happening in ER settings, so I think we could have a better understanding of that.

Then, lastly, just increasing meaningful involvement of people with lived experience in planning and implementation of policy and programs. I mean, have you ever seen a toy company design a toy and not have a kid touch it or think about it? You would never do that. It would not be a successful toy, so why do we do this for mental health services? Those services are impacted, of course, how they're delivered around policy, so having peers involved in policy formulation, planning and implementation is also critically important.

Jennifer Bright:

Amen. I love that you ended with that, nothing about without, absolutely. I have so many things I want to follow up with, but before we do that, I want to turn to Drew. The pandemic catapulted, I guess I would use that word, our consciousness and the proliferation of telehealth as a means of providing services. We've seen fluctuation. We've seen the good and the challenges that are proposed by that, but

maybe you could share with the audience some reflection on what your organization has experienced. What are the challenges in workforce that are presented by that modality?

Andrew Bertagnolli:

Certainly. Thank you for having me. I'm excited to hear from you all as well and what you're hearing and feeling out there in the world.

I work for One Medical. One Medical is a primary care organization. I think as, even prior to the pandemic, we were beginning to come to terms with how do we provide additional mental health and behavioral health support in a primary care arena, recognizing that, for many people, that's their primary source of mental health care is the primary care space. We started to explore the telehealth area and looking at the evidence and really seeing, yes, this is an evidenced approach, we can provide these types of services. It also allowed us to scale out in our organization because we were then freed up with some of the issues around providing physical space for a mental health provider inside of a primary care clinic because it made it more financially viable, frankly, for us to move that into the virtual community.

Pandemic comes along and, as you said, catapults, thrusts us into this environment where we went from a small pilot to full-scale implementation within a matter of weeks, also trying to keep up with a now distributed workforce. Whereas, before we had people going into offices, they tended to be tied to a particular location, they now are literally spread across the entire nation and as we scrambled to meet those needs.

I'm going to focus in a little more on the challenges with interjurisdictional practice. It's really one of the big pinch points that we are now experiencing as a lot of the COVID exceptions and COVID regulations have now expired or are due to expire soon. I think, I'm going to talk about this in three buckets in terms of the consumer or the patient or the client, the system or the operational issues, and then also the providers themselves and the practitioners.

As I mentioned, access increased, which is wonderful, which is something we were needing and we knew we needed to do, was able to really reach deeper into more rural communities. Also, even inside our urban communities, now they had a convenience factor, not having to deal with traffic, parking, transportation issues. Challenges still exist there. I think that we need to be always aware of the digital divide issues that exist in our communities both inside the urban areas as well as in the rural communities. We have pockets in our urban area that do not have stable WiFi or stable broadband in and then in buildings. These people are in their homes, in their apartment buildings, and they're not able to get a signal or able to connect to wireless.

We had patients going to Starbucks, patients going to McDonald's, patients going to sit outside of an office where they could get the WiFi through the window, so really needing to think about how do we create a network that allows us to have equal access to the high-speed internet that's required to do the video care that we're talking about. Also, I think it helped reduce stigma even further because, now, you don't have to walk through a doorway that says mental health, behavioral health, psychiatric center or whatever the terminology is. I think this is particularly important in certain communities and marginalized communities for which there was even increased stigma with regard to seeking services.

The consumer I think benefits from all of this I think is my short answer there. I think, from the delivery system, operationally, telehealth allowed us to really broaden our applicant pool for looking for licensed clinical staff. We're able to now recruit more broadly. People can sit anywhere and have the license that we need for the patient care. We also saw a decrease in failed to keep appointments, short cancellations. We saw that drop dramatically. We were able to keep our people busy, keep our clinicians providing the services that they do.

The other hand of that is increased complexity of operations. I will say 56-fold if we take all of our stakes and territories. It's very challenging to match the individual seeking service with the person who's licensed in their area in a quick way. We have a lot of behind-the-scenes things that we have to do to make sure we can connect quickly the service provider with the right... or the right service provider with the right... with the patient for where they're licensed.

I'm keeping my compliance and legal partners very busy helping to understand the ever-changing landscape of telehealth practice laws. A lot of them are focused on the provision of medicine. It's unclear how that impacts behavioral health services, particularly your psychotherapy providers, psychologists, social workers, et cetera. Some states say, "Oh, you default to the medical law." Some folks, some states say, "No. Here's this special thing for mental health." There's conflicting information from guilds sometimes trying to provide information across the whole country, but recognizing that there are many, many different nuances in the law. There's no real one-stop shop to even understand what they are. If we had a database, for example, that explained what is the variation in telehealth laws, where they exist or outdated, they don't specifically speak necessarily to mental health.

Then, also, from a operation and systems standpoint is billing. When I go to hire someone, I have to be thinking how am I going to utilize this person? How am I going to bill? For example, the licensed master's level counselors are not able to bill Medicare, so I can only use them in certain settings. I can only get them credentialed through credentialing in some areas and not others. Again, it adds a layer of complexity in maintaining or in recruiting and also deploying these individuals. This is let alone the alphabet soup that exists in licensure nomenclature with LCSW, LMHC, LPCC, all of the different acronyms and trying to help our recruiting partners and others understand the nuances.

Also, if we think of the providers and think of the actual practitioners, I myself, I'm a licensed psychologist, I hold 18 licenses, it has been a scavenger hunt to get that. The complexity of acquiring and maintaining these licenses is incredibly burdensome. It's very hard to have individuals help us. When we had our administrative staff say, "Hey, let us help you," it's very hard. I've got to log onto my school and get a transcript. I've got to contact my first state of licensure and have them send verification to every other state. There are lots of different requirements. I'm ineligible in some states because of coursework I did or did not take. The complexity there is quite a burden for my providers. Most providers come to us with one, maybe two licenses, tops, and I'm getting my folks generally have between eight and 10, so it's a yearlong-or-more process.

Then, after you get the license, there's the maintaining them. They all expire at different dates. They all have different CE requirements associated with them. Some will allow certain amount of remote learning versus in-person requirement. It can be quite a challenge. We actually have a shared spreadsheet that we've developed to try to help navigate and make sense of some of the confusion. Some licenses require renewal every year, some every three years, and then it varies by license type. In states where you have psychologists, social workers, master's levels, counselors, and marriage and family therapists, those may be four different sets of rules in one given jurisdiction. It just becomes, again, that operational nightmare.

Jennifer Bright:

I'm taking away from this conversation that we have a lot of complexity that we have to smooth over. Not to diminish the detail of what you're saying, I do want to make sure we have some time for some audience dialogue. If I could turn and see if we have some audience questions to stimulate more, and then you can keep adding to the layers of complexity here.

Let me ask if there are any questions from our audience, points of clarification, specific experiences you've had that you want to share. If there are no questions, I will ask one. Please.

Speaker 6:

What are [inaudible 00:37:04]. What's the status of that?

Jennifer Bright:

The question is what is the current state of play of federal licensure laws for telehealth, and then there was changes made during the pandemic, and is that sustained?

Andrew Bertagnolli:

I think, during the pandemic, many of the regulatory issues and licensing issues were lessened and loosened, allowing a much easier cross-jurisdictional practice. Those often were temporary and usually were connected to emergency orders issued by governors in different states. As the emergency orders have now all been dropped down, they've now gone back to the prior state. Again, we're seeing more complexity and often a scramble of how to now where... We've been providing care for someone with that. Now, how to get them matched up or get my person licensed where that client is?

Keris Jan Myrick:

[inaudible 00:38:01].

Jennifer Bright:

Yes. Absolutely, Keris.

Keris Jan Myrick:

The other question I think that's important to ask when we're thinking about telehealth is what were the regulations that expanded broadband access for people who were on lifeline programs and will those continue, because that became an access issue for people who either they had one device or they had limited broadband. They may be in a family situation, and so they had to make really tough decisions about how am I going to use my technology for my kid who's now home doing school at home? That's the first thing that has to happen, so they may not be able to have enough broadband in order to be able to participate in telehealth. I like to think of the two things hand-in-glove if you will that, while you're trying to think about the telehealth regulations for providers, also what regulations and things do we need to look at on the consumer side to make sure that they have enough broadband and access to telehealth?

Jennifer Bright:

That's a great point. Any other questions? I'm going to go way to the back since I took one from up front.

Josh:

Oh, it's on now. Sorry. Thank you all so much for the conversation so far. I was-

Jennifer Bright:

Could you stand just because I'm hearing a faceless voice?

Josh:

For sure. Yeah. Sorry about that. My name is Josh. This is a question for Andrew, if any others have thoughts, too, and not telehealth specifically, but as you likely know in the recently proposed updates to the Medicare physician fee schedule, there were some proposed changes for the supervision requirements for I think some of those practitioner types you were speaking about like for master's level counselors and marriage and family therapists and the like so that they could practice under general supervision and not under direct supervision from other folks. Would that get at some of the billing complications that you were speaking about when trying to deploy those professionals across the workforce or would that, I guess, ease some of those burdens that you all are experiencing?

Jennifer Bright:

In part.

Andrew Bertagnolli:

The master's level counselors are independent practitioners and they can practice without supervision, so just to clarify that point. In a Medicare situation, you could always build them out in what's called an incident-to visit. If they had a visit with a primary care provider and then a subsequent visit with one of those counselors, you could build that visit out under the prior Medicare laws. I think what you might be talking about is more with regard to nurse practitioners. That has freed up a little bit, but still some of the state... Practicing across state lines is still a challenge even with those regulations changing because those are state level laws and state level regulations that we're having to follow.

Jennifer Bright:

Well, I know that this issue of workforce is going to continue to come up throughout the panels. It's obvious that this is a bedrock issue. We're coming down on time, so to give everybody the last word, which is always my favorite thing, we've covered a lot of ground, and it's clear there's a lot of complexity here, so I'd love each of our panelists to leave the audience with one, maybe two, thoughts of what's one change that could really help smooth that complexity or could empower some creative problem solving in the area of workforce development? I'm going to work in reverse order and start with Marley and then finish with Russ.

Marley Doyle:

I think one thing is that the first place to start is to identify an organization or a person to actually be in charge of doing the work and then, from there, set up the relationships that... and all the players and all the stakeholders that are needed. One of the problems is that, if everybody is trying to solve the issue in a different way, it's very confusing. I don't think it's very effective, to be honest, and so, if you can have a center or an organization that you say this is the organization that we're going to task to solve the workforce issues in our state, our region or even locally, I think that that is a great place to start because, then, they can bring in all the players. It'll be much more effective and people can start rowing in the same direction.

Jennifer Bright:

Well, my favorite analogy, so leadership with radical collaboration. All right, Keris?

Keris Jan Myrick:

I think, to advance peer workforce, the first thing to think about, of course, is the wages and the rates that you're setting at the state level for the peer workforce because it's a contributing factor,

secondarily, to understand any of the systemic barriers such as, for example, what kind of criteria to qualify. Some states have interpreted the CMS criteria very strictly, meaning, you have to have a high school diploma or GED. That is not what CMS says, so always read really carefully. It says you need to have a high school equivalency. That could be what the state decides. Also, lastly, supervision, having supervisors who understand what peer support is, and to include peer supporters who have the training and experience as part of the array of supervisors who supervise peer support.

Jennifer Bright:

Fair compensation, be flexible and keep a wide tent. All right. Drew?

Andrew Bertagnolli:

Because much of what I touched on is really at that state level and jurisdictional level, I think is there some way to begin to convene stakeholders to look at ways of harmonizing some of the different laws? It often does take legislative changes at the state level, but is there a way for us to have a more consistent approach to how we acquire and maintain licenses in our various states and territories?

Jennifer Bright:

If anybody is from NCSL, CSG, NASHP, there's your mandate. All right. Russ?

Russ Petrella:

Mine is kind of a simple solution. We have to make these better jobs. These jobs are hard. They're economically not always feasible for people. We have to have a career path where people can advance. There has to be good training, good support from their leaders so that people can be excited about going to work as opposed to it being something they dread and they can't wait to get out of this and do something else.

Jennifer Bright:

Wonderful. Thank you so much to our panelists, and please join me in thanking them. Thanks for the opportunity to have this discussion. Great. Nice job.