

Minnesota Mental Health Action Group
Workforce Action Team
Summary
June, 2004

1. Current academic training programs systems are difficult to get into. Qualified candidates are unable to get in, contributes to a lack of culturally specific providers
 - Develop an approach of weighing of entrance requirements/thresholds for recruiting providers that are from specific cultural or ethnic areas
 - Mentoring program with child psychologists
 - Examine qualification thresholds for training programs at University and colleges
 - Focus on outreach to increase number of minority providers thru the use of grants and educational opportunities
 - MN department of Minority and Multicultural health to offer incentives for diverse candidates to enter into training programs
 - Establish mentorship program for multicultural providers

2. Academic training programs do not prepare providers for practice and community care situations.
 - Common curriculum and education requirement for multi-disciplines, should have a common baseline for all practitioners
 - Structure training to address routine community needs rather than specialized
 - Training programs should require rotation in community-based clinics, primary care clinics, and community mental health centers
 - Child psychiatrists are highly specialized to deal with complex cases. Training programs should respond to non-specialized e.g. non child psychiatrist to address usual disorders seen in communities

3. Increase recruitment, availability of training programs, and reduce payment barriers for advanced practice prescribers (CNS/NP/PA) Under-utilization of NP/PA's – more graduating in primary care than jobs exist
 - Increase existing training in BH specifically – North Dakota and St. Scholastica
 - Scope of practice (e.g. nurse practitioner prescription Rx ability)
 - State should take the lead in having a common operating platform regarding eligibility as a credentialed BH provider for MA, consistent use of CPT codes including H-code
 - Require specialized training for the NPs/PAs to be designated as providers and eligible for reimbursement
 - Establish scholarships or loan repayment programs to increase number of providers – MDH loan repayment to target BH providers
 - Encourage Primary care based providers such as NP to explore BH – licensing Board to mandate – legislative recommendation or resolution BH section in credentialing/recredentialing
 - Offer loan repayment for encouraging providers to work in the field of BH – MDH/Federal/State.

4. Standardize qualifications of staff such as case managers, teachers, care coordinators these professionals control access to community resources, but are inconsistently trained and prepared.
 - Additional training and state certification without creating additional barriers – base line level of training and skills
 - Establish specific CME requirements for provider to practice in the field
 - On the job training programs, identifying key components and baselines, training for case managers
 - Workforce established job titles and requiring MA rules – uniform terminology for skill levels and on-job training/career path

5. Movement from SOS/RTC to community based placement. What will be done with the workforce?
 - Psychiatrist in the community will be directly impacted. State needs to encourage Psychiatrists to be in the community, doing outreach and staffing for the demands of the community where the RTC's are
 - Monies and staffing need to follow the SPMI population
 - There needs to be augmentation of current community health resources and additional efforts in retention and enhancement of behavioral health services in communities
 - Development of a State Task Force to bring counties together with SOS to plan. Will DHS follow thru that funding and services are maintained in the community. Recommendation that funding not being decreased.

6. Psychiatry Residency- foreign born residents (visa issues – can't stay in area after program completion) or don't stay in area (J-1)
 - Strengthen community based strategies to increase J-1 visa professionals' interest in remaining in MN after graduation.
 - Defined retention plans that include
 - A tool box for recruiting and retaining foreign trained clinicians in communities that will encourage cultural integration and long term retention
 - An association that connects J-1, communities and payers
 - Conference for Recruitment and Retention
 - Sponsor workshop or conference to discuss and disseminate community best practices in retention
 - Assist with waiver applications to stay in area

7. Use of Interns to address shortages in BH providers
 - The current situation is that the number of potential internship sites have decreased
 - FFS – MA allow billable with modifier except 90801
 - Credentialing standards vary by third party payer
 - Steps
 - Work with third party payers in re-define payment rules (including government sources) to reimburse for intern services under appropriate

documented supervision service agreement – only done in Rule 29 payers & CHC now by FFS & DHS. Includes psychologists, social workers and LMFT. Credential “institution” or “training site” as approach

- Payers that reimburse for services rendered in internships if supervised by a credentialed provider
 - UBH
 - Medicaid
 - BCBSM
- Work with licensing boards and academic programs to adjust expectations and/or work to revise credentialing expectations.

8. Use of multi-disciplinary teams to work with very young children (0-3)

- Recognize Team approach in reimbursement methods
- More health professionals doing behavioral health shared care in multiple settings
- Evaluate payment policies of BH and Public Health, and medical personnel regardless of setting where services are performed

9. Shared Care Expansion and Model/Integrated Care

- Each share care system is unique. Need to expand and agree on what is “shared care/integrated care”
 - The focus is on the interface between primary care and psychiatry
 - Shared care” is consultative to primary care M.D.s (Broader than just M.D.s) (timely, evidence based outcomes)Canada, England, Australia
 - Integrated medical and psych team rather than isolated providers
 - Co-location as much as available
 - Other health care practioners can effectively deliver BH services
- Assess fiscal realities of integrated model

10. Alternatives

- Videoconferencing(ITV)
 - Clarify and educate what is reimbursable and what is not
 - Consider how to promote telemedicine in BH.
 - Current payers that cover services
 - Medicaid
 - BCBSM
 - UBH
- Online consultation – access to psychiatrists for consultation
 - No billing “codes” for psychiatrist to MD consultations
 - Consultative role of psychiatry needs to be defined and expanded
 - Establish MD to BH provider code