Behavioral Health Advisory Commission

Final Report:
Findings and Recommendations

Prepared for:

The Honorable Clerk of the House of Representatives

The Honorable Clerk of the Senate

Representative Adrian C. Madaro, House Chair of the Joint Committee on Mental Health, Substance Use and Recovery

Senator Julian Cyr, Former Chair and Current Senate Vice Chair of the Joint Committee on Mental Health, Substance Use and Recovery

Representative Aaron Michlewitz, Chair of the House Committee on Ways and Means

Senator Michael Rodrigues, Chair of the Senate Committee on Ways and Means

May 3, 2023

Table of Contents

Letter from the Co-Chairs

To the Legislature:

The Commission was established by Chapter 77 of the Acts of 2022, *An Act Establishing the Behavioral Health Trust Fund and the Behavioral Health Advisory Commission*. Credited with over $190 million in federal COVID-19 recovery funds, the Behavioral Health Trust Fund presents an opportunity to fill long unaddressed gaps in the behavioral health delivery system.

The Behavioral Health Advisory Commission was tasked with investigating the state of behavioral health in the Commonwealth and submitting recommendations to the Legislature on the disbursement of money from the Trust Fund "for the purpose of addressing barriers to the delivery of an equitable, culturally-competent, affordable and clinically-appropriate continuum of behavioral health care and services."

Our main objective from the start was to highlight not only the needs of Massachusetts residents seeking behavioral health services, but also the needs of the behavioral health system, including the behavioral health workforce delivering vital care throughout the Commonwealth.

With appointments from the Governor, the Senate President, the Speaker of the House, and the Senate and House Minority Leaders, as well as many behavioral health organizations, the Commission included a wide array of stakeholders from government, business, nonprofit, academic, and advocacy sectors. We wish to acknowledge all Commission members who contributed valuable knowledge, experience, and perspectives over the course of our meetings and deliberations.

The Commission identified many programs and services worthy of additional investment, especially for young people. The Commission could have easily provided recommendations for spending the amount allocated several times over. The recommendations included in this report result from difficult but necessary choices to prioritize the expedited and efficient use of these funds. Ultimately, the Commission hopes its findings and recommendations will inform the disbursement of monies in the Trust Fund, as well as legislative, policy, and other changes needed to equitably bolster the behavioral health and wellness of Commonwealth residents.

It has been an honor to serve as Co-Chairs of the Behavioral Health Advisory Commission. We greatly appreciate Senate President Karen Spilka and House Speaker Ron Mariano for appointing us to lead this timely endeavor. We also want to thank all our fellow Commission members for their time, attention, and engagement and the public for their participation and input. Finally, we wish to extend our sincere appreciation to the members of both our staff – Gloribel Rivas, Liz Ganz, Jess Bresler, and Amanda Graff – without whom this report would not have been possible.

We are pleased to submit this report with recommendations to the Massachusetts Legislature from the Behavioral Health Advisory Commission.

Yours in service,

Julian Cyr, Co-Chair
State Senator
Cape and Islands District

Adrian Madaro, Co-Chair
State Representative
First Suffolk District

Commissioners

The 22-member Behavioral Health Advisory Commission included the following leaders in government and behavioral health:

State Senator Julian Cyr, Co-Chair
Cape and Islands District, Former Chair and Current Vice Chair, *Joint Committee on Mental Health, Substance Use and Recovery*

Former Senator Sonia Chang-Diaz
Former Chair, *Joint Committee on Racial Equity, Civil Rights, and Inclusion*

Former Secretary Marylou Sudders
Executive Office of Health and Human Services

Amara Anosike, Esq.
Director of Behavioral Health Policy and Advocacy, *Boston Children's Hospital*
Appointed by: Speaker Ron Mariano

Scune Carrington
Director of Integrated Care, *Massachusetts League of Community Health Centers*
Appointed by: Speaker Ron Mariano

Dr. Charles Clayton Daniels, Jr.
CEO, *Fathers' UpLift, Inc.*
Appointed by: Senate President Karen Spilka

Rebekah Gewirtz
Executive Director, *National Association of Social Workers – Massachusetts Chapter*

Jacqueline Hubbard, Esq.
Policy Director, *National Alliance on Mental Illness*

Eric Masi
President and CEO, *Wayside Youth & Family Support Network*
Appointed by: Senate President Karen Spilka

Dr. Debra Pinals
Director of the Program in Psychiatry, Law and Ethics and Adjunct Clinical Professor of Psychiatry, *University of Michigan Medical School and University of Michigan Law School*, Senior Medical and Forensic Advisor and Editor-in-Chief, *National Association of State Mental Health Program Directors*
Appointed by: Speaker Ron Mariano

Steve Walsh
President and CEO, *Massachusetts Health and Hospital Association*

State Representative Adrian Madaro, Co-Chair
First Suffolk District, Chair, *Joint Committee on Mental Health, Substance Use and Recovery*

Representative Bud Williams
Eleventh Hampton District, Chair, *Racial Equity, Civil Rights, and Inclusion*

Representative Matthew Muratore
First Plymouth District
Appointed by: House Minority Leader Brad Jones

Rocio Calvo, PhD
Associate Professor of Global Practice, *Boston College School of Social Work*, Director, *Latinx Leadership Initiative*
Appointed by: Former Governor Charles D. Baker

Lydia Conley
President and CEO, *Association for Behavioral Healthcare*

Maryanne Frangules
Executive Director, *Massachusetts Organization for Addiction Recovery*

David Matteodo
Executive Director, *Massachusetts Association of Behavioral Health Systems*

Danna Mauch, PhD
President and CEO, *Massachusetts Association for Mental Health*

Dr. Elsie Mireya Taveras Benavidez
Chief of the Division of General Academic Pediatrics and Executive Director of the Kraft Center for Community Health, *Massachusetts General Hospital*
Appointed by: Former Governor Charles D. Baker

Wanda Visnick, MSN, CNP, PMHNP-BC, NCSN, HN-BC, Psychiatric Mental Health Nurse Practitioner, *Justice Resource Institute*
Appointed by: Senate Minority Leader Bruce Tarr

Margaret Weiss
Director of Clinical Research, *Cambridge Health Alliance*
Appointed by: Senate President Karen Spilka

Introduction

The Behavioral Health Advisory Commission (the "Commission"), established under Chapter 77 of the Acts of 2022, *An Act establishing the Behavioral Health Trust Fund and the Behavioral Health Advisory Commission* (the "Act"), hereby submits its final report on findings and recommendations to the General Court as required by the Act (this "Final Report").

The Act established the Behavioral Health Trust Fund (the "Trust Fund"), which received $192 million in federal funding received by the Commonwealth under the federal *American Rescue Plan Act of 2021*, 42 U.S.C. 802(c) ("ARPA"). The Trust Fund, to be administered by the Secretary of Health and Human Services (the "Secretary"), must be expended "for the purpose of addressing barriers to the delivery of an equitable, culturally-competent, affordable and clinically-appropriate continuum of behavioral health care and services."

The Commission was charged with identifying and assessing various aspects of the behavioral health care system in the Commonwealth and, based on those findings, making recommendations to the Legislature on the disbursement of the money in the Trust Fund. Such recommendations must prioritize the needs of communities disproportionately impacted by the COVID-19 pandemic and comply with rules and guidance pertaining to eligible uses of COVID-19 state and local fiscal recovery funds under ARPA.

The full legislative charge is as follows:

> *SECTION 1. (a) There shall be a Behavioral Health Trust Fund that shall be administered by the secretary of health and human services, who shall expend the funds, subject to appropriation, for the purpose of addressing barriers to the delivery of an equitable, culturally-competent, affordable and clinically-appropriate continuum of behavioral health care and services. There shall be credited to the fund all amounts that are transferred, or authorized to be transferred thereto, or directed to be deposited therein, and all amounts received as gifts, grants or contributions for the purposes of the fund. Any money remaining in the fund at the close of a fiscal year shall not revert to the General Fund.*
>
> *(b)(1) There shall be a behavioral health advisory commission to make recommendations to the general court on the disbursement of the money in the fund. The commission shall consist of: the chairs of the joint committee on mental health, substance use and recovery, who shall serve as co-chairs; the chairs of the joint committee on racial equity, civil rights, and inclusion; 3 members appointed by the senate president who work in the behavioral health field, 1 of whom shall be a professional in the field of children's mental health and 1 of whom shall be a professional in the field of behavioral health services in correctional settings; 3 members appointed by the speaker of the house of representatives who work in the behavioral health field, 1 of whom shall be a professional in the field of children's mental health and 1 of whom shall be a professional in the field of behavioral health services in correctional settings; 1 member appointed by the minority leader of the senate; 1 member appointed by the minority leader of the house of representatives; the secretary of health and human services; the president of the Massachusetts Association for Mental Health, Inc. or a designee; the president of the Association for Behavioral Healthcare, Inc. or a designee; the executive director of the National Alliance on Mental*

Illness of Massachusetts, Inc. or a designee; the executive director of Massachusetts Association of Behavioral Health Systems, Inc. or a designee; the executive director of Massachusetts Organization for Addiction Recovery, Inc. or a designee; the executive director of Massachusetts chapter of the National Association of Social Workers, Inc. or a designee; the president of the Massachusetts Health and Hospital Association, Inc. or a designee; and 2 members appointed by the governor, 1 of whom shall have expertise in developing behavioral health workforce training education and 1 of whom shall have expertise in addressing disparities in access to mental and behavioral health care for populations disproportionately experiencing barriers to care.

(2) The commission shall identify and assess: (i) current behavioral health workforce challenges including, but not limited to: (A) existing workforce pipeline issues; (B) emerging workforce needs; (C) 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 to support workers pursuing tertiary degrees and for those who do not require advanced degrees including, but not limited to, mental health workers, sitters, nurses, social workers, psychologists, other masters' level licensed behavioral health providers and psychiatrists; (D) programs to ensure retention of current behavioral health workforce; and (E) the availability of trauma-informed supports and services for behavioral health practitioners and related staff; (ii) factors that create or perpetuate disparities in mental and behavioral health care including but not limited to race, ethnicity, language, gender, sexual orientation, gender identity and barriers to access for lesbian, gay, bisexual, transgender, and queer individuals; (iii) economic barriers to treatment; (iv) access to early intervention services; (v) diversion for people with mental illness and substance use disorder from the criminal legal system; (vi) access to community-based services; (vii) the feasibility of increasing behavioral health competency of staff in both behavioral health settings and settings where there are frequent interactions with patients with behavioral health diagnoses through training to increase competency for sitters, mental health workers, emergency department personnel, medical-surgical staff that frequently interact with psychiatric boarders and other caregivers in de-escalation tactics, crisis management, rapid response, psychiatric diagnoses and other related topics; (viii) diversion from the juvenile justice system; (ix) treatment for people with mental illness or substance use disorder who are incarcerated or under supervision by the criminal justice system; (x) the feasibility of training programs to increase the behavioral health competency for workforce in nonhospital settings including, but not limited to, group homes and skilled nursing facilities, to allow patients to receive baseline behavioral health services where they are living; and (xi) any other factors the commission deems relevant for addressing barriers to the delivery of an equitable, culturally-competent, affordable and clinically-appropriate continuum of behavioral health care and services. Based on the commission's findings, the commission shall make recommendations for the disbursement of money in the fund. The commission's recommendations shall prioritize the needs of communities disproportionately impacted by the 2019 novel coronavirus pandemic and comply with rules and guidance pertaining to eligible uses of coronavirus state and local fiscal recovery funds under the federal American Rescue Plan Act of 2021, 42 U.S.C. 802(c).

(3) The commission shall submit its findings and recommendations to the clerks of the senate and house of representatives, the joint committee on mental health, substance use and recovery and the senate and house committees on ways and means not later than June 1, 2023.

(c) Annually, not later than October 1, the secretary shall file a report with the clerks of the senate and house of representatives, the joint committee on mental health, substance use and recovery and the house and senate committees on ways and means on the fund's activities, which shall include, but not be limited to: (i) the source and amount of funds received; and (ii) the expenditures made from the fund and the purposes of such expenditures.

SECTION 2. This act shall take effect as of December 13, 2021.

The Commission undertook a thorough and deliberative process to address issues concerning behavioral health in Massachusetts. This Final Report presents the Commission's findings and recommendations as required by the Act.

Part I details the Commission's activities since its inception. Agendas, minutes, presentations, and handouts, if any, for each Commission meeting can be found in Appendix A.

Part II presents the Commission's findings on the state of behavioral health in the Commonwealth. Additional resources can be found in Appendix B.

Part III contains the Commission's final recommendations for disbursement of money in the Trust Fund.

Executive Summary

Although the Commonwealth and the nation more broadly has long struggled to address the health care needs of residents, the COVID-19 pandemic exacerbated challenges in every sector of the health care system and the behavioral health system in particular. Fortunately, significant state and federal action following the pandemic culminated in historic investment in behavioral health care in the Commonwealth by the Legislature, both through annual budget funding increases for and the allocation of federal recovery funds to the behavioral health care system.

The Legislature established the Behavioral Health Trust Fund, directing to it $192 million of the billions of dollars made available to the Commonwealth under the federal American Rescue Plan Act ("ARPA"). The Legislature also established the Behavioral Health Advisory Commission to identify and assess behavioral health in the Commonwealth and make recommendations for disbursement of money in the Behavioral Health Trust Fund based on its findings.

The Commission was formed in the fall of 2022 once all appointments had been made and promptly began its work investigating the state of behavioral health in Massachusetts. The Commission drew on the vast experience and knowledge of Commission members to conduct a thorough study of the myriad challenges facing the Commonwealth's behavioral health delivery system.

This report details the Commission's findings and recommendations pursuant to its statutory charge under Chapter 77 of the Acts of 2022, *An Act Establishing the Behavioral Health Trust Fund and the Behavioral Health Advisory Commission*.

Key Findings

The Commission finds that the Trust Fund will have the greatest and most immediate impact if directed towards initiatives that: (1) target recruitment and retention of the behavioral health workforce, and (2) prioritize youth access to behavioral health services and supports. Additionally, a commitment to diversity, equity, and inclusion should underpin all investments.

Overview of Recommendations

Based on these two key findings, the Commission developed the following recommendations for utilizing the Trust Fund to bolster the Commonwealth's behavioral health delivery system:

1. **Loan Forgiveness: $80 to $100 million**
2. **Scholarships: $20 to $30 million**
3. **Paid Internships, Practicums, and Field Placements: $20 to $30 million**
4. **Reimbursement for Clinical Supervision: $20 to $30 million**
5. **Professional Fees and Practice Costs: $2 to $5 million**
6. **Behavioral Health Support for Health Care Workers: $5 to $10 million**
7. **Commercial Rate Analysis: $500,000 to $1 million**
8. **Youth and Schools: $5 to $10 million**

I. Commission Activities

The Commission met five times. All meetings were held virtually via Microsoft Teams and livestreamed on the Legislature's website for public viewing. Below are summaries of each meeting. The minutes for each meeting and any information presented, if applicable, can be found in Appendix A.

First Meeting – Monday, November 9, 2022 at 1:00PM

The Commission met to begin its work assessing the state of the behavioral health care delivery system in the Commonwealth. Commission members identified areas of the behavioral health delivery system that require immediate attention and could benefit from Trust Fund investment. Commission members discussed the behavioral health care delivery system in the Commonwealth and opportunities to address challenges with investments from the Trust Fund. The meeting notice, agenda, and recording can be found at https://malegislature.gov/Events/Hearings/Detail/4391.

Second Meeting – Wednesday, November 28, 2022 at 1:00PM

The Commission met to continue its work assessing the state of the behavioral health care delivery system in the Commonwealth. Co-Chairs Cyr and Madaro gave a presentation summarizing behavioral health workforce-related issues discussed in the first meeting. Co-Chairs Cyr and Madaro led a discussion on workforce challenges in the Commonwealth. The meeting notice, agenda, and recording can be found at https://malegislature.gov/Events/Hearings/Detail/4409.

Third Meeting – Monday, December 19, 2022 at 1:00PM

The Commission met to continue its work assessing the state of the behavioral health care delivery system in the Commonwealth. Co-Chairs Cyr and Madaro gave a presentation summarizing behavioral health delivery system and health equity-related issues discussed in the first meeting. Chair Cyr led a discussion on barriers and access to behavioral health care. Chair Madaro led a discussion on behavioral health and the criminal legal system. The meeting notice, agenda, and recording can be found at https://malegislature.gov/Events/Hearings/Detail/4429.

Fourth Meeting – Tuesday, April 18, 2023 at 1:00PM

The Commission met to continue its work assessing the state of the behavioral health care delivery system in the Commonwealth. Co-Chairs Cyr and Madaro gave a presentation summarizing the recommendations received from Commission members in past Commission meetings and via written testimony. The co-chairs led Commission members in a discussion on the recommendations and requests before the Commission. The meeting notice, agenda, and recording can be found at https://malegislature.gov/Events/Hearings/Detail/4505.

Fifth and Final Meeting – Wednesday, May 3, 2023 at 1:00PM

The Commission met to complete its work. Co-chairs Cyr and Madaro presented the draft Final Report and invited Commission members to provide any final thoughts or comments regarding the proposed recommendations. The meeting notice, agenda, and recording can be found at https://malegislature.gov/Events/Hearings/Detail/4518.

II. Key Findings on the State of Behavioral Health

The purpose of the Commission is to present its findings on the overall state of behavioral health in the Commonwealth, and to make recommendations to the Legislature on how best to direct money contained in the Trust Fund.

This section includes a brief overview of each topic and the Commission's findings. Additional information, resources, and reports for each topic can be found in Appendix B.

***

Workforce Findings

The Commission finds that more behavioral health providers are leaving the health care field than are entering. They report extreme burn-out due to increased patient acuity, caseloads, and relatively low reimbursement rates and wages.

The Commission finds the ongoing behavioral health crisis is largely a product of years of persistent strains on and underinvestment in the behavioral health delivery system and workforce. The Association of Behavioral Healthcare ("ABH"), a member of the Commission, submitted written testimony succinctly describing how workforce shortages contribute to the Commonwealth's behavioral health access challenges:

> "*In a recent survey conducted of ABH outpatient mental health providers, ABH found that* ***a workforce crisis is crippling our members' ability to provide care and causing significant access delays in community-based mental health treatment****. These trends increase prescriber wait times and threaten to close programs. Consequently, individuals with severe and persistent mental illness do not have access to vital, cost-effective, and medically necessary services. These access challenges are caused by the* ***historic undervaluing of community-based behavioral health services****; while individuals with behavioral health diagnoses drive a significant majority of total healthcare costs in the country, behavioral health services represent only a small fraction of spending*."

The widespread shortage of health care providers persists across every health care sector, resulting in a dire need for increased services at all levels of care. In particular, there is a lack of behavioral health providers sufficient to meet rising demand for services. These challenges are not new, but they were exacerbated by the pandemic as demand for services increased exponentially while the number of available beds, providers, and options for care shrunk. Funds must therefore be leveraged to address both workforce recruitment and retention efforts.

Access to Behavioral Health Care Findings

Since March 2020, self-reported mental health conditions, overdoses, and suicidality increased dramatically as people struggled with the effects of isolation and the effects of losing employment, loved ones, and traditional support systems.

Many people who could have benefited from early interventions and upstream services were unable to access the care and supports they needed during the height of the COVID-19 pandemic. As their behavioral health deteriorated after being left untreated, many ended up waiting for days, weeks, and even months in emergency departments unable to meet their needs or move them to more appropriate settings. The number of psychiatric patients boarding –

already at crisis levels before COVID-19 – rose 200 to 400% monthly during the pandemic, largely due to lack of capacity in less-acute settings, behavioral health providers leaving the field, and increased demand for services at all levels of care.

Importantly, the behavioral health crisis is particularly pronounced in younger populations especially vulnerable to the isolating and distressing events of the pandemic. The nation has seen a significant increase in young people seeking behavioral health services, but the availability of these services – particularly for children of color, children with limited English proficiency ("LEP"), and children who are clients of Commonwealth agencies – could not meet demand even before COVID-19 due to bed, provider, and other staffing shortages. Indeed, despite the expansion of tele-behavioral health services during the pandemic, advocates say that behavioral health needs dramatically increased while services shrunk across the board for children. Service availability remains significantly reduced compared to before COVID-19. Older adults also experienced acute isolation and loss during and in the aftermath of the pandemic, highlighting the need to address behavioral health challenges at all stages of life.

Health Equity Findings

Both the pandemic and the ongoing behavioral health crisis have had a disproportionate impact on Black and Indigenous individuals and other people of color (BIPOC), LGBTQ+ individuals, young people, and other historically marginalized communities, all of whom more acutely experience the broader effects of the concurrent public health emergencies.

The Commission acknowledges that systemic, institutional, and structural racism and oppression in the health care system is pervasive, and this report is insufficient to fully address the topic. However, as the Commonwealth continues to bolster and expand the behavioral health care system, Commissioner members urge the Legislature to ensure it takes an equity-driven approach that centers the social determinants of health in the disbursement of money from the Trust Fund.

III. Final Recommendations

Data show that, even before COVID-19, both the number of people seeking behavioral health care and the intensity of their needs were increasing beyond the capacity of the behavioral health delivery system. Since 2020, there has been a significant increase in need: one in three Massachusetts adults reported needing behavioral health care for themselves or a close relative from January 2020 to March 2021. Nationally, 40% of Americans say the pandemic exacerbated their need for behavioral health care. While these historic challenges have been met with equally historic investments in behavioral health on both the state and federal levels, there remains much more to be done. The Behavioral Health Trust Fund provides a unique opportunity to bolster the Commonwealth's behavioral health system, which can only be accomplished by significantly expanding the behavioral health workforce.

Recommendation 1: Loan Forgiveness

Findings

The current MA Repay program administered by the Executive Office of Health and Human Services ("EOHHS") through a contract with the Massachusetts League of Community Health Centers supports behavioral health and primary care staff that work in community health centers, community mental health centers, and inpatient psychiatric units and facilities. The program provides loan repayment awards on a sliding scale according to provider type and whether the provider works part-time or full-time, in exchange for four years of service, or five years in the case of child and adolescent psychiatry.

However, the Commission finds that the MA Repay program faces a $88.5 million ***deficit*** based on eligible applications for psychiatrists, psychologists, and primary care physicians; master's level mental health and primary care professionals; and bachelor's level mental health and primary care professionals. By contrast, the program has a $9.6 million ***surplus*** on eligible applications for inpatient psychiatric mental health nurse practitioners and mental health workers despite inpatient mental health workers being the highest vacancy position in inpatient psychiatric units. The lack of use of these funds is largely due to the short application timeframe that allowed only current employees to apply and prevented facilities from using the program as a recruitment tool to fill the 400+ vacant mental health worker positions.

The Commission also finds there is a need to bolster the behavioral health workforce serving justice-involved populations.

Recommendations

The Commission recommends that all efforts to bolster the behavioral health workforce prioritize the recruitment and retention of a culturally, ethnically, and linguistically diverse workforce that reflects the diversity in the general population. The Commission further recommends:

- Significant additional investment in the MA Repay program with an expansion of the practice settings that are eligible for participation beyond the current settings to include health care professionals:
    - Providing behavioral health services on hospital medical and surgical floors and emergency departments;
    - Providing behavioral health assessment and treatment of children with co-occurring developmental needs;

    - Providing outpatient and community-based services, including hospital outpatient departments;
    - Working in substance use disorder (SUD) treatment settings; and
    - Providing behavioral health services and supports through programs run or contracted for by state agencies, including school-based providers;
- An extended timeframe for applications;
- Authorizing EOHHS to have the flexibility to spend the funds in accordance with the receipt of eligible applications in different provider categories, as well as settings and providers determined by EOHHS to have the highest need; and
- Funding for additional initiatives to recruit and retain: (1) providers who commit to working with justice-involved populations (2) providers in underserved and geographically isolated areas; and (3) providers of diverse race, ethnicity, sexual orientation, and gender identity who can provide linguistically and culturally tailored care.

Commission members expressed the importance of incentivizing providers to practice in settings that serve children and that serve older adults. Commissioners also noted that the first round of MA Repay only included Licensed Independent Clinical Social Workers ("LICSWs") and not Licensed Certified Social Workers ("LCSWs"). The Commission supports the inclusion of LCSWs and recommends correcting this omission in subsequent rounds.

Commission members also urge EOHHS to, where possible, consider average pay for comparable positions across behavioral health settings and settings with the highest need for behavioral health workers when determining how to prioritize total allocations to each provider type and setting.

Additionally, Commission members raised the need to promote loan repayment opportunities to all eligible providers in the Commonwealth, with an emphasis on reaching diverse providers, including those who speak languages other than English.

The Commission recommends an investment in the range of **$80 to $100 million**, of which **$2 to $5 million** should be specifically directed to providers serving justice-involved populations.

Recommendation 2: Scholarships

Findings

The Commission discussed the merits of scholarship programs versus loan repayment programs for individuals who face barriers to taking out loans. Commission members considered experiences in other states regarding effective design and implementation of scholarship programs. In the interest of putting the current funds to use as quickly as possible, a larger portion of the available monies was recommended for the existing loan repayment program. However, the Commission recognizes a robust scholarship program as a critical component to help diversify and strengthen the workforce. The Commission finds that the federal Health Resources and Services Administration ("HRSA") does not identify psychiatric shortage areas in Massachusetts for current scholarship programs and that a state-level scholarship program could be built around the federal program.

The Commission finds that a scholarship program must be thoughtfully designed around aspects such as the timeline of how payments are distributed and strategies to ensure a qualified job is available to scholarship recipients when they are ready to fulfill their commitment.

Recommendations

The Commission recommends that all efforts to bolster the behavioral health workforce should prioritize the recruitment and retention of a culturally, ethnically, and linguistically diverse workforce that reflects the diversity in the general population. The Commission further recommends creating and funding a scholarship program that:

- Enables colleges and universities to develop a workforce pipeline that provides a clear path to careers in behavioral health for individuals seeking bachelor's- and master's-level degrees;
- Prioritizes diverse applicants and placements in areas of highest need, including by engaging in recruiting efforts in underrepresented communities;
- Prioritizes current health care providers seeking career advancement through additional education, training, certification, or licensure;
- Makes scholarships for tuition, fees, and stipends available for those who commit to working in behavioral health roles in inpatient, outpatient, acute care, substance use disorder, and community- and clinic-based settings and state-run or state-contracted settings for a requisite amount of time based on licensure type and required training; and
- Considers non-traditional paths to entering the workforce, such as part-time work or career advancement efforts by current health care providers.

The Commission recommends an investment in the range of **$20 to $30 million**.

Recommendation 3: Paid Internships, Practicums, and Field Placements

Findings

The Commission finds that unpaid clinical hours required for field placements, internships, apprenticeships, and practicums necessary for completing degrees and obtaining licensure create barriers to entering and staying in the field for people without financial means.

Recommendations

The Commission recommends funding for historically unpaid positions for both bachelor's- and master's-level candidates training in the behavioral health field who agree to work in areas of high need. The Commission recommends that funding prioritize diverse applicants, including those who speak languages other than English, and placements in areas of highest need, as well as current health care providers seeking career advancement. Waitlist and patient flow data could be indicators of areas of highest need.

The Commission recommends an investment in the range of **$20 to $30 million.**

Recommendation 4: Reimburse for Clinical Supervision

Findings

The Commission finds that being expected to provide supervision without compensation contributes to health care providers feeling overburdened and leads to them leaving the field.

Recommendations

The Commission recommends funding stipends or bonuses for currently non-reimbursable time spent providing clinical supervision in both inpatient and community-based settings to students pursuing degrees in behavioral health and clinicians in training working toward licensure or certification.

The Commission recommends that funding prioritize supervision provided by and to diverse providers, including those who speak languages other than English, and providers in areas of highest need, as well as providers supervising current but unlicensed health care providers pursuing career advancement.

The Commission recommends an investment in the range of **$20 to 30 million.** An investment at this level is estimated to fund supervision for over 2,000 students and clinicians in training to pay community-based supervisors for the unreimbursed time spent providing supervision.

Recommendation 5: Professional Fees and Practice Costs

Findings

The Commission finds that covering one-time expenses, such as for exam preparation, license and certification fees, or continuing education, could be an incentive for providers to remain in settings serving high-need areas, particularly for diverse providers and current health care providers pursuing career advancement. Defraying these costs will increase the behavioral health workforce pipeline by reducing barriers to obtaining licensure and certification, which is necessary for both increasing the number of qualified clinicians as well as the number of clinicians who can provide supervision to future clinicians in training.

The Commission also finds that cumbersome licensure and certification processes may delay new licensure/certification and renewals, further eroding provider recruitment and retention.

Recommendations

The Commission recommends a pilot program or one-time spending initiative that gives health care employers flexibility to cover fees associated with training or practice costs for behavioral health providers. The Commission also recommends a study of licensure and certification processes and participation, including an analysis of demographics among licensed and certified behavioral health providers.

The Commission recommends an investment in the range of **$2 to 5 million**, prioritizing diverse providers and providers working in high-need areas.

Recommendation 6: Behavioral Health Support for Health Care Workers

Findings

The Commission finds that mental health and emotional support for health care workers is needed now more than ever to ensure satisfaction, well-being, and resiliency of the workforce.

Recommendations

The Commission recommends investing in programs that provide behavioral health support for health care workers, such as the MASStrong Pilot Program that provides evidence-based and

trauma-informed group peer behavioral health support to health care workers and provides small stipends to incentivize participation.

The Commission recommends an investment in the range of **$5 to 10 million** for these programs. An investment at this level would expand access to MASStrong to an estimated 5,000 to 10,000 additional health care workers.

Recommendation 7: Commercial Rate Analysis

Findings

The Commission finds that workforce challenges will remain without sufficient payment rates for behavioral health services.

Recommendations

The Commission recommends funding a comprehensive study, conducted or contracted for by the Health Policy Commission in consultation with the Division of Medical Assistance (MassHealth) and the Division of Insurance, relative to rates paid by private and public payors, including all contracted health insurers, health plans, health maintenance organizations, behavioral health management firms and third-party administrators under contract to a Medicaid managed care organization or primary care clinician plan, and their impact on access to high-quality behavioral health care in the Commonwealth. This study should produce findings on and implementation strategies to achieve the rate levels necessary to sustain an equitable, fully staffed, and competitively waged behavioral health system. Commission members emphasized the importance for this study to be completed expeditiously.

The Commission recommends an investment in the range of **$500,000 to $1 million**.

Recommendation 8: Youth and Schools

Findings

The Commission finds that transitional programs in schools successfully help students adjust back to their communities from medical or behavioral health hospitalizations and prolonged absences. This includes bridge programs like bryt interventions and other non-reimbursable school-based programs providing behavioral health services and supports to young people, as well as school-based programs partnering with community-based providers and workforce extender programs like the Massachusetts Child Psychiatry Access Program ("MCPAP").

Recommendations

The Commission recommends:

- Additional investment in transitional programs, with an expansion of eligibility to remove hospitalization as a requirement for participation in bridge programs;
- Additional investment in other non-reimbursable school-based programs providing behavioral health services and supports to young people; and
- The expansion of transitional and other school-based behavioral health programs with a focus on geographic equity to ensure these resources are available to students throughout the Commonwealth.

The Commission recommends an investment in the range of **$5 to $10 million**.

Appendix A

Documents Related to Commission Activities

Subsection 1: Minutes of the First Commission Meeting

Subsection 2: Presentation and Minutes of the Second Commission Meeting

Subsection 3: Presentation and Minutes of the Third Commission Meeting

Subsection 4: Presentation and Minutes of the Fourth Commission Meeting

Subsection 5: Minutes of the Fifth/Final Commission Meeting

Subsection 1

Minutes of the First Commission Meeting

Behavioral Health Advisory Meeting Minutes

Wednesday, November 9, 2022
12:00PM - 1:30PM

Event Description

This was the first meeting of the Behavioral Health Advisory Commission established by Chapter 77 of the Acts of 2022. This meeting was livestreamed and recorded online.

Commission Members Present

- **Representative Adrian Madaro**, **Chair,** Joint Committee on Mental Health, Substance Use and Recovery
- **Senator Julian Cyr, Chair,** Joint Committee on Mental Health, Substance Use and Recovery
- **Secretary Marylou Sudders**, Executive Office of Health and Human Services
- **Representative Matthew Muratore**, 1st Plymouth District
- **Eric Masi**, President and CEO of Wayside Youth & Family Support Network
- **Dr. Charles Clayton Daniels, Jr.**, Chief Executive Officer, Fathers' UpLift, Inc.
- **Margaret Weiss**, Director of Clinical Research, Cambridge Health Alliance
- **Amara Anosike**, Director of Behavioral Health Policy & Advocacy, Boston Children's Hospital
- **Dr. Debra Pinals**, Behavioral Health System and Forensic Psychiatric Consultant and Adjunct Clinical Professor of Psychiatry, University of Michigan Medical School
- **Scune Carrington**, Director of Integrated Care, Massachusetts League of Community Health Centers
- **Danna Mauch**, President and CEO, Massachusetts Association for Mental Health (MAMH)
- **Lydia Conley**, President and CEO, Association for Behavioral Healthcare
- **Jacqueline Hubbard**, Policy Director, NAMI
- **David Matteodo**, Executive Director, Massachusetts Association of Behavioral Health Systems
- **Maryanne Frangules**, Executive Director, Massachusetts Organization for Addiction Recovery (MOAR)
- **Rebekah Gewirtz**, Executive Director, NASW-MA
- **Steve Walsh**, President and CEO, Massachusetts Health & Hospital Association
- **Rocio Calvo**, Associate Professor of Global Practice at the Boston College School of Social Work and Director of the Latinx Leadership Initiative (LLI)
- **Dr. Elsie Taveras**, Chief of the Division of General Academic Pediatrics and Executive Director of the Kraft Center for Community Health at Massachusetts General Hospital

Commission Members Absent

- **Senator Sonia Chang-Diaz**, Chair, Racial Equity, Civil Rights, and Inclusion
- **Representative Bud Williams,** Chair, Racial Equity, Civil Rights, and Inclusion

Agenda

I. Welcome from the Chairs
II. Introduction of Commission Members
III. Review of Commission's Charge
IV. Commission Open Discussion and Preliminary Suggestions
V. Future Meetings

Welcome from the Chairs

The Commission has been charged with making recommendations to the General Court on how to distribute funds from the Behavioral Health Trust Fund. The Trust Fund was allocated $198 million of federal funds from the American Rescue Plan Act (ARPA). Our Commonwealth is experiencing a behavioral health crisis, exacerbated by the COVID-19 pandemic. *An Act Addressing Barriers to Care for Mental Health* (ABC 2.0) is now in effect because more than 90 days have passed since its signing by Governor Baker. The Chairs hope to use the Behavioral Health Trust Fund to build on legislative reforms to invest in the workforce, emergency response initiatives, programs around continuing care, and health equity in the behavioral health space.

Introduction to Commission Members

Chair Madaro called on Commission members and invited them to briefly introduce themselves.

Review of the Commission's Charge

Chair Cyr reviewed the charge of the Commission as outlined in Chapter 77 of the Acts of 2022, reminding Commission members that the Commission is tasked with identifying and assessing:

i. Current behavioral health (BH) workforce challenges
ii. Factors that create or perpetuate disparities in BH care (including but not limited to race, ethnicity, language, gender, sexual orientation, gender identity, and barriers to access for LGBTQ+ individuals)
iii. Economic barriers to people receiving treatment
iv. Access to early intervention services
v. Diversion for people with mental illness and substance use disorder (SUD) from the criminal legal system
vi. Access to community-based services
vii. The feasibility of increasing the BH competency of staff through training, in both BH settings and non-BH settings (such as Emergency Departments)
viii. Diversion from the juvenile justice system
ix. How people with mental illness or SUD are treated by the criminal justice system
x. The feasibility of increasing the BH competency of staff through training in nonhospital settings (such as group homes and skilled nursing facilities)
xi. Any other factors the Commission deems relevant for addressing the delivery of equitable, culturally competent, affordable, and clinically appropriate continuum of BH care and services

The Commission is directed to make recommendations for the disbursement of the money in the fund based on these findings, and to prioritize the needs of communities disproportionately impacted by COVID-19.

Open Discussion and Preliminary Suggestions

Chair Madaro opened the discussion and allowed Commission members to share preliminary suggestions and ideas on how funds should be disbursed.

Eric Masi
Eric shared his perspective as someone representing a community mental health center (CMHC) active in assisting kids and young adults. Eric shared the following workforce challenges:

- Biggest challenge is that CMHCs can recruit but struggle to retain workers
- They provide the first job for many people out of college or graduate school
- CMHCs serve as a training ground for the BH care system, but they have a hard time helping folks see a career with them
    - If they can get folks to stay 3-4 years, a promotion happens, and they can then see a path for themselves
- They lose far too many people to group practices and nationwide telehealth companies where clinicians make more money and carry a lighter caseload
- Community health centers serve to clear the intensity and acuity in the public sector
- Workforce enhancements have helped

Lydia Conley

- People enter employment with ABH members to be trained to become BH clinicians and then often go to other settings
- ABH members are a feeder pipeline to the behavioral workforce
- Lydia identified the following issues in clinic-based settings:
    - More workers are leaving than coming in
    - Hoping to see strategic evaluation of the role that clinics and the community-system play in feeding the pipeline for the entire health care delivery system

Rocío Calvo
Spoke about workforce challenges from the perspective of Latino, bilingual, and bicultural social workers and identified the following:

- **Retention issues** (disclaimer: received funding and have tried to find out why people are leaving)
    - People don't see a path forward because they don't have culturally and linguistically relevant supervision
    - Many clinicians in training feel that they are brought to community centers to decrease the waiting list (necessary) but that their personal career development is not on the table from the get-go
    - Many people don't have their licenses and need to take exams for licensure. BC is training social workers to get their licenses and take exams in school
    - Clinical settings need to provide bilingual, multicultural supervision. She currently has supervisors across the state through her program
- Relatively low compensation continues to be a challenge in retaining clinicians in community-based settings

Dr. Charles Daniels
Dr. Daniels mentioned staff are being poached from community-based organizations to larger organizations within MA through hiring recruiters. This makes it difficult for smaller organizations to compete and build expertise that is beneficial to communities being served. Smaller organizations need to get creative about their benefits packages to retain staff, including through the provision of bonuses.

Additionally, Dr. Daniels highlighted the shortage of clinicians working with men and women behind bars or re-entering the community, especially Black and brown men. There are little to no incentives to work with this population. The shortage highlights the demand for care and service,

and the shortage of clinicians with time, expertise, and financial capability to work with this population. He highlighted the opportunity to build up this workforce.

To address the shortage of clinicians, Dr. Daniels believes it is imperative to start talking to high school students before they graduate about prospective careers in BH. Many kids want to make a difference but are not sure how. Dr. Daniels would like to think about how to interweave BH into their curriculums and expose high school students early on through preparation programs. He would like these programs and opportunities to show students how they can contribute to their communities before graduation.

David Matteodo
David highlighted challenges within the inpatient psychiatric system. He mentioned the following workforce challenges:

- A third of all psychiatric beds are offline
- 3000 licensed beds in MA (not including DMH continuing care beds) and we're running on average about 2,400 beds
    - **Approximately 500 beds are offline due to staffing shortage**
- ~600 people are boarding in emergency rooms
- There is incredible demand that cannot be met
- Patient acuity increases make it harder to retain staff

Additionally, he mentioned that the flow of patients creates challenges. Inpatient psychiatric facilities are responsible for helping move patients through the system, and there are hundreds of patients that could be in more appropriate settings. However, there are bottlenecks for continuing care beds through DMH.

Rebekah Gewirtz
She believes the Latinx social work group at Boston College is doing great work. She believes social workers are on the front lines, undervalued, overtaxed, and underpaid. Social workers start weighing their options and evaluating how long they can hold up society without properly being reimbursed and receiving a proper salary. Rebekah would like to explore ways we can incentivize entities and organizations to raise up the social workforce specifically. She believes social workers have a holistic view of the person and the environment and are great advocates for clients and policy changes.

She identifies burnout as a major challenge. It's difficult to hire social workers. Once people achieve the highest certification – LICSW – they may want to leave health care settings and clinics and pursue something else. Rebekah asks us to consider:

- How are we incentivizing LICSWs to stay?
- Continuing credits for supervising LCSWs
- Initiatives to address unpaid field placements in social work (because it’s difficult for people to enter and remain if they don't already have financial security)
- Additional scholarships and loan forgiveness (Mass League is opening up to LCSWs which is incredible but what else are we doing?)
- More opportunities to students from historically marginalized communities to be able to pursue social work
- Focus on social workers

Amara Anosike
Boston Children's sees about a third of the state's pediatric boarders. Children get stuck with nowhere to go after being in an inpatient unit. They are experiencing workforce issues, including a shortage of social workers, psychiatrists, psychologists, psychiatric nurse practitioners, and

sitters. Sometimes, overtime needs to be paid to nurses so that patients are safe in emergency departments or inpatient settings due to a shortage of sitters. Amara proposed the following:

- Provide more enhanced crisis stabilization services and adequately reimburse for those services
- Loan-repayment, grants, scholarships, and support for diversionary programs
- Provide support for aspiring BH professionals before they have loan payments
- Increase funding and availability of school-based BH services
- Train non-specialists to assist individuals with mild to moderate BH conditions
- Increase access to continuing care and group homes
- Support children in their homes, schools, and communities

Scune Carrington

Scune highlighted the challenges in the journey to licensure for Black and brown social workers. Exams and licensure are costly. Black and brown test takers typically have more costly experiences as they face additional barriers to passing the exam on the first try. Each exam has a fee. If aspiring Black and brown social workers struggle to pass the licensing exam, then it's difficult to diversify the field. This impacts health centers because they may lose workers who are unable to become credentialed. Scune shared a story of an individual in Western Massachusetts. The individual spent 4 years going through credentialing process. It was discouraging for them. Scune would like the Commission to consider advocating for policy changes that allow clinical settings to retain BH workers who do not pass licensing exams instead of firing them.

Dr. Pinals

Some of Dr. Pinals' comments were inaudible. Dr. Pinals thanked prior legislators for their assistance in developing her career. She asked the Commission to consider the use of DMH and training grants for other disciplines and for giving people early exposure to mission-driven careers in BH. Dr. Pinals also believes we need mid-level to senior-level supervisors who are knowledgeable and to adequately pay supervisors for their time. We also need a diverse pool of supervisors to allow aspiring BH professionals to see themselves in the field. She believes we do not have enough BH professionals working in the criminal legal system. She encourages the Commission to pursue credentialing consolidation where possible to lessen the burden of paperwork on aspiring BH professionals.

Maryanne Frangules

Maryanne discussed workforce issues. She believes those currently in the workforce with lived experience are essential. She would like the Commission to consider building a lasting strategy to bolster the BH workforce. She believes people from marginalized communities, who have experienced racial health disparities, should receive the help they need if they want to start programs to serve those with BH needs. Namely, we should offer them technical assistance with navigating governmental agencies and departments. Individuals from marginalized backgrounds often want to help their own communities from a peer level. There also needs to be a warm hand-off for those transitioning to continuing care programs and assistance with transportation.

Dr. Taveras

Dr. Taveras proposes substantial investments in community partners to expand and invest in the BH workforce. Central in our inability to meet access is our workforce. She also proposes community investments, including loan-repayment, scholarships, stipends to work in community-based settings, and assistance with living expenses. She encourages the Commission to think about how to build the pipeline in a diverse way.

As we think about expanding services and emergency response services, Dr. Taveras notes that pediatric mental health (MH) is huge crisis. She proposes making investments in urgent care and urgent support systems in the pediatric community. Children are struggling. She encourages community embeddedness for some of the services offered, including upscaling community health care workers and upscaling peer-support/recovery coaches. She says that if we want to increase services for ethnic minorities, underserved minorities, and BIPOC individuals then we need to bring clinical services to the community.

She encourages the Commission to think about innovation in the digital space. She suggests we can increase access to BH by bringing underserved populations into the digital space.

Danna Mauch
Danna says we must link service development closely to housing. If we're to stabilize people and prevent future crises, then these investments are critical to make. Plans to develop youth access centers is something we should accelerate. Peer-run services should be accelerated as well. Scholarships are critical to creating opportunity to people. Targeting students from linguistically and culturally diverse communities and offering them opportunities and inviting them into our field would make a big difference.

She encourages the Commission to consider removing economic barriers for families with fewer means to access treatment and care and to study the intersection of the BH and criminal legal systems. We are fortunate in MA to have a platform established for bidding out the expansion of diversion services. We need to build on these platforms. Evidence-based models have already been adopted in MA but not on a wide-scale. She would also like to see investments in reentry.

Dr. Daniels
A lot of interventions that have been created by POC for their communities do not fit in the evidence-based label. Dr. Daniels asks how we can adopt these models as a state for communities of color, since acceptance by the state affects funding. Dr. Daniels would like these programs to receive the same support as models that do fit the evidence-based mold due to disparities in outcomes.

Dr. Daniels also spoke about “parking-lot dads” or fathers who were unable to attend prenatal doctor’s visits with their spouses during the COVID-19 pandemic. They were forced to view their newborn children through their phones, and they could not be present. This has affected their wellbeing. Dr. Daniels asks how we can provide care for these fathers through MH support. Reimbursement for MH supports for new fathers is a challenge.

Dr. Daniels is seeing a large and unmet demand for Black and brown clinicians. Black and brown clinicians already have high caseloads and no space to take on other individuals who are specifically requesting of someone of color. Some individuals do not want treatment if their clinician isn't Black or brown, which affects their care. Dr. Daniels asks how we can target Black and brown clinicians going through the pipeline.

Dr. Daniels proposes additional support for clinicians and the peer-to-peer workforce. We need more resources, self-care opportunities, and care for our providers. There is funding for loan forgiveness in clinician shortage areas like Cape Cod. Dr. Daniels would like to expand that to other shortage areas and reidentify where those shortage areas exist. He also would like the Commission to examine stronger reimbursements for smaller organizations and group-practices. They are providing many services that are not billable to traditional payors. These services include food, clothing, child-care, advocacy and more.

Steve Walsh

Steve Walsh urges the Commission to act quickly and make immediate workforce investments in areas experiencing crises. These ARPA dollars were intentionally established as a trust fund that can be repopulated with additional funds. The existing funds should be spent to address the current crisis we are in, including immediate and pipeline workforce investments and repopulate the trust for additional needs. He wishes to see an initial focus on retention and recruitment for employees today across all behavioral health settings.

Secretary Sudders
Her comments were mostly inaudible to members of the Commission due to her connection. However, the Secretary expressed her gratitude for scholarship programs that enabled her to enter the public sector as a social worker. She also believes the Commission should act quickly to make investments.

Lydia Conley
She would like the Commission to produce or find an inventory of existing student loan programs. She would like to Commission to investigate the opportunity to get into the scholarship, tuition-reimbursement space. The MassHealth Section 1115 waiver included a lot of the issues and proposals being discussed that could possibly be replicated. She highlights the need to review reimbursement for supervision.

Eric Masi
Mental health professionals are overloaded. Productivity expectations are significant. There needs to be a method to show BH professionals that they are on track to career growth, including through opportunities to write papers, provide supervision, or engage in a sabbatical.

He also proposes reaching out to high school and middle school students and offering scholarships to allow them to see this as a field. He proposes expanding opportunities for a future without debt for aspiring BH professionals. He asks: How do we get people out of hospitals? How do we support MH staff and community partners?

Dr. Weiss
There is a tremendous increase and acuity on the inpatient units. There are staff injuries and nursing shortage. There is a neurodevelopmental disorder response shortage. That's why the development of appropriate services is essential.

In Canada, peer-run program in communities have a huge upstream effect and delivers care in the community within the cultural and linguistic parameters of the population.

She highlights the importance of school-based programs.

Jacqueline Hubbard
- We are crushing people by not providing support for people that are aging.
- Housing and homelessness need to be addressed.
- DC has programs that train peers to work in group homes and assisted living facilities.
- Proposes involving peers at the beginning of the plan to bring in their perspectives.

<u>Chair Cyr's Closing Remarks and Announcements</u>
This is a Special Commission. The Commission will hold at least one more meeting, possibly two, before the end of the calendar. The Commission is accepting written testimony via email.

Minutes taken by Jessica Martinez, Legislative Aide for Chair Adrian C. Madaro

Subsection 2

Presentation and Minutes of the Second Commission Meeting

Summary of the First Behavioral Health Advisory Commission Meeting

November 28, 2022

Topics for Discussion

1. Common Themes/Topics identified by Commission Members, including:
    a. ***Workforce Recruitment***
    b. ***Workforce Retention***
    c. Delivery System Improvements to address Service Access, Availability, and Quality
        i. NOTE: this topic will be discussed at the next Commission meeting
2. For each topic, we'll discuss:
    a. Issues identified by Commission Members
    b. Solutions/initiatives proposed by Commission members
    c. Allocated funds for programs/initiatives (i.e., FY23 budget, EcoDev, ARPA, etc.)
    d. Current programs/initiatives already in place/underway

Topic #1 - Workforce Recruitment

Statutory Charges related to Workforce Recruitment

The Commission is directed to identify and assess current behavioral health (BH) workforce challenges, including:

- Existing workforce pipeline issues
- The feasibility of grant, scholarship and other pipeline development programs that mitigate the financial burdens of entering and progressing up the BH workforce pipeline to support workers pursuing tertiary degrees and for those that do not require advanced degrees

Issues Identified - Workforce Recruitment

1. Extreme **shortages** in healthcare providers (HCPs) entering the field
    a. NOTE: Not just those with advanced degrees, specialty training, or licensure - also basic care staff (e.g., sitters)
    b. Particular shortages of **diverse HCPs**
2. Difficulty in **recruitment and retention** of clinicians, because:
    a. The path to entering the BH workforce/field is ***expensive***
        i. Can't afford education costs, clinical placements/cost of living, etc.
    b. ***Barriers to obtaining certification/licensure*** (bottleneck/disparities with costly exams)
        i. The credentialing process can be long and many clinicians cannot afford to wait it out or become too disheartened to stay
    c. Lack of clinicians who can ***supervise*** those seeking supervised hours
        i. Particularly for diverse clinicians seeking supervision from diverse superiors

Proposed Solutions - Workforce Recruitment

#1 - Target Young People to Expand the Workforce Pipeline

- Presenting **BH care career options** to middle school and high school students prior to graduation
- Enhance **preparation and vocational training** for BH care

Proposed Solutions - Workforce Recruitment

#2 - Defray the Cost of Education

- Loan relief is effective to a point
- Front-end solutions are also needed, including:
  - Scholarships, grants, & other **low-debt/debt-free education** options
  - **Non-traditional grants/stipends** (e.g., for living expenses and other costs associated with obtaining certification/licensure)
  - Incentives for organizations to **increase salaries**, encouraging more would-be HCPs to enter the field knowing a career in healthcare will support them and their families

Proposed Solutions - Workforce Recruitment

#3 - Ensure Workforce Diversity, including People with Lived Experience

- Enhance front-end investments for **diverse candidates** and candidates who commit to **working with underserved populations**
- Invest in programs that create an **employment pipeline for peers**
- Consider **administrative literacy programs** that assist HCPs with navigating bureaucracy (e.g., licensure, certification, insurance, business models, etc.)

Current FY23 Investments - Workforce Recruitment

FY23 Budget

- *Line Item 4513-2020*: several carve-outs for workforce initiatives, including **$500K** for a MH workforce pipeline program
- *Line Item 4512-0200* [BSAS]: **$9M** in carve-outs to address the SUD workforce crisis, including **$3M** for technical assistance and training to increase the number of providers delivering culturally, ethnically and linguistically diverse services in communities of color
- *Line Item 4000-0020*: **$1M** for the nursing and allied health workforce development initiative to increase the number of students entering the field
- *Line Item 1410-0075*: **$275K** for the Train Vets to Treat Vets Program, a BH career development program for returning veterans

Eco-Dev

- *Line Item 1599-6087*: **$50M** to support scholarships for students seeking a degree in high-demand fields, including healthcare and nursing in particular
- *Line Item 7009-7477*: **$2.5M** for a nursing workforce pipeline grant program

Current/Existing Initiatives - Workforce Recruitment

- **DMH Residency Training Grants**
  - Consider expanding to other disciplines
- **Strategic clinical partnerships (e.g. Boston College and Bridgewater State Hospital)**
  - Consider expanding to other client populations with specialized needs
  - Consider expanding to ensure more equitable geographic distribution of providers
- **Loan Repayment Programs (discussed further in the next topic)**
  - ARPA - $110M for HCPs working in CHCs, CMHCs, and inpatient settings
  - ARPA - $15M for SUD providers working in community-based settings
  - The Administration's Behavioral Health Roadmap also includes proposed loan repayment incentives for practitioners with "diverse cultural, racial, ethnic, and linguistic backgrounds and competence"

Questions for Discussion - Workforce Recruitment

- What, if any, additional initiatives or programs are currently in place or in the process of being implemented that seek to address the problem of workforce recruitment?
- Of the existing programs and initiatives to address workforce recruitment, are there professions, providers, or specific groups that do not have access to these or any similar programs or initiatives?
- Are there any additional initiatives or programs not discussed today that could address workforce recruitment?

Topic #2 - Workforce Retention

Statutory Charges related to Workforce Retention

The Commission is directed to identify and assess current BH workforce challenges, including:

- Emerging workforce needs
- The feasibility of grant, scholarship and other pipeline development programs that mitigate the financial burdens of entering and progressing up the BH workforce pipeline
- Programs to ensure retention of current BH workforce
- The availability of trauma-informed supports and services for BH practitioners and related staff

Issues Identified - Workforce Retention

1. **Shortages:** More HCPs are leaving the field than entering
    a. Many HCPs are leaving the BH field entirely, due to conditions or simply aging
    b. Shortages are particularly acute for HCPs working with specific populations that require specialized training (e.g., youth, people behind bars)
2. **Career Stagnation:** Limited pathways for career development/advancement
    a. HCPs obtain full licensure/certification then leave for higher paying opportunities
3. **Conditions:** HCPs are overworked, underpaid, and lack incentives to stay
    a. Public sector/non-profit organizations that rely heavily on public reimbursement serve as training grounds for HCPs who then leave for higher paying positions at larger, national, and/or private organizations
    b. High caseloads (particularly for clinicians of color)
    c. Increasing acuity

Workforce Retention - Proposed Solutions

1. Provide **financial and other incentives** to encourage HCPs to stay
   a. Grants, stipends, and loan forgiveness
   b. Expand loan forgiveness opportunities in state-identified "shortage areas"
   c. Continuing education opportunities
   d. Revisit/increase reimbursement rates, particularly to support smaller organizations
2. Invest in **non-traditional grants/stipends** to retain HCPs
   a. Reimburse mentoring and supervising expenses
   b. Provide free continuing education credits for supervising lower-level clinicians
3. Provide more **advancement opportunities**
4. Create **networks of expertise** (multi-disciplinary consultation)
5. Invest in the **mental health of the workforce** - both clinicians and peers
   a. Provide incentives to employers for giving mental health breaks/addressing staff self-care

Current FY23 Investments - Workforce Retention

FY23 Budget

- *Line Item 4513-2020*: carve-outs for workforce initiatives, including **$5.5M** for a loan forgiveness program and **$2.5M** to address ED boarding through staffing investments and rate incentives
- *Line Item 5095-0017*: **$20M** for loan forgiveness/tuition reimbursement for DMH clinical BH workers
- *Line Item 4512-0200* [BSAS]: **$9M** in carve-outs to address the SUD workforce crisis

Chapter 257 Rate Reserve

- *FY23 Budget Line Item 1599-6903*: **$230M** to fund the cost of the reserve and costs of using an updated rate methodology
- *Eco Dev Line Item 1599-6066*: **$225M** to enhance payments to providers, with **$100M** to be provided in FY23 solely to increase payments to direct care, front-line and medical/clinical staff

Summary of Loan Repayment Programs

- **Massachusetts Loan Repayment Program (MLRP)**
  - Overview of the program and who can apply
- **Student Loan Repayment Program (SLRP)**
  - Overview of eligible workers, loan repayment amount, and other program information
- **Loan Repayment Program for Health and Human Service Professionals**
  - Overview of eligibility requirements, award amounts, prioritized workers and other information around the program

Questions for Discussion - Workforce Retention

- Are there any additional issues related to workforce retention?
- Of the existing programs and initiatives to address workforce retention, are there professions, providers, or specific groups that do not have access to these or any similar programs or initiatives?
- What, if any, additional initiatives or programs are currently in place or in the process of being implemented that seek to address the problem of workforce retention?
- Are there any additional initiatives or programs not discussed today that could address workforce retention?

Next Commission Meeting Discussion Topic:

Delivery System Improvements to address Service Access, Availability, and Quality

Date TBD

Behavioral Health Advisory Meeting Minutes

Wednesday, November 28, 2022
1:00PM - 2:30PM

Event Description

This was the second meeting of the Behavioral Health Advisory Commission established by Chapter 77 of the Acts of 2022. This meeting was livestreamed and recorded.

Commission Members Present

- **Representative Adrian Madaro**, **Chair,** Joint Committee on Mental Health, Substance Use and Recovery
- **Senator Julian Cyr, Chair,** Joint Committee on Mental Health, Substance Use and Recovery
- **Secretary Marylou Sudders**, Executive Office of Health and Human Services
- **Representative Matthew Muratore**, 1st Plymouth District
- **Eric Masi**, President and CEO of Wayside Youth & Family Support Network
- **Dr. Charles Clayton Daniels, Jr.**, Chief Executive Officer, Fathers' UpLift, Inc.
- **Margaret Weiss**, Director of Clinical Research, Cambridge Health Alliance
- **Amara Anosike**, Director of Behavioral Health Policy & Advocacy, Boston Children's Hospital
- **Dr. Debra Pinals**, Behavioral Health System and Forensic Psychiatric Consultant and Adjunct Clinical Professor of Psychiatry, University of Michigan Medical School
- **Scune Carrington**, Director of Integrated Care, Massachusetts League of Community Health Centers
- **Danna Mauch**, President and CEO, Massachusetts Association for Mental Health (MAMH)
- **Lydia Conley**, President and CEO, Association for Behavioral Healthcare
- **Jacqueline Hubbard**, Policy Director, NAMI
- **David Matteodo**, Executive Director, Massachusetts Association of Behavioral Health Systems
- **Maryanne Frangules**, Executive Director, Massachusetts Organization for Addiction Recovery (MOAR)
- **Rebekah Gewirtz**, Executive Director, NASW-MA
- **Steve Walsh**, President and CEO, Massachusetts Health & Hospital Association
- **Rocio Calvo**, Associate Professor of Global Practice at the Boston College School of Social Work and Director of the Latinx Leadership Initiative (LLI)

Commission Members Absent

- **Senator Sonia Chang-Diaz**, Chair, Racial Equity, Civil Rights, and Inclusion
- **Representative Bud Williams,** Chair, Racial Equity, Civil Rights, and Inclusion
- **Dr. Elsie Taveras**, Chief of the Division of General Academic Pediatrics and Executive Director of the Kraft Center for Community Health at Massachusetts General Hospital

Welcome from the Chairs

Recap of First Meeting

Workforce Recruitment: Chair Madaro reviewed common themes identified by Commissioners related to shortage of providers across all licensure types and challenges in recruiting.

Challenges: Specific challenges identified included the high cost of education/training, barriers to certification and licensure, and a lack of supervision/supervisors.

Proposed solutions:

1. Reaching younger people with opportunities and encouragement to enter the behavioral health field.
2. Defraying the cost of education. Loan forgiveness programs are effective to a point but, front-end solutions such as scholarships, low debt/debt free education, non-traditional grants (i.e., for living expenses, costs associated with certification and licensure), and higher salaries are recommended.
3. Ensure workforce diversity, including people with lived experience by enhancing front-end investments for diverse candidates and for those who commit to working with underserved populations, creating employment pipelines for peers, and developing programs that assist health care providers in navigating bureaucracy (i.e., licensure, certification, insurance etc.)

Current Funding Opportunities and Programs: Commission materials reviewed specific investments made through the FY23 state budget and the Economic Development bill to bolster the workforce. These include DMH residency grants, strategic clinical partnerships and loan repayment programs.

Discussion:

What, if any, additional initiatives or programs are currently in place or in the process of being implemented that seek to address the problem of workforce recruitment?

- The administration came out with a retention initiative with $130 million.
- Several Commissioners urged swift action to increase the pipeline.
- Commissioners reiterated the benefit of scholarships and suggested investment in programs that can accelerate the process as quickly as possible such as trainings that are shorter-term such as those for LPNs, CNAs, and LMHCs.
- William James College has a program that reduces tuition for those seeking an LMHC degree.
- New workers to the behavioral health field are overwhelmed by the intensity and acuity and need supervision.
- It is important to pay for supervision time and for unpaid internships (especially for social work practicums). Supervision hours should count toward continuing education requirements.
- Management development and leadership training programs are needed also.
- We can look to other states for ideas.

- Michigan and California have proposals for paid programs for social work and mental health workers to pay students for field placements in areas of high need (i.e., working with older people, working with children etc.) as determined by the state.
- RI has eliminated the master's level test for social workers. This is a cost neutral proposal.
- MA Rehab has been critical in bringing people in recovery into the workforce and this could be something to build on.
- Sunsetting DSRIP program had specialty training and supervision programs that could serve as models as well as organizations that are doing this work like Accelerating the Future and The Boston Foundation.
- The importance of peer supports was also stressed.

Of the existing programs and initiatives to address workforce recruitment, are there professions, providers, or specific groups that do not have access to these or any similar programs or initiatives?

- We could help incarcerated individuals with their transition and utilize their diverse personal experiences to make a difference.
- We should tailor programs for the different needs in rural communities.
- It was noted that nurses are not represented on the Commission. Several Commissioners stressed the need to build the capacity of nurses and nurse practitioners trained in mental health as "physician extenders."
- The importance of working with children was raised and it was suggested that bolstering the workforce for kids should be looked at differently, across all licensure types. An example of the need for training and services for neurodevelopmental disorders and the current waitlist for services being so long that it becomes meaningless for a condition that needs timely treatment was given as an example of the type of consequences present when considering care for children.
- We should be looking at LADCs and recovery coaches as well.

Are there any additional initiatives or programs not discussed today that could address workforce recruitment?

- Signage/public announcements, job postings, public education campaigns; must be on the social media platforms that young people use (ie. TikTok). Both money and intentionality are needed.
- It was noted that FY23 had $1million for public awareness campaign for behavioral health workforce opportunities and we could follow up to see how that has rolled out.
- Recruiting of young people in college, and even younger (high school, middle school) through school curriculum, summer internships.
- Health benefits, child-care, transportation, flexible schedules are all ways to incentivize workers.

Workforce Retention

Chair Cyr reviewed common themes identified by Commissioners related to shortage of providers across all licensure types and challenges in workforce retention.

Challenges: Specific challenges identified included career stagnation, and conditions of being overworked and underpaid.

Proposed solutions:

1. Financial incentives
2. Non-traditional grants (i.e., for living expenses, costs associated with certification and licensure)
3. Advancement opportunities
4. Networks of expertise (Programs to support non-specialists in the community to handle mild to moderate conditions and alleviate pressure on specialists.)

Current Funding Opportunities and Programs: Commission materials reviewed FY23 state budget, Chapter 257 Rate Reserve investments, and existing loan repayment programs.

Discussion:

Are there any additional issues related to workforce retention?

- Providers leaving because they felt pressure to change their practice styles to meet the needs of patients in the context of a provider shortage. Training for providers to learn evidenced-based short term models of care was one successful strategy.

Of the existing programs and initiatives to address workforce retention, are there professions, providers, or specific groups that do not have access to these or any similar programs or initiatives?

- Suggestion of the MCPAP model for schools. MCPAP is a great model when providers know to use it – maybe we need to promote it more?
- DMH ED Diversion program has been successful in diverting children home with community-based supports.

What, if any, additional initiatives or programs are currently in place or in the process of being implemented that seek to address the problem of workforce retention?

- $130 million program that is being administered by MA League of Community Health Centers for recruitment and retention could be good model.
- During the pandemic the $31 million from EOHHS to retain employees saved the inpatient psychiatric hospital system. It was closely monitored and audited.
- Again, sunsetting DSRIP programs may provide models.

Are there any additional initiatives or programs not discussed today that could address workforce retention?

- Helpers need help too. Mental health services for practitioners.
- How were the organizations that have loan repayment programs decided and who is missing? Broadening the list and identifying gaps would be helpful.
- Correctional sites are left out.

- Behavioral health providers who are treating kids boarding on medical floors can't take advantage of the current ARPA funding that is focused on primary care providers and inpatient units.
- Parents of children with emotional disturbances having trouble working because of the needs of the children.
- Again, health benefits, child-care, transportation, and flexible schedules are all ways to incentivize workers, but staff also stay for their peers and colleagues. Whatever we can do to let people have time and space to connect and get the critical support from their colleagues would help with retention.

Chairs' Closing Remarks and Announcements

Chair Cyr observed that the overarching theme is swiftness. This work will take the form of recommendations to the Legislature, and we want to be ready to go early in the session. He renewed the request for specific proposals from the Commissioners and from other groups,

The next meeting is scheduled for December 19 at 1PM where we need to discuss health equity as part of our mandate. He would like to establish a deadline that proposals be due and suggested it be by the end of that week (which would be December 23). Staff will begin to prepare an inventory of proposals received.

Chair Madaro reminded Commissioners that the next discussion will focus on the behavioral health delivery system and how to improve quality and access to underserved communities before closing the meeting.

Subsection 3

Presentation and Minutes of the Third Commission Meeting

Summary of the First BH Advisory Commission Meeting

November 28, 2022

Topics for Discussion

1. Common Themes/Topics identified by Commission Members, including:
   a. Workforce Recruitment and Retention (discussed at the last Commission meeting)
   b. Delivery System Improvements to address Service Access, Availability, and Quality

1. Today, we'll discuss:
   b. Issues with the Delivery System identified by Commission Members
   c. Solutions/initiatives proposed by Commission members that address service access, availability, and/or quality
   d. Allocated funds for programs/initiatives addressing service access, availability, and/or quality (i.e., FY23 budget, EcoDev, ARPA, etc.)
   e. Current programs/initiatives addressing service access, availability, and/or quality already in place/underway

Topic #3 - Delivery System Issues (Access, Availability, and Quality)

Statutory Charges related to the BH Delivery System

The Commission is directed to identify and assess:	
Barriers to care, including:	• Factors that create or perpetuate disparities in BH care including race, ethnicity, language, gender, sexual orientation, gender identity and barriers to access for LGBTQ+ individuals • Economic barriers to treatment
Access to care, including:	• Access to early intervention services • Access to community-based services
MH/SUD care and diversion of people with MH/SUD in the **criminal legal system**, including:	• Diversion for people with MH/SUD from the criminal legal system • Diversion from the juvenile justice system • Treatment for people with MH/SUD who are incarcerated or under supervision by the criminal justice system
Workforce-based system improvements, including:	• The feasibility of increasing BH competency of staff in BH settings and settings where there are frequent interactions with patients with BH diagnoses • The feasibility of training programs to increase the BH competency for workforce in non-hospital settings, including group homes and skilled nursing facilities, to allow patients to receive baseline BH services where they are living

Issues Identified - BH Delivery System

1. Compromised **Patient Flow** through the System
    a. Patients get stuck at every level of care (e.g., ED boarding because no inpatient beds, then waiting in inappropriate/too-acute beds because nowhere to safely discharge to)
    b. Particularly an issue with pediatric boarding
2. Lack of **Services** in Non-Hospital Settings
3. Insufficient **Diversion** from Inpatient and Carceral Settings

<u>Underlying Issue</u>: ***Workforce shortages contribute to many - if not most - of the issues with the BH delivery system***

Proposed Solutions - BH Delivery System

#1 - Improve Patient Flow Through the System

- Focus on **continuing care** at every level of care
- Ensure **warm hand-offs** throughout the continuum of care, particularly with transportation
- Fund programs that **increase BH care and services in primary care settings** through:
    - Training opportunities for non-specialists and PCPs; and
    - Integration of BH specialists into primary care practices/settings

Proposed Solutions - BH Delivery System

#2 - Increase Services in Non-Hospital Settings

- Invest in **BH urgent care** and other community-focused services
- Invest in **innovation** in care provision, including training and education on providing and seeking digital care
- Fund **school-based BH programs**
- Address all **social determinants of health**, particularly housing
- Focus on **evidence-based interventions** and revisit what "evidence-based" can/should mean, particularly within BIPOC communities

Proposed Solutions - BH Delivery System

#3 - Divert People from Inpatient and Carceral Settings

- Enhance **crisis services in emergency departments** to divert patients back into community-based settings through
  - Increased availability
  - Reimbursement
- Investing in **re-entry programs** for returning citizens, particularly those with BH needs leaving carceral settings, to reduce recidivism
- Expand access to services **at all levels of care**

FY23 Budget Investments - Access/Barriers to Care

- *Line Item 5042-5000 (DMH)*: **$113M** for MH care for young people
- *Line Item 5046-0000*: almost **$519M** for adult MH and support services
- *Line Item 5047-0001*: over **$22M** for acute inpatient MH services and emergency service programs providing BH crisis response services
- *Line Item 5095-0015*: almost **$275M** for inpatient facilities and community-based MH, including **$5M** for new continuing care beds
- *Line Item 7004-9033*: **$12.5M** for rental subsidies for DMH clients
- *Line Item 4513-2020*: **$13M** to increase BH outreach, access and support, including over **$3.5M** to increase student access to tele-BH services in schools
- *Line Item 7061-0028*: **$6M** for school-based services, including **$1M** for a universal MH screenings pilot program for K-12 students
- *Line Item 7061-9607*: **$2.8M** for recovery high schools
- *Line Item 4200-0200*: **$2.05M** for SHARE to provide grants for student BH wellness programs
- *Line Item 4000-0950*: almost **$268M** for community-based BH services for children
- *Line Item 4512-0200*: **$218M** to BSAS, including **$7M** carve-out for new recovery centers

FY23 Budget Investments - Criminal Legal System

- *Line Item 4512-0200* [BSAS]: authorizes spending for municipal jail diversion programs, including **$1.35M** carve-out for DPH-procured jail diversion programs for nonviolent offenders with OUD
- *Line Item 0339-1005*: **$500K** for municipal programs piloting or expanding approaches to divert young people from the criminal legal system
- *Line Item 0340-0203*: almost **$500K** for drug diversion programs for nonviolent young adults charged with drug-related crimes
- *Line Item 4200-0200*: **$600K** carve out for a youth detention diversion program
- *Line Item 4512-2020*: **$3.61M** for a matching grant program supporting municipal public safety reform, including jail diversion programs
- *Line Item 7010-1192*: Local funding for educational initiatives, including **$100K** for a juvenile diversion program in New Bedford and Fall River
- *Line Item 8900-003*: **$4.8M** for DOC to implement mandated BH reforms
- *Line Items 8910-1010 & 8910-1101*: Over **$3M** in combined funding for regional behavioral evaluation and stabilization units that provide forensic MH services to people behind bars
- *Line Item 1599-0105 & 1599-0107*: **$18.5M** to expand MAT at county correctional facilities and **$2.5M** to expand long-acting injectable MAT in correctional facilities

ABC 2.0 Highlights - Youth Access to BH Care

- Coverage for MH acute treatment, collaborative care, emergency services programs (ESPs), and annual MH wellness exams
- Several initiatives to track, study, report on, and reduce pediatric ED boarding, including the creation of a youth ED boarding portal
- School-based BH programs and BH crisis response planning
- Interagency Review Teams to resolve issues for youth seeking BH services
- Student Stakeholder Advisory Commission
- Limits to the use of suspension and expulsion in secondary and early education programs

ABC 2.0 Highlights - General Access to BH Care

- Coverage for collaborative care, ESPs, and annual MH wellness exams
- Several initiatives to track, study, report on, and reduce adult ED boarding, including the creation of an adult ED boarding portal
- EDs must make BH professionals available 24/7, including via Telehealth
- 988 implementation and expanded BH crisis response
- Updates to the law to implement and enforce BH parity
- The Office of BH Promotion to coordinate statewide BH initiatives
- DMH to create a plan to address continuing care beds for those awaiting discharge from acute psychiatric facilities

Current/Existing Initiatives - Access/Barriers to BH Care

- Providing BH care in EDs to divert patients to community-based settings
  - E.g., Boston Children's, DMH ED diversion programs (established in FY23 budget)
- BH Roadmap initiatives
- School-based BH programs
- 988 and BH Help Line
- Significant investments in broadband infrastructure and internet access to facilitate and enable the use of Telehealth for BH care

Current/Existing Initiatives - Criminal Legal System

- ARPA: **$5M** for re-entry programs (grant program administered by DOC in collaboration with the Commissioner of Probation) and **$6.25M** for re-entry programs administered by DOC in collaboration with DPH
- FY23 Budget: Middlesex Restoration Center & Commission continuation
- FY23 Budget (outside section): ***ALL*** correctional facilities must make ***ALL*** MAT available to people behind bars [ends pilot program]
- Eco Dev: **$1M** for a pilot program at county correctional facilities to assess and treat people with alcohol use disorder (AUD) with FDA-approved medications for AUD
- ABC 2.0: Reforms to MH Watch (voluntary transfers to inpatient psychiatric facilities)

Questions for Discussion - Barriers/Access to BH Care

- How can we improve access to community-based BH services and supports?
- What, if any, additional initiatives or programs are currently in place or in the process of being implemented that seek to address access to BH care?
- Are there specific groups or populations that face increased challenges to accessing BH services and supports or existing programs and what, if any, steps could be taken to alleviate these group- or population-specific challenges?
- Are there any additional initiatives or programs not discussed today that could reduce barriers or otherwise increase access to BH care?

Questions for Discussion - Criminal Legal System

- Are there additional initiatives/programs currently in place or in the process of being implemented that seek to *divert* people with BH needs from the criminal legal or juvenile justice system?
- Are there additional initiatives or programs are currently in place or in the process of being implemented that *expand access* to BH care behind bars?
- How can we improve access to BH services and supports to people behind bars or otherwise involved with the criminal legal system?
- Are there specific groups or populations that face increased challenges to accessing BH services and supports and what, if any, steps could be taken to alleviate these group- or population-specific challenges?
- Of existing programs and initiatives addressing BH care behind bars, are there specific groups that do not have access to these or any similar programs or initiatives?
- Are there any additional initiatives or programs not discussed today that could address BH care for people behind bars?

Behavioral Health Advisory Meeting Minutes

Monday, December 19, 2022
1:00PM – 2:30PM

Event Description

This was the third meeting of the Behavioral Health Advisory Commission established by Chapter 77 of the Acts of 2022. This meeting was livestreamed and recorded.

Commission Members Present

- **Representative Adrian Madaro**, **Chair,** Joint Committee on Mental Health, Substance Use and Recovery
- **Senator Julian Cyr, Chair,** Joint Committee on Mental Health, Substance Use and Recovery
- **Secretary Marylou Sudders**, Executive Office of Health and Human Services
- **Representative Matthew Muratore**, 1st Plymouth District
- **Eric Masi**, President and CEO of Wayside Youth & Family Support Network
- **Dr. Charles Clayton Daniels, Jr.**, Chief Executive Officer, Fathers' UpLift, Inc.
- **Dr. Margaret Weiss**, Director of Clinical Research, Cambridge Health Alliance
- **Amara Anosike**, Director of Behavioral Health Policy & Advocacy, Boston Children's Hospital
- **Dr. Debra Pinals**, Behavioral Health System and Forensic Psychiatric Consultant and Adjunct Clinical Professor of Psychiatry, University of Michigan Medical School
- **Scune Carrington**, Director of Integrated Care, Massachusetts League of Community Health Centers
- **Danna Mauch**, President and CEO, Massachusetts Association for Mental Health
- **Lydia Conley**, President and CEO, Association for Behavioral Healthcare
- **Jacqueline Hubbard**, Policy Director, National Alliance on Mental Illness
- **David Matteodo**, Executive Director, Massachusetts Association of Behavioral Health Systems
- **Maryanne Frangules**, Executive Director, Massachusetts Organization for Addiction Recovery
- **Rebekah Gewirtz**, Executive Director, NASW-MA
- **Steve Walsh**, President and CEO, Massachusetts Health & Hospital Association
- **Rocio Calvo**, Associate Professor of Global Practice at the Boston College School of Social Work and Director of the Latinx Leadership Initiative (LLI)
- **Joy Rosen** on behalf of **Dr. Elsie Taveras**, Chief of the Division of General Academic Pediatrics and Executive Director of the Kraft Center for Community Health at Massachusetts General Hospital

Commission Members Absent

- **Senator Sonia Chang-Diaz**, Chair, Racial Equity, Civil Rights, and Inclusion
- **Representative Bud Williams,** Chair, Racial Equity, Civil Rights, and Inclusion
- **Wanda Visnick,** Justice Resource Institute

Welcome from the Chairs

Approval of the Meeting Minutes

The Commissioners voted unanimously to approve the minutes from the November 9th and November 23rd Commission meetings. There were no revisions made to the minutes.

Recap of First Meeting – Outstanding Topics

Behavioral Health Delivery System – Quality and Availability of Services

Chair Madaro reviewed common themes identified by Commissioners related to barriers to behavioral health care and health equity, access to behavioral health care, behavioral health within and diversion of people with behavioral health needs from the criminal legal system, and workforce-based system improvements.

Challenges include:

- The compromised patient flow through the system, which results in patients getting stuck at every level of care. This issue is particularly acute in younger populations;
- The lack of services in non-hospital settings; and
- Insufficient diversion from inpatient and carceral settings.

Underlying each of these issues is an extreme workforce shortage.

Proposed Solutions

- Improving patient flow through the system by focusing on continuing care, warm-handoffs, and increasing behavioral health care and services in primary care settings;
- Increasing the availability of services in non-hospital settings, including investing in behavioral health urgent care, school-based behavioral health programs, and other community-focused services; and
- Focusing on diverting people from inpatient and carceral settings by enhancing crisis services, investing in reentry programs, and expanding access to services at all levels of care.

Current Funding Opportunities and Programs

Commission materials reviewed specific investments made through the FY23 state budget and the American Rescue Plan Act to bolster the behavioral health delivery system. This included several initiatives and programs designed to enhance access and reduce barriers to behavioral health care services and supports, as well as those focused on diverting people with behavioral health needs from the criminal legal system and expanding access to behavioral health care behind bars.

Commissioners also reviewed initiatives and programs included in ABC 2.0, the comprehensive mental health bill signed into law in August 2022. ABC 2.0 sought to expand youth access to behavioral health care and supports, including enhancing behavioral health supports and services in school environments and several initiatives to address emergency department boarding. ABC 2.0 also sought to expand access to behavioral health care and supports for all Commonwealth residents, including codifying 988 implementation, the creation of a new Office of Behavioral Health Promotion, and implementation and enforcement of long-overdue parity requirements.

Discussion: The Behavioral Health Delivery System

1. How can we improve access to community-based behavioral health services and supports? What, if any, additional initiatives or programs are currently in place or are in the process of being implemented that seek to address access to behavioral health care?

Existing initiatives and programs that were discussed include the following:

- The Department of Public Health (DPH) Equitable Approaches to Public Safety (EAPS) Program received a slight increase in funding from FY22 in the FY23 annual budget.
    - EAPS funding is available to communities for alternative response to behavioral health crises in the community, which can increase the number of clinicians who are trained to deliver behavioral health services and supports in communities.
    - EAPS Programs could interface well with Community Behavioral Health Centers (CBHCs), as envisioned by the Baker Administration's Behavioral Health Roadmap, once CBHCs start coming online.
    - Commissioners discussed whether EAPS programs can be connected to CBHCs to ensure collaborative work in crisis response, particularly due to the extensive planning that went into standing up the EAPS program.
    - Commissioners recommend increasing EAPS funding or supplementing EAPS funding with money from the Behavioral Health Trust Fund (BH Trust Fund) to hire more clinicians and ensure more access to these and other programs.
- In addition to the several student loan repayment programs discussed at the last Commission meeting as vital to workforce ***retention*** efforts, Commissioners recommend additional workforce ***retention*** as well as workforce ***recruitment*** initiatives aimed at expanding opportunities for would-be clinicians seeking to enter the field.
    - This includes paid internships, tuition-free education/scholarships, and other opportunities that defray the cost of seeking an education, including costs associated with housing, transportation, health care, and childcare.
    - Commissioners discussed the lack of diversity in the clinical workforce, noting that the focus should be on incentivizing entrance to the behavioral health workforce by providers who:
        - Would otherwise be unable to enter the field without financial assistance;
        - Hold historically marginalized identities and/or speak other languages;
        - Have lived experiences with behavioral health (i.e., prioritize and uplifting the voices and participation of peer specialists and recovery coaches);
        - Commit to working with high-need populations (e.g., youth, people involved with the criminal legal system, people of color and people with limited English proficiency (LEP)); and
        - Commit to working in high-need settings and communities.
    - Commissioners recommend initiatives that defray the cost of obtaining and maintaining licensure (see, e.g., the initiative for Latinx social workers run by Commissioner Calvo (LLI) that creates a clear pathway to working in community-based settings by enabling students to complete their practicums in such settings and continue working as social workers upon licensure), including:
        - Paying for the costs associated with taking licensing exams for providers who work in specific high need settings;

        - Assisting providers who speak other languages with preparing for licensing exams and taking the exams, which Black, Indigenous, and other People of Color (BIPOC) and people with LEP experience greater difficulties in passing; and
        - Paying for providers to obtain continuing education unit (CEU) credits needed to maintain licensure, particularly specialty CEUs.
    - Commissioners recommend examining disparities/inequities in existing loan repayment opportunities as, for some professions, the available amounts do not fully cover the loan debts for all types of providers.
        - For example, social workers are eligible for up to $50,000 in loan repayment but most social work programs cost more than $70,000 to attend and students still have other expenses (e.g., housing, transportation, childcare, etc.). By contrast, psychiatrists are eligible for payments of $150,000 (part-time) to $300,000 (full-time).
        - Commissioners further recommend using the BH Trust Fund to fill in these gaps while also increasing the limits and extending eligibility to more providers working in settings not included in the original legislation.
    - Commissioners recommend initiatives that enhance and compensate supervision. Supervision is critical to ensuring a diverse workforce, particularly supervision provided by providers of color and providers who speak other languages as these populations tend to have higher caseloads.
    - Commissioners discussed the need to increase salaries and reimbursement rates as a workforce recruitment and retention tool and recommend expanding or standing up new programs that administer salary supplements, particularly for specialty populations (see, e.g., salary supplements administered by the Massachusetts League of Community Health Centers (MLHC)).
- Several housing-first initiatives are underway to expand access to and the availability of low threshold housing for vulnerable populations, including transitional and affordable housing; however, housing-first opportunities should be drastically expanded.
- Massachusetts provides some transportation assistance for people with behavioral health needs but should enhance transportation services beyond "PT1" for people who experience difficulties attending behavioral health programs due to transportation.
    - Commissioner Frangules offered to provide a list of programs doing this work.
- Commissioners discussed existing MassHealth initiatives and programs aimed at increasing access to behavioral health services, including:
    - The expansion of Early and Periodic Screening, Diagnosis, and Treatment (EPSPT) that allows young people to receive behavioral health treatment and services, including in school settings, without a formal diagnosis;
    - The expansion of MassHealth to ensure young people have access to behavioral health treatment and services, about which Commissioners recommend undertaking efforts to enhance public understanding; and
    - Beginning in early January 2023, allowing LICSWs and licensed psychiatrists in solo-practices to bill Medicaid for behavioral health services.

2. On the topic of health equity, are there specific groups or populations that face increased challenges to accessing behavioral health services and supports or existing programs? If so, what, if any, steps could be taken to alleviate these group- or population-specific challenges?

- Young people, and particularly those who receive services from state agencies, have a difficult time accessing behavioral health services due to the lack of available services and programs, as well as disagreements on the agency level as to what, if any, agency should be responsible for the provision of such services, leading to children waiting days, weeks, and months to be placed in an appropriate setting.
    - Kids of color are overrepresented in terms of agency involvement (e.g., the Department of Children and Families (DCF)) and thus face increased barriers to obtaining care.
    - Children with both medical and behavioral health needs, many of whom are LEP, also face increased barriers to accessing behavioral health services due to unavailability of services.
    - Young people with LEP experience extremely long wait times for services because there are not many providers who can provide behavioral health services or assessments in their spoken language, which makes it very difficult to assess needs and cognitive potential.
        - Commissioners recommend training paraprofessionals to provide behavioral health care in different languages to reduce the strain on clinicians who speak other languages.
    - Commissioners recommend increasing capacity in and the number of DCF facilities, congregate care facilities, group homes, and continuing care units to reduce wait times, particularly for agency-involved youth in inpatient units.
- School-based behavioral health presents a great opportunity to reduce barriers to care and prevent downstream illness, but the BIRCh Center recently identified disparities in access to these school-based programs as many school services are based on community wealth.
    - The Neighborhood Partnership Program, led by Boston Children's Hospital, established school-based behavioral health programs in 25 public schools and also provides online resources for school-based behavioral health care; however, most comprehensive behavioral health services provided in schools are not reimbursable (e.g., services provided by non-behavioral health providers like teachers that address social determinants of health) and the program itself is predominantly funded by donations.
    - Commissioners suggest assessing the TCHATT model in Texas (providing technical assistance education and referral supports to schools) and expanding the Massachusetts Child Psychiatry Access Program (MCPAP) model to school-based services (see, e.g., autism services) to reduce barriers to care, particularly for children from low-income families, children of color, and children who experience other social determinants of health barriers.
- People with LEP continue to face barriers to care as there are not enough providers who can provide behavioral health services in the languages spoken throughout the Commonwealth. Moreover, providers who have language skills are often overburdened with high caseloads and subsequently experience burn out at higher rates.
    - Commissioners stress the importance of focusing efforts to increase the workforce on individuals with language capacity and those who commit to working with high-need populations like children.
- There is a high need for behavioral health care providers trained in and services tailored to the specific needs of black men and boys, who experience high rates of police

brutality, incarceration, suicide, and other behavioral health challenges exacerbated by their population-specific experiences.
    - Commissioners stress the importance of providing incentives to providers in all settings who commit to working with this particularly vulnerable population.
- People eligible for services in Department of Mental Health (DMH) state hospitals are often denied admission because the majority of available beds are occupied by people referred by court systems (forensic admissions) who could be treated in other settings.

3. Are there any additional initiatives or programs not discussed today that could reduce barriers or otherwise increase access to behavioral health care?

Although workforce shortages contribute heavily to care access, short-term solutions will not add enough new providers to the field to accommodate need. Commissioners discussed ways to innovate how behavioral health care is delivered to enhance access. For example:

- The Cambridge Health Alliance (CHA) Health Equity Research Lab received a NIMH Grant to create and implement an electronic triage system to address large waitlists.
    - The system gathers information about patient needs so providers can conduct risk assessments, determine which patients have the most urgent needs, and, when appropriate, refer patients to urgent care settings to reduce the number of people on the waitlist for the hospital.
    - Commissioners recommend investing in similar innovation/technology.
- CHA is also in the process of obtaining a grant to set up an urgent care within high schools, which can be a way to increase youth access to services.
- Commissioners discussed how, despite the expansion of tele-behavioral health services during the pandemic, the need dramatically increased while services were reduced for children. Service availability remains significantly reduced compared to before COVID.
    - Commissioners recommend that the Commonwealth continue to invest in telehealth expansion while also innovating how behavioral health is delivered.
- Evidence shows that integrated care in community-based and school settings can increase access to behavioral health services and reduce stigma by normalizing behavioral health care, particularly in communities of color and for people with LEP.
- Training providers in evidence-based short-term behavioral health therapy and group interventions can relieve strains on the system.
    - "Strongest Family" programs like those in Canada and many Scandanavian countries could provide a good model for the Commonwealth.
    - This web-based program includes weekly contact with providers and group follow up visits to reduce strains on clinicians by relying on paraprofessionals trained to deliver behavioral health care and supports.
    - The estimated statewide implementation cost is less than $500,000 and would deliver immediate access to care in a scalable way.
- Commissioners discussed the need for increased services at all levels of care, especially for clients of state agencies, as state hospitals are overwhelmed by the number of people who remain inpatient awaiting placement in residential and other less-acute settings.

Discussion: Behavioral Health and the Criminal Legal System

1. Beyond what was detailed earlier in the presentation, are there additional initiatives or programs currently in place or in the process of being implemented that seek to divert people with behavioral health needs from the criminal legal or juvenile justice system?

- Commissioners discussed the following initiatives and programs focused on diverting people with behavioral health needs from the criminal legal and juvenile justice systems:
    - The Mental Health Advocacy Program for children helps children and family access mental health services and avoid continued contact with the juvenile justice system; however, Commissioners noted that children cannot access the program without parental consent, barring access for children in DCF custody.
        - Commissioners recommend a similar program for DCF-involved youth.
    - DMH funds mobile crisis services and jail diversion programs for people with behavioral health needs.
    - Recovery courts (formally known as drug courts) are doing good work, featuring supportive teams that connect people to peers, treatment, and recovery coaches to help participants enter and maintain recovery.
- Commissioners noted that, even when a person is diverted from custody, the underlying criminal complaint will remain active and can cause future issues down the line for people who come into contact with the criminal legal system.
    - Commissioners recommend reexamining and, in some cases, decriminalizing certain low-level offenses to reduce overall contact with the criminal legal system by all citizens, but particularly people with behavioral health needs.
- Commissioners applauded reforms to the information included in a CORI but noted that many HR personnel do not know how to interpret the information included, leading to employers not extending employment opportunities to people with criminal records.

2. How can we improve access to behavioral health services and supports for people behind bars or otherwise involved in the criminal legal system? Are there additional initiatives or programs that expand access to behavioral health care behind bars? In existing programs and initiatives addressing behavioral health behind bars, are there specific groups that do not have access to these or any similar programs or initiatives?

- Commissioners discussed the need to end the practice of incarcerating male-identifying people with substance use disorder (SUD) subject to civil commitment (Section 35).
    - This will necessitate expanding behavioral health services and supports for men outside of carceral settings as was done with female-identifying people.
    - Commissioners questioned whether courts are the appropriate route to obtaining access to behavioral health care and services.
    - Commissioners also discussed Bridgewater State Hospital, currently operated by the Department of Corrections (DOC), and recommend reexamining the services provided at Bridgewater, transitioning to more DMH involvement (including operation), or the creation of a new facility altogether.
- The Executive Office of Health and Human Services (EOHHS) currently oversees several reentry programs for people involved in the criminal legal system, in addition to the following programs:
    - Several reentry programs receive funding from the Ralph Gants Reentry Services Program (RGRSP). The RGRSP has expressed interest in focusing its work on

people with cooccurring behavioral health conditions due to this population having one of the highest rates of recidivism in the criminal legal system.
    - Due to high recidivism rates among people with cooccurring behavioral health conditions, Commissioners recommend expanding efforts to seal or expunge criminal records.
    - A criminal record – even for minor offenses – presents significant long-term barriers to housing, employment, and other socioeconomic factors that contribute to stability and mental wellbeing, though there are some subsidies/housing vouchers available through DMH and the Department of Housing and Community Development (DHCD) that bypass some of the limitations for a person with a criminal record as well as programs that indemnify employers with commercial insurance that will not cover or allow coverage for employees with criminal records.
  - EOHHS collaborates with the Centers for Medicare and Medicaid Services (CMS) on the Behavioral Health Justice Initiative, which works to ensure people behind bars are enrolled in MassHealth 30 days prior to their release from correctional settings.
  - The WISR Reentry Model, associated with a roughly 50% reduction in recidivism rates, is in the process of being implemented across the Commonwealth.
    - It begins pre-release services 30 to 90 days before participants' return to the community (including comprehensive assessments and transitional treatment planning) and, upon release, provides intensive case management services to support participants with housing, healthcare, employment and other key needs.
  - The Middlesex County Restoration Center, once fully implemented, will divert people with behavioral health needs both from arrest and emergency departments by providing 24/7 access to services at the Center.
  - Commissioners noted that there are existing housing subsidies for people with criminal records, but such records create other barriers to success, including with employment, which could be mitigated by increased expungement and sealing.
  - Medicaid is currently examining reentry services and bundled payment rates for reimbursement as fee-for-service models are inapplicable to the holistic nature of reentry services. Commissioners recommend reimbursing reentry services similar to how the Assertive Community Treatment (ACT) model is reimbursed.
- Commissioners discussed current efforts to expand access to medications for opioid use disorder (OUD) and alcohol use disorder (AUD) behind bars and lessons that can be learned regarding continuity of care for people with SUD or psychiatric conditions.
  - Commissioners noted that these efforts are largely a result of litigation brought under the Americans with Disabilities Act.
  - Commissioners discussed how medications for addiction treatment (MAT) can be changed when a person is incarcerated due to formulary differences and recommend looking at other states that have implemented a "medication follows the person" model for all behavioral health conditions.
- Commissioners noted that many – if not all – jails provide both short- and long-term behavioral health services to people incarcerated for up to two and a half years.

- Commissioners discussed how some jails have strengthened access to behavioral health (e.g., the Middlesex County youth unit provides enhanced behavioral health services and vocational training) but suicide rates in Massachusetts jails and prisons remain among the highest in the nation, highlighting the need to focus on treating people behind bars in a clinically safe and appropriate manner.
- Commissioners recommend a focus on transitioning people behind bars to communities through treatment planning (e.g., connecting people to community-based services and MAT prior to release).

3. Are there any additional initiatives or programs not discussed today that could address behavioral health care for people behind bars, including initiatives or programs to divert people with behavioral health needs from carceral settings?

- Commissioners note that current diversion efforts must acknowledge the racism and stigma that affect how, and which, individuals are charged with crimes.
  - Commissioners noted that, second to people of color, people with behavioral health needs are overrepresented in the criminal legal system.
  - Commissioners discussed the importance of incarcerating fewer people altogether by decriminalizing certain low-level offenses and not building more prisons.
  - Commissioners noted that 25% of Commonwealth residents have a criminal record, which has enormous economic and social consequences, particularly for people with behavioral health needs, because a criminal record compromises recovery by increasing barriers to stabilizing factors (e.g., employment, housing).
- Commissioners discussed how the availability and quality of behavioral health varies dramatically between county correctional facilities.
  - Commissioners recommend working with sheriffs to improve, expand, and standardize behavioral health care provided behind bars.
- Commissioners discussed the Mission Criminal Justice Model, developed by Commissioner Pinals, in which clinicians and recovery coaches help people with co-occurring behavioral health conditions both in correctional settings and upon release.
  - Commissioners noted that New Hampshire is also utilizing this model for all patients leaving psychiatric hospitals, which could be adopted in Massachusetts.
  - Commissioners Pinals and Frangules will forward additional information.
- Commissioners discussed approaches to behavioral health crisis response, including the differences between co-response (embedding behavioral health clinicians like social workers and others into police response units) and alternative response (solely relying on behavioral health professionals, including peer specialists, to respond to behavioral health crises in the community).
  - EOHHS and DMH provide diversion services through co-responder programs.
  - Commissioners recommend that both types of programs be expanded throughout the Commonwealth; however, alternative response should be prioritized to reduce law enforcement involvement in behavioral health crises.
  - Commissioners further recommend diverting people with behavioral health needs from the criminal legal system prior to charges being filed (see, e.g., the approach taken by the 2012 Valor Act that enables courts to, at arraignment, divert people with a history of military service to treatment programs).

Chairs' Closing Remarks and Announcements

The next meeting will be held on January 30, 2023 at 1:00pm, at which Commissioners will begin the process of evaluating proposals received by the Commission and discuss preliminary recommendations for the disbursement of money from the BH Trust Fund.

The Commission continues to accept written testimony via email at jointcmte-mentalhealth@malegislature.gov. Commissioners previously agreed to continue accepting submission until December 23, 2022. Co-Chairs Cyr and Madaro proposed extending the cut-off date to December 30, 2022, to which there was no opposition.

The meeting was adjourned at 2:30PM.

Subsection 4:

Presentation and Minutes of the Fourth Commission Meeting

APRIL 18, 2023 MEETING

Behavioral Health Advisory Commission

Recruitment

Recruitment: Loan Repayment

Recommendation: Additional funding for the existing **MA Repay** (student loan repayment program administered by the MA League of Community Health Centers)

MA Repay currently supports behavioral health and primary care staff that work in:

- Community Health Centers (CHCs)
- Community Mental Health Centers (CMHCs)
- Inpatient psychiatric units

The program allows for awards on a sliding scale according to provider type and whether the provider works part-time or full-time, in exchange for 4 years of service.

Specifically, the program allows for awards for:

- **Psychiatrists** up to $300K
- **Psychologists & Primary Care Physicians** up to $150K
- **Master's level mental health & primary care professionals** up to $50K
  - *This includes nurse practitioners, physician assistants, advance practice registered nurses, pediatric clinical nurse specialists, and licensed behavioral health providers*
- **Bachelor's level mental health & primary care professionals** up to $30K
  - *This includes community health workers, recovery coaches and family partners.*
- **Inpatient psychiatric mental health nurse practitioners** up to $100K
- **Inpatient mental health workers** up to $40K

Recruitment

HHS reports that the program faces a $88.5 million deficit based on eligible applications for Psychiatrists, Psychologists & Primary Care Physicians, Master's level mental health & primary care professionals, and Bachelor's level mental health & primary care professionals.

However, the program has a $9.6 million surplus on eligible applications for Inpatient psychiatric mental health nurse practitioners and inpatient mental health workers.

(A) Legislative Language from Statute	(B) Number of Applications	(C) Sum of Total Debt	(D) Sum of Possible Awards	(E) Total Funds Available to be Awarded	(F) Variance
Psychiatrist	180	$41,815,402	33,918,586	$19,068,847	-14,849,739
Psychologist and Primary Care Physician	263	$51,626,209	24,753,990	$10,896,484	-13,857,506
Master's Degree Level Behavioral Health and Primary Care Professional	2,058	$184,338,302	80,767,348	$31,781,412	-48,985,936
Bachelor's Degree Level Mental Health and Primary Care Professional	1,462	$83,729,970	29,026,442	$18,160,807	-10,865,635
TOTALS in tracks with award deficits	**3,963**	**361,509,883**	**168,466,366**	**79,907,550**	**-88,558,816**
Inpatient Psychiatric Mental Health Nurse Practitioner	75	$8,367,502	5,251,520	$12,712,565	7,461,045
Inpatient Mental Health Worker	267	$20,984,960	5,114,988	$7,264,323	2,149,335
TOTALS in tracks with award surpluses	342	$29,352,462	$10,366,508	$19,976,888	**9,610,380**

Source: Executive Office of Health and Human Services

Recruitment: Loan Repayment

Recognizing this shortfall with the current criteria, what are thoughts about the Commission recommending an expansion of the practice settings that are eligible for participation beyond the current insurance-based payment settings to state-run or state-contracted settings such as those run by the Department of Mental Health (DMH), the Division for Children & Youth with Special Health Needs (DCU), Department for Developmental Services, etc.?

Recruitment

Scholarships

Fund scholarships to state universities for nursing and behavioral health professional programs that prioritize diverse applicants and placements in areas of highest need.

- What is the right level of commitment required to receive a scholarship?
- How would these commitments be enforced?
- If an individual defaults on their commitment to stay working in an eligible setting for the requisite time, how realistic is it that the state would seek repayment of the scholarship?
- Should scholarship efforts be focused on the Master's or doctoral level versus the Bachelor's level?
- How do you design a scholarship program to attract new interest in the field as opposed to individuals who are already gravitating to this course of study?

Recruitment

Loan Repayment vs. Scholarships

How do we weigh investment for loan forgiveness versus scholarships?

Recruitment

On-the-Job Training

Internships and Field Placements

Fund historically unpaid positions for both Bachelor's & Maser's level candidates training in the behavioral health field who agree to internships and field placements in areas of highest need.

Clinical Supervision

Fund stipends or bonuses for currently non-reimbursable clinical supervision in community-based settings to train students and support individuals working toward licensure.

Retention

Retention

Support for Health Care Providers

Additional funding to build upon the MASStrong Pilot Program, which provides evidence-based and trauma-informed group peer behavioral health support to health care professionals and provides small stipends to incentivize participation.

Question: Should we be making investments in other programs, as well?

Retention

Commercial Rate Analysis

Fund a comprehensive study, conducted or contracted for by the Health Policy Commission in consultation with the Division of Insurance, relative to commercial rates and the impact of under-reimbursement on access to high-quality behavioral health care in the Commonwealth.

Has this type of study been done before?

How available is the needed data?

How do we envision the results of such a study would be used?

Retention

Professional Fees and Practice Costs

Fund a pilot program to reduce or eliminate fees required for initial licensure for those committing to working in high-need settings.

Which fees are thought to present the biggest barriers? Licensing fees? Malpractice insurance? Continuing education?

Are investments better made elsewhere as these can be thought of as "the cost of doing business"?

Health Equity

Health Equity Recommendations

General Investments

- Fund initiatives that improve access to behavioral health services in underserved communities, including formerly incarcerated individuals, LGBTQIA+ communities, Limited English Proficiency communities, etc.

Criminal Legal System Diversion

- Fund expansion of behavioral health diversionary programs from the criminal legal system. For example, MassHealth Behavioral Health Supports for Justice-Involved Individuals (BH-JI).

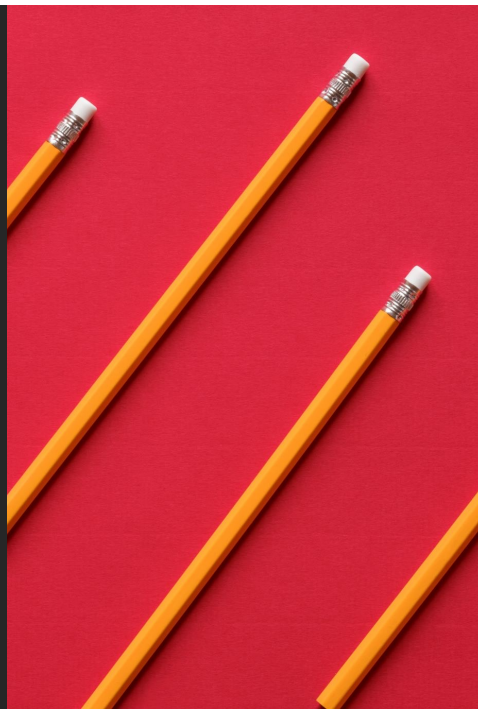
Are there other existing programs that could be bolstered?

Youth

Recommendations for Schools

- Additional funding for the Bridge programs (aka bryt intervention) that help students transition back to school from mental health or medical disruption with a focus on geographic equity to ensure these resources are available to students throughout the Commonwealth.

- Should we be making investments in other programs, as well?



Is there anything missing from the general recommendations presented that is important to address?

Next Steps

Comments and feedback from today's meeting will be incorporated into draft recommendations to be distributed by the Chairs.

Commission members will be requested to review draft recommendations and provide timely feedback in advance of next meeting.

The next meeting is on **May 3 at 1PM**.

Behavioral Health Advisory Meeting Minutes

Tuesday, April 18, 2023
1:00PM - 2:30PM

Event Description

This was the fourth meeting of the Behavioral Health Advisory Commission established by Chapter 77 of the Acts of 2022. This meeting was livestreamed and recorded.

Commission Members Present

- **Representative Adrian Madaro**, **Chair,** Joint Committee on Mental Health, Substance Use and Recovery
- **Senator Julian Cyr, Chair,** Joint Committee on Public Health and Vice Chair, Joint Committee on Mental Health, Substance Use and Recovery
- **Eric Masi**, President and CEO of Wayside Youth & Family Support Network
- **Dr. Charles Clayton Daniels, Jr.**, Chief Executive Officer, Fathers' UpLift, Inc.
- **Margaret Weiss**, Director of Clinical Research, Cambridge Health Alliance
- **Amara Anosike**, Director of Behavioral Health Policy & Advocacy, Boston Children's Hospital
- **Dr. Debra Pinals**, Behavioral Health System and Forensic Psychiatric Consultant and Adjunct Clinical Professor of Psychiatry, University of Michigan Medical School
- **Scune Carrington**, Director of Integrated Care, Massachusetts League of Community Health Centers
- **Danna Mauch**, President and CEO, Massachusetts Association for Mental Health (MAMH)
- **Lydia Conley**, President and CEO, Association for Behavioral Healthcare
- **Jacqueline Hubbard**, Policy Director, NAMI
- **David Matteodo**, Executive Director, Massachusetts Association of Behavioral Health Systems
- **Maryanne Frangules**, Executive Director, Massachusetts Organization for Addiction Recovery (MOAR)
- **Rebekah Gewirtz**, Executive Director, NASW-MA
- **Rocio Calvo**, Associate Professor of Global Practice at the Boston College School of Social Work and Director of the Latinx Leadership Initiative (LLI)
- **Wanda Visnick**, Psychiatric Mental Health Nurse Practicioner, Justice Resource Institute

Commission Members Absent

- **Representative Bud Williams,** Chair, Racial Equity, Civil Rights, and Inclusion
- **Dr. Elsie Taveras**, Chief of the Division of General Academic Pediatrics and Executive Director of the Kraft Center for Community Health at Massachusetts General Hospital
- **Steve Walsh**, President and CEO, Massachusetts Health & Hospital Association
- **Representative Matthew Muratore**, 1st Plymouth District

Welcome from the Chairs

Written Testimony Received by Committee

Workforce Recruitment

Chair Cyr reviewed current deficits and requests for recruitment, including loan repayment

- Recommendation: Additional funding for the existing MA Repay (student loan repayment program administered by the MA League of Community Health Centers)
    - Currently supports staff that work in community health centers (CHCs), community mental health centers (CMHCs), and inpatient psychiatric units
    - *Recognizing this shortfall with the current criteria, what are some thoughts about the Commission recommending an expansion of the practice settings that are eligible for participation beyond the current insurance-based payment settings to state-run or state-contracted settings such as those run by the Department of Mental Health (DMH), the Division for Children & Youth with Special Health Needs (DCU), Department for Developmental Services, etc.?*

Leigh Simons Youmans: The short turnaround timeframe for application for MA Repay created an issue with applications and hospitals would appreciate more time to use this as a means of recruitment. She suggests expanding settings eligible workers can work in, as if they do not work directly in inpatient mental health, they are not eligible for loan forgiveness. Many hospitals also have outpatient offices, where workers would also not be eligible for loan forgiveness. She agrees about focusing on marketing and extending the timeframe for people to apply, which would allow employers to use loan forgiveness to recruit new staff. She states that if we allow Bachelor-level workers to engage in loan forgiveness, it may incentivize them to move on to higher level behavioral health positions through the workforce pipeline.

Lydia Conley: ABH is one of the organizations that brought forward the suggestion to expand to state-contracted settings. There are other funds that cover substance use delivery settings. Her organization would support expanding loan repayment to include substance use as part of eligible behavioral health settings. On the Bachelor's level, they fully support the creation of the workforce pipeline. Her understanding is that acquisition of educational debt is only for inpatient settings, so ABH supports expanding to other community settings.

Amara Anosike: Many of the pediatric providers at Children's are actually in developmental medicine, as they work with children with autism. This population of providers was also excluded from the loan forgiveness program. Providers on medical floors engaging in psych consult services were excluded from this program. She encourages the Commission to pursue anything to incentivize providers to work with children, as this is a setting of great need.

Dr. Debra Pinals: Are individuals working in justice-involved settings included? These are also shortage areas in need as well. Going back to MA Repay, are there reasons why applications were rejected? It would be good to know. If expanded, we would like to collect more data.

Eric Masi: Encourages the Commission to emphasize children's services and pay particular attention to providers working with children under DCF.

Margaret Weiss: Encourages the Commission to put a focus on children with neurodevelopmental disorders and expand eligibility to settings that provide neurodevelopmental

assessments or treatments, as many have been closed due to COVID-19. This will carry high, long-term costs.

Wanda Visnick: Many organizations support loan forgiveness for MA Repay. ABH members and other members of the organization who serve pediatrics or justice-serving individuals would like to see it expanded to include these professionals. She also encouraged the Commission to think of inpatient and hospital services versus outpatient services.

Rocio Calvo: Encourages the Commission to expand settings to school-based settings. Many students, particularly BIPOC children, receive mental health services at school.

Rebekah Gewirtz: She wants to make sure we are not just including LICSWs but also LCSWs who do a lot of on the ground work. We must also consider supporting social workers and other behavioral health providers who serve elderly populations.

David Matteodo: Do we know what groups signed up for loan forgiveness previously?

- Recommendation: Fund scholarships to state universities for nursing and behavioral health professional programs that prioritize diverse applicants and placements in areas of highest need.
    - *What is the right level of commitment required to receive a scholarship?*
    - *How would these commitments be enforced?*
    - *If an individual defaults on their commitment to stay working in an eligible setting for the requisite time, how realistic is it that the state would seek repayment of the scholarship?*
    - *Should scholarship efforts be focused on the Master's or doctoral level versus the Bachelor's level?*
    - *How do you design a scholarship program to attract new interest in the field as opposed to individuals who are already gravitating to this course of study?*
    - *If we have limited money, who should we focus on scholarships being received by?*
    - *How do we weigh loan repayment versus scholarship?*

Lydia Conley: The Health Policy Commission stated that individuals are less likely to enter the behavioral health field than in the past. We support scholarships for community-based settings, as they are the training ground for professionals before they move into other areas of the field. They have also been historically excluded from scholarships and loan forgiveness.

Dr. Debra Pinals: With loan repayment, there is no way to know what individuals will do either. In Michigan, she and her colleagues tracked expectations of what the work would be and doled out the dollars in an incremental way; this would allow them to earn scholarships over time. The enforcement mechanism was just withholding payments.

Leigh Simons Youmans: Psychiatric shortage areas are almost nonexistent in MA. This would be a helpful way of building around the federal program. We are not going to get through this crisis through retention alone; we need more people in the field, and scholarships help with recruitment. Some of our hospitals do have programs to progress employees below Bachelor's level who are already working in the settings.

David Matteodo: We need to attract new people, especially on the inpatient side and on the Bachelor's level. Anything we can do to encourage that will build up the workforce pipeline. Stick with a four year commitment like loan forgiveness.

Rocio Calvo: Recruiting Spanish speaking students, Boston College has over 200 graduates who identify as Hispanic or Latinx workers. The Boston College Latinx Leadership Initiative provides scholarships and stipends, and in turn students work in community health settings. Their practicums occur in community health settings in Spanish-speaking areas of highest need; and most stay there for a few years as they get their license. They pair students with supervisors who know how to help Spanish-speaking social workers. One of the things they've been doing is having individuals engaging in classes part-time and using their full-time position during the day as their field placement.

Scune Carrington: We should be incentivizing state schools and universities. Additionally, the default rate on these programs is 18%. We should not make it punitive and instead provide scholarships in installments. Life happens and we don't want to punish students, particularly BIPOC individuals. Many of the scholarships, you have to work full time and be in a traditional setting. For many BIPOC, they do it on a part-time basis. If we are going to incentivize people, we need to include those outside the traditional two-year program.

Eric Masi: Loan repayment is not applicable to many folks, and scholarships would be. In the community, we are talking about creating a workforce pipeline for folks who do not have a degree, and scholarships would provide an incentive for them to work in the field and go into schooling. We should also talk about retention bonuses in the community, and targeted towards those in high schools or starting out in the field.

Danna Mauch: MAMH did a study to create an inventory of various programs and tactics such as loan forgiveness, scholarships, and retention bonuses. There were a number of reports that spoke to the need for retention bonuses.

Rebekah Gewirtz: There are programs for social workers that require field placements of 1600 hours in your first year and 2400 hours in your second year that are unpaid. Scholarships and paying for field placements may help build up the pipeline. We need to provide scholarships for BIPOC and those where English is not their first language.

Wanda Visnick: We need to prioritize the workforce given limited funds. Recruitment into the field now is more important in the short-term rather than recruiting in high schools. Use scholarship as reimbursement for field placement hours.

- Recommendation: Fund historically unpaid positions for both Bachelor's & Master's level candidates training in the behavioral health field who agree to internships and field placements in areas of highest need.

- Recommendation: Fund stipends or bonuses for currently non-reimbursable clinical supervision in community-based settings to train students and support individuals working toward licensure.

Lydia Conley: Supports this investment to diversity and opportunity in the workforce, including through compensating individuals for their supervision.

Wanda Visnick: Let's increase funding for compensating supervision and field placement. There's an absolute need for supervision on the Master's level. She would define the highest need by waitlists and patient flow.

Eric Masi: How can individuals see a path through the workforce pipeline through scholarships, stipends for field placement, etc. There have only been two YCF, the youth crisis stabilization units, in the Commonwealth. We need to look at CBHCs and residential and partial hospitalization programs.

Scune Carrington: We could incentivize LICSWs to engage in supervision in community health centers and use loan repayment and retention bonuses to have LICSWs stay in the field and not move on to privatization.

Workforce Retention

Chair Madaro reviewed the MASStrong Pilot Program and other opportunities to incentivize participation and retention.

- *Should we be making investments in other programs, as well?*
- *How can we help providers with self-care?*

Rocio Calvo: Anything that furthers the career of providers of care. If they are a LCSW, make sure they have supervision to move forward to LICSW. Our program pays for preparation exams, CEUs, and licensing fees.

David Matteodo: Retention bonuses helped and saved the hospitals during COVID-19, which would have been in worse shape in terms of workforce without it. If it goes to nurses particularly, they should have to stay in one location for a while; inpatient psychiatric hospitals are currently losing nurses to travelers.

Scune Carrington: When you graduate as a social worker, you graduate as a generalist. If you want to become a specialist in EMDR, DBT, etc. it costs $5,000 to $10,000. It would be great to focus on paying for these training sessions for those focusing on groups such as children, elderly, etc.

Dr. Debra Pinals: We are increasingly looking at wellness cafes, virtual meeting opportunities, check-ins, etc. for providers. We know that from the data from COVID-19, EAPs will not serve the entire workforce.

- *How would commercial rate analysis be used?*

Lydia Conley: If at the end of the pipeline, wages are still terrible and you can't afford to live in MA or pay student loans, it will not help the workforce. There was a Millman study that looked at commercial rates and was able to make a connection between rates and out of network use, which shows that commercial rates are broken.

Leigh Simons Youmans: The Massachusetts Health and Hospital Association filed language that would look at rates and reimbursement and how they affect salaries.

- Recommendation: Fund a pilot program to reduce or eliminate fees required for initial licensure for those committing to working in high-need settings.

- *Which fees are thought to present the biggest barriers? Licensing fees? Malpractice insurance? Continuing education?*
- *Are investments better made elsewhere as these can be thought of as "the cost of doing business"?*

Eric Masi: Rate increases may not get people to stay because the amount over your paychecks is slim. Instead, people are very motivated by bonuses.

Wanda Visnick: If we give organizations the ability to have funds, they will determine what is best for retention at their location.

Dr. Debra Pinals: There's so much administrative burden with maintaining licensure right now. It's hard to find trainings and continuing education is burdensome. Perhaps there could be flexible dollars for organizations to reduce that administrative burden.

Health Equity

Chair Cyr discussed general investments and criminal legal system diversion. There is a roadmap on the current state of healthcare for behavioral health providers.

- Recommendation: Fund initiatives that improve access to behavioral health services in underserved communities, including formerly incarcerated individuals, LGBTQIA+ communities, Limited English Proficiency communities, etc.
- Recommendation: Fund expansion of behavioral health diversionary programs from the criminal legal system. For example, MassHealth Behavioral Health Supports for Justice-Involved Individuals (BH-JI)
    - *Are there other existing programs that could be bolstered?*

Rebekah Gewirtz: Is there a way to turn these initiatives inward to fund behavioral health programs that are for underserved communities?

David Matteodo: If there is any money left in this fund, it should be diverted to underserved communities, as we know that those who are severely mentally ill die 10 to 20 years earlier than their peers. Regarding the criminal legal system, if we could, we should do outreach to the courts to help access DMH beds for people other than forensic patients.

Dr. Debra Pinals: There is so much going on in the justice space with MassHealth. Is the point of this to expand programs or to expand the workforce, because court clinics are having a hard time recruiting. What would the diversionary program look like? How do we expand the workforce who are able to work across the lifespan or in the criminal legal system?

Eric Masi: Health equity and diversification of our workforce is a possibility in the community. Many BIPOC work as direct care staff but don't progress up the pipeline; how do you support and retain folks who don't see this as a place they are encouraged to make a career?

Lydia Conley: Massachusetts has been a leader in bringing in peers and recovery coaches. New York State's Medicaid program pays a higher rate for services delivered in a language other than English. This may not be a recruitment factor but it would help with retention.

Amara Anosike: School-based behavioral health is an equity issue because that is where kids are. I would raise that as an area to support behavioral health equity.

Youth

- Recommendation: Additional funding for the Bridge programs (AKA Bryt intervention) that help students transition back to school from mental health or medical disruption with a focus on geographic equity to ensure these resources are available to students throughout the Commonwealth.
    - *Should we be making investments in other programs, as well?*

Amara Anosike: Very supportive of this program, there is also a technical assistance center for schools. One thing to consider is telehealth and how to pay for telehealth services in schools.

Rocio Calvo: Boston College has a program now in Boston Public Schools that is sponsored by Children's Hospital that supports social workers. They have a commitment to have one social worker per school. The goal is to do preventive care so that kids don't go on to need acute care. This program creates a cohort of support so that social workers who work alone in schools can connect with others to create a system of support.

Wanda Visnick: I do think if we are to give additional funding, there should be a caveat. Many schools will only help students as they reenter school after a hospitalization, while we are trying to prevent students boarding in the ED. She would like to see more support for students who are struggling with attendance or are struggling with their mental health.

Closing Remarks and Announcements

This is a Special Commission. Comments and feedback from today's meeting will be incorporated into draft recommendations to be distributed by the Chairs. Commission members will be requested to review draft recommendations and provide timely feedback in advance of our next meeting. Our next meeting will be on May 3rd at 1PM.

Subsection 5:

Minutes of the Fifth/Final Commission Meeting

DRAFT
Behavioral Health Advisory Meeting Minutes

Wednesday, May 3, 2023
1:00PM - 3:00PM

Event Description

This was the fifth meeting of the Behavioral Health Advisory Commission established by Chapter 77 of the Acts of 2022. This meeting was livestreamed and recorded.

Commission Members Present

- **Senator Julian Cyr, Chair,** Joint Committee on Public Health and Vice Chair, Joint Committee on Mental Health, Substance Use and Recovery
- **Representative Bud Williams,** Chair, Racial Equity, Civil Rights, and Inclusion
- **Amara Anosike**, Director of Behavioral Health Policy & Advocacy, Boston Children's Hospital
- **Dr. Debra Pinals**, Behavioral Health System and Forensic Psychiatric Consultant and Adjunct Clinical Professor of Psychiatry, University of Michigan Medical School
- **Scune Carrington**, Director of Integrated Care, Massachusetts League of Community Health Centers
- **Abigail Kim on behalf of Lydia Conley**, Senior Director of Public Policy, Association for Behavioral Healthcare
- **Amanda Stone on behalf of Jacqueline Hubbard**, Communications & Public Policy Specialist, NAMI Massachusetts
- **David Matteodo**, Executive Director, Massachusetts Association of Behavioral Health Systems
- **Maryanne Frangules**, Executive Director, Massachusetts Organization for Addiction Recovery (MOAR)
- **Rebekah Gewirtz**, Executive Director, NASW-MA
- **Rocio Calvo**, Associate Professor of Global Practice at the Boston College School of Social Work and Director of the Latinx Leadership Initiative (LLI)
- **Wanda Visnick**, Psychiatric Mental Health Nurse Practicioner, Justice Resource Institute
- **Steve Walsh**, President and CEO, Massachusetts Health & Hospital Association
- **Danna Mauch**, President and CEO, Massachusetts Association for Mental Health (MAMH)
- **Dr. Elsie Taveras**, Chief of the Division of General Academic Pediatrics and Executive Director of the Kraft Center for Community Health at Massachusetts General Hospital

Commission Members Absent

- **Representative Adrian Madaro**, **Chair,** Joint Committee on Mental Health, Substance Use and Recovery
- **Eric Masi**, President and CEO of Wayside Youth & Family Support Network
- **Dr. Charles Clayton Daniels, Jr.**, Chief Executive Officer, Fathers' UpLift, Inc.
- **Margaret Weiss**, Director of Clinical Research, Cambridge Health Alliance
- **Representative Matthew Muratore**, 1st Plymouth District

Welcome from the Chairs
Senator Cyr welcomed members and began by taking attendance.

Review of Meeting Minutes
Motion was made and seconded to accept the past two meetings' minutes. Vote was unanimous.

Review and Discussion of Draft Report
Based on feedback from Commission members, a paragraph was added to emphasize that the money in the Fund could be spent multiple times over, particularly for programs for youth.

Rebekah Gewirtz: Wanted to highlight youth and also mention that loneliness amongst older adults is also an issue that could be included in the report.

Dr. Debra Pinals: Agreed with Rebekah and mentioned that a report on this topic had recently been published by the Surgeon General.

David Matteodo: Suggested a sentence explaining how the Commission arrived at the figures.

Senator Julian Cyr: Explained that the amounts were arrived at using Commission members' feedback. Loan repayment received the highest amount due to outstanding need.

Recommendation One: Loan Forgiveness

Based on feedback from Commission members, an additional description of the loan forgiveness program was included, including the application process and language expanding eligibility to more workers and emphasizing the high number of inpatient vacancies.

Wanda Visnick: Mentioned that deleting the word "inpatient" before nurse practitioners would expand the coverage to all nurse practitioners. Really likes allocation for community-based versus inpatient. Thinks if we cannot do ratio, we could base it on percentage of time workers spend on behavioral health.

Dr. Debra Pinals: Brought up that the more fitting term instead of justice-involved would be criminal legal and juvenile justice settings. Just want to make sure this is a consideration for loan forgiveness programs. Thinks it should be prorated to time they are spending on behavioral health, and that language should be justice-involved settings.

Rocio Calvo: Thinks we need to emphasize areas of high need, such as those who speak a second language.

Abigail Kim: Suggests we should put thresholds and amounts for each type of provider, like MA Repay. Suggests a similar breakdown of eighty percent community-based, twenty percent inpatient-based. Wants prioritization of lower paid jobs in the community setting, as there is a drain to private and inpatient care. Justice-involved populations would include organizations providing re-entry programs, diversion programs, and those that provide a warm hand-off.

Scune Carrington: Wants to amplify Abigail's suggestion, as community-based care has a higher mix of insurers and lower pay.

David Matteodo: Disagrees with suggested distribution, as there are also shortages in inpatient. There are 600 beds offline because of 1,000 vacancies. Suggests the best way to phrase it is have flexibility for provider category and choose areas of most need.

Amara Anosike: Wants to build on what David said, inpatient is the only place you can't turn away patients, we should be careful to not invest in one to the harm of the other. Also questions how $80 million deficit will be covered by investment. Would be in support of breakdown, just thinks 80/20 is too severe. Would not want to portray that inpatient roles are attractive, as patients may be violent to themselves or others. Thinks we should think about patient population.

Senator Julian Cyr: Wants to ensure funds are going to full-time employees in behavioral health. Concerned about adding more professions to list for loan forgiveness as it is already highly coveted.

Maryanne Frangules: Wants to ensure this expands beyond social workers. Would also love to cover recovery coaches.

Danna Mauch: Emphasized the goal of the commission, which is to help with community-based behavioral health workforce crisis.

Recommendation Two: Scholarships

Based on commission members feedback, language includes those from underserved communities and expands eligible settings to include community-based settings.

Rocio Calvo: Questions why funds would be limited to only public state colleges and universities. Cites example of program at a private college that could benefit.

Julian Cyr: Concern about spending more money on scholarships, as money has to be out of the door in a few years due to ARPA funds. Fine with money going to private colleges, and suggests including language where EOHHS can have flexibility on where scholarships go. Sees scholarship piece as pilot that would have to be funded by other means.

Rebekah Gewirtz: Thought we would include language that expands beyond DCF to other state agencies, but this was modified.

Wanda Visnick: Thinks funding should be on the lower side to focus more funding on the fourth and fifth recommendations.

Scune Carrington: Agrees with current language and what it is funded at.

Danna Mauch: Loan forgiveness entices workers in the private setting to move into a public setting, while scholarships help with recruitment for years down the line. Both are necessary. Need to stress that we need accountability for those who receive funds.

David Matteodo: The terms drafted were you need to work for four years and if not, you have to pay it back.

Recommendation Three: Internships, Practicums, and Field Placements

There was no feedback from commission members on this recommendation.

Recommendation Four: Reimburse for Clinical Supervision

Based on commission members feedback, community-based and inpatient settings were both included as reimbursable settings.

Rocio Calvo: Would like to include diversity language for internships and reimbursement as well. Also concerned that there are not enough diverse clinicians to provide supervision, so would this include those who are floating between agencies or organizations to supervise.

Abigail Kim: Wants to ensure language is clear that reimbursement is for the supervisor and not the students seeking field placement.

Wanda Visnick: Would like to add clinicians in the field who are going back for more training, such as those seeking EMDR training, to those whose supervisors could receive reimbursement.

Senator Julian Cyr: Said that some details will need to be hashed out by EOHHS, and commission members should stay engaged in the process.

Recommendation Five: Professional Fees and Practice Costs

There was no feedback from commission members on this recommendation. Added a study of licensure and certification processes and participation, to study who our providers are.

Recommendation Six: Behavioral Health Support for Health Care Workers

There was no feedback from commission members on this recommendation.

Recommendation Seven: Commercial Rate Analysis

Based on commission members feedback, included private and public payors, as MassHealth partners with private entities.

Rebekah Gewirtz: Thinks rates are critical, and that an investment of less than $1 million is low. Would prefer it say $500,000 to $1 million to ensure the correct amount is invested.

Dr. Debra Pinals: Thinks study should include findings and also implementation strategies.

Abigail Kim: Include MassHealth in consultation as it sets the rates.

David Matteodo: Seconds Dr. Pinals and suggests language be MassHealth and its contractors.

Scune Carrington: Would like equity somewhere in the recommendation, as well as a timeframe of when the study will take place.

Recommendation Eight: Youth and Schools

Based on commission members feedback, the Chairs were wondering whether to include additional programs and organizations keeping in mind the limited nature of the funds.

Danna Mauch: Given there are two priorities for funding workforce and youth mental health and the high need for youth behavioral health services, questions whether there could be more funding shifted to this recommendation, e.g., Community Behavioral Health Centers (CBHCs).

Senator Julian Cyr: Discussed some of the existing challenges that influenced the decision to limit funding in this area, particularly the workforce shortages that prevent wider implementation of youth behavioral health programming. He also noted that many of these types of services are more likely to be reimbursable through other payment models, which further influenced the decision to focus funding on recommendations without significant funding streams.

Danna Mauch: Recommends including more language that explains the context and rationale for why the final recommendations limit funding in this area. (**Senator Julian Cyr:** we will make this change to the Letter.)

Wanda Visnick: Would love to see the findings modified in the definition to not include the specific program "bryt" and make it broader to just say "transitional programs," just keeping the bryt program as an example. Would also like to see a prioritization on programs that are in partnerships with schools, like CBHCs or organizations that allow other agencies into the schools to see clients. Looking at waitlists over time, schools are saying that they don't want therapists coming into schools even though that's where kids spend most of their time, but we should be prioritizing these external programs that expand access.

Amara Anosike: Agrees with Danna and Wanda around how youth and schools are prioritized, would like to add to the number. Also notes there are many programs and services in schools that are not reimbursed, like the Boston Children's Neighborhood Partnership program that embeds social workers and pediatricians in schools but is privately funded. Similarly, the statewide school based behavioral health technical assistance center codified in ABC 2.0 is not fully funded and could really benefit from funds. Notes that MCPAP also could use increased funding given they have expanded their program, which is a workforce extender, would also address workforce challenges in addition to youth behavioral health needs.

Senator Julian Cyr: Emphasized the need to invest in programs that don't just serve Boston areas but programs across the Commonwealth, but also the need to really think about how much is directed to this recommendation given the limited funds and high need for workforce investment. He also reminded the Commission that April revenue numbers are much lower than originally expected and funding across the board will need to reflect that reality.

Rebekah Gewirtz: Completely supports these programs and thinks they are critical, but this is the first time there is a significant amount of money available for investing specifically in the behavioral health workforce. She notes that the Trust Fund is specifically to be invested in the workforce and wants the Commission to be mindful of opening the door to programs to be spent beyond programs that aren't specific to the behavioral health workforce, which is necessary for even being able to staff the programs providing these critical services to young people.

Commission members discussed the general approach behind recommendations and the need to have funding focus on workforce initiatives at substantially greater levels than programmatic work, due largely to the nature of the funds (one-time ARPA money that must be out the door by 2024 cannot be relied upon to sustain programs).

Dr. Deb Pinals: Agrees with Danna's suggestion for language explaining why funding for workforce initiatives were prioritized over all other programs.

Wanda Visnick: Agrees with limiting the funding for youth and schools to the lower end of the range even though they are so important, because schools have had money allocated for school-based programs. She would like to see this last piece used as an opportunity to expand partnerships between schools and community based providers to both increase community access and expand school based supports to alleviate strains in both settings based on need.

Danna Mauch: Reminded members that the proposed recommendation for youth services was one of the two key findings, because of this, we shouldn't altogether eliminate funding for youth behavioral health. Moreover, the recommendation is really an extender for the workforce. These investments are designed to link schools and community behavioral health services, which is a model that can help address the workforce crisis by providing alternative staffing structures and leveraging assets that are in the schools, which is where kids spend most of their time.

***

Rosio Calvo: Requested a timeline of what will be happening next in this process.

David Matteodo: Wondering why there is no mention of retention.

Senator Julian Cyr: Believes loan repayment and supervision investments constitute retention initiatives, but will ensure the language clearly speaks to retention. He thanked everyone for the feedback and wisdom provided, and gave closing remarks on the good this money will do and the good, perhaps unprecedented work that Massachusetts is doing to address behavioral health.

Vote on Passage of Recommendations

- Rep. Bud Williams: absent
- Dr. Charles Clayton Daniels, Jr.: absent
- Margaret Weiss: absent
- Senator Julian Cyr: yea
- Amara Anosike: yea
- Dr. Debra Pinals: yea
- Scune Carrington: yea
- Danna Mauch: yea
- Abigail Kim on behalf of Lydia Conley: yea
- Amanda Stone on behalf of Jacqueline Hubbard: yea
- David Matteodo: yea
- Maryanne Frangules: yea
- Rebekah Gewirtz: yea
- Rocio Calvo: yea
- Wanda Visnick: yea
- Steve Walsh: yea
- Eric Masi: yea

Closing Remarks and Announcements

We will circulate the final draft and provide absent members an opportunity to submit a vote. Members may be asked to provide quotes for a press release and the final report will be submitted to the Legislature, which will then work to identify the proper vehicle for recommendations, likely budgetary, in the coming weeks or months. The members adjourned.

Appendix B: Additional Resources

Behavioral Health Workforce

- An Acute Crisis: How Workforce Shortages are Affecting Access and Costs, Massachusetts Health & Hospital Association (October 2022).
- Creating a Robust, Diverse, and Resilient Behavioral Health Workforce in Massachusetts, Blue Cross Blue Shield Foundation (September 2022).
- State Strategies to Recruit and Retain the Behavioral Health Workforce, National Conference of State Legislatures (May 2022).
- Health Care Workforce Trends and Challenges in the Era of COVID-19: Current Outlook and Policy Considerations for Massachusetts [Special Focus on Registered Nurses, Direct Care Workers, and Behavioral Health Providers], Massachusetts Health Policy Commission (March 2023).

Health Equity and Youth Access to Behavioral Health Services and Supports

- Massachusetts Responds to the Crisis in Children's Behavioral Health, Massachusetts Association of Health Plans (January 2023).
- Structural Racism and Racial Inequities in Heath: Summary of Focus Group Key Themes and Findings, Blue Cross Blue Shield Foundation (May 2022).
- A Blueprint for Health Equity, Health Equity Task Force, Massachusetts General Court (July 2021).
- Building Toward Racial Justice and Equity in Health: A Call to Action, Massachusetts Attorney General's Office (n.d.).

General Resources

- A Focus on Health Care: Five Key Priorities for the Next Administration, Blue Cross Blue Shield Foundation (December 2022).
- Roadmap for Behavioral Health Reform, Executive Office of Health and Human Services (EOHHS) and MassHealth (n.d.).
    - Main website for the Behavioral Health Roadmap: https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform
- Behavioral Health Equity Policy Suggestions, SAMHSA (n.d.) (includes links to several resources regarding behavioral health).
- Mental Health Resource Guide for State Policymakers, Council of State Governments (October 2021).