NORTH DAKOTA BEHAVIORAL HEALTH WORKFORCE: *Next Steps*

October 2022

WICHE

www.wiche.edu/behavioralhealth

Working Draft

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Acknowledgements

The Western Interstate Commission on Higher Education Behavioral Health Program (WICHE BHP) wishes to acknowledge the members of the North Dakota Behavioral Health Strategic Plan's Aim 7 committee for their leadership role in creating the plan for this project, and their time, energy, and commitment to the cause of moving forward the work on behavioral health workforce in North Dakota. WICHE BHP especially recognizes and thanks Rebecca Quinn, Mandi-Leigh Peterson, Heather Brandt, and Lacresha Graham for their crucial roles in giving direction and assistance to this project, and as the Aim 7 Committee's points-of-contact.

Aim 7 Committee:
Rebecca Quinn, Center for Rural Health, University of North Dakota
Mandi-Leigh Peterson, Healthcare Workforce Initiative, UND School of Medicine & Health Sciences
Lacresha Graham, Behavioral Health Division, Department of Health and Human Services
Heather Brandt, Behavioral Health Division, Department of Health and Human Services
Tami Conrad, Behavioral Health Division, Department of Health and Human Services
Stacy Kusler, Center for Rural Health- Primary Care Office, UND School of Medicine & Health Sciences
Karen Bernhardt, Center for Rural Health, University of North Dakota
Kalee Werner, Primary Care Office, Department of Health and Human Services
Laura Anderson, Behavioral Health Division, Department of Health and Human Services
Kurt Snyder, Heartview Foundation
John Butgereit, North Central Human Service Center
Sonja Bauman, Healthcare Workforce Initiative, University of North Dakota
Kelly Nagel, Systems and Performance, Department of Health and Human Services
(Bevin Croft and Ebony Flint of the Health Services Research Institute)

Additionally, our sincere appreciation is extended to the dozens of key stakeholders and community members who contributed their time and input for stakeholder interviews, as well as the dozens of North Dakotans who gave of their time, expertise, and experience to participate in the North Dakota Behavioral Health Workforce Summit.

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Background and Purpose

This report—*North Dakota Behavioral Health Workforce: Next Steps*—is the result of a collaborative project of the Aim 7 Committee, which was established through the North Dakota Behavioral Health Strategic Plan, and the Western Interstate Commission on Higher Education's Behavioral Health's Behavioral Health Program (WICHE BHP). The project included multiple objectives: research of past and current behavioral health workforce efforts in North Dakota; key stakeholder interviews; planning and hosting of a Summit with community stakeholders; and, the reporting of a draft strategic plan and recommendations.

Behavioral Health Strategic Plan and Aim 7 Committee

For the past 15-plus years, behavioral health and workforce stakeholders have sought to understand and improve the behavioral health workforce situation across North Dakota. As early as 2007, North Dakota's behavioral health workforce stakeholders gathered in Bismarck at a Search Conference to discuss the workforce issues then faced. A report prepared by the Schulte Group in 2014 also included issues related to the behavioral health workforce. In 2015 and 2016, the state conducted a behavioral health assessment process resulting in a comprehensive report on gaps and related recommendations. From that report, the state acknowledged the need for a focus on behavioral health workforce and then conducted a thorough discovery and development of a behavioral health strategic plan in 2018. This first iteration of the plan included 13 goals (or "aims"), with the seventh one directed to addressing the behavioral health workforce gaps and needs identified.

Exhibit 1. Thirteen Categories from North Dakota Behavioral Health System Study

APRIL 2018 BEHAVIORAL HEATLH SYSTEM STUDY

Served as a component of interim legislative committee studies during the 65th Legislative Interim.
This report presents the findings from the North Dakota Comprehensive Behavioral Health Systems Analysis, conducted by the Human Services Research Institute (HSRI) for the North Dakota Department of Human Services' Behavioral Health Division.

The 250-page report provides more than 65 recommendations in 13 categories. This set of recommendations is intentionally broad and far-reaching; it is not expected, nor suggested, that stakeholders in North Dakota endeavor to implement all these recommendations at once.

1. **Develop a comprehensive implementation plan**
2. **Invest in prevention and early intervention**
3. **Ensure all North Dakotans have timely access to behavioral health services**
4. **Expand outpatient and community-based service array**
5. **Enhance and streamline system of care for children and youth**
6. **Continue to implement/refine criminal justice strategy**
7. **Engage in targeted efforts to recruit/retain competent behavioral health workforce**
8. **Expand the use of tele-behavioral health**
9. **Ensure the system reflects its values of person-centeredness, cultural competence, trauma-informed approaches**
10. **Encourage and support the efforts of communities to promote high-quality services**
11. **Partner with tribal nations to increase health equity**
12. **Diversify and enhance funding for behavioral health**
13. **Conduct ongoing, system-side data-driven monitoring of needs and access**

The Aim 7 goal was to: "Engage in targeted efforts to recruit and retain a qualified and competent behavioral health workforce." Within Aim 7 in the 2018 Final Report, the following were the recommendations:

7.1 Establish single entity for supporting workforce implementation (Short Term)
7.2 Develop single database of statewide vacancies for behavioral health positions (Short Term)
7.3 Provide assistance for behavioral health students working in areas of need in the state (Short & Long Term)
7.4 Raise awareness of student internships/rotations (Short & Long Term)
7.5 Conduct comprehensive review of licensure requirements/reciprocity (Short Term)
7.6 Continue establishing training/credentialing program for peer services (Short Term)
7.7 Expand credentialing programs to prevention/rehabilitation practices (Short & Long Term)
7.8 Support a robust peer workforce through training, professional development, competitive wage (Short & Long Term).

As the work progressed and some recommendations were completed, Aim 7 was revised and updated to reflect both the progress made and other needs having been identified since the publishing of the report in 2018. By April 2021, the committee and stakeholders had accomplished 13 percent of the objectives within the Aim. By October of that year, 40% of the objectives were achieved.

By April 2022, 75% of the work assigned under Aim 7 had been accomplished. Revisions were made to the Aim, changing from five goals and 15 objectives to 12 Action Steps, three Goals, and six Objectives.

Exhibit 2. Aim 7, October 2021 Dashboard

Exhibit 3. Aim 7, April 2022 Dashboard

The prior action step of convening a Behavioral Health Workforce Collaborative remained. Notably, the first objective (7.1) had an additional action step added: "Select a contractor with expertise in Behavioral Health Workforce to facilitate a Behavioral Health Summit."

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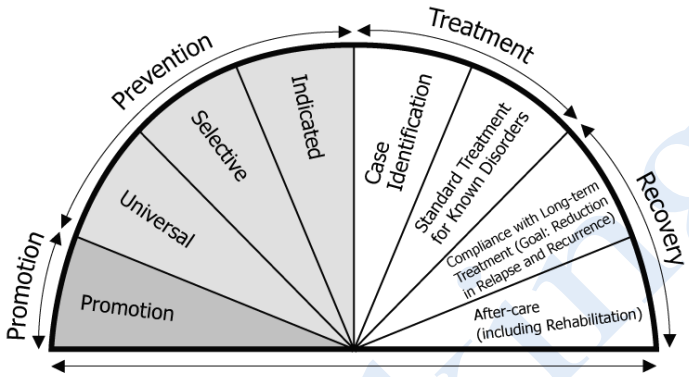
Between May and September 2022, the Aim 7 committee worked with WICHE BHP to review the behavioral healthcare workforce efforts to date; design and plan for the Summit; and, participate in—and recommend others to participate in—key stakeholder interviews. The committee spent significant time developing the agenda with WICHE BHP, with an emphasis on ensuring that there was sufficient opportunity for attendees to learn about current and past behavioral healthcare workforce efforts throughout the state and also to provide input from their organizational or community perspectives. Additionally, the committee sought to allow for enough time in the agenda to allow for a framework for a strategic plan to develop, while also respecting attendees' time and energy by keeping the Summit to 12 hours over a two-day span.

Key Stakeholder Interviews

Interviews were held over the summer and early autumn. Key stakeholders represented a cross-section of North Dakota, including community- and state-based providers, mental health and substance abuse services, organizational position, and geography. These interviewees also represented every component of the continuum of care, from promotion through recovery. All interviews were conducted virtually, with some as one-on-one and others in groups, at a date and time chosen by the interviewees. Most interviews were an hour in length, although a few exceeded that timeframe, and a few were limited to 30 minutes. Interviewees were asked four broad questions: 1) What is top of mind when it comes to North Dakota's behavioral health workforce?; 2) What information and data best informs their perspective(s)?; 3) What one change would they make to either improve the behavioral health workforce environment or to mitigate known problems?; and, 4) Who else should be interviewed?



A multitude of perspectives and information were gained from these interviews. Seemingly no specific behavioral health workforce issue was left unidentified; taken as a whole, every aspect of the continuum was discussed, from promotion through recovery. Issues were broadly identified as the following:

- ✓ Primary/secondary student recruitment to behavioral health workforce
- ✓ Funding for services and workforce initiatives
- ✓ Career pathway development
- ✓ Career satisfaction
- ✓ Competition for workforce between organizations
- ✓ Internship and supervisory costs
- ✓ Loan repayment
- ✓ Data

- ✓ Occupational licensing boards capacity and coordination
- ✓ Scope of practice and credentialing
- ✓ Executive and legislative, statewide, state-to-local, local-to-local cooperation and coordination

These issues fell into four broad categories:

1. Collaboration, coordination, integration
   a. Strategy development and implementation infrastructure
   b. Data, including on varying initiatives and costs
   c. Accountability for decisions, gathering feedback, measuring impact
2. "Pipeline" and workforce recruitment and retention programs
3. Licensure, credentialing, and certification
4. Funding, capacity building, and other resources

The Summit

The Summit was held on September 25 and 26 in Bismarck. The Summit was open to all in the community, with key stakeholders contacted individually as necessary to ensure their participation. Across the two days, there were over 60 attendees hailing from all areas of the state. The intent of the Summit was threefold: 1) Review past and current (or anticipated) behavioral health workforce efforts; 2) Learn of behavioral health workforce efforts from other states; and, 3) Identify specific action steps toward creating a strategic plan.

There were five distinct "desired outcomes" for the Summit:

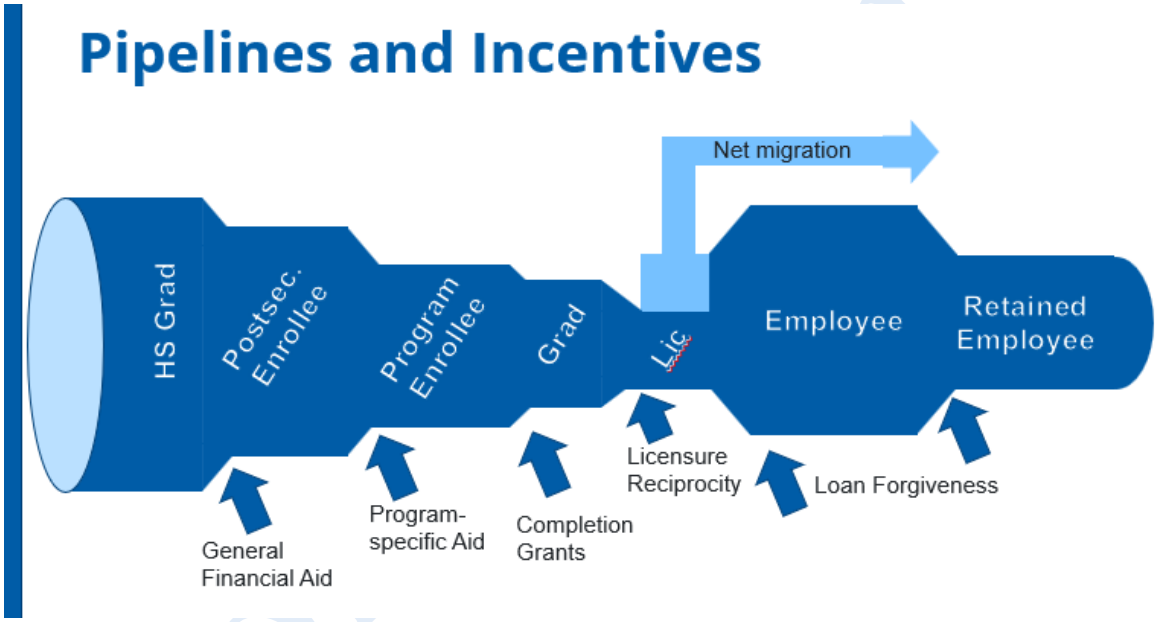
Desired Outcome #1: Prioritized list of workforce issues
Desired Outcome #2: Agreement on a consolidated list of prioritized work force issues
Desired Outcome #3: A list of workforce issues recommendations with respective recommendation action steps
Desired Outcome #4: Agreement on a consolidated list of work force issues recommendations with respective recommendation action steps
Desired Outcome #5—Agreement on Next Steps: A process for development of a draft strategic plan, drawing from this Workforce Summit's work products:
○ Workforce issues
○ Workforce issues recommendations with respective recommendation action steps

The agenda was designed to provide both sufficient time as a whole group to learn and raise issues, as well as small group opportunities for more in-depth discussion. Further, the agenda was tailored to offer strategic planning frameworks, including those in use by North Dakota in other efforts and from other states, such as the Behavioral Health Workforce Employment and Training project out of Plymouth State University. Importantly, participants were guided toward identifying overarching categories, goals, objectives, and

action steps. Emphasis was placed on answering as many of the following questions as possible about these recommendations and action steps: Who, When, Why, Where, and How. In particular, the breakout groups were asked to consider and identify timeframes for each of these levels and the 'who'. That is, to give some thought to the entity or entities, or groups that should lead and/or implement these action steps. All of the Summit documents, including key reference material (e.g., North Dakota Behavioral Health Strategic Plan), were uploaded to an unique website for participants and the general public to access: **https://www.wiche.edu/policy-research/data-resources/north-dakota-behavioral-health-materials/**.

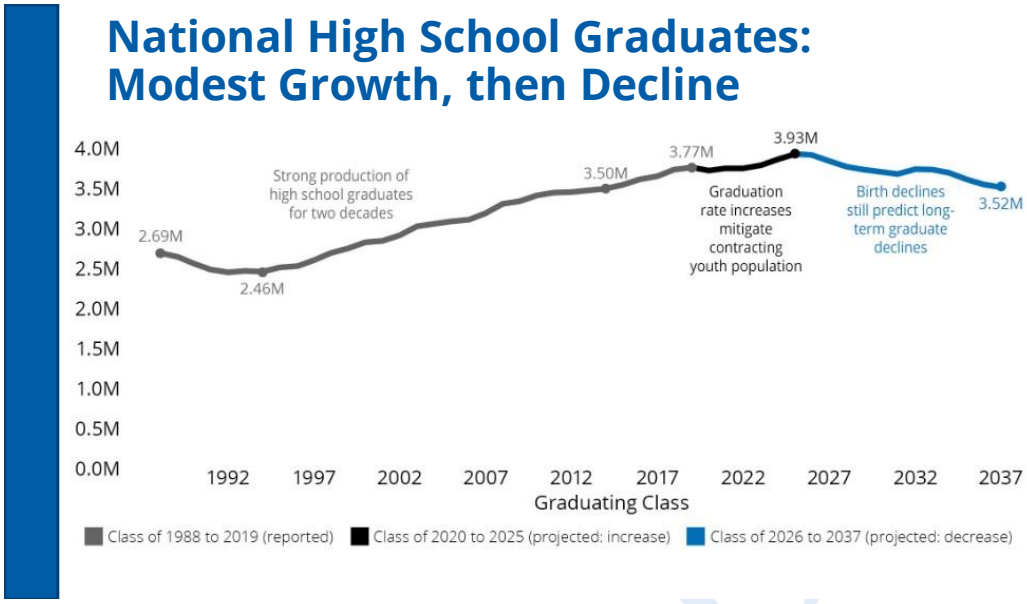
WICHE BHP presented data on the overall workforce environment across the WICHE states from a higher education and 'pipeline' perspective.

Exhibit 4. Conceptual workforce pipeline and "leakage"



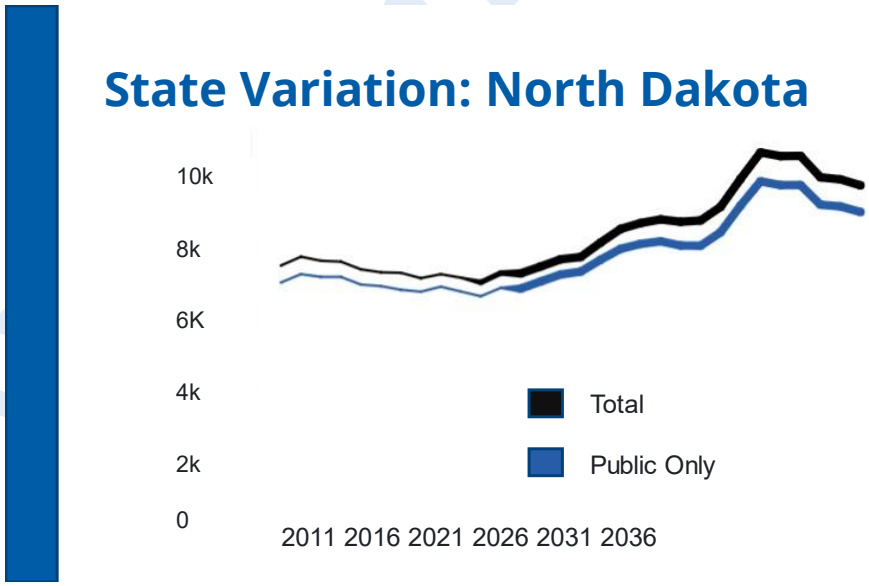
Participants reviewed data showing areas of challenge and opportunity in North Dakota. Information presented showed that North Dakota, while faced with declining enrollment and completion rates as are neighboring states, also had possible competitive advantages. North Dakota is showing an increase in the population that is becoming workforce eligible, a result of the early-century oil boom and aging of children born since—an increase not seen in its neighbors:

Exhibit 5. National High School Graduation Rates



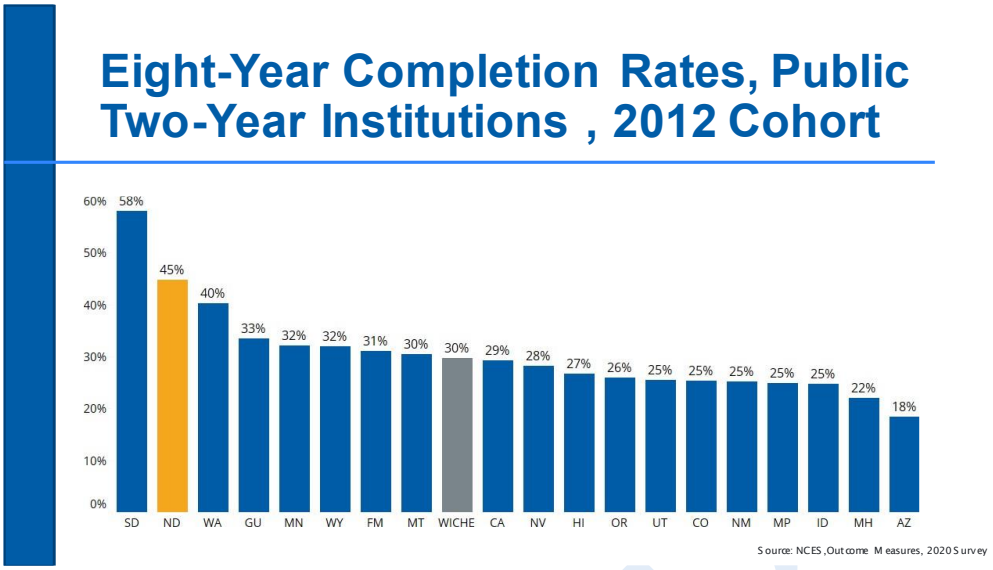
These high school graduates are not the only source of potential behavioral health postsecondary students—adults increasingly make up a big chunk of postsecondary enrollees. However, they are representative of a potential source of employees for the behavioral health workforce. This trend is slightly different in North Dakota (below); however, the trend accelerates later but is steeper and longer.

Exhibit 6. North Dakota High School Graduation Rates



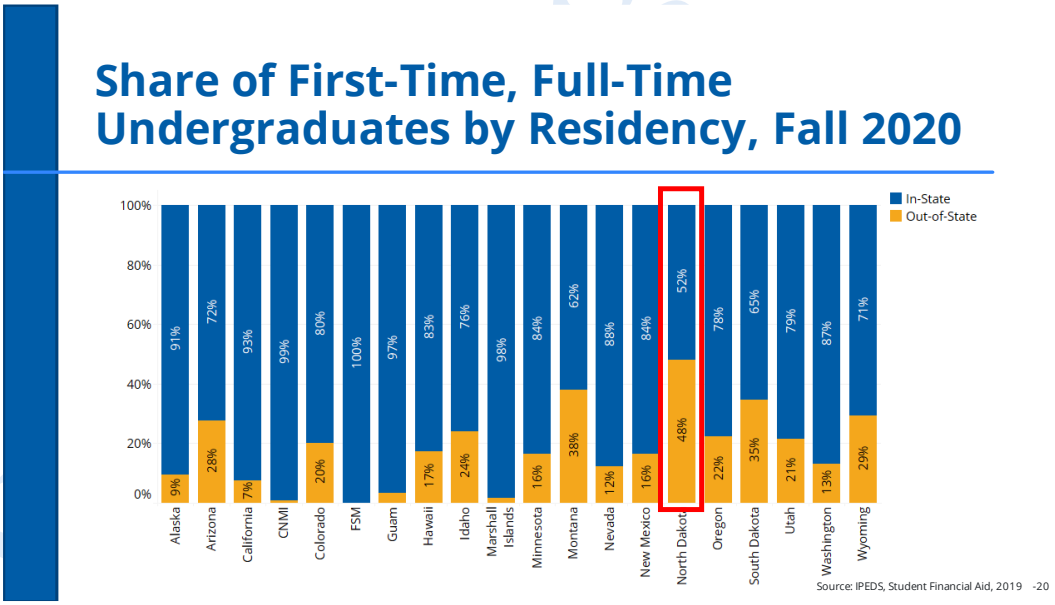
North Dakota is also witnessing a higher completion rate for two-year institutions than all but South Dakota in the western U.S.:

Exhibit 7. North Dakota High School Graduation Rates



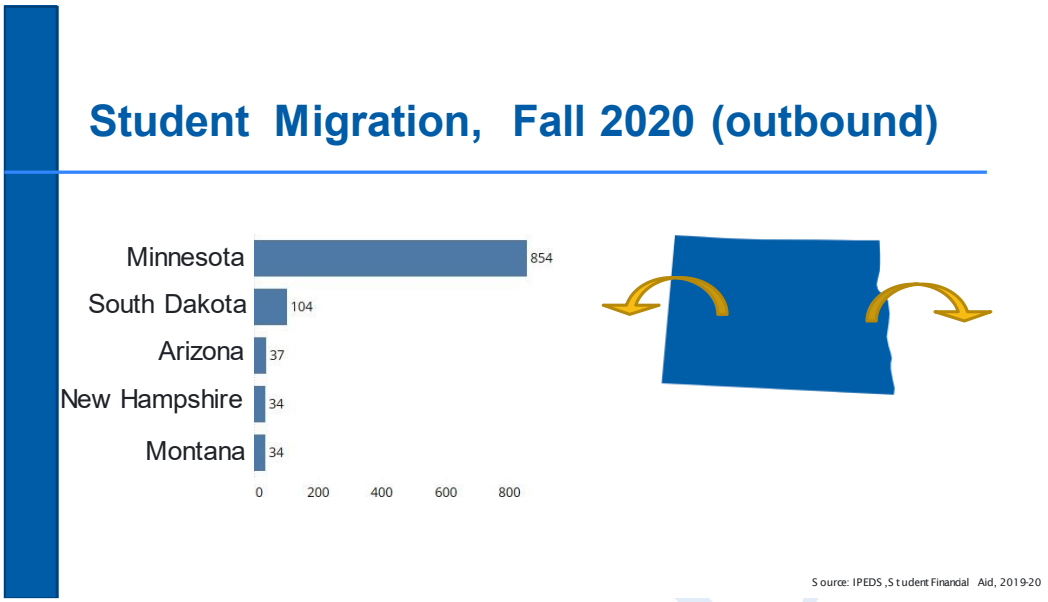
A challenge noted, however, is that North Dakota has a lower percentage of undergraduates who reside in North Dakota:

Exhibit 8. Residency of Undergraduates, Fall 2020



And while Minnesotans comprise the vast majority of student in-migration to North Dakota for college, they also are the largest number of students migrating out of North Dakota after graduating.

Exhibit 9. Student Outbound Migration



National and North Dakota Behavioral Health Professionals Data

Information was presented touching on some of the behavioral health professional trends and projections in North Dakota and nationally. Several of the maps contained in *The Behavioral Health Workforce in North Dakota: A Status Report, Behavioral Health Workforce Implementation Plan, Sixth Biennial Report (2021)* were presented, including this one displaying the vast parts of North Dakota considered Health Professional Shortage Areas (Exhibit 10).

According to the Health Resources and Services Administration's National Center for Health Workforce Analysis (Exhibit 11):

"Between 2017 and 2030, the total supply of all psychiatrists is projected to decline as retirements exceed new entrants. Rapid growth in supply of psychiatric nurse practitioners and psychiatric physician assistants may help blunt the shortfall of psychiatrists, but not fully offset it. In 2030, the supply of these three types of providers will not be sufficient to provide any higher level of care than the national average in 2017, which does not fully meet need….

Further, the results here illustrate that the nation is producing many social workers trained at the master's level…modeling results suggest that if current trends continue, the overall national supply of social workers will grow rapidly and through 2030 should be more than sufficient to meet demand. However, the role of social workers in care delivery continues to evolve. To the extent that the nation relies greatly on social workers in a patient-centered medical home model that better integrates behavioral health and primary care, the increase in demand for social workers could be substantially higher than the projections in this report."

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Exhibit 10. Health Professional Shortage Areas—Mental Health

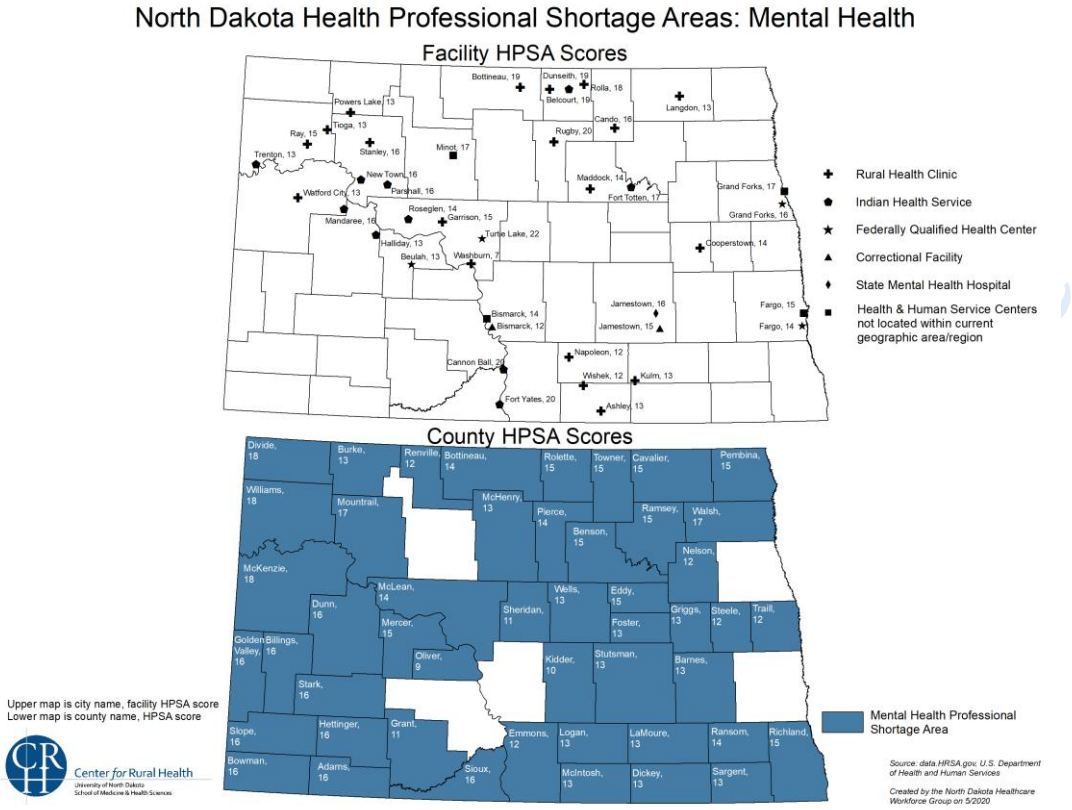


Exhibit 11. HRSA Behavioral Health Workforce Projections

	Adult Psychiatrists	Child & Adolescent Psychiatrists	Nurse Practitioners	Physician Assistants	Psychologists	Social Workers	Marriage & Family Therapists	Addiction Counselors	Mental Health Counselors	School Counselors
Supply [a]										
Estimated supply, 2017	33,650	8,090	10,450	1,550	91,440	239,410	53,080	91,340	140,760	116,080
New entrants, 2017-2030	10,270	5,000	9,520	1,770	49,400	367,520	39,190	33,300	72,860	158,440
Attrition [b]*, 2017-2030*	(14,850)	(2,810)	(2,770)	(350)	(29,670)	(82,760)	(18,080)	(28,030)	(45,150)	(52,640)
Change in work patterns [c]	(2,050)	(450)	(300)	(80)	(7,730)	(10,800)	(1,540)	(2,730)	(4,150)	(3,750)
Projected supply, 2030	27,020	9,830	16,900	2,890	103,440	513,370	72,650	93,880	164,320	218,130
Total Growth, 2017-2030	(6,630)	1,740	6,450	1,340	12,000	273,960	19,570	2,540	23,560	102,050
% growth, 2017-2030	-20%	22%	62%	86%	13%	114%	37%	3%	17%	88%
Demand										
Estimated demand, 2017	38,410	9,240	10,450	1,550	91,440	239,410	53,080	91,340	140,760	116,080
Projected demand, 2030 [d]	39,550	9,190	12,050	1,670	95,600	268,750	57,970	105,410	158,850	119,140
Total growth, 2017-2030	1,140	(50)	1,600	120	4,160	29,340	4,890	14,070	18,090	3,060
% growth, 2017-2030	3%	-1%	15%	8%	5%	12%	9%	15%	13%	3%
Adequacy of Supply, 2030										
Total Projected Supply (minus) Demand	(12,530)	640	4,850	1,220	7,840	244,620	14,680	(11,530)	5,470	98,990

Notes: All numbers reflect full time equivalent (FTEs); Numbers presented are rounded to the nearest ten and may not sum due to rounding; Negative numbers are in parenthesis;

[a] For all professions except psychiatrists, the model assumes that demand and supply are equal in 2017.

[b] Includes retirements and mortality.

[c] For example, changes from full-time to part-time hours, or vice versa.

[d] Demand growth reflects changing demographics.

Best Practices

Summit participants were provided with ideas and considerations that have been found important in other states' successful workforce efforts and that should be addressed regarding North Dakota behavioral health workforce efforts:

- Where workers are needed rarely coincides with where workers are educated and trained
- Typical recruitment strategies for professionals focus at the end of the pipeline, or post-graduation, and seek to entice relocation
- Too often higher education views rural/remote learners as "place bound" and not as "community or place committed"
- Need to seek ways to engage place committed learners, extend education and training opportunities to them, and develop local workforce where they are needed

Examples from other states included a 2 + 2 degree initiative (Northern Mariana Islands and University of Alaska-Anchorage), providing degree opportunities while leveraging community-committed students who are far more likely to return home to provide services; Community Behavioral Health Aide credentialing in both Alaska and Minnesota, career development options for extending both the professional career pathway and serving rural and tribal areas that have less access to services; and, the Future Health Professionals program, formerly known as Health Occupations Students of America (HOSA), that promotes careers in all health fields and that is currently in operation in North Dakota.

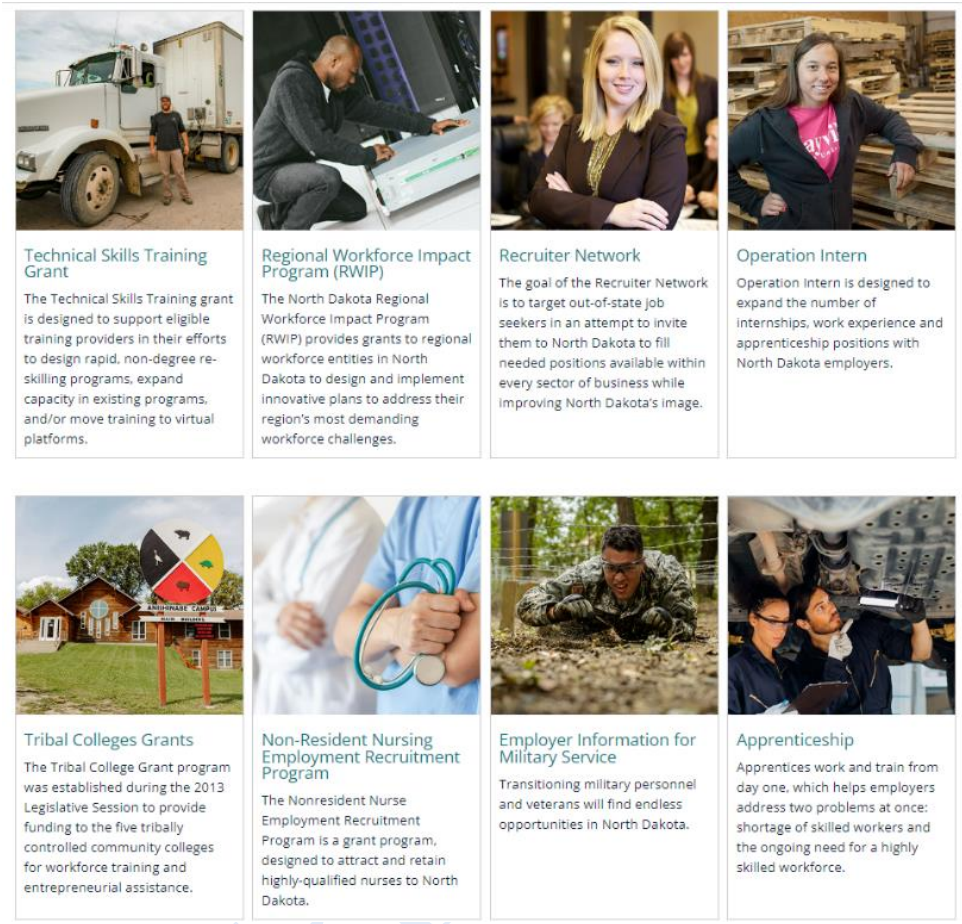
Behavioral Health Workforce Initiatives

A number of relevant existing workforce initiatives and various health- and workforce-related plans were noted. These included the Department of Commerce's efforts and the Workforce Development Council, and the State Health Improvement Plan. The Department of Health and Human Services' workforce-related initiatives were also presented:

- 1915i State Plan Amendment: Grants for providers to bill for Medicaid
- Peer Support Services: Certified Peer Support Specialist I and II
- Partnerships for Success: Ensuring trained workforce in prevention
- Free Through Recovery and Community Connect: Peer Support Specialists and Care Coordinators

Other workforce initiatives were discussed. Among these was the North Dakota Primary Care Office's various loan repayment programs: North Dakota Health Care Professional Student Loan Repayment Program, Federal State Loan Repayment Program (SLRP), and National Health Service Corps (NHSC). Also discussed were the workforce programs

Exhibit 12. North Dakota Department of Commerce Workforce Initiatives



Legislative committee work and legislation was presented. A sample of the recent bills and committee work included (adapted from the *Legislative Bills and Studies Relating to Behavioral Health Workforce*, https://www.ndlegis.gov/files/resource/committee-memorandum/23.9173.01000.pdf):

"Senate Bill No. 2018 (2021) - Appropriation of $250,000 from the general fund to the Department of Commerce in the grants line item for the rural health care grant program to provide matching funds to an organization assisting in the recruitment, distribution, and supply, and enhancing the quality and efficiency of personnel providing health services in rural areas of the state.

Senate Bill No. 2125 (2021) - Relating to the health care professional student loan repayment program.

House Bill No. 1018 (2019) - Appropriation of $200,000 from the general fund, designated from the discretionary funds line item, to the Department of Commerce for the rural health care grant program to provide matching funds to an organization assisting in the

recruitment, distribution, and supply, and enhancing the quality and efficiency of personnel providing health services in rural areas of the state.

Senate Bill No. 2143 (2019) - Relating to the health care professional student loan repayment program.

Senate Bill No. 2236 (2019) - Relating to licensure and regulation of behavior analyst professionals and the regulation of applied behavioral analysts of psychologist examiners and to the Board of Integrative Health Care.

Senate Bill No. 2339 (2019) - Relating to qualification for addiction counseling licensure for an applicant licensed in another jurisdiction.

Senate Bill No. 2361 (2019) - Relating to the licensing of social workers.

Human Services Committee (2019-20 Interim)
Implementation of Behavioral Health System Study Recommendations
The committee studied the implementation of the recommendations of the HSRI study of North Dakota's behavioral health system. The committee received updates regarding the status of implementation of recommendations included in the HSRI study of the state's behavioral health system. The Behavioral Health Planning Council, in conjunction with behavioral health stakeholders, is coordinating the development of a strategic plan to implement the recommendations.

Acute Psychiatric Treatment Committee (2021-2022 Interim)
In September 2021, DHS and HSRI provided a report regarding the implementation of the recommendations from the HSRI report through July 2021. Of the 13 aims identified in the HSRI report, Aim 7 relates to the engagement in targeted efforts to recruit and retain a qualified and competent behavioral health workforce. Through July 2021, HSRI has completed 20 percent of this aim. The estimated completion date for this aim is the end of June 2022."

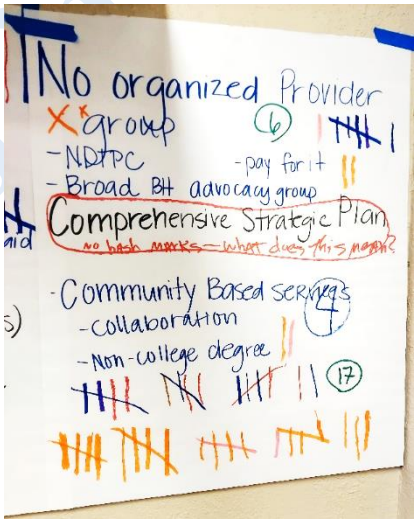
Pre-Summit WICHE BHP System-Level Recommendations

At the Summit, WICHE BHP offered three system-level recommendations for consideration and to serve as a potential starting point for discussion. These recommendations were based on the information gathered throughout the summer. And, perhaps as importantly, they are founded on recommendations that have been proposed across various workforce efforts. These efforts include the Behavioral Heath Strategic Plan, *Behavioral Healthcare Workforce Solutions in North Dakota: Improving Access to Care*, *The Behavioral Health Workforce in North Dakota: A Status Report, Behavioral Health Workforce Implementation Plan, Sixth Biennial Report (2021): Health Issues For The State Of North Dakota,* and *Behavioral Health Workforce in North Dakota: Education Requirements, Licensing Requirements, and Licensed Professionals*:

1. Create a collaborative task force—or identify and enhance an existing collaborative—to: a. Oversee and implement a state-level behavioral health workforce strategic plan; b. Coordinate, integrate, and communicate behavioral health workforce-related initiatives and efforts, including strategic planning at the regional and local levels; c. Evaluate, and be accountable for, strategic plan outcomes. ▪ Establish as time-limited ▪ Conduct a network mapping exercise to identify existing resources (human, financial, infrastructure) and any gaps. ▪ Sufficiently support the collaborative effort, especially with appropriate staffing levels.
2. Identify and coordinate and/or integrate workforce relevant data collection, reporting, and analysis.
3. Review and assess the full costs to agencies and providers to implement strategic workforce initiatives.

Priority Workforce Categories

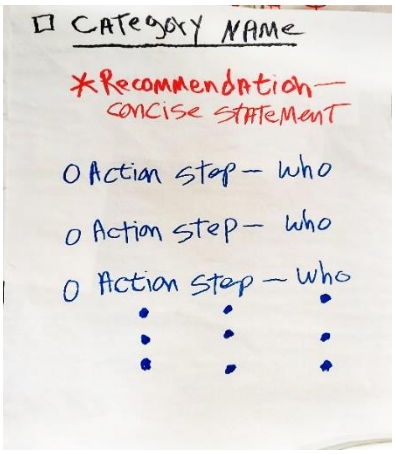
Given the relatively short length of the Summit and the diversity of organizations and areas of interest of the participants, direction was provided to first focus on identifying and adopting a recommendation about which categories of behavioral health workforce should be prioritized. These categories, which were to be developed further with goals, objectives, and action steps, are representative of what was at the top of mind for the group, and, in a general sense, align with what key interviews revealed. In some cases, one or more breakout groups went deeper or were more detailed with one or more of the categories. The participants did not rank order or prioritize these categories, although the timing of the implementation of some of the recommended objectives was discussed.



After the first round of breakouts on the first day, there were 20 sheets of potential categories and possible goals, objectives, or action steps. The participants spent the last plenary session reviewing the work of the breakout groups, including asking questions and clarifying individual items. At the end of the first day, participants cast votes to indicate which of the items they thought most relevant, pressing, or achievable. WICHE BHP facilitators counted the tallies, and combined votes across similar items. At the beginning of the second day, participants were presented with the revised recommended categories. The following are the six Priority Categories that were adopted, although it is important to note that these were not set in a priority order:

Recommended Priority Categories	**1. Licensure**
	2. Retention
	3. Recruitment
	4. Community-based Services
	5. Reimbursement
	6. Marketing/Branding/Communication

Priority Workforce Recommendations



After adopting the six Priority Categories, the Summit continued with participants spending the bulk of the day in breakout groups reviewing, discussing, clarifying, and agreeing to specific recommendations within each category. Again, participants were encouraged to consider the previously discussed strategic planning components, including taking a "systems thinking" approach that would allow for strategies that address all points along the continuum of care. Where possible, participants were encouraged to identify who—agencies, groups, individuals, communities, etc.—would take the lead on any individual action steps.

After almost four hours of breakout groups, participants reconvened to review and discuss the work products. The group identified 30 individual recommendations. Each Priority Category included at least one recommendation; however, the constraints of the Summit—limited time and a diverse participant group—meant a range of individual recommendations from one to nine. The following are the recommendations by Priority Category:

Priority Category	*Recommendations*
1. Licensure	**1.1 Standardize and make consistent behavioral health workforce policies and practices across licensing boards**
	1.2 Identify opportunities to streamline licensure to advantage of emerging workforce trends, e.g. retirees.
2. Retention	**2.1 Encourage, incentivize, and innovate collaborations, such as job sharing and shared supervision, across behavioral health agencies and providers**
	2.2 Create a workforce culture that is supportive of behavioral health

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	2.3 Improve organizational leadership, culture, and training capacities
	2.4 Assist community provider agencies in creating engaging work environments
3. Recruitment	**3.1 Create a workforce pipeline that can be utilized in all areas of the state**
	3.2 Identify, design, and market a behavioral health workforce-specific career pathway
	3.3 Create a behavioral health workforce scholarship program for North Dakota residents
4. Community-Based Services	**4.1 Enhance, address length, and on-going funding of training for non-licensed services**
	4.2 Provide funding for innovation and program flexibility for rural and tribal areas
	4.3 Review and consolidate qualifications and disqualifications for peer support and care coordination positions across programs
	4.4 Create and enhance apprenticeships and work-based learning opportunities
	4.5 Consider mirroring Home and Community Based Services cost supports for rural and tribal areas
	4.6 Utilize the 'designee model' of SSI/SSDI to increase pathways for entrance into behavioral health professions
	4.7 Identify and coordinate on local level costs regarding workforce competition
	4.8 Integrate services into existing behavioral health services and systems
	4.9 Designate a behavioral health organization to coordinate services
5. Reimbursement	**5.1 Identify current reimbursement needs, including gaps in service and full provider costs**
	5.2 Ensure full reimbursement for state-funded services

	5.3 Move licensed professions to 100% reimbursement rate
	5.4 Enhance or ensure adequate reimbursement for administrative, legal, and other behavioral health service costs to participate in programs
	5.5 Provide outreach and engagement to rural and tribal areas and organizations
	5.6 Clarify which services and professions can bill and for which programs
6. Marketing/Branding/ Communication	**6.1 Review the Aim 7 committee structure, needed resources, and potential future role(s)**
	6.2 Create a community-based behavioral health workforce backbone organization
	6.3 Implement a systemic, data-driven approach to identifying workforce development needs, including fielding of needs and gaps and a workforce pipeline analysis
	6.4 Consider creation of a statewide organization representing providers
	6.5 Coordinate behavioral health workforce efforts with current allied health and overall workforce efforts
	6.6 Convene behavioral health stakeholders for a statewide workforce conference

Key Takeaways, Recommendations, and Next Steps

The behavioral health community in North Dakota has been improving the workforce situation in the state for decades. This has happened, and continues to this day, even in the face of local and national workforce and behavioral health trends that have complicated, if not negatively impacted, the workforce environment, including population changes, the impact of the SARSCoV2/COVID-19 pandemic, and economic conditions. Because of this history and the accompanying track record of success, the community and the state are well-positioned to take the next steps to address behavioral health care workforce issues faced in 2022 and beyond.

And in fact, in the time between the conclusion of the Summit and the drafting of this report, some of the priority workforce action steps identified are under consideration or have been initiated, including some that are part of, or will be impacted by, larger, related efforts such as changes to licensing boards and changes to the Workforce Development

Council. There is momentum; and the Summit and this overall project should serve as additional and crucial energy to enhance current and future efforts.

To that end, there are nine key takeaways, four recommendations, and four next steps that WICHE BHP has identified from this project. A number of these were either known or suspected prior to the Summit and then became clearer afterward. The following represent WICHE BHP's key takeaways, recommendations, and next steps based on research, key interviews, and the results of the Summit.

Key Takeaways

A. There is a visible and tangible commitment from a diverse, statewide community of interest to addressing behavioral health workforce issues.
B. Planning, design, strategy, leadership, and implementation of workforce initiatives are reliant on a relatively small number of dedicated people, organizations, and agencies (especially the Aim 7 Committee, the Division of Behavioral Health, and the Center for Rural Health).
C. Care and intentionality must be given to the behavioral health workforce needs of, and impacts on, local communities, particularly in rural and tribal areas.
D. As well, initiatives must maintain a focus on how impacts are felt across the state with an eye toward a comprehensive, multi-level, systemic approach.
E. There remain important similarities and differences between mental health and substance use/substance abuse/addiction workforce fields, as well as between public and private services and providers.
F. Any initiatives must be designed to have an impact throughout the 'pipeline'—from primary school through retirees/career changers—and across the entire continuum of care—from promotion, to prevention, to early intervention and through treatment and recovery.
G. Leveraging existing efforts, initiatives, and collaboratives by adding or enhancing behavioral health workforce components will be a crucial strategy on achieving both short- and long-term meaningful change and improvement.
H. Sufficient resources, including funding and capacity building across varied agencies, organizations, and communities of interest will be critical to achieving success in any efforts.
I. Time is of the essence to take advantage of—or mitigate against—overall workforce and employment trends.

WICHE BHP Recommendations

Based on the results of the Summit and the work conducted through the summer, the following represent WICHE BHP's priority recommendations for North Dakota. The recommendations made and refined at the Summit align well with the results of the key interviews and with previous workforce efforts. Further, these recommendations are only possible due to the progress made over the past six years. It is important to note that these recommendations are WICHE BHP's best advice on prioritizing the 30 recommendations

adopted at the Summit, and that the state and community should seek to achieve as many of the Summit recommendations as is appropriate. Lastly, these recommendations have contingencies and dependencies, both across these four and the 30 Summit Recommendations; some cannot be implemented before another, others will only work if two or more are implemented at the same time.

1. *Fully fund and resource a 'backbone' organization to lead behavioral health workforce initiatives in North Dakota.*

This recommendation has existed in different forms in various North Dakota behavioral health strategic planning documents, reports, and studies. As noted above in *Key Takeaways*, it is glaringly obvious that the success to-date of workforce initiatives has relied heavily on an array of largely unresourced committees or collaboratives, or on individual organizations and individuals. Future success in the current challenging workforce environment will require a comprehensive, strategic approach. As such this recommendation is foundational to any medium- to long-term workforce efforts; capacity must be built and enhanced to achieve lasting impacts. From the pre-Summit recommendations:

Create a collaborative task force—or identify and enhance an existing collaborative—to:
a. Oversee and implement a state-level behavioral health workforce strategic plan;
b. Coordinate, integrate, and communicate behavioral health workforce-related initiatives and efforts, including strategic planning at the regional and local levels;
c. Evaluate, and be accountable for, strategic plan outcomes.

- Establish as time-limited
- Conduct a network mapping exercise to identify existing resources (human, financial, infrastructure) and any gaps.
- Sufficiently support the collaborative effort, especially with appropriate staffing levels.

This recommendation primarily aligns with Priority Recommendations 6.1, 6.2, 6.3, 6.5, and 6.6.

2. *Design and field 'pipeline' and workforce costs needs assessment/gaps analyses.*

While there are many data available, both quantitative and qualitative, there is a need to understand the supply and demand to inform a pipeline initiative. Likewise, there were substantial conversations throughout this project, in interviews and at the Summit, regarding whether or not the state knew what real costs providers were facing, including for licensure, e.g., supervision, legal, administrative, etc., and reimbursement for both services provided and workforce recruitment and retention efforts. Further, initiatives to expand the workforce through apprenticeships and work-based learning will depend on which costs are incurred and which are reimbursable (the gap). These analyses should consider the factors noted above in the strategic planning approach undertaken at the Summit, i.e., impacts on rural and tribal areas, the continuum of care, and across the

spectrum of behavioral health professionals. A workforce costs analysis should include the costs faced by providers and organizations on the local level from competition for both qualified behavioral health workers and from other industries. This recommendation aligns with Summit Recommendations 2.1, 3.1, 4.7, 5.1, 5.2, 5.4, and 6.3.

3. *Enhance existing recruitment programs and create new ones.*

This recommendation includes three components that were raised in interviews or at the Summit, outlined below. There are obvious opportunities in the near-term to take advantage of an expected growth in high school graduates, career changes, and other recent employment trends.

a. Create a behavioral health workforce scholarship for North Dakota residents to incentivize residents who are community- or place-committed to remain or return to serve with an emphasis on the professions and areas most in need.
b. Create a career pathway into the workforce for individuals who lack degrees, those who are switching careers, or retirees.
c. Create a 'Behavioral Health Workforce Innovation Fund' to identify and incentivize innovative approaches to community collaboration on workforce needs, such as job- and supervision-sharing, retiree/career changers recruitment, and retention efforts such as organizational leadership culture, workplace environment, training, and career development and satisfaction.

This recommendation aligns with Summit Recommendations 2.1, 3.2, 3.3, and 4.2.

4. *Collect, review, and report on behavioral health workforce-related licensure regulations, policies, and procedures.*

The area of licensure is complex and continues to receive significant attention by the legislative and executive branches, as well as from the impacted communities. There is no doubt, however, that the multitude of workforce issues identified through this project remain difficult to categorize and to resolve. The intent of this recommendation is to identify any barriers to licensure, such as renewals and current licensees who are seeking dual-licensure and any potential changes that would streamline licensure requirements across the relevant boards. Other examples include reviewing and revising, where appropriate, statutes and regulations that are unnecessarily burdening providers and individuals, such as background checks and disqualification criteria. This recommendation aligns with Summit Recommendations 1.1, 1.2, and 4.3.

Next Steps

The results of the Summit produced six Priority Workforce Categories and 30 Summit Recommendations across those six categories. These six categories are inter-related, and many of the recommendations either overlap in some way or are contingent on each other for implementation. That said, and as mentioned above, some of these recommendations can be pursued individually or in some combination in the short-term and have positive

impact. WICHE BHP further refined these, based on the work done throughout this project, to xxx recommendations.

The following are proposed next steps specifically for completing and implementing the strategic plan. These should serve to guide the anticipated public review and input to this report and its recommendations. It is important to note that these steps do not necessarily need to be taken in consecutive order; it is expected that some of these steps will have to occur concurrently. Ideally, these next steps would take place within the next six months, aiming for initial completion by June 2023:

1. **Review the strategic plan**
    a. Clarify priority categories and recommendations.
    b. Identify 'quick wins'.
        i. Which recommendation(s) are in progress at the current moment?
        ii. Which can be initiated quickly?
        iii. Which would take advantage of existing circumstances?
    c. Identify other short- or medium-term recommendations or action steps that will require legislative or executive action.

2. **Implement identified 'quick wins'**
    a. Establish a collaborative group or coalition to represent the behavioral health community on workforce issues in the short-term.
    b. Create a short-term plan of action to achieve identified action steps and recommendations.
    c. Identify state resources necessary to achieve any

3. **Finalize the strategic plan**
    a. Define specific action steps.
    b. Identify lead agencies/organizations and timeframes.
    c. Calculate the needed resources to support goals, objectives, and action steps.

4. **Implement the strategic plan**
    a. Develop an overall strategic plan calendar to guide and integrate efforts.
    b. Track short-term progress toward any 'quick wins' initiatives.
    c. Establish a mechanism to communicate about the strategic plan to the broader behavioral health community and to gather feedback and input.
    d. Design and field any identified analyses or assessments.

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Appendix A: Strategic Plan Template

1. Licensure				
Context				
Known Initiatives				
	Objective/Outcome	**Resources**	**Lead(s)**	**Deadline(s)**
1.1 Standardize and make consistent behavioral health workforce policies and practices across licensing boards				
1.2 Identify opportunities to streamline licensure to advantage of emerging workforce trends, e.g. retirees				
2. Retention				
Context				
Known Initiatives				
	Objective/Outcome	**Resources**	**Lead(s)**	**Deadline(s)**
2.1 Encourage, incentivize, and innovate collaborations, such as job sharing and shared supervision, across behavioral health agencies and providers				

2.2 Create a workforce culture that is supportive of behavioral health				
2.3 Improve organizational leadership, culture, and training capacities				
2.4 Assist community provider agencies in creating engaging work environments				
3. Recruitment				
Context				
Known Initiatives				
	Objective/Outcome	**Resources**	**Lead(s)**	**Deadline(s)**
3.1 Create a workforce pipeline that can be utilized in all areas of the state				
3.2 Identify, design, and market a behavioral health workforce-specific career pathway				
3.3 Create a behavioral health workforce scholarship program for North Dakota residents				
4. Community-Based Services				
Context				

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Known Initiatives				
	Objective/Outcome	**Resources**	**Lead(s)**	**Deadline(s)**
4.1 Enhance, address length, and on-going funding of training for non-licensed services				
4.2 Provide funding for innovation and program flexibility for rural and tribal areas				
4.3 Review and consolidate qualifications and disqualifications for peer support and care coordination positions across programs				
4.4 Create and enhance apprenticeships and work-based learning opportunities				
4.5 Consider mirroring Home and Community Based Services cost supports for rural and tribal areas				
4.6 Utilize the 'designee model' of SSI/SSDI to increase pathways for entrance into behavioral health professions				
4.7 Identify and coordinate on local level costs regarding workforce competition				
4.8 Integrate services into existing behavioral health services and systems				
4.9 Designate a behavioral health organization to coordinate services				
5. Reimbursement				

Context				
Known Initiatives				
	Objective/Outcome	**Resources**	**Lead(s)**	**Deadline(s)**
5.1 Identify current reimbursement needs, including gaps in service and full provider costs				
5.2 Ensure full reimbursement for state-funded services				
5.3 Move licensed professions to 100% reimbursement rate				
5.4 Enhance or ensure adequate reimbursement for administrative, legal, and other behavioral health service costs to participate in programs				
5.5 Provide outreach and engagement to rural and tribal areas and organizations				
5.6 Clarify which services and professions can bill and for which programs				
6. Marketing/Branding/Communication				
Context				
Known Initiatives				
	Objective/Outcome	**Resources**	**Lead(s)**	**Deadline(s)**

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6.1 Review the Aim 7 committee structure, needed resources, and potential future role(s)				
6.2 Create a community-based behavioral health workforce backbone organization				
6.3 Implement a systemic, data-driven approach to identifying workforce development needs, including fielding of needs and gaps and a workforce pipeline analysis				
6.4 Consider creation of a statewide organization representing providers				
6.5 Coordinate behavioral health workforce efforts with current allied health and overall workforce efforts				
6.6 Convene behavioral health stakeholders for a statewide workforce conference				

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Appendix B: Stakeholder Interviews

Rebecca Quinn, Center for Rural Health, University of North Dakota
Mandi-Leigh Peterson, Healthcare Workforce Initiative, University of North Dakota
Lacresha Graham, Behavioral Health Division, North Dakota Department of Human Services
Heather Brandt, Behavioral Health Division, North Dakota Department of Human Services
Tami Conrad, Behavioral Health Division, North Dakota Department of Human Services
Bevin Croft, Health Services Research Institute
Stacy Kusler, Workforce Specialist, Center for Rural Health- Primary Care Office, University of North Dakota, School of Medicine & Health Sciences
Karen Bernhardt, Center for Rural Health, UND
Kalee Werner, Manager, Primary Care Office, Department of Health
Ebony Flint, Health Services Research Institute
Sonja Bauman, Healthcare Workforce Initiative, University of North Dakota
Kurt Snyder, Executive Director, Heartview Foundation
Janell Regimbal, Insight to Solutions
Carlotta McCleary, North Dakota Federation of Families for Children's Mental Health
Carl Young, North Dakota Behavioral Health Planning Council Executive Committee
Lorraine Davis, Native American Development Center, BHPC Executive Committee
Emma Quinn, BHPC Executive Committee
Brenda Bergsrud, Director at Midstate Volunteer Program/Amachi Mentoring
Katie Ralston Howe, Workforce Development Director, Department of Commerce
Janna Pastir, Department of Commerce
Monica Haugen, Behavioral Health Division (Medicaid)
Patti Senn, Soul Solutions Recovery Center
Tim Blasl, North Dakota Hospital Association
Kelly Nagel, Director, Systems and Performance, Department of Health
Amy Veith, Department of Corrections and Rehabilitation
Yvette Anderson, Free Through Recovery Clinical Administrator, Department of Corrections and Rehabilitation
Laura Anderson, Assistant Director, Behavioral Health Division, Department of Human Services
Dale Wolf, Pastor, Lighthouse Church Fargo
John Butgereit, Director, North Central Human Service Center
Katie Nermoe, Sanford Health
Kelly Nagel, Director, Systems and Performance, Department of Public Health
Dr. Wehbi, North Dakota State Health Officer, Department of Health and Human Services
James Knopik, Manager, Addiction and Prevention Program and Policy, Behavioral Health Division, North Dakota Department of Health and Human Services
Thomas Volt, Drug Prevention Specialist, Behavioral Health Division, North Dakota Department of Health and Human Services
Kali Bauer, Community Prevention Administrator, Behavioral Health Division, North Dakota Department of Health and Human Services
Michael Salwei, Executive Director, Sanford Health
Sarah Prenger, Senior Executive Director of Primary Care and Behavioral Health, Sanford Health
Kathryn Norby, Executive Director of Family Medicine and Behavioral Health, Fargo, Sanford Health
Cassandra Froke, Sanford Health

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Appendix D: Summit Agenda.

North Dakota Behavioral Health Workforce
Summit and Strategic Planning

(https://www.wiche.edu/policy-research/data-resources/north-dakota-behavioral-health-materials/)

Day One: Monday, September 26, 1:00-5:00	
Plenary Meeting Room: ▪ **Judicial Room, 1st floor**	**Breakout Meeting Rooms:** ▪ **Governors Room, 2nd floor** ▪ **Executive Suite 114, 1st floor** ▪ **Executive Suite 106, 1st floor**

12:30-1:00: Check In

1:00-2:30: Plenary

- Welcome and Introductions: Rebecca Quinn and Kurt Snyder (Aim 7 Committee)
- Discovery Report Summary and Strategic Planning (WICHE)
- North Dakota Workforce Pipeline (WICHE)
- Best Practices in Behavioral Health Workforce (WICHE)
- Breakout Objectives and Desired Outcomes (WICHE)

2:45-3:45: Breakout Sessions

- Discuss Discovery Report, North Dakota behavioral health workforce initiatives and needs, and 'best practices'

Desired Outcome #1: Prioritized list of workforce issues

4:00-5:00: Plenary

- Breakout session report outs on prioritized lists of work force issues
- Preview Day Two
- Meeting Review: **+/Δ**
- Adjourn

Day Two: Tuesday, September 27, 9:00-4:00	
Plenary Meeting Room: ▪ **Judicial Room, 1st floor**	**Breakout Meeting Rooms:** ▪ **Governors Room, 2nd floor** ▪ **Executive Suite 114, 1st floor** ▪ **Executive Suite 106, 1st floor**

9:00-10:00: Plenary

- Review of results from Day One
- Further discussion and clarification of identified workforce issues and priorities

Desired Outcome #2: Agreement on a consolidated list of prioritized work force issues (from breakout sessions work of Day One, Desired Outcome #1)

10:15-12:00: Breakout Sessions:

- Prioritize workforce issues
- Begin development of recommendations and next steps

Desired Outcome #3: A list of workforce issues recommendations with respective recommendation action steps

12:00-1:30: Lunch on your own

1:30-2:45: Breakout Sessions, continued:

- Finalize development of workforce recommendations and next steps

Desired Outcome #4: Agreement on a consolidated list of work force issues recommendations with respective recommendation action steps

3:00-4:00: Plenary

- Breakout session report outs on recommendations and next steps
- Final remarks
- Meeting Review: **+/Δ**
- Adjourn

Desired Outcome #5—Agreement on Next Steps: A process for development of a draft strategic plan, drawing from this Workforce Summit's work products:

- Workforce issues
- Workforce issues recommendations with respective recommendation action st

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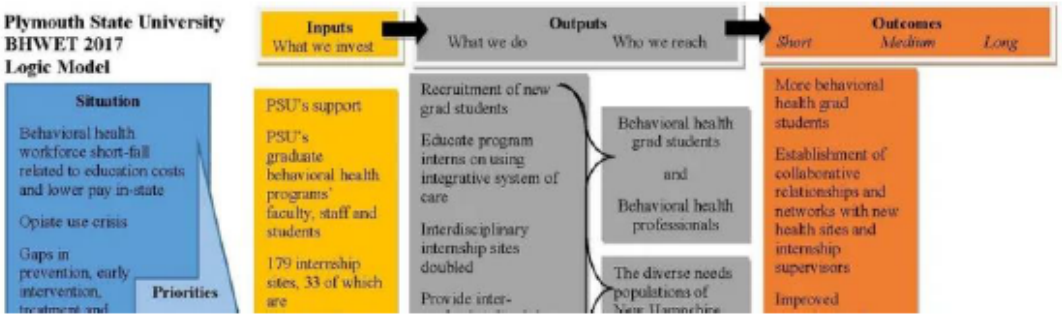
Appendix E: Summit Cheat Sheet.

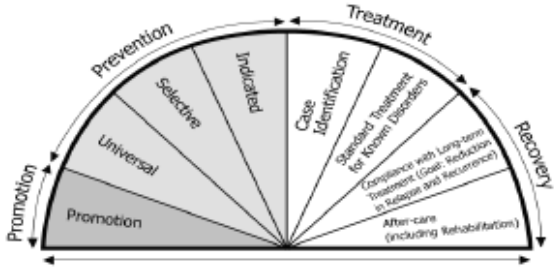
WICHE
Western Interstate Commission for Higher Education – Behavioral Health Program
3035 Center Green Drive Suite 200 Boulder, CO 80301-2204 303.541.0200 (ph) 303.541.0291 (fax)
Collaboration across the West – Since 1955

North Dakota Behavioral Health Workforce Summit
Strategic Planning Cheat Sheet
(https://www.wiche.edu/policy-research/data-resources/north-dakota-behavioral-health-materials/)

Strategic Planning Considerations

- Logic model concepts
- "What, Why, Who, When, How"
- Who's in the room, who's not in the room
- Honest, focused, realistic conversation
- "Systems thinking"





FUNDING
WORKFORCE
BEST PRACTICE

Other Planning Considerations

- East and west
- Rural and urban and tribal
- Mental health and substance abuse/addiction
- Levels of care and continuum of care
- Age
- Credentialed/licensed and certified/trained
- Private and public employers
- Funding source(s): federal, state, local, private
- Short-/medium-/long-term

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WICHE
Western Interstate Commission for Higher Education – Behavioral Health Program
3035 Center Green Drive Suite 200 Boulder, CO 80301-2204 303.541.0200 (ph) 303.541.0291 (fax)
Collaboration across the West – Since 1955

Issues

- Primary/secondary students
- Funding
- Career development
- Career satisfaction
- Competition
- Internship and supervisory costs
- Loan repayment
- Data
- Occupational licensing boards capacity and coordination
- Scope of practice
- Executive/legislative, statewide, state-to-local, local-to-local cooperation and coordination

Initiatives

Ideas

Draft System-Level Recommendations

1. Create a collaborative task force—or identify and enhance an existing collaborative—to:
   a. Oversee and implement a state-level behavioral health workforce strategic plan;
   b. Coordinate, integrate, and communicate behavioral health workforce-related initiatives and efforts, including strategic planning at the regional and local levels; and,
   c. Evaluate, and be accountable for, strategic plan outcomes.

   1.1 Establish as time-limited.

   1.2 Conduct a network mapping exercise to identify existing resources (human, financial, infrastructure) and any gaps.

   1.3 Sufficiently support the collaborative effort, especially with appropriate staffing levels.
2. Identify and coordinate and/or integrate workforce relevant data collection, reporting, and analysis.
3. Review and assess the full costs to agencies and providers to implement strategic workforce initiatives.

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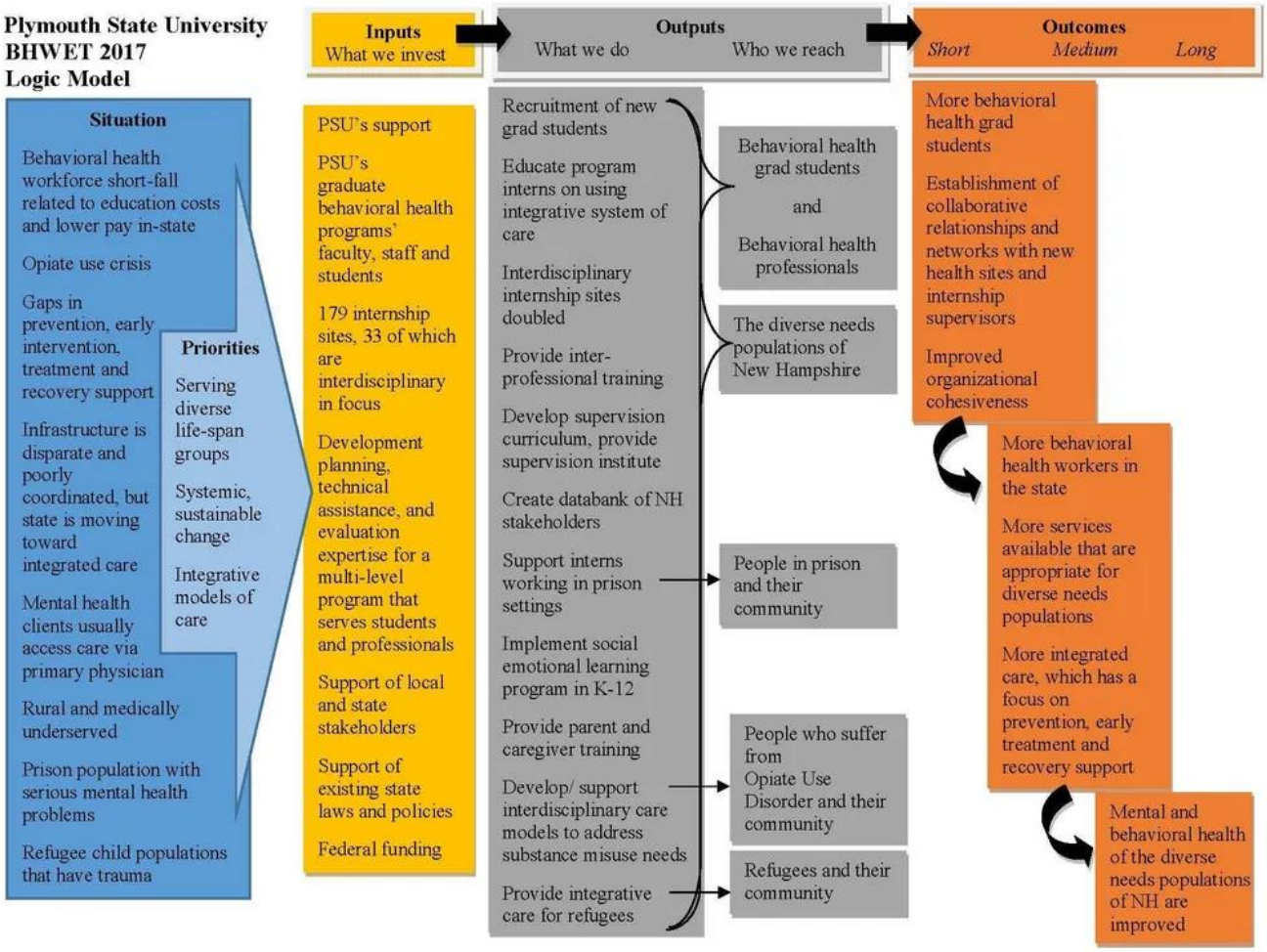
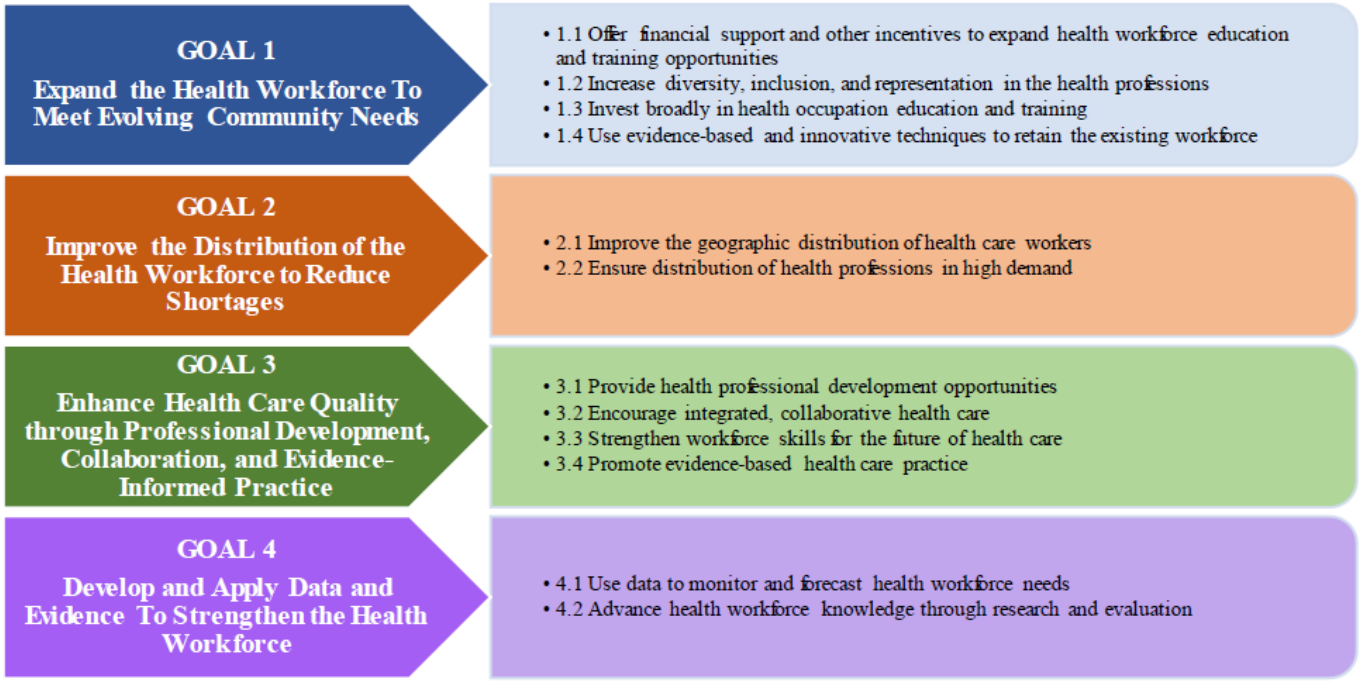
Appendix F. Plymouth State University HRSA Behavioral Health Workforce, Employment, and Training Grant Logic Model.



Appendix G: U.S. Department of Health and Human Services Healthcare Workforce Strategic Plan 2021.

Strategic Plan Framework

Below is a high-level framework of the Strategic Plan's goals and objectives:



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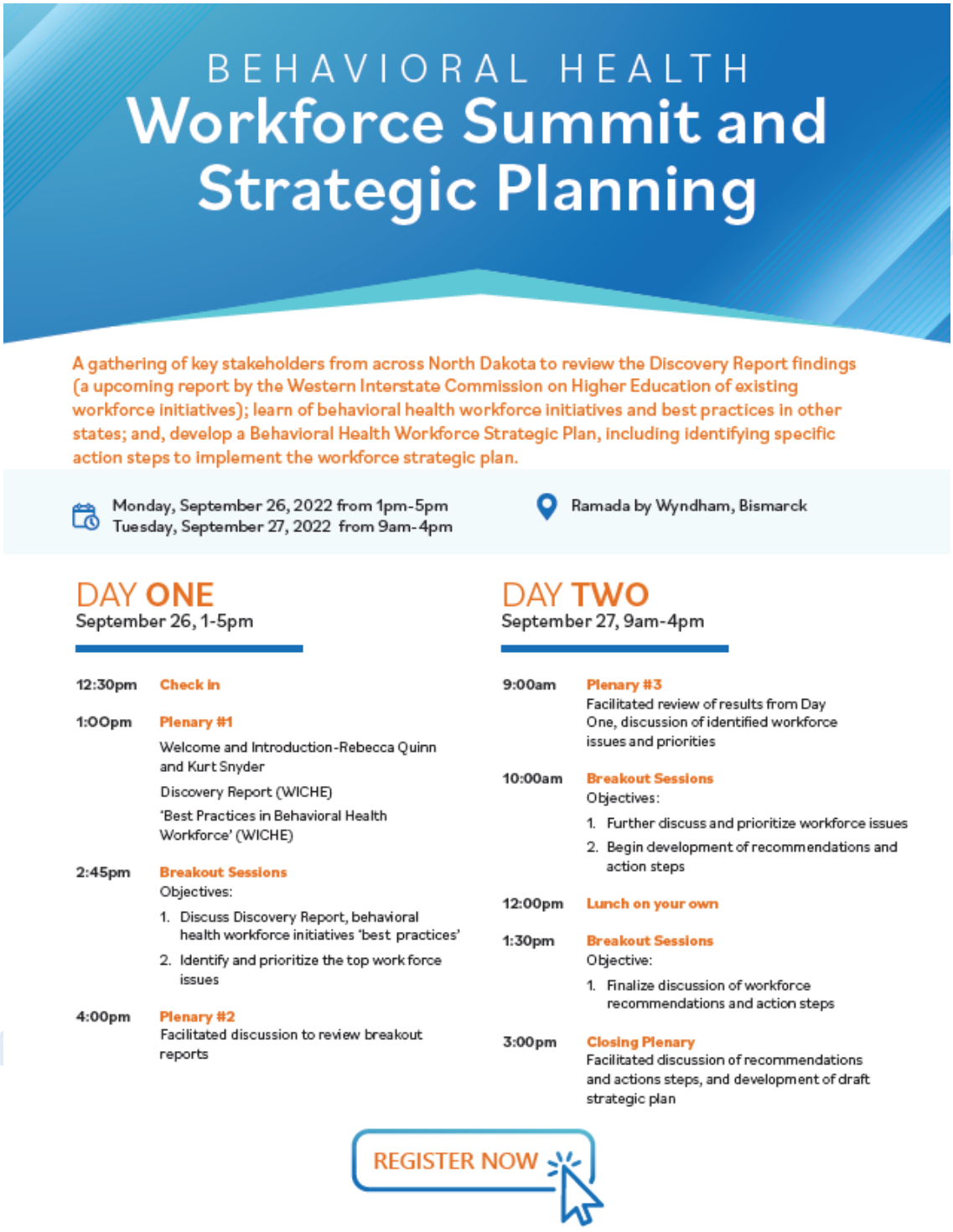
Appendix H: Summit Invitation.



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Appendix I: Degree Programs, Sixth Biennial Report 2021: Health Issues for the State of North Dakota.

Table 7.1
***Behavioral health degree programs at North Dakota academic institutions.*[1]**

Degree Program	North Dakota Academic Institutions
Doctor of Medicine (MD)	UND (ACCME, ACGME, & LCME accredited)
PhD Clinical Psychology	UND (APA accredited)
PhD Counseling Psychology	UND (APA accredited)
Doctor of Occupational Therapy	UND (granted candidacy status by ACOTE) & Uni. of Mary (granted candidacy status by ACOTE)
Master of Occupational Therapy	UND (ACOTE accredited)
MA/MS Counseling	UND, Uni. of Mary, & Uni. of Jamestown (not accredited) NDSU (CACREP accredited)
MS Social Work	UND (CSEW accredited)
Behavior Analysis	UND (track within MS in Special Ed. degree)
MA/MS School Psychology	Minot State University (NASP accredited)
Psychiatric-Mental Health Nurse Practitioner	UND (ANCC, NACNS, NONPF accredited)
Addiction Studies	UND, Uni. of Mary, & Uni. of Jamestown (track within degree programs) Minot State University (NASAC accredited)
BS Social Work	UND, Uni. of Mary, & Minot State University (CSWE accredited) Sitting Bull College (candidacy status by CSWE) NDSU (dual degree with Minot State)
Social Work Associate	NDSCS, Cankdeska Cikana Community College, & Nueta Hidatsa Sahnish College
Human Services Associate	Bismarck State College, Dakota College at Bottineau, Nueta Hidatsa Sahnish College, United Tribes Technical College, & Sitting Bull College

Table 7.2
North Dakota academic institutions with behavioral health degree programs.[1]

North Dakota Academic Institution	Degree Programs
University of North Dakota (UND)	Medical school & psychiatry residency program *Doctorate*: clinical and counseling psy., OT *Masters*: counseling, OT, psychiatric NP, social work, special ed. w/ behavior analysis *Bachelors*: psychology, social work
North Dakota State University (NDSU)	*Masters*: clinical mental health counseling, school counseling *Bachelors*: human development, psychology
University of Mary	*Doctorate*: OT *Masters*: clinical and addiction counseling *Bachelors*: social work, psychology
Minot State University	*Masters*: education specialist in school psy. *Bachelors*: addiction studies, social work, psychology
University of Jamestown	*Masters*: clinical counseling *Bachelors*: psychology w/ addiction studies
Bismarck State College	*Associates*: human services, social work, psychology
Dickinson State University	*Bachelors*: psychology
Cankdeska Cikana Community College	*Associates*: social work
Dakota College at Bottineau	*Associates*: human services, psychology
Nueta Hidatsa Sahnish College	*Associates*: human services (addiction and social work concentrations)
North Dakota State College of Science (NDSCS)	*Associates*: social work, psychology, occupational therapy assistant
Valley City State University	*Bachelors*: human services, psychology
United Tribes Technical College	*Associate*: human & social services
Sitting Bull College	*Bachelors*: social work *Associates*: human services

Appendix J: Behavioral Health Workforce Definitions, Sixth Biennial Report 2021: Health Issues for the State of North Dakota.

DEFINING BEHAVIORAL HEALTH WORKFORCE

There are a variety of ways to define behavioral health workforce. The definition should include the providers who treat individuals with behavioral health disorders and should examine their education, scope of practice, and level of independence in the treatment environment. In North Dakota, a simple method for defining the behavioral health workforce is to utilize the tiered classification system established in 2017 by the North Dakota Legislature. This classification system for mental health professionals was based on a thorough review of education and statutory guidelines along with scope of practice, to ensure that professionals are being fully utilized within their scope of practice.[1] Behavioral health educational programs available in North Dakota, including those that meet licensure requirements, are listed in Table 7.1 and Table 7.2 below.

The Tiered System

Determining which professions are included in the behavioral health workforce is challenging due to varying education requirements, scopes of practice, and levels of responsibility. A broad definition of behavioral health workforce includes providers of substance abuse and mental health services, as well as those providing services in supportive roles. Established in 2017 by the North Dakota Legislature, the tiered classification system is a simple way of defining the behavioral health workforce. This system classifies the various professions based on the required level of education and scope of practice. There are four tiers within this system.[1]

Tier 1

Professionals in Tier 1 are those with the greatest responsibility, scope of practice, education/training, and ability to practice autonomously. This tier is further broken down into two subsections. Tier 1a are the professionals with expertise in behavioral health (i.e., psychiatrists and psychologists) and Tier 1b are the professionals without expertise in behavioral health but may interact and work with aspects of the behavioral health field (i.e., physician assistants, advanced practice registered nurses).[1]

Tier 2

Professionals in Tier 2 are those that are able to work as independent clinicians. This tier is also further broken down into two subsections. Tier 2a are the professionals with comprehensive training in the diagnosis and treatment of a broad array of

behavioral health conditions (i.e., licensed clinical social workers, licensed professional clinical counselors, licensed marriage and family therapists). Tier 2b are the professionals with an area of expertise that is limited to a specific population (i.e., licensed addiction counselors, registered nurses).[1]

Tier 3

Tier 3 has the largest variety of professionals with many different practice descriptions. This includes licensed associate professional counselors, licensed professional counselors, licensed master social workers, licensed associate marriage and family therapists, occupational therapists, licensed practical nurses, licensed and registered behavior analysts, school psychologists, vocational rehabilitation counselors, and human resource counselors.[1]

Tier 4

Professionals in Tier 4 have the narrowest scope of practice and must work under other behavioral health professionals (i.e., behavior technicians, assistant behavior analysts, mental health technicians, case aids).[1]

Non-Tiered

There are professions that are not currently in the tiered system that provide behavioral health services in North Dakota. These professions include licensed baccalaureate social workers and peer support specialists.[1]

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Appendix J: North Dakota Primary Care Office Mental Health Loan Repayment Programs.

Mental/Behavioral Health Loan Repayment Programs

Program Type	North Dakota Health Care Professional Student Loan Repayment Program	Federal State Loan Repayment Program (SLRP)	National Health Service Corps (NHSC)
Program Description	The State of North Dakota has established loan repayment programs for health care professionals willing to provide services in areas of this state that have a defined need for such services.	Federal State partnership to assist sites in the recruitment of health care providers.	The NHSC is part of the Bureau of Health Workforce and coordinates the recruitment and retention of health professions.

Eligible MH/BH Disciplines	• Clinical Psychologists (licensed by the State Board of Psychologist Examiners)
	• Behavioral Health Professionals:
	  • Licensed Addiction Counselors
	  • Licensed Professional Counselors
	  • Licensed Social Workers
	  • Registered Nurses
	  • Specialty Practice Registered Nurses
	  • Behavioral Analyst
		• Clinical Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Marriage and Family Therapist, Psychiatric Nurse Specialist	• Nurse Practitioner (psychiatric/mental health, PNS)
			• Mental and Behavioral Health (psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Marriage & Family Therapist, Physician Assistant)
			• Providers who provide **SUD treatment** at an NHSC approved site; Physicians, NP, CNM, PA, behavioral health professionals, SUD counselors, RN, pharmacists.

Where Providers Serve	Providers must serve in areas of the state with a defined need for such services.	Providers must serve in Health Professional Shortage Areas (HPSAs)	Providers must serve in a Health Professional Shortage Area (HPSA) at an approved NHSC site.

Financial Benefits	Providers can enter into an agreement up to 5 years.
	Discipline / State Match / Community Match
	Clinical Psychologist / $ 60,000 / $15,000
	Behavioral Health / $ 20,000 / $ 2,000
		• Receive up to $50,000/year for year 1 and 2 (Example: $50,000 Federal Funds, $50,000 Community Match)
		• Receive up to $20,000/year for year 3 and 4
		• Receive up to $10,000/year for year 5
		• Site or community organization must provide a 1:1 match.
			• Year 1 and 2
			  • HPSA 14+ $50,000 FT $25,000 PT
			  • HPSA 0-13 $30,000 FT $15,000 PT
			• Years 3 & 4 $20,000 FT $10,000 PT
			• Years 4 & 5 $10,000 FT $5,000 PT

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Program Type	North Dakota Health Care Professional Student Loan Repayment Program	Federal State Loan Repayment Program (SLRP)	National Health Service Corps (NHSC)
MH/BH Provider Selection Criteria	• Health care professional's specialty • Need for the specialty in the area • Education and experience • Date of availability and anticipated term of availability • Willingness to accept Medicaid and Medicare patients • Letters of recommendation • Personal statement questions	• U.S. citizen or U.S. national • Must not have outstanding contractual obligations for health professional service • Must not have a judgment lien against their property for a debt to the U.S. • Must not be excluded, debarred, suspended or disqualified by a Federal agency • Have unpaid government or commercial loans for school tuition, reasonable educational expenses, and reasonable living expenses, segregated from all other debts	• U.S. citizen or U.S. national • Currently work, or applying to work, at an NHSC-approved site • Have unpaid government or commercial loans for school tuition, reasonable educational expenses, and reasonable living expenses, segregated from all other debts • Licensed to practice in state where employer site is located
Community Selection Criteria	Public and private entities are eligible for this program. Site criteria is based on the following factors: • Located in an area that is statistically underserved • Located at least 20 miles outside the boundary of a city with more than 40,000 residents	• Must be located in HPSA • Sites must be public or nonprofit private status • See all patients regardless of ability to pay • Accept patients covered by Medicare, Medicaid and CHIP • Not discriminate in the provision of services • Must have sliding fee scale or charity care plan.	• Must be located in HPSA • See all patients regardless of ability to pay • Accept patients covered by Medicare, Medicaid and CHIP • Not discriminate in the provision of services • Must have sliding fee scale *see NHSC site guidelines for full details.
Service Commitment	Must practice full-time for up to five years.	Must practice a minimum of two years. Full-time and part-time practice is available.	Must practice a minimum of two years. Full-time and part-time practice is available.
Payments	Payments are made at the conclusion of each twelve month period of service directly to the lender after completion of annual verification form. Community match payments are made to lender or provider. Funds provided through this program are non-taxable income.	Lump sum payments 90 days after the contract start date. Community match payments are made to lender or provider. Funds provided through SLRP are non-taxable income.	Lump sum payments 90 days after the contract start date; NHSC loan repayment is non-taxable income.
Application Deadline	Complete applications are due March 15.	Applications are reviewed quarterly during scheduled State Health Council meetings.	After January 1 each year; sign up at nhsc.hrsa.gov to be notified when the application cycle is open.
Penalties	No penalties are incurred as payments are made after the service year is provided.	The amount of loan repayments paid to the participant representing any period of obligated service NOT completed; $7,500 multiplied by the number of months of obligated service NOT completed; and interest on the above amounts at the maximum legal prevailing rate.	The amount of loan repayments paid to the participant representing any period of obligated service NOT completed; $7,500 multiplied by the number of months of obligated service NOT completed; AND interest on the above amounts at the maximum legal prevailing rate.

Updated 12/6/18

Kalee Werner | kaleewerner@nd.gov | 701-805-1071 | SLRP & North Dakota State Loan Repayment Programs
Stacy Kusler| stacy.kusler@und.edu | 701-777-3300 | NHSC
http://www.ndhealth.gov/pco/main.asp & https://ruralhealth.und.edu/projects/primary-care-office