Spring 2020

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Washington's Health Workforce Sentinel Network
Early COVID-19 Response Report:
Behavioral/Mental Health/Substance Use Disorder Clinics 5/3/2020

The Spring 2020 Washington Health Workforce Sentinel Network added four questions about the impact of the COVID-19 crisis on health care facilities' workforce and operations. These questions were in addition to the regular detailed questions about their health workforce changes and issues that are obtained twice yearly.

Below is a report of initial responses (from 17 facilities as of April 29) to the COVID-19 questions from behavioral-mental health clinics/outpatient mental health and substance abuse clinics across Washington. More COVID-19 related findings will be reported as they become available, and will be reported along with responses for other workforce demand questions, as well as for other types of health care facilities, on the Sentinel Network dashboard (see wa.sentinelnetwork.org).

When responding to the COVID-19 emergency (since approximately February 2020), which occupations and/or service roles, if any, were most affected at your facility(ies), and in what ways?

THEMES: PPE needs, high employee stress, service delivery disruption and need for alternative models

- *All direct service staff had to be relocated to their homes to provide telephone/telemedicine services to clients. At our youth homeless shelter we had/have no access to PPE. Admin staff continue to come into the office and comply with social distancing. In the Medicaid population there is a problem with access to the technology needed for us to stay in contact with our high risk clients who are mentally ill substance abusers. It's difficult work in the best of situations but remote work with these clients has been very challenging.*
- *Completely changing the way we provide therapy and getting reluctant patients up to speed. Employee stress and health has also been a challenge.*
- *The first impact was shortage of hand sanitizer, surgical masks and N95 masks. Our work loads increased as we tried to provide additional services to clients, educate re: COVID-19 impacts and increase social distancing. We have increased hiring of temporary and contingent staff, because regular staff have needed to stay home with children who no longer have school or daycare or needed to quarantine due to exposure to someone who was COVID + either at home or at work. We have also been much more stringent regarding requiring staff with any cold/flu like symptoms to stay home, so our work force is reduced because in the past staff would have worked if their symptoms were minor.*
- *We had several difficulties with PPE supplies and staffing.*
- *Delivering serveries once groups of 10 or more were told not to take place. Example sober support groups, DBT groups, etc. Getting PPE such as masks, and cleaners. Then loss of participation of patients giving into fear of the pandemic. Case managers are having the hardest time with DSHS and SSA being closed.*
- *Less demand for services except for residential care. If we did not have sufficient reserves or capitated payments, we would have to furlough staff.*
- *More demand for PPE and inability to obtain it. We only have about 300 surgical masks. Staff have made cloth masks for our residential clients and the staff at that facility.*
- *PPE needs, employee mental health*
- *We are a mental health agency that provides expressive play therapy for children who have suffered trauma. Play therapy cannot be done with social distancing, so we have had to move to telehealth to do our work. Meanwhile our children and families are experiencing the collective trauma and additional stress that increases the demand for services.*
- *We have had less demand for services, implemented a freeze on hiring. We have been unable to get PPE. All services are now delivered via telehealth. My agency pays for an EAP for all employees and each employee can access up to six free visits on any given topic with an EAP counselor.*

Behavioral Health Clinics

Occupations/Service Roles Most Affected (cont.)

- *As a counselor, my groups have been cut down to 6 in a room. The rooms in the units are very small and it is almost impossible to maintain social distancing.*
- *I do see a certain percentage of staff reeling from not only the virus but the economic factors that are impacting their friends and families. We most likely will experience a death of a client or co-worker and this weighs on peoples minds as well. From a business standpoint - all of our encounters/services are down - which will ultimately impact our revenues and push us to consider furloughs and lay-offs in the future.*
- *Problematic vacancies: We are desperately needing to increase our capacity to offer behavioral health to Spanish speaking populations that is linguistically and culturally appropriately. COVID19 has aggravated this need significantly.*
- *Mobilizing a large portion of our workforce to work from home and provide telephonic client appointments.*
- *Inadequate access to PPE, inadequate access to disinfectant products, and unexpected expense of purchasing telehealth licenses prior to HCA notifying providers HCA would purchase Zoom licenses.*
- *Students being able to continue clinical experiences. Difficulty recruiting telepreceptors for telemental health.*

Is there anything about your facility(ies)' staffing arrangements that made it easier or harder to respond to the emergency? If so, for which occupations and why?

THEMES: Problematic - Concerns re: older vulnerable workforce, workforce regulations, prior workforce shortages exacerbated by the emergency. Helpful – Prior implementation of EMRs and telehealth.

- *Staff were resistant to work from home preferring the stability and comradeship of the office. HR legal advice was that we could not send at risk workers home unless everyone went home. Our agency is set up with a terminal server and cloud based EMR which made the transition relatively smooth. The hardest lift was the changing recommendations/ information coming from the State HCA - too little and too late to make changes to record keeping in a timely manner.*
- *We do have many part time employees and that has been a challenge, getting up to speed on paperwork for those that were laid off, the employees with children faced the most challenges when schools were closed.*
- *We have been able to hire temporary staff for our entry level positions. Our challenge has been the skilled workers such as psychiatrists, RNs, ARNPs, Mental Health Professionals and licensed social workers. We have not been able to hire up for those positions and so have identified what we consider essential services and reduced any others in order to best utilize the work force we have left.*
- *Had to rely on agency staffing most of the time & they were unable to chart so we had difficulty fulfilling requirements.*
- *The ability of clinicians to work from home, with phone and teleahealth sessions. When life gets back to a new normal, a hybrid model should be adopted of both in-person sessions and teleahealth at the patients choice.*
- *We have a number of staff in high risk categories. Our staff tends to be older as people often move here to retire and want to work a few more years. This is true in administration and clinical staff.*
- *Work in Behavioral health and staff was able to telehealth after the first couple of weeks. We had to wait for federal and state changes in telehealth rules which are biased toward MDs, nurses and LCSWs and exclude LMHCs and LMFTs. the lack of legal equitability to LCSWs makes things more difficult that they should be restricting people who are actually better clinically trained to provide counseling to individuals and families.*
- *About half of our staff are in a high-risk category for COVID-19 and more than have of the caregivers of the children we see (many of our caregivers have underlying health issues, and/or are grandparents).*
- *Our service delivery system moved from face to face in person services to all telehealth. My agency reduced our workforce due to COVID-19 and eliminated five support staff positions.*
- *Nothing as it relates to structure. We of course have been experiencing a workforce shortage for a long time…The virus has only enhanced this challenge. Many staff are asking for hazard pay - … something I believe should be considered.*
- *IT investments in our last two years were a life saver as it allowed us to stand up virtual care relatively quickly. COVID19 created a mindset open for rapid adoption of new approaches and technologies. We are proven that we are more capable to accept change in a crisis. Never waste a good crisis!*
- *Our information system structure enables a relatively swift change from in-office to telephonic services.*
- *Given we use a community based model of service, all direct service staff had tablets and phones.*
- *At the clinic students weren't even allowed to telehealth in with providers due to potential 'data breach' coming from student laptops. EPIC unwilling to allow students to remote in to view charts and add a security feature.*

Behavioral Health Clinics

From your experiences with the COVID-19 emergency, what are your facility(ies)' top workforce needs over the short and longer term that could be alleviated by new or modified policy, regulatory, and/or payment rules?

Short term workforce impact	Needs
Mental health clinicans still needed	*New model of payment from MCOs - fee for service did not work before the pandemic and works even less now*
	Permanent adoption of teleahealth for individuals who do not want to come into clinics
Clerical Staff that we can't afford to pay	*Grants or available funds*
Getting 2 new hires on board	*Quicker licensing approval for new grads who have passed testing*
Staffing, training	*Financial support*
[Workforce needs during and post COVID-19 crisis]	*Continue current waivers*
	Hazard pay
	Better rates [for] rural/frontier areas
SUD/OUD	*Licensures*
Behavioral health, care coordinators	*Capitated pay $5pmpm*
Pharmacy Techs	*More scope flexibility*
Naturopath care	*Pay for prescribed supplements*

Longer term workforce impact	Needs
Need more clinicians, workforce	*Need licensed therapists - Increase reimbursment for licensed staff under Medicaid*
	New model of payments not fee for service
	Need access to MAs
	Intern completion to enable entry into workforce
Younger individuals to join behavioral healthcare	*Permanent adoption of telehealth*
[Need modifications of Medicare billing rules]	*Need Medicare to accept LMHCs; Change CMS preference for LICSWs*
	Allow LCPC.LCP to bill Medicare
	Continue telehealth billing allowance for Medicare
[Other billing, regulation needs]	*Allow as billable practice-care coordination*
	Continue current waivers for rural areas
Keeping younger mental health workers in Washington	*Lower the cost of education of behavioral health students*
Better integration with public universitys and community mental health services	*Find a way to partner universities with cmhcs for traing of students and interns*
Clinical, precepting telehealth services training	*Coordination with local universities*
	Train staff to teleprecept
	Fix…student laptop perceived security issue
Capacity for behavior change	*Funding/payment that incentivises measurable behavior change*

Behavioral Health Clinics

Are there additional important workforce issues resulting from the COVID-19 emergency at your facility(ies) that you feel should be recognized and addressed?

THEMES: Prior workforce issues exacerbated by COVID-19 emergency, workforce safety concerns, funding/reimbursement changes needed, emergency policy changes helpful.

- *Youth homeless shelters should be near the top of the cue in obtaining PPE due to the high risk for kids and staff.*
- *Fear with working with any positive residents going forward after people return from being home.*
- *Several issues with workforce before Covid-19, but made even worse due to Covid-19. Community behavioral health is lacking younger workers due to low pay, and high burnout. Education cost and the economics of Seattle metro area drive away to many of the young graduates from entering community BH. Also needs to be a shift in the ideology of starting own practice, which is nice in theory, but unrealistic till later in the career if at all. Employees of BH workers should get some sort of incentive to help pay back student loans to retain workers.*
- *Better funding for [B]H services through increases in fee per service Medicaid. True party Parity with LCSW and LMHCA and LMFT. Coordinating universities with CMHCs for training purposes. Use of CMHC as mandated training centers for graduate and post graduate internships in Behavioral health with actual curricula for training just like medical residency programs.*
- *When and how do we open our facility safely again?*
- *No, our number of clients have declined due to COVID-19 stay at home orders from the Governor.*
- *Yes. Not ensuring that the chain coming in the prison have been tested before coming into a facility.*
- *State level changes expanding timelines for license renewal, etc. has been helpful*