



BREAKING POINT

Ohio's Behavioral Health Workforce Crisis

Abstract: The COVID-19 pandemic and the resurgent opioid epidemic are exerting extreme pressure on Ohio's behavioral health care system. Demand is rapidly growing for mental health and addiction treatment, lengthening wait times and wait lists for life-saving services. Key staff are becoming harder for providers to recruit and retain due to a perfect storm of social, economic, and regulatory factors. Swift action to address longstanding structural and funding challenges, education and recruitment needs, and regulatory relief is critical to ensuring that quality behavioral health care remains accessible to Ohioans in need.



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INTRODUCTION

Across Ohio and the United States, communities seek to recover from the dual public health crises, economic devastation, and social disruption caused by the COVID-19 pandemic and the resurgent opioid and drug overdose epidemic. As people cope with these historic challenges, thousands are seeking mental health or substance use disorder (SUD) treatment—many for the first time. With rising demand, providers of community-based behavioral health care have noted high wait times for services due to **severe, prolonged, and worsening shortages of front-line behavioral health staff** in clinical and medical roles.

Workforce issues that predate the pandemic have now worsened to unprecedented levels, leaving fewer professionals and community providers to sustain care and respond to growing demand. These factors have created a perfect storm that jeopardizes behavioral health care providers' ability to respond to crisis, provide essential mental health and addiction services, and sustain our workforce. There are several causes behind this. They include: **natural attrition and stress, missing or unrecognizable advancement pathways for new or aspiring clinicians, a lack of parity in the private insurance market** that drives reliance on public payers, the **economic impacts of the pandemic**, and **rigid credentialing requirements**.

Some of these causes have been accelerated by the pandemic; others are products of it. The behavioral health workforce shortage has been amplified by labor trends across the economy. With large service-sector employers able to offer incentives that behavioral health care providers cannot sustainably match, positions in our system that require non-traditional hours and on-call time are becoming less attractive to job seekers. Additionally, the pandemic has made workers more conscious of the personal risks associated with home- and community-based settings (even with wide access to safe and effective vaccines). Most of these contributing factors are out of the hands of individual provider organizations and beyond their ability to fix despite extraordinary efforts made by many provider leaders. **More can and must be done to incentivize talented job seekers to recognize the value of and pursue behavioral health careers.**

The implications of this workforce shortage are grave for Ohioans with acute and chronic behavioral health needs. **Clinical staff are proving difficult to find, easy to lose, and costly to replace.** Furthermore, turnover in our work has a human cost as relationships with patients are severed and rebuilt time and again. We believe these trends can be addressed with action at the state level to support patients and families at higher risk of waiting for services or being forced to forego essential treatment.

Community-based behavioral health care is essential health care for many Ohioans going through their darkest days. Prevention, treatment, crisis intervention, and social and recovery supports form the basis of a full continuum of care that allows people to recover and thrive. This document will explore our workforce shortage's severity, causes, and potential solutions. While correcting course will not be simple, it will be necessary to prevent irreversible damage to Ohio's behavioral health continuum of care and the thousands who rely on it. Simply put: **Our behavioral health support system is at its breaking point.**



UNPRECEDENTED DEMAND: THE STATE OF BEHAVIORAL HEALTH IN THE U.S. AND OHIO

Every year, millions of Americans and hundreds of thousands of Ohioans seek professional assistance for mental health care and substance use disorder (SUD) treatment. Behavioral health conditions are highly treatable and common among U.S. adults, adolescents, and children regardless of gender, race, geographic location, and socioeconomic background. Many people live with significant behavioral health issues, and many more support family members and friends receiving services.

According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) 2020 National Survey on Drug Use and Health, 14.5% of Americans aged 12 or older (roughly 40.3 million people) had a substance use disorder in the year prior to the survey. In 2020, 21% of adults (or 52.9 million people) lived with a mental illness nationally. Roughly 17 million people lived with co-occurring mental illness and SUD.ⁱ In Ohio, specifically, the prevalence of serious mental illness is over 6% of the population aged 18 and older, higher than both regional and national averages.ⁱⁱ

These figures are accompanied by increased rates of suicidal thoughts, suicides attempted and completed, drug and alcohol use, and overdose deaths in Ohio and nationwide. Nationally, suicide rates have increased by 35% since 1999.ⁱⁱⁱ According to SAMHSA, “in 2020, 4.9% of adults aged 18 or older (or 12.2 million people) had serious thoughts of suicide, 1.3% (or 3.2 million people) made a suicide plan, and 0.5% (or 1.2 million people) attempted suicide in the past year.”^{iv} In Ohio, there was a 27.4% increase in the number of suicide deaths between 2010 and 2019. Suicide was the second leading cause of death among Ohioans between the ages of 10 and 34 years and the 11th leading cause of death overall.^v

Rates of substance use and associated disorders requiring treatment—fueled by the ongoing opioid and drug overdose epidemic and stressors related to COVID-19—are also on the rise. Nearly 8% of Ohio’s population aged 12 and older has had a substance use disorder in the past year, which is slightly higher than regional and national averages. Recent data show that Ohio had the third highest rate of overdose deaths among states last year.^{vi} From 2018 to 2019, overdose deaths increased by 7% in Ohio, according to the Ohio Department of Health.^{vii} The number of drug overdose deaths between April 2020 and April 2021 increased by 26.6%.^{viii}

Workforce data show a 353% increase in demand for behavioral health treatment between 2013 and 2019.

According to Mental Health America’s latest reporting (in which higher rankings indicate worse performance in comparison to other states), Ohio ranks 25th in overall prevalence of mental health and substance use issues for adults and children. The state ranks 36th in prevalence of mental health and substance use issues for adults and 19th for children when ranked separately.^{ix} According to data gathered by The Health Policy Institute of Ohio (which also ranks states 1 to 50 with lower rankings being more desirable), Ohio is ranked 24th in the number of suicide deaths annually, 29th for the percentage of adults with diagnosed depression, and 27th in excessive alcohol consumption in adults.^x Workforce data from the Ohio Department of Mental Health and Addiction Services (OhioMHAS) show a 353% increase in demand for behavioral health treatment between 2013 and 2019 with an average annual increase of 29%. OhioMHAS predicts an annual rise in statewide demand of 5.6% per year over the next decade.^{xi}

Reported Changes in Behavioral Health Service Demand (August to October 2021)

(As percentages of responses from 68 Ohio behavioral health agencies, excluding N/A and Unknown responses)

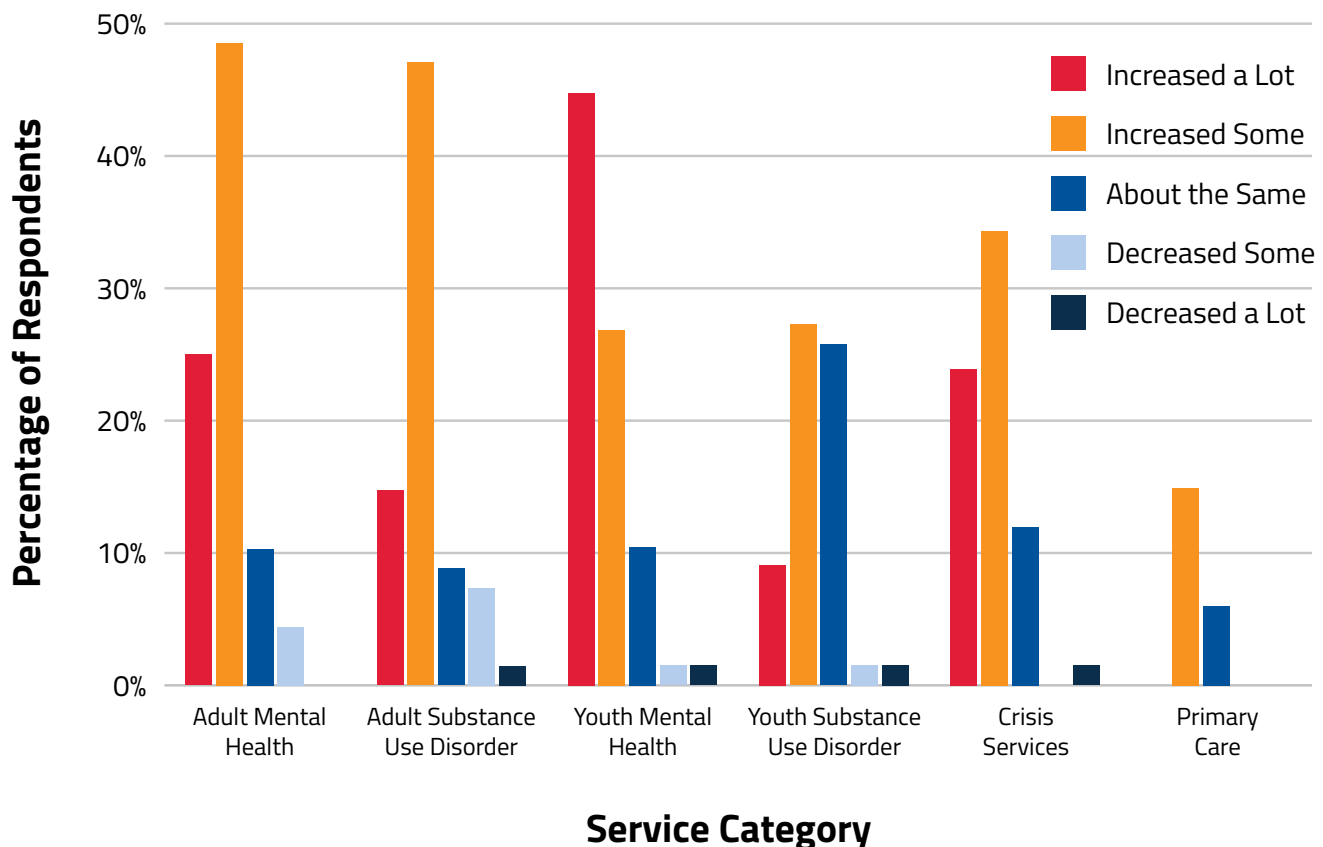


FIG. 1

SOURCE: THE OHIO COUNCIL

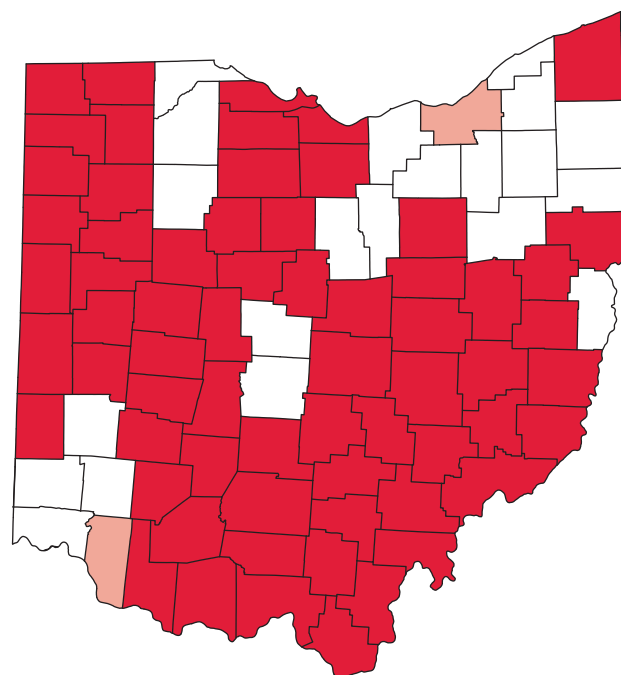
Furthermore, national survey data show that stressors related to the COVID-19 pandemic have negatively affected the country’s mental health and led to increased substance use when compared to pre-pandemic levels.^{xii} In September 2020, OhioMHAS expressed public concern over increased alcohol use among Ohioans during the pandemic^{xiii}, and state alcohol tax collection outperformed projections month after month. The dual public health crises of the opioid and overdose epidemic and COVID-19 pandemic will continue to increase demand for behavioral health services based on data collected in our 2021 workforce survey.

In November 2021, The Ohio Council conducted a survey of our members to gather data on workforce trends and demands for services. Sixty-eight organizations responded, representing a reliable cross-section of approximately 43% of our membership. Providers reported spikes in demand for behavioral health services in the three months preceding the survey with marked increases in requests for youth mental health services, adult mental health services, and crisis services. [Fig. 1]

This increased demand is reflected in the number of clinics at or beyond capacity—particularly in rural Ohio. Health Professional Shortage Areas (HPSAs) are a designation used by the U.S. Health Resources and Services Administration (HRSA) to identify geographic regions and populations with limited health care providers in primary care, dental health, or mental health. Seventy-six percent of the counties in Ohio are mental health HPSAs. [Fig. 2]^{xiv} As more people have sought treatment, nearly every rural county has had a shortage of mental health providers.

With behavioral health providers stretched to their limit, many Ohioans are going without treatment or seeking it from hospital emergency rooms. From 2006 to 2013, the utilization of emergency rooms increased significantly from people seeking services for mental health symptoms and substance use disorders. People utilizing emergency rooms for depression and anxiety increased by 55.5%. People utilizing emergency rooms for substance use disorder treatment increased by 37%, and people utilizing emergency rooms for the treatment of psychosis or bipolar disorder increased by 52%.^{xv} This has stretched the limited capacity of Ohio’s hospitals during the pandemic.

Ohio’s Health Professional Shortage Areas: Mental Health, by County (2021)



- Whole County is Shortage Area
- Part of County is Shortage Area
- None of County is Shortage Area

FIG. 2

SOURCE: U.S. HRSA

While hospital emergency rooms are equipped to help patients in acute crisis, they are not intended to be the behavioral health system’s primary “front door.” Without reliable access to other care options such as community-based crisis centers, mobile crisis response, and outpatient clinics, patient needs and care can become misaligned. Private and public payers alike can wind up spending more on intense treatment. Outcomes can suffer, and patients and families can experience deeper despair resulting from the need for more intensive and expensive care or—worse yet—entry into the criminal or juvenile justice systems.

IMPACTS ON SERVICES

The rising demand for services and the decreasing availability of staff is impacting organizations’ wait times for services and lengthening wait lists. The increased demand for adult and youth mental health services, in particular, is having a substantial impact on wait times and wait lists for these services. [Fig. 3 & Fig. 4]

Reported Changes to Behavioral Health Wait Times (August to October 2021)

(As percentages of responses from 68 Ohio behavioral health agencies, excluding N/A and Unknown responses)

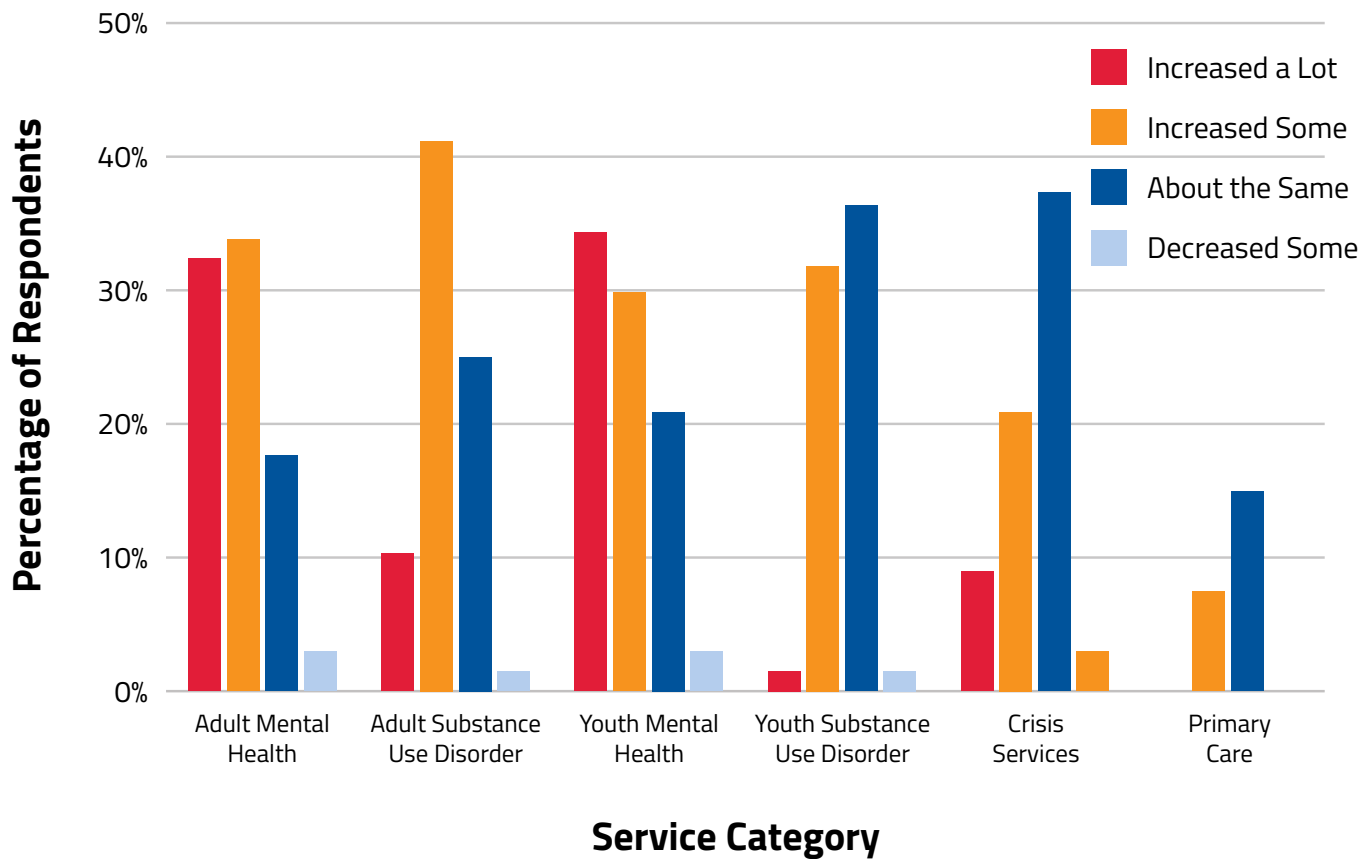


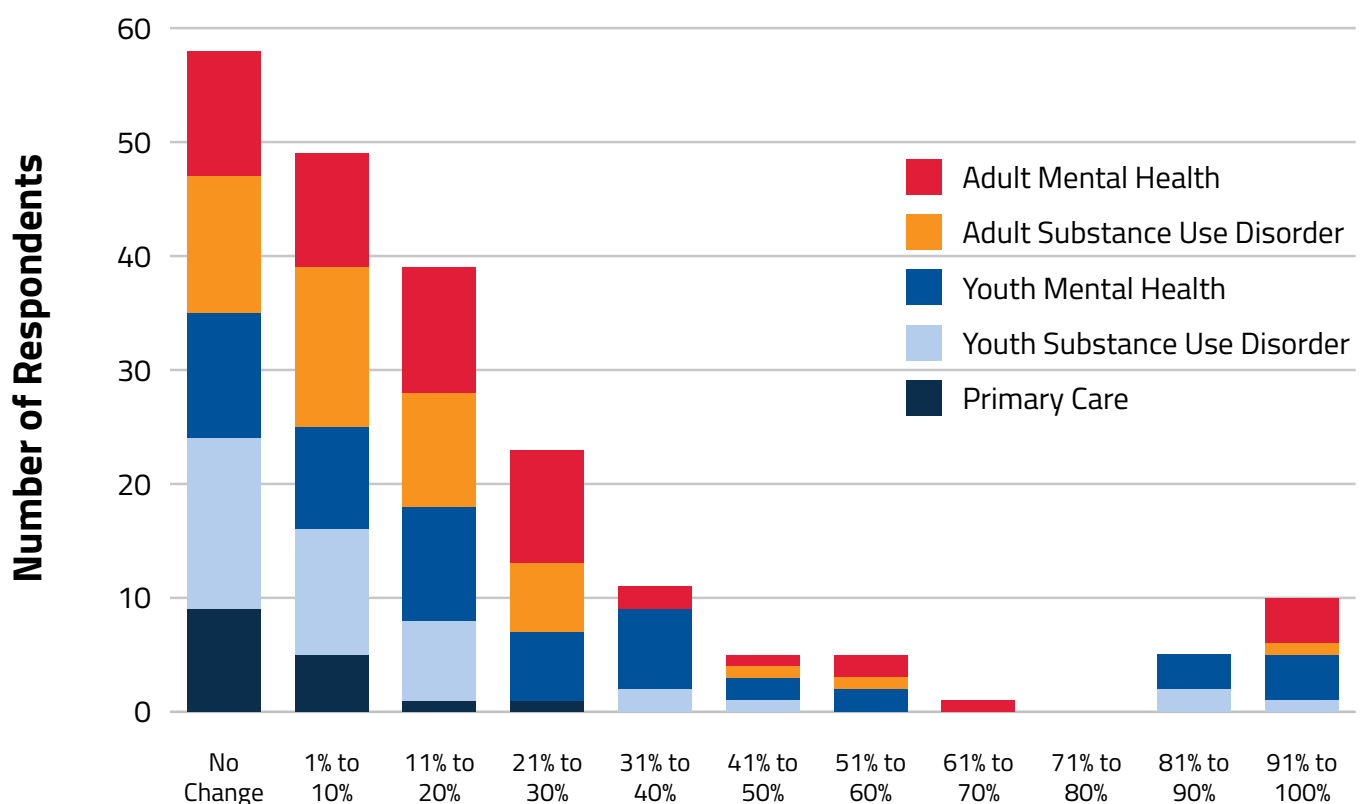
FIG. 3

SOURCE: THE OHIO COUNCIL

As patients wait to receive care from a shrinking number of staff, it is likely that some patients' symptoms will worsen, escalating what would otherwise have been a routine outpatient service request into an immediate need for crisis support. Crisis support is itself a service limited by staff availability stemming from the need for 24/7 accessibility and narrow coverage under private and public payers. Ohio Council members have expressed serious concerns about this dynamic's negative impacts on patients' outcomes, recovery, and long-term wellness. The longer a person waits, the more likely a negative outcome becomes.

Growth in Agency Waitlists by Service Category (August to October 2021)

(As a count of responses from 68 Ohio behavioral health agencies, excluding N/A and Unknown responses)



Approximate Changes in Waitlist Length by Service (August to October 2021)

FIG. 4

SOURCE: THE OHIO COUNCIL

Data suggest that high demand and its ripple effects in the labor market are also affecting clinical service revenue. More than 70% of respondents to The Ohio Council's workforce survey reported that clinical services revenue overall had declined "a lot" or "some" between the August-to-October window in 2019 and the same period in 2021. More than 69% of respondents reported declines in revenue from mental health services, specifically, and more than 71% reported declines in revenue from substance use disorder treatment. Just 22% percent reported that clinical services revenue "increased some." [Fig. 5]

At first, these data would seem to be at odds with rising demand, but they, too, are a facet of the workforce shortage. As demand has spiked, staff have left community practice for private practice or to seek more competitive wages and benefits. Some have left for other job sectors or reduced hours. Some have exited the workforce entirely. Staff loss lowers capacity, which increases the number of people waiting for services. More patients waiting means fewer receiving services and fewer reimbursements being processed. Revenues drop, which affects behavioral health organizations' overall financial stability and inability to provide incentives and benefits necessary to attract and retain talent. Higher turnover then results in worsening wait lists and increased wait times. This feedback loop cannot be broken without intentional course correction and policy changes. Behavioral health care staff need to know they will be valued, advanced through their profession, and compensated fairly. If those assurances cannot be made, more staff will leave, and more needs will go unmet. Access to behavioral health care and positive patient outcomes will continue to decline until a statewide workforce plan is formed and implemented.

Two-Year Change in Company-Wide Clinical Services Revenue (Fall 2019 to Fall 2021)

(As percentages of responses in each service category, excluding N/A responses from agencies that do not offer MH/SUD)

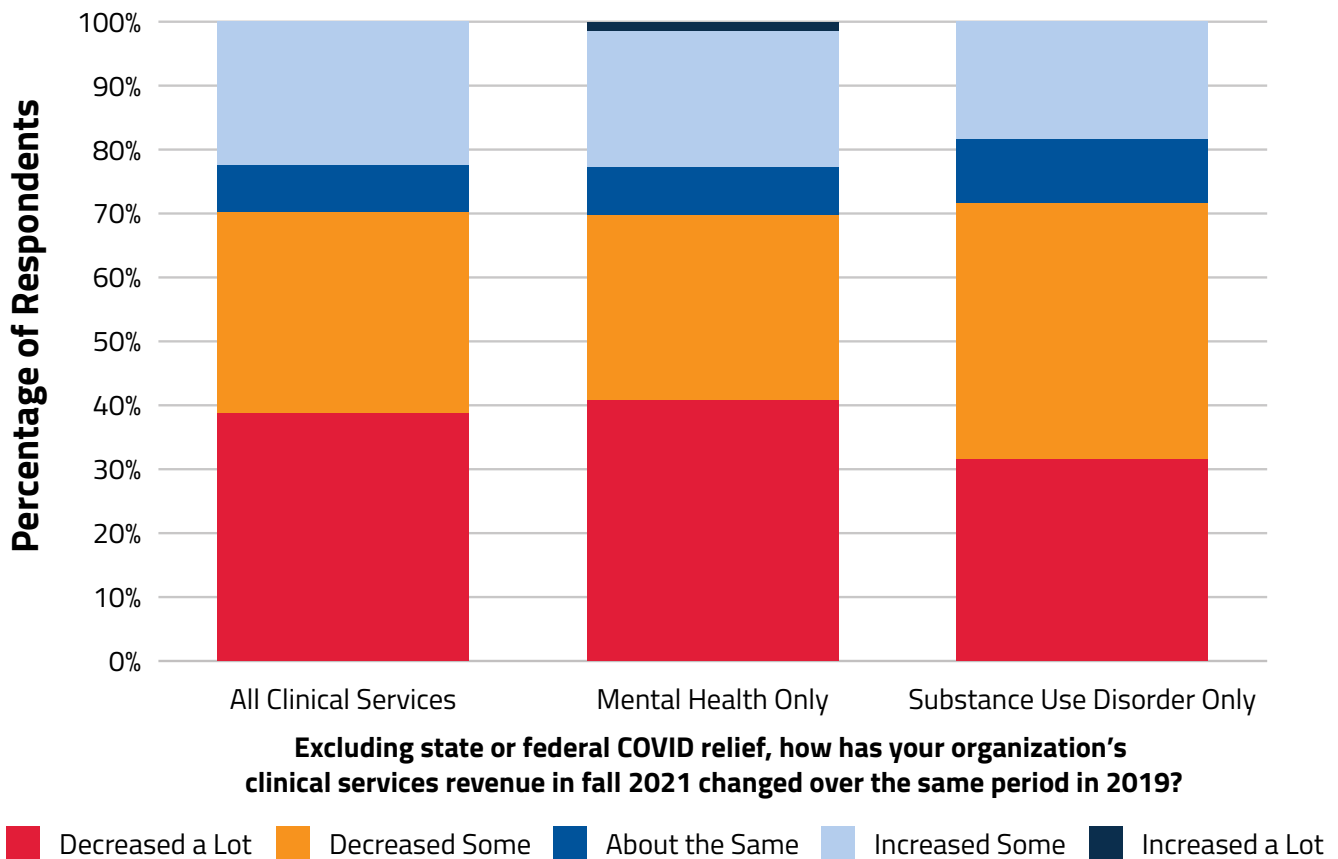


FIG. 5

SOURCE: THE OHIO COUNCIL



SHORT SUPPLY: THE SHRINKING BEHAVIORAL HEALTH WORKFORCE

As was explored in the previous section, demand for behavioral health care in Ohio is at an all-time high. With surging demand and wider awareness of mental illness and addiction, behavioral health has (at long last) been recognized as essential health care. The impacts and limitations of COVID-19 have drastically accelerated the trend of increasing demand. As more people seek a shrinking number of appointments at behavioral health providers, Ohio's behavioral health workforce—already stretched by systemic compassion fatigue, historical under-financing, rising turnover rates, and onerous regulatory and professional licensure requirements—has begun to buckle under the increased strain.

THE EXTENT OF THE WORKFORCE SHORTAGE

Ohio's behavioral health workforce includes a broad array of highly educated, trained, and licensed/credentialed professionals. These include psychiatrists, nurses, advance practice nurses, psychologists, social workers, counselors, marriage and family therapists, and chemical dependency counselors as well as many trained paraprofessional staff. These practitioners, many of whom are required to attain a master's degree or higher to practice in the field, specialize in the treatment of children and adolescents, older adults, or people involved in the criminal or juvenile justice systems that experience mental health or substance use disorders. And yet, Ohio is ranked 26th in behavioral health workforce availability with a ratio of 380 individuals for every one provider.^{xvi} Data suggest that this will not be enough to meet future needs.

The U.S. Health Resources and Services Administration (HRSA) released information in September 2018 detailing the projected number of providers required in each state to meet unmet needs by 2030. The dataset used 2016 data as the baseline. In 2016, Ohio's behavioral health workforce was insufficient to meet demands for treatment in every category and, with minimal exceptions, this disparity will increase by 2030.^{xvii} According to Ohio Department of Medicaid data current as of November 2021, the state has far fewer than the number of physicians, psychologists, social workers, counselors, and marriage and family therapists needed to meet projected demands in 2030. [Table 1] The Ohio Council predicts that this disparity and associated negative outcomes for patients will increase if corrective action is not taken soon.

It is important to note that these projections were calculated prior to the COVID-19 pandemic, which has drastically increased the workforce shortage for behavioral health providers and employers across all industries. Based on current trends in workforce availability and the added challenges of COVID-19, we estimate that the pre-pandemic 2030 need projections—while already discouraging—are, in fact, *more* favorable than the reality that Ohio is approaching. With the impacts of the pandemic factored in, shortages are likely to be worse than projected.

Behavioral Health Position	State Supply: 2021 ^{xxviii}	Current Shortfall/Surplus vs. Projected 2030 Need:
Counselors (Addiction)	5,546	+946
Counselors (Mental Health)	5,533	-1,337
Marriage and Family Therapists	147	-2,263
Nurse Practitioners/CNPs	1,186	+656
Psychologists	262	-3,748
Psychiatrists	830*	-1,190
Physicians	1,141	-1,109
Social Workers	7,765	-2,895

*May 2020 BLS estimate.^{xxix} All other supply data derived from ODM November 2021 licensure records.

TABLE 1 SOURCES: U.S. HRSA, OHIO MHAS, U.S. BUREAU OF LABOR STATISTICS

Recent Difficulty in Behavioral Health Staff Recruitment & Retention

(As percentages of responses from 68 behavioral health agencies covering August to October 2021)

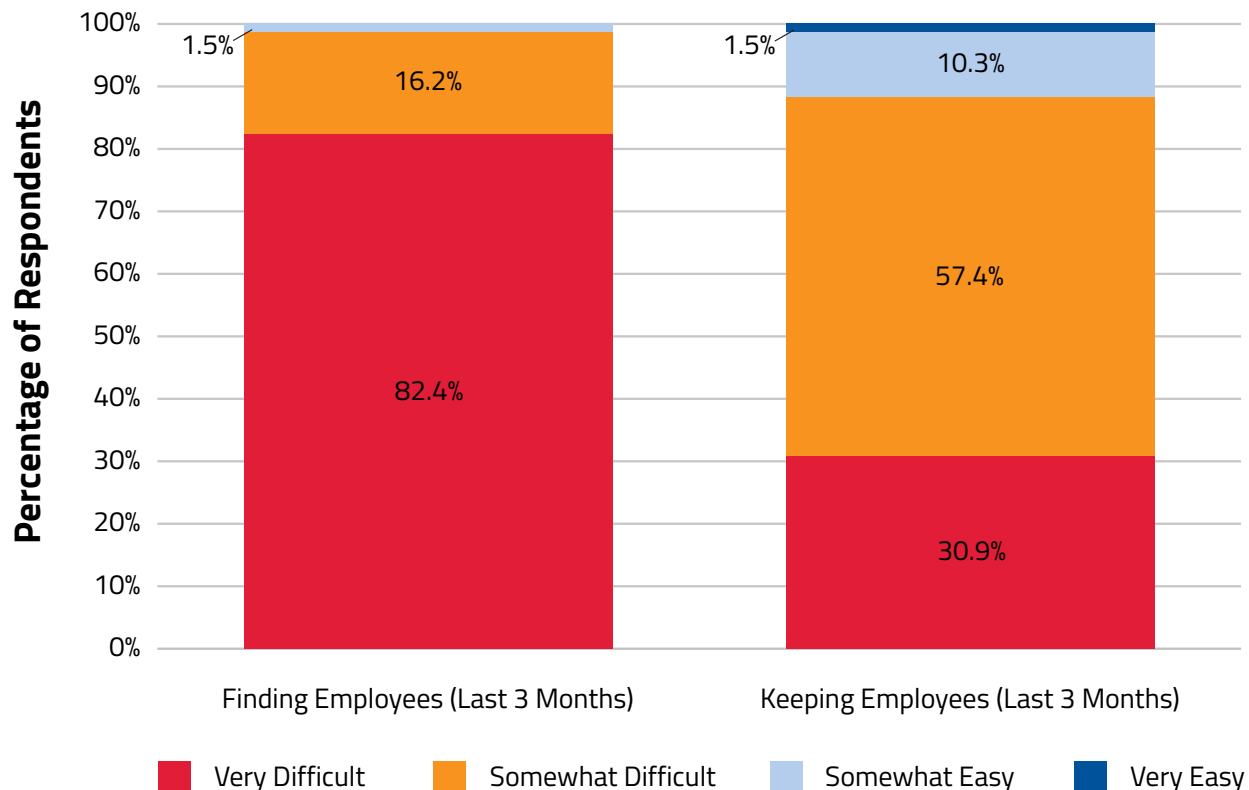


FIG. 6

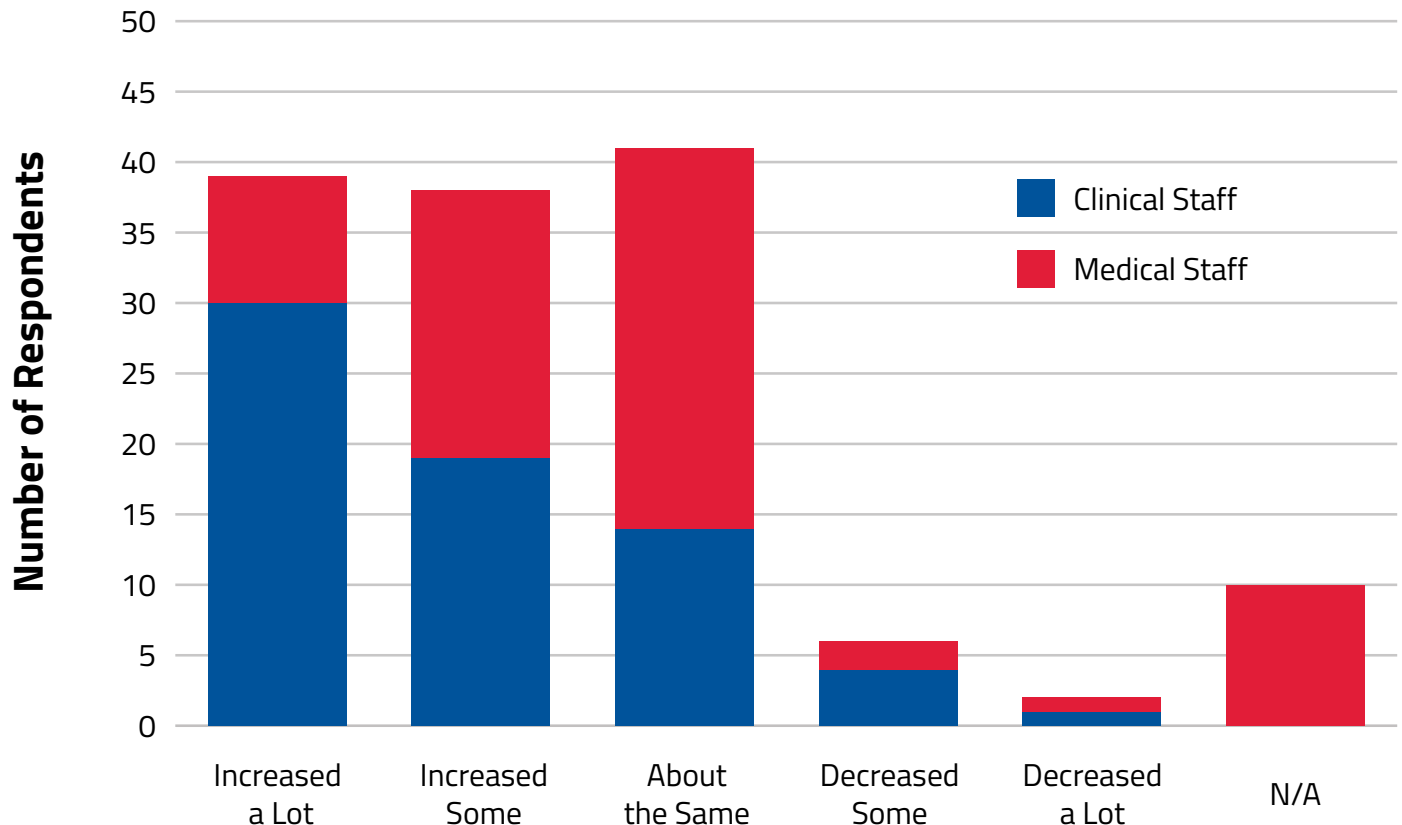
SOURCE: THE OHIO COUNCIL

Current behavioral health staff shortages are reflected in qualitative data from provider organizations. Based on Ohio Council survey data from November 2021, broad swathes of the behavioral health system are experiencing extreme difficulty in the retention of current staff and the recruitment of new staff, especially for clinical and medical positions. Roughly 98.6% of organizations reported difficulty hiring new staff, and 88.3% of organizations reported difficulty retaining current staff. [Fig. 6] Organizations reported significant increases in turnover rates from August to October 2021 for clinical and medical positions. Seventy-two percent of organizations reported increased turnover for clinical staff, and 41% of organizations reported increased turnover for medical staff. [Fig. 7]

Moreover, the time to fill vacant clinical and medical positions is exceedingly lengthy, according to respondents. About 91.2% of responding organizations reported clinical positions are typically vacant for 46 days or longer. Roughly 85.3% of organizations reported medical positions remain vacant for 46 days or longer. [Fig. 8] More staff are departing behavioral health organizations. Positions are remaining open for months, leading to workforce gaps that strain remaining staff, create care backlogs, and lengthen wait lists.

Changes in Behavioral Health Job Turnover (August to October 2021)

(As a count of responses from 68 Ohio behavioral health agencies)



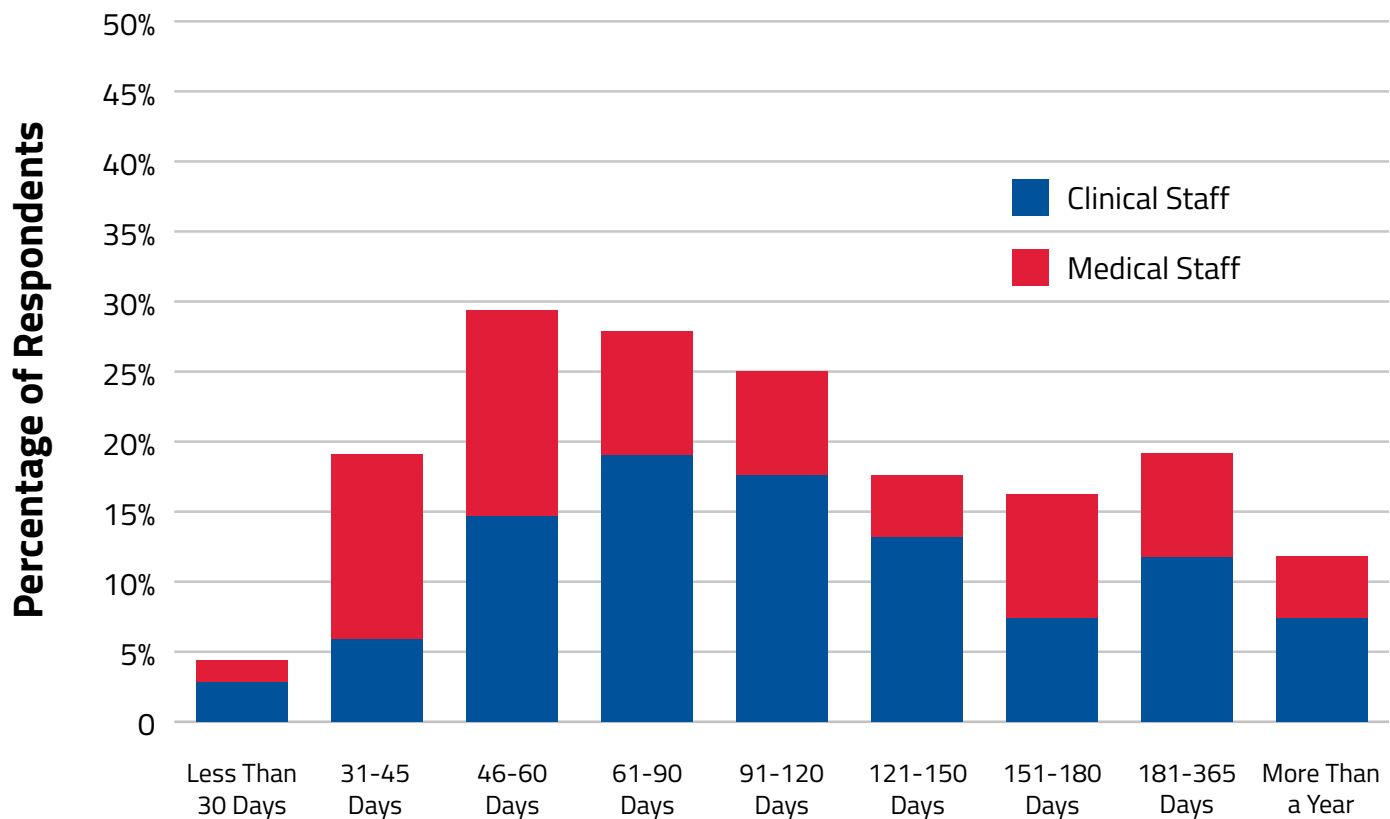
How has turnover in these categories changed over the last 3 months at your agency?

FIG. 7

SOURCE: THE OHIO COUNCIL

Approximate Time Needed to Fill Behavioral Health Jobs by Category

(As percentages of responses from 68 Ohio behavioral health agencies)



How long have positions in these categories taken to fill at your agency in recent months?

FIG. 8

SOURCE: THE OHIO COUNCIL

The Role of Telehealth

At the start of the pandemic, many behavioral health care organizations pivoted to address rising demand and infection concerns with new telehealth and teletherapy options. The benefits of telehealth were explored in [The Ohio Council’s September 2021 telehealth whitepaper](#), which concludes that telehealth is an essential tool that has sustained capacity and access to existing and available behavioral health care.

Telehealth is not a silver-bullet solution to the current workforce crisis. The issues outlined in this section have worsened *despite* the widespread adoption of telehealth and the flexibilities it affords patients and professionals. Even with most behavioral health organizations offering telehealth now, wait times and wait lists have continued to grow. While any suite of solutions to the workforce crisis can and should include the continued use of telehealth (and the regulatory relief that has made its expansion possible), the modality is just one tool of many that must be considered.

Significance of Obstacles to Behavioral Health Staff Recruitment & Retention

(As percentages of responses from 68 Ohio behavioral health agencies covering August to October 2021)

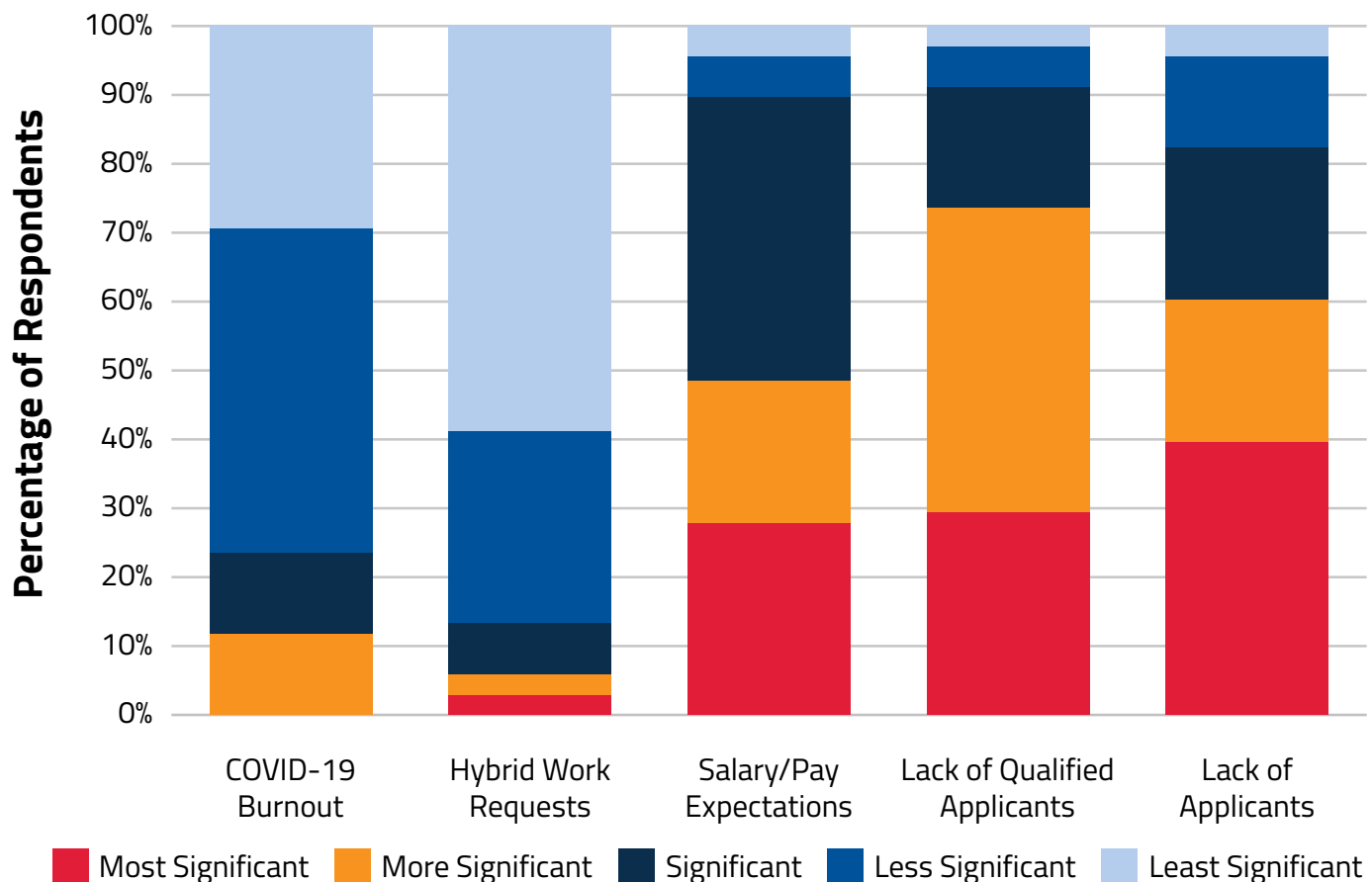


FIG. 9

SOURCE: THE OHIO COUNCIL

CAUSES OF THE WORKFORCE SHORTAGE

The workforce shortage has its roots in several systemic causes. Some pre-date the COVID-19 pandemic. All have been exacerbated by it. A 2016 study conducted by the Behavioral Health Workforce Research Center housed within the University of Michigan School of Public Health found that a lack of required licensure or certification was the most common barrier to filling vacant behavioral health positions. The second most common barrier was the inability to offer a competitive salary.^{xviii} As is explained below, this is due to a history of complex regulatory factors and historical under-financing across the continuum of care. Our recent survey confirms that the obstacles noted in the 2016 study remain in place for Ohio behavioral health care providers in 2021. Organizations responding to The Ohio Council’s survey reported a lack of qualified applicants as the primary obstacle to recruiting behavioral health staff followed by the lack of applicants generally and then salary/pay expectations. [Fig. 9]

As professionals leave to enter private practice or other health care sectors, or exit the profession entirely, remaining staff must take on even higher workloads to meet Ohioans' growing needs.

Cause 1: Natural Attrition, Pandemic Stress, and Lack of Professional Value

Ohio's behavioral health care staff are among our state's most dedicated, caring, and committed professionals. The life-saving work of provider organizations cannot happen without the talented people who make it possible; they are the most valuable asset that our patients and our system have. As in all health and human services fields, however, that dedication comes with stress, natural attrition, and turnover given the rewarding but challenging nature of the profession. Clinicians and medical staff often work long hours; maintain non-traditional schedules that include nights and weekends; remain on call in case of emergencies; and deal with difficult, stressful situations in complex, community-based settings.

In the current market, it is especially challenging to recruit and retain physicians, nurses, and independently licensed clinicians, as well as providers who specialize in the treatment of children and adolescents, older adults, and co-occurring mental health and substance use conditions. As professionals leave to enter private practice, work in other health care positions, take jobs in other sectors, or exit the profession entirely, remaining staff must take on even higher workloads to meet Ohioans' growing needs. This leads to a self-reinforcing cycle of stress and compassion fatigue among front-line care staff.

Difficulty filling positions and high turnover rates can also be attributed in part to the challenges of working in a community-based setting. Beyond the adjustment of not having a set work location, non-traditional schedules, and often working out of a vehicle, there are also potential personal health and safety concerns related to the client population and in high-risk community locations. In 2018, health care and social assistance occupations had the highest number of reported injuries and illnesses, accounting for nearly one in five injury and illness cases.^{xix} Health care and social assistance occupations have also reported the most days away from work for medical treatment due to work-related injuries.

Community behavioral health providers understand the deeply personal reasons that many clinical and medical professionals have for leaving the behavioral health system. The work is stressful, emotionally intense, and (as the next subsection will explore) often undervalued and under-compensated. The so-called "Great Resignation" has affected nearly every sector of the U.S. economy, and—given the inherent demands of the field, safety concerns, the rising cost of child care, and pandemic-related complications with home life—it is understandable why many talented, committed behavioral health professionals have chosen to make a change. The talent that Ohio needs to care for our citizens living with mental illness or addiction will not remain in or return to the field unless these big-picture factors are addressed.

Behavioral health care attrition rates have roots in how Americans and Ohioans have historically thought and talked about mental health and addiction and the stigmas associated with those conditions. Systemic cultural issues related to professional recognition and a lack of acknowledgment of the system’s essential nature are contributing to employees’ burnout and resignation rates. Whereas concerted efforts have been and are being made to honor and thank health care workers broadly, little direct recognition has been given to the behavioral health care professionals who have worked on the pandemic’s front lines alongside first responders and hospital staff since March 2020.

Broader recognition of behavioral health care workers’ importance and pandemic-related risks and sacrifices would improve morale among clinicians. It would help jump-start policy conversations on topics such as hero pay, stronger workforce initiatives, and a realignment of the system’s professional ladder that could help address the workforce crisis. As essential health care providers, behavioral health care organizations and their needs must be considered alongside physical health care in all planning discussions. All solutions to the system’s crisis involve critically evaluating how Ohio values its behavioral health care workforce and how that value can be communicated to professionals.

Cause 2: Insufficient Insurance Coverage & Reimbursement

Reimbursement rates from private and commercial insurance carriers are a key contributing factor in the compensation challenge for community behavioral health providers. For example, payments for behavioral health office visits compared to medical office visits are vastly different. A Milliman report found reimbursements for primary care services were 24% higher than behavioral health services in 2017, a 4% increase from 2015.^{xx}

Furthermore, the inequality in reimbursement rates leads to even less treatment accessibility for many in need of services. Due to the low reimbursement rates combined with the complex and administratively burdensome process of billing insurance, many providers (typically psychiatrists and therapists) will only accept cash for their services. In a 2014 nationwide study conducted by JAMA Psychiatry, it was found that the percentage of psychiatrists who accepted private fee-for-service insurance was significantly lower than physicians of other specialties. At the time of the study, 57% of psychiatrists were not accepting new patients with private insurance, and 55% were not accepting new patients with Medicaid.^{xxi}

Another complicating factor related to insurance and adequate compensation is the imposition of non-quantitative treatment limitations (NQTLs). Examples of NQTLs include: limiting or excluding benefits based on medical necessity; formulary design for prescription drugs; refusing to pay for higher-cost services

Enforcing parity regulations and simplifying the violation reporting process would improve access to care and help address workforce issues.

Whereas a retail store can raise prices to increase wages and attract more applicants, providers are held to set pricing for many of the services they offer.

or treatments until it is shown that a lower-cost option is not more effective; and restrictions based on provider type or specialty.^{xxii} The federal Mental Health Parity and Addiction Equity Act (MHPAEA) instructs insurance plans on how to comply with implementing equal benefits for medical and behavioral health conditions and expressly prohibits NQTLs for behavioral health products that are not also in place for medical products. However, parity violations are difficult to monitor and enforce as they require consumers to initiate parity complaints with the Ohio Department of Insurance. Furthermore, the MHPAEA does not require payment parity for plans covering behavioral health services. Enforcing existing parity regulations and simplifying the violation reporting process would improve access to care and ease some of the system's artificially high financial hurdles and help address the workforce issues to which they contribute.

Challenges in the commercial payer market must also be considered alongside those with public payers (such as Medicare and Medicaid) that set rates based on federal regulations that are adjusted for allowable costs rather than rates that cover providers' total cost of care. Medicare coverage offers a limited or narrow set of covered services and eligible professionals that is similar to offerings in many commercial plans. Ohio Medicaid, however, has been expanded to include a wide array of mental health and substance use treatments—far beyond those available under most commercial plans or Medicare—and recognizes a wide range of licensed and credentialed professionals, including paraprofessionals and peer providers. Medicaid community behavioral health rates were overhauled in 2018 as part of the Medicaid BH Redesign initiative, and a number of rates were adjusted in 2019 to address service access concerns.

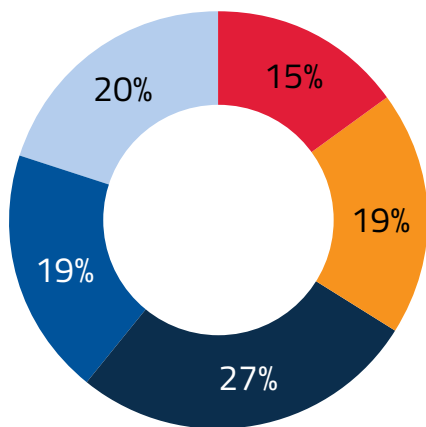
The Medicaid rate-setting process is cumbersome, however, and rates cannot change quickly in response to supply and demand. Whereas a retail store can raise prices to increase wages and attract more applicants, providers are held to set pricing for many of the services they offer due to the structure of the Medicaid program and reimbursement rates that lag behind market fluctuations. This, combined with an unwillingness by commercial insurance carriers to adequately reimburse behavioral health services despite federal requirements, contributes to a market in which prices cannot be adjusted easily to match demand.

Even with these federal and state regulatory barriers that artificially restrain reimbursement rates, Medicaid is the preferred payer for behavioral health care in Ohio. Indeed, behavioral health is the *only* health care sector that prefers Medicaid to private pay or commercial insurance. Addressing this structural imbalance can be done by incentivizing commercial payers to: 1) expand coverage, 2) adjust reimbursement rates to cover providers' total costs and recognize all available licensed and credentialed practitioners, (including paraprofessionals and peer providers), and 3) fully enforce insurance parity through the MHPAEA. These steps are needed to address this underlying cause driving workforce shortages.

These dynamics are more than just market trends to behavioral health professionals. They are a drag on community behavioral health provider revenues and, by extension, individual practitioners' take-home pay. Pay in behavioral health care positions is well below that for similar positions with similar education and licensure requirements in other health care sectors due to the limits on what behavioral health providers can charge. The gap in compensation for the behavioral health field is similar across all positions and levels of education and experience.^{xxiii} Given these disparities, many front-line staff have left behavioral health to work for hospital systems, other general health care providers, insurance companies, or other job sectors.

Despite these issues, most survey respondents have implemented one or more incentive programs to retain current staff and recruit new employees. [Fig. 10 & Fig. 11] Unfortunately, these efforts often cannot be as significant as incentives offered by for-profit corporations or larger healthcare systems that have only increased with the workforce shortages caused by the pandemic. This competitive disadvantage has led agencies to lose staff to retail stores, restaurants, warehouses, and other service-sector employers that do not operate under the necessary but limiting parameters of the behavioral health care system. This factor is largely outside providers' control but within the power of the State of Ohio to address through MHPAEA enforcement, alignment of commercial coverage and reimbursement beyond Medicaid coverage, and review of Medicaid rates to address routine inflationary costs.

Shares of Responding BH Organizations Offering Recruitment/Retention Incentives

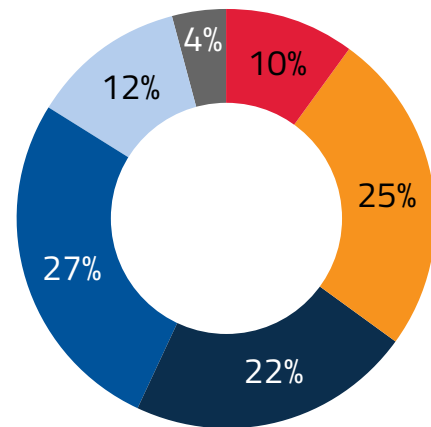


- Loan Repayments
- Retention Bonuses
- Signing Bonuses
- Tuition Assistance
- Other

FIG. 10

SOURCE: THE OHIO COUNCIL

No. of Retention/Recruitment Incentives Offered by Responding BH Organizations



- Zero Incentives
- 1 Incentive
- 2 Incentives
- 3 Incentives
- 4 Incentives
- 5 Incentives or More

FIG. 11

SOURCE: THE OHIO COUNCIL

Cause 3: Excessive Professional Licensing and Education Requirements

Another barrier to increasing the workforce in the behavioral health field is stringent education and licensing requirements. Entry-level behavioral health positions generally require state licensure and often a master's degree. Behavioral health education and professional development lacks a clear career ladder or terminal job trajectory for anyone with the desire to pursue this field of work below a master's degree.

Young professionals wanting to enter the field face a cost-benefit dilemma. For many, acquiring a master's degree means investing multiple years of time and taking on significant student loan debt. The average student loan debt to obtain a medical degree is approximately \$203,000.^{xxiv} The average salary for a psychiatrist in Ohio is approximately \$238,000.^{xxv} The average student loan debt to obtain a Master's of Social Work is approximately \$76,000.^{xxvi} The average starting salary for a social worker with a master's degree in Ohio is approximately \$44,000.^{xxvii}

The system cannot continue to function without offering career opportunities and professional licensing or certification opportunities for undergraduate degree attainment and/or apprenticeship programs. Recruiting aspiring behavioral health professionals requires more opportunities for terminal job attainment. Career ladders with defined entry, exit, and re-entry points can create new, attractive opportunities for service- and mission-minded talent even if entry-level wages are lower than other professions.

Ohio's Chemical Dependency Professionals Board has developed a licensure and certification structure that could serve as a model for other professional disciplines. It offers certification and licensure that recognizes various levels of educational degree attainment, professional experience in practice settings, along with completion of competency examinations. It is but one example for Ohio's rule-making bodies to consider.

It should also be noted that community behavioral health organizations have historically been the training ground for people entering the mental health or addiction workforce and for people who recently graduated as counselors, social workers, or therapists. In fact, it is *required* to complete a field placement (typically in a community behavioral health setting) to obtain a master's degree in these disciplines. While the community setting is ideal for training new professionals, it is also a workforce barrier for most organizations due to the financial cost and time investment of training, supervising, and then replacing staff in two-year cycles. Once new professionals have obtained independent licensure, they often leave for better paying positions in other sectors of health care, the insurance industry, or private practice.



SOLUTIONS AND RECOMMENDATIONS

While the hours are long and the work is difficult, there are many passionate and dedicated behavioral health professionals committed to their clients and communities. More needs to be done to incentivize job seekers to pursue and recognize the value of careers in behavioral health care. Expanding behavioral health career education and exploration in secondary education, creating educational supports for career selection, and helping job seekers understand of the requirements to practice in Ohio will help recruit and retain a high-quality workforce.

As more Ohioans with mental health and addiction disorders require and seek treatment, the workforce must be available to handle the rising demand and provide services to those in need. Without intervention, adults, children, and families who need mental health and addiction services will not be able to access them and, in some instances, need to escalate to crisis services as a result.

Immediate action must be taken to safeguard the growing number of Ohioans living with behavioral health conditions. The Ohio Council believes there are several strategies that can help address the workforce shortage. Some of these steps are applicable to the health care job sector broadly, but others are specific to positions in community behavioral health care.

The most important and urgent step that should be taken is demonstrating value for behavioral health careers within the health care system by establishing clear career pathways and competitive compensation comparable to that offered to similarly credentialed health care specialists in other fields. This will encourage existing staff to stay and draw young talent into the field to meet Ohioans' growing needs.

When possible, one-time stimulus funds should be leveraged to offer incentives to maintain the limited workforce that is available currently and to recruit qualified employees into community behavioral health organizations. However, it is essential to identify ongoing funding and solutions that can be implemented when COVID-related stimulus dollars are no longer available.

The Ohio Council's policy recommendations to increase the number of licensed and unlicensed behavioral health workforce providing direct services include:

SHORT-TERM: TARGETED RELIEF & INFRASTRUCTURE DEVELOPMENT

- **Approve the remaining components of the plan from the Ohio Department of Medicaid for the use of American Rescue Plan Act funds for Home and Community Based Services Spending.**^{xxx} This plan allocates desperately needed funding for immediate and short-term workforce recruitment and retention. It would help providers pay for badly needed sign-on and retention bonuses, expand current workforce through paid internships, provide scholarship opportunities, and enhance technology to increase efficiencies and reduce administrative burdens.
- **Provide funding opportunities for salary and cost-of-living incentives** in high-demand jobs (e.g., community behavioral health centers) and high-need areas (e.g., rural areas).
- **Develop and expand state and local-level tuition reimbursement, student loan forgiveness/repayment programs, training stipends, health insurance subsidies, housing stipends, child care subsidies, transportation stipends, and state tax credits** to people entering and currently working in behavioral health organizations.
- **Provide financial resources and/or technical assistance opportunities to behavioral health providers** to develop and implement local workforce development strategies and succession planning.
- **Develop and fund incumbent worker training programs, scholarships, internships, field placements, and residency positions in behavioral health organizations.**
- **Create a statewide, centralized technical assistance center to market and support individuals in accessing and navigating federal and state student loan and tuition assistance programs.**
- **Develop global public awareness campaigns to elevate the career opportunities and growth available in behavioral health professions,** including outreach to middle and high schools.

SHORT-TERM: ENFORCE EXISTING PARITY REQUIREMENTS

- **Increase education to individuals, families, providers, and employers about mental health and addiction insurance parity and increase oversight and enforcement of mental health parity among all insurance plans to increase coverage for behavioral health services.**
- **Incentivize commercial insurance plans to provide direct reimbursement for all levels of licensure and certification among behavioral health professionals.**

SHORT-TERM: REMOVE ADMINISTRATIVE BARRIERS

- **Reduce administrative barriers and expedite applications for licensed providers in good standing applying for Ohio licensure from out of state.**
- **Create dedicated resources to compensate community-based behavioral health organizations that provide training for residents, students, and newly licensed behavioral health trainees** in their field education and first two years of clinical practice to achieve advanced licensure.
- **Reduce burdens in documentation and service requirements related to treatment planning** and align with standard medical care that integrates treatment planning into each session or note.

MID-TERM: DEVELOP NEW REIMBURSEMENT & LICENSURE MODELS

- **Develop policies to implement and fund the Certified Community Behavioral Health Clinic (CCBHC) model** supported by the U.S. Substance Abuse and Mental Health Services Administration. This would offer a prospective payment model and allow organizations to provide enhanced services and higher salaries.
- **Restructure and create community behavioral health reimbursement strategies to include alternative payment models that will support wages and benefits commensurate with education, experience, and levels of responsibility.** These strategies must align with efforts to integrate traditional behavioral health workers as part of integrated bi-directional health care teams, assertive community treatment teams, non-clinical care settings, schools, etc.
- **Develop new reimbursement models that align incentives and risk sharing** so providers can develop creative interventions and efficient practices to meet the needs of the population served.
- Pending the availability of new, dedicated funding sources for home- and community-based services, **identify targeted reimbursement adjustments that will augment access and reduce gaps in community-based behavioral health care.**
- **Modernize state licensure requirements across all behavioral health professional disciplines to include certification and licensure options at all educational levels** (i.e. associate's, bachelor's, master's, and doctorate).

LONG-TERM: STRENGTHEN THE WORKFORCE PIPELINE

- **Identify opportunities to create innovative financing models for the recruitment of new workers,** such as career impact bonds (CIBs). CIBs create education financing through public and private sector investments with an arrangement requiring students to pay back the cost of education overtime as a percentage of their wages.^{xxxi}
- **Require education programs and accrediting bodies to prioritize establishing coursework that is reflective of current behavioral health practice.** Such coursework should cover education and licensure requirements and practice in community-based settings while keeping pace with emerging evidence-based practices, quality improvement approaches, and models of care based on inter-professional teams.
- **Develop career ladders, including training programs, professional development, continuing education, and opportunities for licensure and certification** at all levels of education across all professional disciplines.



CONCLUSION

The community behavioral health workforce is at its breaking point. The behavioral health workforce crisis was a growing cause for concern prior to 2020 and has only worsened since the pandemic began two years ago. The demand for employees across the economy has led to increased starting wages and improved benefit packages that are nearly impossible for non-profit organizations to compete with due to perceived lack of value of the work, challenging and unpredictable work settings and schedules, and insurance reimbursements that are static and do not keep pace with inflation or the cost of doing business.

In addition, administratively burdensome regulations and licensure make it difficult for behavioral health care providers to recruit and sustain an adequate workforce. As the demand for behavioral health services continues to increase, so does the need to recruit and retain qualified staff. The current shortage of skilled and highly trained workers requires immediate planning and action to ensure that Ohio can meet current demand, adapt to consistently growing behavioral health needs, sustain access to a full continuum of care, and provide quality services across the state. We must act now to build career pathways and a workforce pipeline that brings young and aspiring talent into these professions.

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About The Ohio Council

The Ohio Council is a statewide trade and advocacy organization that represents over 160 private businesses that deliver community-based mental health and substance use disorder services. Ohio Council members operate in all parts of the state and serve children, adults, and families through prevention, treatment, and recovery support services. The Ohio Council strategically pursues effective policy solutions to meet the rising demand for community-based mental health and addiction services.

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