HEALTH AFFAIRS INSTITUTE

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Workforce, Capacity, and Resources

Children's In-Home and Community-Based Services Improvement Evaluation: Phase 4

Prepared by

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Prepared for

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Introduction

Evaluation Overview

Mental and behavioral health of children and youth is critical to the well-being of West Virginia (WV). In partnership with the WV Department of Human Services (DoHS), West Virginia University Health Affairs Institute is evaluating the State's mental and behavioral health system for children and youth. The multi-year, mixed method Evaluation captures perspectives and experiences of stakeholders at all levels of the mental and behavioral health system: organizations and facilities; providers, including cross-sector partners; caregivers; and youth with mental and/or behavioral health needs.

The Evaluation offers insight into the experiences of people who interact with the mental and behavioral health system. During and after data collection, WV DoHS and stakeholders across the system are actively engaged in making changes to policies and practices that are not reflected in the presented data.

This report is focused on Workforce, Capacity, and Resources, and highlights data collected between August 2023 and June 2024; more than 1,000 stakeholders participated in surveys, interviews, and/or focus groups. Comparisons are made to previous years of data from this Evaluation when appropriate.

SURVEYS **INTERVIEWS** **FOCUS GROUPS**

The services of interest to the Evaluation include:

- Assertive Community Treatment (ACT)
- Children's Mobile Crisis Response and Stabilization (CMCRS)
- Wraparound Facilitation Services: West Virginia Children's Mental Health Wraparound (CMHW) and Children with Serious Emotional Disorders (CSED) Waiver Wraparound (Wraparound)
- CSED Waiver Mobile Response
- Behavioral Support Services, including Positive Behavior Support (PBS)
- Residential Mental Health Treatment (RMHT)
- Children's Crisis and Referral Line (CCRL)

Findings Overview

Findings are highlighted to provide insight into stakeholder perspectives, share suggestions from respondents for expanding on what's working, and to inform dialogue around opportunities for system improvements. Quotes are used to illustrate themes and/or to highlight unique perspectives.

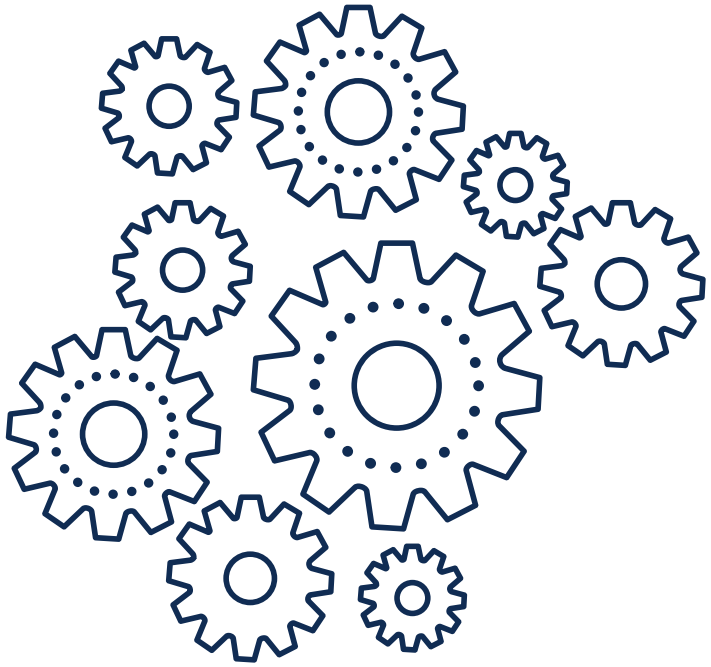
Evaluation reports and additional information about WV's work related to youth mental and behavioral health can be found online at https://kidsthrive.wv.gov.

In this Evaluation:

- ***Providers*** include stakeholders who deliver youth mental and behavioral health services, healthcare providers, law enforcement officers, judges, attorneys, probation officers, DoHS workers, and school administrators. When findings are unique to a provider type, that is specified.
- ***Caregiver*** is used to refer to biological parents, foster parents, or kinship care providers.
- ***Organizations*** refer to community mental health centers, hospitals, RMHT facilities, and other entities that provide the mental and behavioral health services and interventions of interest to the Evaluation, as reported by organizational leaders and administrators in the Organization and Facility Survey.
- ***Youth*** is used to refer to the continuum of children, youth, and young adults, ages 0-21, who receive or are eligible for the services outlined above.

Workforce and Capacity

Background



The mental and behavioral health workforce includes individuals who deliver services, as well as staff involved in diagnosis, referrals, and activities that help coordinate care.

Most results presented in this report are from primary data collected throughout the Evaluation. In some instances, secondary data from external sources is used (and noted) to offer additional understanding or context.

National mental and behavioral workforce shortages are being felt in West Virginia. An "adequate" workforce can be summarized in terms of "the right numbers with the right skills in the right place at the right time."[1] Long-standing workforce shortages have been exacerbated by growing rates of behavioral health disorders among youth, increased public awareness of the issue, and the disruptive impact of the COVID-19 pandemic.[2] System-level stakeholders who participated in this Evaluation recognized state and nationwide challenges impacting the mental and behavioral health workforce and understood the capacity constraints and burden the State faces beyond their communities.

Some roles within the mental and behavioral health system are more specialized (and require more trainings and certifications) than others. While more workforce is needed across the system, it is within the specialized roles that the greatest needs tended to emerge; they are also the ones whose preparation to interact with youth with mental and behavioral health needs (i.e., degrees and licensure) tend to take the longest (see more below).

1 Stokker, J. & Hallam, G. (2009). The right person, in the right job, with the right skills, at the right time. A workforce-planning model that goes beyond metrics. Library Management, 30(8/9). pp. 561-571.

2 American Academy of Child & Adolescent Psychiatry (AACAP). (2004). Policy statement on Behavioral Healthcare Workforce Shortage.

Workforce and Capacity among Youth-Serving Organizations

Leaders and administrators of organizations and agencies that offer mental and behavioral health services in West Virginia, as well as providers, and system-level stakeholders, were asked about their perceptions on capacity of the workforce in general, and capacity to deliver specific services and interventions. Participants were given the opportunity to describe the consequences of capacity shortfalls and any measures being taken to minimize their impact.

Survey responses from organizational leaders and administrators (hereafter referred to as organizations) indicated that only 36% of mental and behavioral health services of interest to the Evaluation had the capacity to serve all of the youth being referred to them in 2023, compared to 57% in 2021. Workforce was perceived as having a considerable impact on capacity in 2021 and 2022, with some improvements reported in 2023.

Other stakeholders from across the system agreed that staffing shortages were one of the biggest barriers to organizational capacity. In addition, many caregivers and youth, as well as some providers and organizations expressed the need for increased capacity to offer services outside of traditional business hours (i.e., on nights and weekends).

THINGS TO CONSIDER:

- The State might consider how a workforce steering committee or task force, with representation from a range of stakeholders (including provider, educational, professional, advocacy, and community interests) can be implemented to identify and problem solve issues impacting capacity of the system. See page 10 below for strategies currently being implemented by organizations to maximize capacity.
- There are well-established national and state initiatives that help address the mental and behavioral health workforce shortages, including the National Health Service Corps (NHSC), the State Loan Repayment Program (SLRP), the J-1 Visa Waiver program, and international recruitment through the H-1b work visa. These programs primarily serve to attract health professionals to underserved areas designated as Health Professional Shortage Areas (HPSA), and are aimed at different populations. A full assessment of the opportunities available to address workforce shortages may be worthwhile. Additional information on these programs is included in Appendix C.

Specific Workforce Needs

72% of organizations reported that there were specific capabilities, skillsets, or credentials that were hard to fill or retain in 2023. The positions that were difficult to recruit or retain were similar over time. Organizations reported the need for more:

- Individuals with graduate degrees that would qualify them for licensure, including licensed clinical social workers and therapists
- Psychiatrists and psychologists
- Case workers and case managers
- Healthcare providers
- School counselors and behavioral analysts

Providers and judges expressed the need for more qualified professionals who can conduct psychological evaluations in 2023; this did not emerge in the data in previous years. Additionally, data indicated that providers and organizations use a wide variety of tools for screening and assessment; the utility of these tools is unclear and might be worth further exploration.

THINGS TO CONSIDER:

There is a need for more professionals who are qualified to conduct psychological evaluations.

- This can be achieved through investments in growing the workforce within the state, or by recruiting out-of-state providers (to move in-state or offer psychological evaluations via telehealth).

- It is also possible that existing providers are qualified but do not conduct psychological evaluations. Exploring DoHS policies should help provide insights into who is considered qualified to conduct psychological evaluations versus screenings and assessments. Findings from that review could shed light on training opportunities to expand the system's capacity to conduct psychological evaluations, which are often used to determine eligibly and need for mental and behavioral health services.

The perceived impact of workforce and capacity on the mental and behavioral health system was consistent across providers, caregivers and youth, and juvenile justice partners (i.e., judges, attorneys, and guardians ad litem), including:

- Recruitment and retention challenges, as well as high turnover rates that hinder communication, collaboration, and care coordination.
- A perceived lack of local providers, services, and resources.
  - For example, one System-Level Focus Group participant noted: "They might have an outside therapist, but they only see him like once a month, or sometimes longer than that, because there's only a very few of them. So they're overwhelmed."
- Difficulties finding services and providers that were a "good fit" for youth and families.
  - Some caregivers and youth were unable to identify providers with characteristics preferred by youth (e.g., for male/female providers).
- Competition with other mental and behavioral health agencies, and neighboring states.

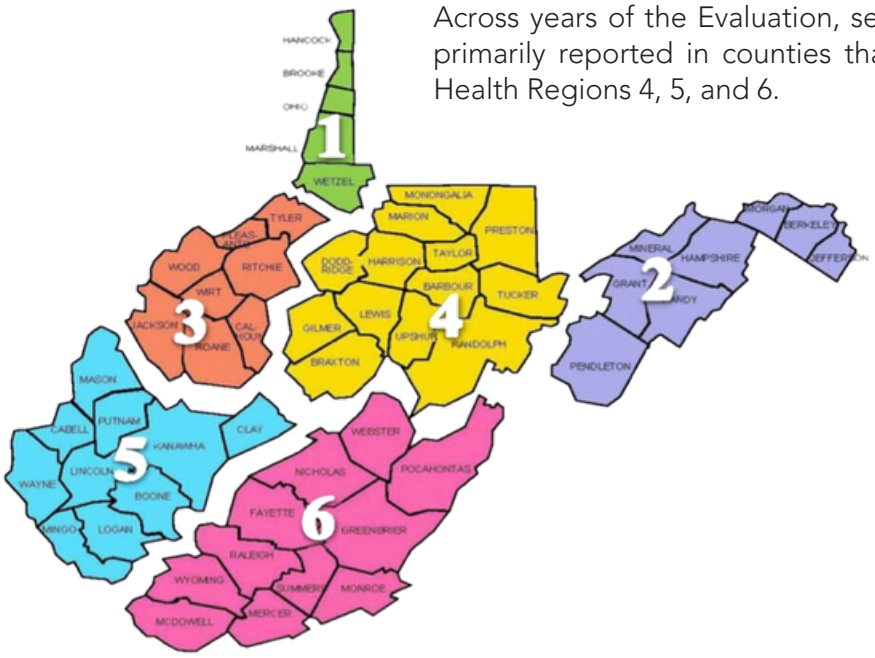
Stakeholders from across the mental and behavioral health system and juvenile justice partners indicated that issues with workforce and capacity contributed to administrative bottlenecks that delayed access to services, and made it difficult for members of the care team (providers and DoHS staff) to build rapport with and engage caregivers and youth in service planning and delivery.

Difficulties with Service Coverage

Staffing challenges contributed to difficulties with service coverage. In 2023, 73% of organizations reported difficulties with service coverage. An item in the 2022 and 2023 Organization and Facility Survey asked whether there were specific counties that were difficult to provide service coverage to (Yes/No), and if yes, which ones and why.

Findings by County:

- In 2022, the greatest number of organizations had difficulties with service coverage in the following counties: **Cabell, Kanawha, Lincoln, McDowell, Nicholas, Pocahontas, Preston, Putnam, Wayne, Webster, and Wyoming.**
- In 2023, the greatest number of organizations had difficulties with service coverage in the following counties: **Boone, Braxton, Kanawha, and Lincoln**.



Across years of the Evaluation, service coverage difficulties were primarily reported in counties that are in Bureau for Behavioral Health Regions 4, 5, and 6.

A follow-up survey item asked about specific challenges experienced by organizations in those counties. The most common reasons for difficulties with service coverage were consistent across years and included:

- Staffing challenges
- Distance/travel in larger and/or rural communities
- The need for more psychiatric services (e.g., acute psychiatric care, medication management)

Fortunately, few organizations reported the need to reduce the hours or days that they offer mental and behavioral health services to offset difficulties with capacity and coverage.

Perceived Availability of Other Providers and Organizations

Strong referral networks can help to offset issues with service coverage and capacity. However, only 32% of organizations reported that there were other providers in their region to whom they could send referrals to in 2023, compared to 26% in 2021. Providers neither agreed nor disagreed that they were aware of other providers in their community.

Mental health, behavioral health, and healthcare providers:

- Somewhat disagreed that there are adequate mental and behavioral health services available in their communities.
- Neither agreed nor disagreed that they were aware of well-trained providers in their communities.
- Somewhat agreed that there are mental or behavioral health providers in their communities with the experience and expertise to support youth.

Juvenile justice partners (i.e., probation officers and attorneys) neither agreed nor disagreed that there were high-quality mental and behavioral health services that were available and accessible in their communities. See the Barriers and Engagement report (July 2024) for additional provider, caregiver, and youth perceptions of specific mental and behavioral health services and interventions that were perceived as needed but not available.

Recruitment and Turnover

High turnover was referenced frequently from stakeholders across the system; however, providers consistently reported short-term intentions to be in their current role and organization(s) this time next year, as well as longer-term intentions to stay (for the next 3-5 years, and for the foreseeable future). In fact, many expressed a commitment to WV and/or Appalachia.

In 2023, more than half of providers identified as Appalachian and agreed that their Appalachian identity is important to them.

All stakeholders recognized that provider turnover can have a negative impact on youth engagement in mental and behavioral health services.
For example, one provider noted:

> *So having to retell your story every time that you meet a new provider is very hindering to a lot of people with trying to continue their care.*

A similar theme emerged during Case Series interviews, that discontinuity of care can lead to re-traumatization (e.g., having to repeatedly recount difficult experiences).

Turnover in the mental and behavioral health system also affects juvenile justice partners. For example, many judges rely on multidisciplinary teams (MDTs) comprised of mental health, behavioral health, and social service providers, as well as DoHS staff, probation officers, and attorneys or guardians ad litem for information about youth, including recommendations for needed services. Judges noted that the effectiveness of MDTs can be negatively impacted by staff turnover and scheduling issues. Judges described how some MDT members have large caseloads, which can lead to burnout, frustration, and turnover, which makes it harder for judges to get timely information and updates about youth's status.

Some participants suggested that administrative burden (e.g., documentation, billing) can also contribute to burnout and turnover.

THINGS TO CONSIDER:

Jobs in mental and behavioral health can be stressful and demanding, and the system requires providers across a wide continuum -- from newly graduated to experienced and licensed experts. Across years of this Evaluation, approximately one third of providers were under the age of 40. Identifying and implementing strategies to prevent burnout and turnover, such as training, reflective supervision, and pay increases, may support workforce capacity across the continuum.

Challenges with the Mental and Behavioral Health Pipeline

Almost all the difficult-to-fill professions reported in survey responses require either a state license or a specific high-level qualification or certification that can take years (and the successful passing of examinations) to acquire. These are characterized as occupations with lengthy "pipelines," the number of years of education and training from high school graduation to becoming certified and/or licensed in these occupations.

Many positions can be filled by individuals with Bachelor's degrees, although some (e.g., licensed practical nurses) can qualify after one year of training. Other occupations that are difficult to hire for fall mostly in the range of 5 to 12 years as the minimum pipeline period for successful employment (see Appendix D for more information). The impacts of any intervention to address the workforce pipeline for these specific positions are long-term, which means that measurable change will not be observed for years. In addition, longer pipelines may discourage individuals from seeking out degrees and licensure in these areas and disciplines.

THINGS TO CONSIDER:

- As a state with a very limited inflow of population, West Virginia relies primarily on its own institutions of higher education to produce sufficient health professional graduates to fill workforce needs. Longer term, to address mental and behavioral health workforce needs, there will need to be an expansion of the state's education and training capacity.
- Data from licensure examinations indicate that the state may not presently have an adequate level of throughput. For example, only two residency programs exist for child and adolescent psychiatrists in the state, offering a total of just 4 places each year. Another example related to healthcare is that only 1,041 WV nurses passed the licensing exam in 2022, according to the National Council Licensure Examination (NCLEX) data, compared to the 1,439 annual openings projected by the Bureau of Labor Services for WV for the period 2020-2023.

THINGS TO CONSIDER:

The purpose of state licensure and certification is to ensure a minimum quality standard for practice. This can also be a barrier to the recruitment of new professionals and those who have licensure in other states, including in the area of telehealth and in reimbursement policies that can limit which professionals can bill for services. DoHS might consider investigating whether time-critical areas of mental and behavioral health practice, such as court-mandated psychological evaluations, could be expedited by more flexible licensure and reimbursement policies, including expanded use of telehealth to permit evaluations to be led by psychiatrists and psychologists from other states.

Strategies for Maximizing Capacity

Wages and Compensation

Pay is a widely recognized issue in the state and nationwide. Pay concerns resulting from inadequate service reimbursement rates were mentioned in the focus groups, and salary ranges in West Virginia were reported to have a considerable impact on staff recruitment.

Low rates of pay relative to neighboring states can lead to loss of the WV workforce to other sectors and/or across state lines. Some smaller organizations reported they were unable to compete with larger organizations for the limited workforce pool available, especially in regard to more experienced workers. **The overall mental and behavioral health workforce shortage has created the workforce capacity problem that WV is currently experiencing; without finding ways to get more individuals into the pipeline, pay increases are likely to redistribute the problem rather than solve it.**

Approximately one third of organizations obtained additional grant funding that was used to increase wages and/or hire additional providers and staff.

THINGS TO CONSIDER:

Organizations might need support to identify whether and which grants are available to help with workforce recruitment and retention. It is likely that smaller organizations and agencies might need additional resources to help with the application process.

Alternative Staffing Models

Organizations reported using a range of strategies to manage their workforce capacity limitations. Many organizations used contract employees, and approximately half used joint staffing or joint supervision. Some also split staff across programs. In 2023:

- 79% of organizations used contract employees
- 49% of organizations used joint staffing models
- 55% of organizations used joint supervision
- 45% of organizations split staff across programs

THINGS TO CONSIDER:

There are pros and cons to using alternative staffing models that need to be considered. Organizations can use these models to offset issues with workforce and capacity; however, potential risks include:

- Bureaucratic and logistical challenges (e.g., tracking time and effort).
- Issues with burnout and turnover by spreading existing providers too thin.
- Varying pay scales for contract and non-contract employees in addition to burden on contract employees to manage their own taxes and benefits.

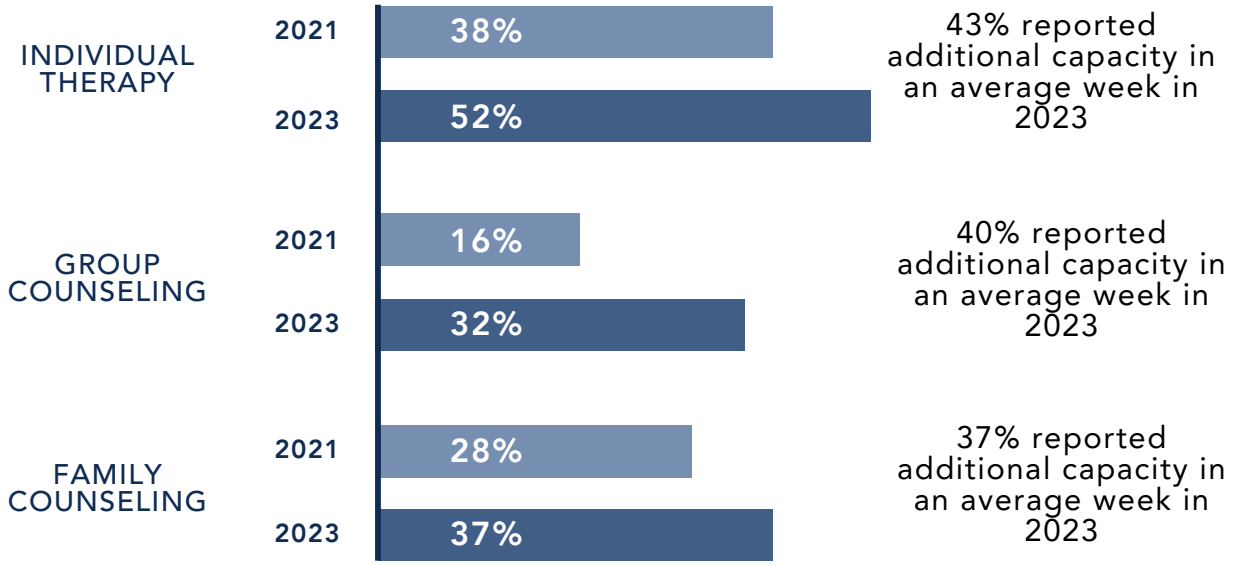
Delivery of Mental and Behavioral Health Interventions

An increasing number of organizations and providers offered mental and behavioral health services, interventions, and resources over time. With respect to case management, care coordination, and treatment planning:

	Organizations in 2023 (% increase since 2021)	Providers in 2023 (% increase since 2021)
Case management	**69% (up 53%)**	**36% (up 25%)**
Care coordination	**50% (up 41%)**	**53% (up 27%)**
Treatment planning	**62% (up 48%)**	**70% (up 24%)**

In 2023, approximately 40% of providers had additional capacity for these tasks in an average week.

The Provider Survey asked mental health, behavioral health, and healthcare providers which services that they offered:



Crisis intervention and medication management were identified as critical services. A greater percentage of organizations and providers offered these services over time:

	Organizations in 2023 (% increase since 2021)	Providers in 2023 (% increase since 2021)
Crisis Intervention	**48% (up 34%)**	**62% (up 24%)**
Medication Management	**45% (up 35%)**	**58% (up 8%)**

While overall capacity has increased over time, few organizations offered supported education, supported employment, or support with independent living. Additional support services offered by mental health, behavioral health, and healthcare providers:

Caregiver training:
- 53% in 2023 (up 29% since 2021)
- 50% had additional capacity in 2023

Outreach and education:
- 60% in 2023 (up 43% since 2021)
- 56% had additional capacity in 2023

Training and Skills

Current Training and Skills

72% of organizations reported having staff with the necessary training and skills to carry out their duties, which is 19% higher than in 2021. Though this is a notable increase, more than one quarter of organizations lacked staff with the necessary training and skills.

The Provider Survey asked mental health, behavioral health, healthcare, and social service providers, as well as juvenile justice partners (i.e., attorneys, guardians ad litem, and probation officers), about their current roles.

- Mental health, behavioral health, and healthcare providers agreed that they have the necessary training to function in their current roles, and this finding was consistent over time.

Level of agreement to the statement "I felt prepared to work with a juvenile with mental or behavioral health needs" varied across social service providers and juvenile justice partners.

- Social service providers agreed, and little variation was observed over time.
- Attorneys somewhat agreed in 2021 and 2023 (their level of agreement was higher in 2022).
- Probation officers somewhat agreed, and little variation was observed over time.

Mental health, behavioral health, healthcare, and social service providers, as well as probation officers, somewhat agreed that they have the necessary training to respond to a mental health crisis involving youth. Findings were consistent over time.

Training Needs and Interests

Providers reported both high levels of confidence in feeling prepared for their role **and** strong desires for further training, something that may reflect learning as a value of this group, and/or some of the challenges inherent in the jobs that they do.

New staff in mental and behavioral health roles come with a baseline range of skills and training, but there is a need for additional and ongoing professional development to maintain and further develop those skills as their careers progress. Experienced staff are highly valued by provider organizations, but **continuous professional development through in-service training can accelerate learning and at least partially compensate for lack of experience.**

The Provider Survey asked about training interests among mental health, behavioral health, and healthcare providers. In 2023, training interests included:

- The National Wraparound Initiative (46%)
- Crisis response and stabilization (46%)
- Trauma-informed care (37%)
- Mental health screening (34%)
- Caregiver training and education (34%)
- Cognitive behavioral approaches (33%)
- Peer support and recovery services (33%)
- Mental health assessments (32%)

Two thirds of mental health, behavioral health, and healthcare providers offered trainings to other providers and staff in 2023, which is 47% higher than in 2021.

- In 2023, 52% had additional capacity to deliver trainings in an average week, which is a 17% increase since 2021.

THINGS TO CONSIDER:

Provider training may be an efficient and effective way to increase competency and confidence of the workforce, quality of care, and morale across the system. For example:

- DoHS might consider the feasibility of leveraging provider capacity to deliver additional trainings, when appropriate.
- Training can accelerate existing providers' learning and skills development.
- Virtual training may be preferred and more accessible to providers across the state.
- There might be an opportunity to offer targeted training on specific mental and behavioral health needs.

Law Enforcement Officers

Some caregivers and youth rely on law enforcement officers when youth and families are experiencing mental or behavioral health crises. See the Use of Mental and Behavioral Health Services and Case Series reports (July 2024) for additional details.

Little variation was observed in terms of law enforcement officers' preparation to interact with youth with mental and behavioral health needs over time, as captured in the Provider Survey. Law enforcement officers:

- Somewhat agreed that they are prepared to handle a mental health crisis involving youth.
- Neither agreed nor disagreed that they have the training necessary to respond to a mental health crisis involving youth.

An increasing number of law enforcement officers received training on how to respond to calls involving youth who were experiencing a mental health crisis, but many continued to express the need for more.

	2021		2023	
	Received	Needed	Received	Needed
De-escalation training specific to youth	**14%**	**50%**	**38%**	**76%**
Responding to calls involving youth experiencing acute mental health crisis	**17%**	**56%**	**39%**	**74%**
Working with CMCRS/CSED Waiver Mobile Response teams	**3%**	**67%**	**4%**	**77%**
Guidance for working with CMCRS/CSED Waiver Mobile Response team	**5%**	**65%**	**26%**	**78%**

THINGS TO CONSIDER:

Communication and trust is critical to collaboration between the different stakeholders involved in identifying, assessing, and delivering services to meet youth needs. DoHS might explore opportunities aimed at increasing communication and trust within and across the children's mental and behavioral health system and juvenile justice. Joint training is one avenue for building trust; another is the identification of champions who would be willing to share their success stories surrounding cross-systems collaborations.

Conclusion

Nearly all stakeholders were aware of national and state-specific issues with workforce and capacity, and recognized that challenges (and solutions) are often complex and multifaceted. Therefore, no single strategy can be expected to bring about the kind of changes that are needed to ensure that mental and behavioral health services are available to meet the diverse needs of youth across the state. Stakeholder feedback and collaboration will be paramount for continuing to understand and address these issues.

Findings suggest several areas of opportunity:

- Expand the workforce and/or provide opportunities to enhance the training, skills, and certification among the existing workforce.
  - More providers who can offer specialized services are needed, including those who are qualified to conduct psychological evaluations.
- Identify strategies to increase recruitment and retention, especially providers who are available to deliver services on nights and weekends.
- Offer competitive salaries and/or other fringe benefits.

- More organizations and providers are offering mental and behavioral health services, interventions, and resources than in previous years.
- Providers are interested in expanding their skills through additional trainings.
- Providers are committed to the mental and behavioral health of WV youth.

The Evaluation captured snapshots of the system across years. Findings suggest there is positive momentum, as well as opportunities for further improvement. Perspectives of stakeholders within the children's mental and behavioral health system, and adjacent systems such as healthcare and juvenile justice, provided valuable insights.

Appendix A: Glossary

This page defines the acronyms used and/or other key terms used throughout the report.

Acronym	Definition
ACT	Assertive Community Treatment
CCRL	Children's Crisis and Referral Line (844-HELP4WV)
CMCRS	Children's Mobile Crisis Response and Stabilization
CMHW	WV Children's Mental Health Wraparound
CSED	Children with Serious Emotional Disorders
DoHS	WV Department of Human Services
MDT	Multidisciplinary Team
PBS	Positive Behavior Support
RMHT	Residential Mental Health Treatment

Appendix B: Data Collection Overview

This report includes data collected throughout the Evaluation. Reports from previous years can be found on the KidsThrive website: https://kidsthrive.wv.gov/Pages/default.aspx.

The table below provides a description of all data collected as part of this Evaluation. Findings in this report are summarized by year for ease of interpretation. References to specific groups at specific points in time in previous reports (e.g., "youth in RMHT at Baseline"), data collection dates, and number of participants are displayed below.

Year [1]	Project Phase	Stakeholder Group	Data Collection Tool	Reference in Previous Reports	Data Collection Dates	Number of Stakeholders
2021	2a	Service Provider Organizations	Organization and Facility Survey	"Baseline"	8/16/2021 – 11/19/2021	102
2021	2a	Service Providers	Provider Survey	"Baseline"	8/16/2021 – 11/19/2021	1,215
2021	2a	Service Providers	Provider Focus Groups	"Baseline"	11/29/2021 – 1/31/2022	71
2021	2a	Service Provider Organization Key Informants	Organization and Facility Key Informant Interviews	"Baseline"	11/3/2021 – 1/13/2022	14
2021	2a	System-Level Stakeholders	System-Level Focus Groups	"Baseline"	10/7/2021 – 11/1/2021	22
2021	2b	Caregivers of Youth in RMHT	Caregiver Survey	"Baseline"	10/28/2021 – 2/17/2022	108
Ongoing [2]	Ongoing [2]	Caregivers of Youth in RMHT	Case Series Interviews	"Rounds 1-5"	2/21/2022 – 4/29/2024	9
2021	2b	Youth in RMHT	Youth Survey	"Baseline"	11/16/2022 – 4/18/2023	115
Ongoing [2]	Ongoing [2]	Youth in RMHT	Case Series Interviews	"Rounds 1-5"	2/17/2022 – 5/3/2024	10
2022	3	Service Provider Oragnizations	Organization and Facility Survey	"Year 2"	11/16/2022 – 3/7/2023	56
2022	3	Service Providers	Provider Survey	"Year 2"	11/9/2022 – 2/28/2023	1,141

Year [1]	Project Phase	Stakeholder Group	Data Collection Tool	Reference in Previous Reports	Data Collection Dates	Number of Stakeholders
2022	3	Caregivers of Youth in RMHT	Caregiver Survey	"Year 2"	11/4/2022 – 1/13/2023	180
2022	3	Youth in RMHT	Youth Survey	"Year 2"	11/2/2022 – 2/17/2023	156
2022	3	Community-Based Caregivers	Caregiver Survey	"Baseline"	12/22/2022 – 3/31/2023	174
Ongoing [2]	Ongoing [2]	Community-Based Caregivers	Case Series Interviews	"Rounds 1-3"	3/14/2023 – 5/1/2024	6
2022	3	Community-Based Youth	Youth Survey	"Baseline"	1/9/2023 – 3/31/2023	51
Ongoing [2]	Ongoing [2]	Community-Based Youth	Case Series Interviews	"Rounds 1-3"	3/13/2023 – 5/1/2024	5
2023	4	System-Level Stakeholders	System-Level Focus Groups	"Phase 4"	12/12/2023 – 1/9/2024	10
2023	4	Service Provider Organizations	Organization and Facility Survey	"Year 3"	8/1/2023 – 11/10/2023	33
2023	4	Service Providers [3]	Provider Survey	"Year 3"	8/28/2023 – 11/30/2023	722
2023	4	Service Providers	Provider Focus Groups	"Phase 4"	3/11/2024 – 3/28/2024	36
2023	4	System-Level Stakeholders	System-Level Focus Groups	"Phase 4"	12/15/2023 – 1/9/2024	10
2023	4	Community-Based Caregivers	Caregiver Survey	"Year 2"	2/21/2024 – 4/26/2024	213
2023	4	Community-Based Youth	Youth Interviews	"Year 2"	6/3/2024 – 6/21/2024	6

Notes: RMHT = residential mental health treatment.
[1] Represents the year used to reference the data in Phase 4 reports.
[2] Case Series participants were recruited from "Baseline" Caregiver Surveys and Youth Surveys. Case Series Interviews were conducted with the same individuals approximately every six months; participants completed up to five interviews over the course of the Evaluation.
[3] Judge interviews were conducted after the Phase 4 Provider Survey was closed for other provider types. Phase 4 judge interviews were conducted between December 2023 and February 2024; of these 722 providers, 20 were judge interviews.

Appendix C: Additional Detail on National and State Programs that Might Support Recruitment Efforts

Federal and Federal/State Government Opportunities:

The best-known government initiatives for addressing health professional shortages are the National Health Service Corps (NHSC) and the J-1 Visa Waiver program. These programs primarily serve to attract health professionals to underserved areas designated as Health Professional Shortage Areas.

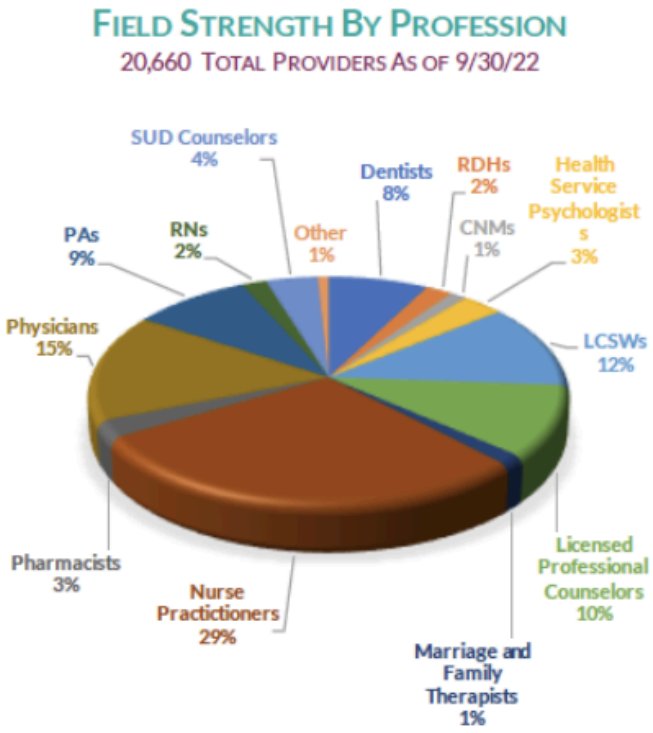
The NHSC operates several programs, all of which are aimed at U.S. citizens and green card holders. The largest NHSC program offers repayment of educational loans to health professionals in return for periods of service in HPSAs. The J-1 Visa Waiver program is aimed at foreign nationals graduating from US medical residencies. In return for serving for three years in an underserved area the program offers a significant work-visa incentive to foreign physicians wishing to stay in the United States after completing their training. NHSC federal programs are administered nationally, WV's SLRP is administered by the WV State Office of Rural Health. Visa waiver opportunities are administered by the State Office of Rural Health and (separately) by the Appalachian Regional Commission (ARC).

Most NHSC opportunities are 100% federally-funded with the exception of the State Loan Repayment Program (SLRP) which is grant funded and (with limited exceptions) requires a 50% state match to federal funding. Many states also have similar state-only loan repayment programs that are fully state-funded. The visa waiver program is unfunded except for a small federal contribution to states for its administration.

Targeting of these programs is heavily reliant on the system though which HPSAs are designated. There is considerable flexibility in HPSA designations as the designation can apply to either healthcare-providing institutions (such as community health centers) or to geographical areas; in the case of geographical areas the designation can be based either on the whole population or on a low-income sub-population. There are also sub-categorized into primary care, mental health or dental care designation. In addition, state governors can designate HPSAs based on local knowledge of underservice. HPSAs are categorized by a scoring system that measures the severity of need in a range from 1-25, with higher scores receiving priority for placement of NHSC applicants. Scores of 19 or more receive the highest priority for NHSC placements.

The NHSC and visa waiver programs contribute substantial numbers to the WV healthcare workforce. Data from the Health Resources and Services Administration (HRSA) HPSA Find website provides a snapshot of current participation in WV. WV has 121 Primary Care HPSAs and 115 Mental Health HPSAs, located in both rural and non-rural areas. In 2023 there were 223 health professionals serving in NHSC programs in WV and a further 35 were serving in the SLRP program. Of the total of 258, 167 were serving in rural locations and 94 were in mental behavioral health professions, although the proportion of the latter who were serving in child and adolescent services was not known at the time of writing. For 2025 applicants to the program, the NHSC website shows 94 placement opportunities available for 2025 across 937 sites in WV, including opportunities for psychiatrists, psychologists, primary care physicians, nurse practitioners, physician assistants, licensed clinical social workers, licensed professional counsellors, licensed practical nurses and case managers. 32 of the opportunities are in sites with a HPSA priority score of 19 or more. Although We do not have a breakdown of the WV NHSC healthcare professionals by profession at the time of writing, Figure 1 shows the percentage breakdown nationally and includes several occupational groups who may be part of the mental and behavioral health workforce.

Figure 1: Breakdown of NHSC Placements by Profession



In addition, WV has access to 30 new visa waiver program places each year, meaning that up to 90 physicians could be serving their three-year term of duty in WV at any one time. As currently operating in WV this program may not be contributing significantly to improving the mental and behavioral health workforce, given that WV used only 24 of its 30 available visa waiver slots in 2022/23, only two of these slots were in rural areas of the state, only three were for primary care positions, and none at all were taken up by psychiatrists (according to 3RNET).

The flexibilities available within the different programs introduce the possibility of making significant inroads into WV's mental and behavioral health workforce shortage, and doing so in ways that can be tailored to areas, services and professions where the need is greatest. NHSC, SLRP and state-only programs, for example, can, and increasingly do, accept a much wider range of health professionals than physicians. Although the visa waiver program is only open to physicians, 10 of WV's 30 annual waiver recommendations are categorized as "flex waivers," allowing them to be used for applicants who do not work within HPSAs but primarily serve HPSA populations. In addition, the designation of HPSAs can be revisited at any time by presenting new or updated data, and state governors are allowed to make HPSA designations based on local knowledge.

One caveat is that administration of these programs is resource-intensive, while funding for administration is limited, with the result that these programs tend to be more reactive than proactive when it comes to prioritizing workforce needs. Any effort to target the programs more effectively would need to take this limitation into account.

International Recruitment

International recruitment is a long-standing strategy for alleviating health workforce shortages. Although best adopted as a short-term solution, some health professions (nursing in particular) have relied on this strategy to a greater or lesser extent for decades.

The international recruitment strategy rests on two foundations – immigration policy, which determines who may obtain a work visa allowing them to work in the United States, and training and certification requirements, which determine the countries whose health professionals are likely to be able to satisfy states' licensing and certification requirements. As a general guide, allied health professions that require a minimum of a four year bachelor's degree fall within the eligibility criteria for an H-1b work visa, but applicants would still need to satisfy the state's licensing and certification requirements before becoming employable.

International recruitment may be technically challenging and requires significant expertise to navigate successfully. Nevertheless, exploring whether there are health care providers in West Virginia who already have some experience in this type of recruitment may uncover the potential to expand any existing recruitment programs to encompass mental and behavioral health workforce recruitment, pending the development of longer-term solutions.

Appendix D: Listing of Pipeline Lengths for Mental and Behavioral Health Professions Identified by the Evaluation as Difficult to Recruit

The List of Pipeline Lengths is intended to provide additional insights into workforce development considerations. Note that the presence of so many specialized mental and behavioral health roles leads to challenges categorizing the workforce. Some groupings, such as psychiatrists, psychologists and licensed clinical social workers, are defined by state licensing requirements; however, others, such as behavior support professionals and case managers, are not. Not all roles identified in the Evaluation match neatly with the position and occupation terminology used more broadly in labor and workforce data sources. Among non-licensed workforce groupings in particular, job requirements and titles can vary considerably; even in the licensed professions, sub-specializations in work with children and adolescents, and for work in mental behavioral health, are not always represented in secondary data.

Role	SOC Code [1]	Licensure Needed	Qualification	Exam or Practice Required	Minimum Trained Period (Years)
Psychiatrist	*	Yes	MD/DO	Residencies	12
Primary Care Physician (Family/General/Internal Medicine/Pediatrician)	*	Yes	MD/DO	Residency	11
Psychologist	19-3030	Yes?	Master's Degree	Supervised Practice	7
Physician Assistant	29-1070	Yes	PAS Graduate Program	PANCE	6
Nurse Practitioner	29-1171	Yes	Master's Degree	AANP or ANCC	3 (5 Recommended)
Registered Nurse	29-1141	Yes	Degree or Diploma	NCLEX	2 (4 Recommended)
Licensed Practical Nurse	29-2061	Yes	Accredited LPN Program in WV	NCLEX-PN	1

	SOC Code [1]	Licensure Needed	Qualification	Exam or Practice Required	Minimum Trained Period (Years)
Licensed Social Worker	21-2020	Yes	MSW	Supervised Practice	6
Case Manager/Case Worker	*	Varies	Varies	Varies	5
School Counselor	21-2020	Certification or License	Master's	Internship	5
Counselor	*	Varies	Varies	Varies	Varies
Probation Officer	21-1092	N/K	Bachelor's + Experience	PPO + Practice	4
Behavioral Analyst	*	N/K	BACB Certification - Master's	Supervised Experience	7
Attorney	23-1011	Yes	JD	State Bar Exam	7

Notes: N/K = not known.
* Indicates professions that either have no designated SOC code or which make up subgroups of SOC codes
[1] SOC = Standard Occupational Classification system used by the federal government.