Introducing Community and Behavioral Health Aide Services in Washington State: A Gap Analysis

Assessing mid-level provider staffing needs in tribal and urban Indian health and behavioral health clinics in Washington State

This presentation and the accompanying crosswalk document were prepared for the Northwest Portland Area Indian Health Board by James Bell Associates, Inc.

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BACKGROUND

Why a Gap Analysis?

- Describing the existing landscape of Washington tribal medical and behavioral health services
- Understanding the need for additional training and licensing pathways for mid-level providers in tribal communities

Getting from where we are to where we want to be

Overview of Gap Analysis Methodology

- Determining where there is a need, deficit, or breakdown (i.e. a gap) between the current and ideal situation
- Determine the root causes of the gap
- Analyze proposed solutions; And/Or,
- Identify root causes that are more versus less subject to influence based on things like: character of the issue, time and monetary parameters, available solutions

Goals of this Gap Analysis

1. Understand what underlying factors contribute to the need for mid-level medical and behavioral health providers in Washington Tribal and urban Indian communities
2. Describe specific data points and qualitative information characterizing this regional demand, meaning how do we know there's a shortage and what does it look like on the ground?
3. Analyze the potential of the Community and Behavioral Health Aide program to address the provider shortage

A quick footnote

- What do the terms “mid-level” and “paraprofessional” refer to?
- Both terms can be used to refer to positions in the medical and behavioral health field that do not require graduate degrees, such as nurses, nurse assistants, mental health counselors, chemical dependency professionals, etc. We use “mid-level” in this analysis and presentation.
- “Mid-level provider” has in the past been used by some in the medical field to refer to Nurse Practitioner and Physician Assistant providers, but those professionals are now commonly referred to as “Advance Practice Providers.”

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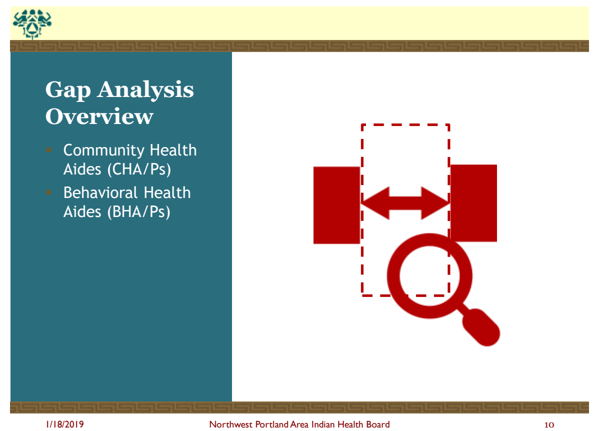

Methods

- Tiered data collection strategy
  - Review of existing data
  - Tribal and urban clinic outreach
  - Key informant inquiries

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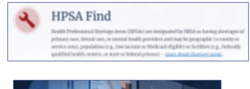
Existing Data Sources

- Health Provider Shortage data
- BHA Program Roll Out Feasibility Report conducted by Cumming
- AIHC Health Profiles
- Data from the Alaska CHA/P & BHA/P Programs



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Tribal and Urban Clinic Outreach

- Clinics/programs were sampled in order to reflect a diversity of: geography, proximity to urban area; service population size; IHS vs. tribally-run
- We asked program personnel about: Current staffing levels; Turnover; Ease of filling open positions; Capacity to meet service demands; Factors influencing overall capacity to provide services

Key Informant Interviews

- Clinic/Program Managers
- Consultants
- Advisory Committee Members

AIM 1

Understand what underlying factors contribute to the need for mid-level medical and behavioral health providers in Washington Tribal and urban Indian communities

Aim 1 Overview

- Background Aim
- Establishing considerations underpinning Aims 2 & 3
- Drawing on existing data from key informants closely involved in CHAP implementation

Identifying Underlying Issues

- We will present information related to current provider shortages; however, identifying the underlying factors contributing to these shortages is key to understanding how the addition of Community and Behavioral Health Aide providers and the associated training and funding infrastructure can address these shortages.

These issues include

A Trained Workforce

Community/ Clinic Infrastructure

Position Funding

A Trained Workforce

- Training that is affordable, culturally and contextually specific, and accessible for tribal students can be very challenging
- The CHA/P and BHA/P program implementation is working towards an accompanying community-partnered education training program through a local tribal college and/or community college partnership

Community/Clinic Infrastructure

- It is critical that infrastructure to support new providers is developed alongside the positions themselves in order for providers and programs to benefit
- Programs will be developed in partnership and support NPAIHB, and funding structures will be in place for program implementation as well as ongoing services and administration.

Position Funding

- New positions must be able to bill against existing funding sources or access new revenue streams
- Exact billing details have not been finalized for the CHA/P and BHA/P programs, but they will be an essential component of implementation

AIM 2

Describe specific data points and qualitative information characterizing this regional demand

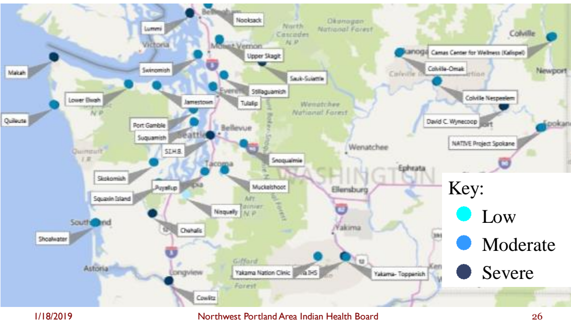
Aim 2 Overview

- Central component of this gap analysis
- Examining concrete metrics and on-the-ground expertise
- Triangulating quantitative and qualitative data sources to gather a richer picture of regional provider demand

Health Provider Shortage Areas

- A Health Provider Shortage Area (HPSA) is a regional designation that indicates practitioner shortages in dental health, behavioral health, or primary care.
- The National Health Service Corps developed a HPSA scoring system to determine regional-level health provider shortages and to thereby prioritize areas of greatest need.
- Scores range from 1 to 26, with 26 being the highest priority.
- A such, we categorized programs into low (1-9), moderate (10-16), and severe (17+) HPSA score groups, indicated by light, medium, and dark blue dots on the following maps

WA Tribal and UIHP Clinic Medical Provider HPSA Designations



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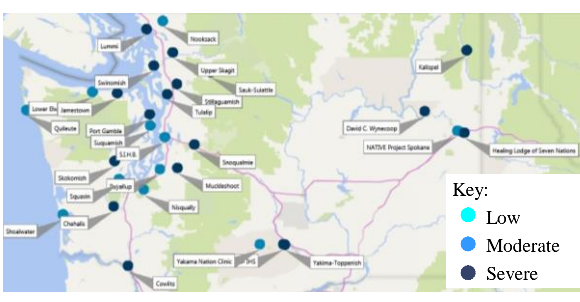
WA Tribal and UIHP Clinic Mental Health Provider HPSA Designations



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Notable Findings from the Cumming Report on BHA rollout

- AIAN individuals and communities experience a large unmet need for providers and access to providers
  - “Of those with a mental [health] disorder, only 32 percent had received mental health or substance abuse services.”
  - Nationally, AIAN individuals have access to 42% fewer providers per 100,000 population than whites
- Demand projections suggest that most tribes in WA could use 1 BHA provider initially, with larger communities eventually adding a 2nd BHA provider

Continuing Beyond the Cumming Report on BHA rollout

- List of BHA training and program needs in the Cumming Report offer a starting point, but will need to be further updated for Washington’s program
- The forthcoming demonstration project with 3-6 students starting later this year will provide key insights for continued planning and roll-out activities

American Indian Health Commission Data

- Data on current behavioral health staffing was a starting point for sampling and outreach to programs (CHAP-comparable provider data not available)
- Service population data provides greater specificity than census or other sources
  - Most programs serve a broader population than solely their tribal members

American Indian Health Commission Data

- Overview of range of services provided
  - Primary and emergency care
  - Obstetrics
  - Youth and elder specific programs
  - Physical therapy
  - Community health services
  - Case management, home-based, and care coordination services
  - Outpatient and Inpatient treatment
  - Individual, family, and group counseling
  - Psychiatric care
  - Suicide prevention

Qualitative Interview Findings

- Behavioral health integration is a key contextual issue when thinking about existing and new providers' roles and capacity
- There is interest in CHA/Ps and BHA/Ps at some facilities because these providers can meet a wide range of service needs whereas other providers may need to be more honed in on a certain scope of practice
- Similarly, there are many instances where current providers *are* practicing beyond the scope of their core duties (e.g. offering transportation, conducting community or home-based outreach, etc.) and that limits their ability to fully do their assigned job or serve more patients

Qualitative Interview Findings

- Varies from agency-to-agency, but both finding and retaining qualified providers at the mid-level is an issue for many agencies
- Other related issues tribal and urban medical and behavioral health programs face include working to offer attractive/competitive salaries, infrastructure barriers to adding providers (e.g. space, funding, equipment),
- Connection to community and service orientation helps retention
- Patient and community outreach benefit health outcomes; asks more of providers and other staff, but is effective for getting patients through the door

AIM 3

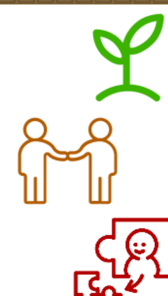
Analyze the potential of the Community and Behavioral Health Aide program to address the provider shortage

Aim 3 Overview

- Understanding how the CHAP program may be able to address the underlying issues established in Aim 1 and the shortage described in Aim 2
- Drawing on data from the Alaska program and Key Informant consultation with those closely involved with CHAP implementation

Advantages of CHA/P and BHA/P staffing in tribal clinics

- Growing our own
- Training/educational investment promotes retention
- Filling a needed service gap



Successes in Alaska

- Increased access to care and provision of services: 550 CHAs in over 170 villages
  - CHA/Ps offer consistent local access to primary care and local emergency response
- Health outcomes have improved in a variety of metrics since CHAP introduction (access to care, infant mortality, life expectancy, hospitalization rates)
- Patients and providers report very favorably about their experiences with CHA/Ps and the impact of their work
- Cost savings related to transport and contract care

Resources and Partnerships to Support the Programs' Success

- Training and education program structure
- NPAIHB CHAP Project
- Alaska program resources, AK CHAP staff, and the Alaska CHAP certification board
- Washington Dental Health Aide Therapy Program

Outstanding Areas to Address

- Certification
- Funding and billing
- Training program curriculum

Limitations

- Staffing data more limited at the mid-level
- Employment numbers and service gaps are in a state of constant flux
- Staffing need is more complicated than vacancies; funding and billing specifics also play an important role

Conclusions

- The need for mid-level medical and behavioral health providers in tribal and UIH programs is well supported by available data
- The broader structure of the Community and Behavioral Health Programs will be critical to their success and merits uniquely focused attention alongside the tasks of recruiting, training, placing, and supporting individual providers