San Diego Workforce Partnership

Addressing San Diego's Behavioral Health Worker Shortage

A needs assessment and vision to attract and retain essential behavioral health professionals

AUGUST 2022

LIVE WELL SAN DIEGO

ALLIANCE HEALTHCARE FOUNDATION
ADVANCING HEALTH AND WELLNESS FOR THOSE IN NEED

NATHAN FLETCHER

CHAIR

San Diego County Board of Supervisors

August 2022

Dear San Diegans:

As Chair of the San Diego County Board of Supervisors, my single highest policy priority since taking office in 2019 has been behavioral health – the intersection of mental health and addiction treatment.

I have witnessed the difficulties in hiring behavioral health workers as we took action to build a better way to deliver services and transform our behavioral health system. As part of my 2021 State of the County Address, I called on our County government to work with entities across San Diego County to develop a strategy to tackle the shortage of trained behavioral health workers in our region.

This report provides a deeper understanding of the worker shortage and outlines existing talent attraction and retention challenges in the behavioral health industry. It also brings new solutions to expand the size and diversity of mental health and addiction treatment professionals in San Diego over the long term.

To develop this transformative strategy, it took many partners. I want to extend my appreciation to the 1,600 San Diego Behavioral Health workers and students who provided input; the members of the San Diego Behavioral Health Workforce Steering Committee and the San Diego Workforce Partnership for leading this effort, and the County of San Diego Health and Human Services Agency and Alliance Healthcare Foundation for investing in this work.

With this roadmap, it is imperative we act with urgency to recruit, train and retain more mental health and addiction treatment professionals to work in San Diego County. Let's get to work!

Sincerely,

Chair Nathan Fletcher
Supervisor, Fourth District
County of San Diego

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Section 1: Executive Summary

San Diego County is facing a significant behavioral health (BH) worker shortage. This report estimates 17,000 BH professionals were employed in 11 key occupations in 2022. This is 8,000 workers short of the 25,000 needed.

This worker shortage is not unique to San Diego. According to the Steinberg Institute, the state's BH workforce can only serve about a quarter of its need[1]. In 2018, researchers from the University of California San Francisco (UCSF) estimated growing shortages over the next 10 years. UCSF estimated California will have 41% fewer psychiatrists and 11% fewer psychologists, licensed marriage and family therapists, licensed professional clinical counselors and licensed clinical social workers than needed by 2028[2].

These statewide projected shortages were all before the outbreak of the COVID-19 global pandemic. Since 2020, community need for behavioral health services, workforce shortages and wage competition from other industries have intensified, intensifying the long-standing workforce shortage to crisis levels.

At the same time, public investment in behavioral health services at the federal, state, and local level continue to increase. Services for crisis care, homelessness prevention, substance use prevention and treatment services, expanded services in public schools and healthcare integration are all driving more demand for BH workers. Demographic trends are not helping; each year more San Diego workers retire than the year before as the "baby-boom" generation ages. In 2018 for example, about half of California's psychiatrists are over 60 years of age (UCSF).

The convergence of these demographic trends, the global pandemic, growing mental health and substance use crises and historic public spending focused on expanding BH services raises a fundamental question:

Is our regional Behavioral Health Workforce equipped to meet the need?

This report sets out to address this question with responses to the following four related lines of inquiry. Below are our key findings and recommendations:

1. How many additional behavioral health professionals in each key occupation does the region need to meet the demand for services today and in the future?

[1] Steinberg Institute, "What is the behavioral health workforce shortage?" Behavioral Health Workforce Strategy Group
[2] UCSF Health Force, "California's Current and Future Behavioral Health Workforce" (2018)

- San Diego's regional behavioral health system currently employs approximately 17,000 professionals in 11 high priority occupations.
- This is approximately 8,000 workers short of the estimated 25,000 professionals needed to meet the population's need for services.
- By 2027, the San Diego region needs an estimated 27,600 to continue meeting unmet need while keeping pace with population growth.
- Based on current trends, an estimated 7,800 BH workers are expected to leave their professions by 2027.
- Starting from the nearly 17,000 workers in the field today, the San Diego region needs to educate, train, attract, employ, and retain 18,500 professionals between 2022 and 2027.

2. What do 1,600 San Diego BH professionals and students say are the principal factors influencing their career decisions?

   - Overall, BH workers reported high levels of satisfaction with their job security (84%), physical safety at work (82%), relationships with coworkers (91%), their boss (84%), the population they serve (93%) and that they are contributing to a purpose they care about (84%). These job quality features are attracting and retaining professionals to the field.
   - 39% of respondents reported varying levels of burnout. This is a relatively low burnout rate. National post-COVID studies find healthcare burnout rates around 50%.
   - 44% of BH respondents reported being somewhat likely (25%) or extremely likely (19%) to search for a job in the next 12 months. This is relatively high compared to national data ranging between 18-37% for various healthcare and behavioral health professionals.
   - Top push factors influencing worker burnout and intent to leave were dissatisfaction with pay (55%), stress on the job (44%), and documentation requirements (39%). In focus groups, stress on the job often related to staffing shortages, high caseload sizes and challenges accessing additional support services and treatment for their clients.

3. What could a long-term regional vision look like to develop, attract, and retain the most resilient, representative, skilled and qualified workforce in the United States?

    - Invest in competitive compensation: San Diego professionals across occupations are paid less than their counterparts in most California counties. Other recommendations described in this report will have limited effect if relative pay gaps for BH jobs continue to increase against other industries, non-BH settings and private practice.

    - Pursue administrative relief opportunities: Streamlining documentation requirements for current frontline professionals was one of the top three push factors. This report includes 12 issue areas and 29 actions to reduce administrative requirements for BH workers aimed at increasing retention and reducing intent to leave the field.

    - Establish regional training centers of excellence (COEs): Multi-partner sites that serve the public and develop core competencies in training and supervision programs are needed to expand the region's BH workforce infrastructure. These COEs would also provide technical assistance and operational support to other community-based organizations to establish their own training programs, and provide applied research opportunities for innovations in service delivery, training efficacy and workforce optimization

    - Build a regional BH workforce training fund: This report estimates a $425M investment is needed to expand the regions BH talent recruitment, training, and education systems for the additional 18,500 workers needed over the next five years. This report provides a financial framework for an initial $128M down payment to train 4,250 professionals.

        - $98M for scholarships, stipends, in-school support, loan forgiveness, expanding programs and other incentives for public service.

        - $30M of philanthropy and flexible public dollars to capitalize a first-in-the nation, regional BH revolving training fund that provides 0% interest loans to students entering specific programs and upfront financing for organizations to establish supervision programs.

    - Continue to listen to workers: This report should be a starting point for regional BH workforce development applied research focused on improving job quality and talent strategies for current and future public sector BH professionals.

4. What are specific projects and initiatives that can accelerate this vision on the ground?

The report includes nine occupational profiles with a description of initial projects for the $128M down payment that would train 4,250 professionals over 10 years. The projects are focused on regional investments to expand the size, diversity and capacity of San Diego's training, education, and clinical supervision system. Selected highlights include:

- $6M to recruit, place, certify and provide on-the-job-training for 600 certified peer support specialists.

- $3M for a regional apprenticeship program to train 600 community health workers.

- $8.5M in scholarships and 0% interest loans to recruit, train, place and certify 1,150 substance use disorder counselors.

- $1.3M to establish a psychiatric technician program with regional community colleges.

- $7.8M for stipends for 260 master of social work students to complete paid internships in BH settings.

- $7M to create 280 new supervision slots for associate social workers to accrue the 3,000 hours required for LCSW licensure. Learn and adapt model for registered nurses, marriage and family therapists, and psychologists in BH settings.

- $64M to train 84 community psychiatrists and 200 psychiatric mental health nurse practitioners to work in integrated teams in community settings, serving as a statewide model to address California's designation as a Health Professional Shortage Area (HPSA) related to a psychiatrist shortage statewide.

- Targeted loan forgiveness and mortgage down-payment assistance in exchange for public service for diverse professionals to build wealth, live and work in San Diego.

Where possible and appropriate, this report targets interventions that have demonstrated evidence attracting and retaining professionals to work in public behavioral health settings defined as follows:

> **Public Behavioral Health Professionals:**
> The full range of providers that serve the Behavioral Health needs of people who may be eligible for publicly-funded health insurance based on economic need. This includes County employees, contracted service providers, FQHCs, hospitals, providers in education settings, and private organizations that serve people eligible for publicly-funded health insurance.

This report lays out a vision to make San Diego home to the most resilient, representative, skilled and qualified BH workforce in the United States. As a result, the system of care will have the workforce needed to provide the highest quality of care possible for all San Diego residents, regardless of economic means or ability to pay.

HOW MANY MORE BEHAVIORAL HEALTH PROFESSIONALS DOES SAN DIEGO NEED?

18,500 more workers needed by 2027

17,000
behavioral health professionals in the current workforce

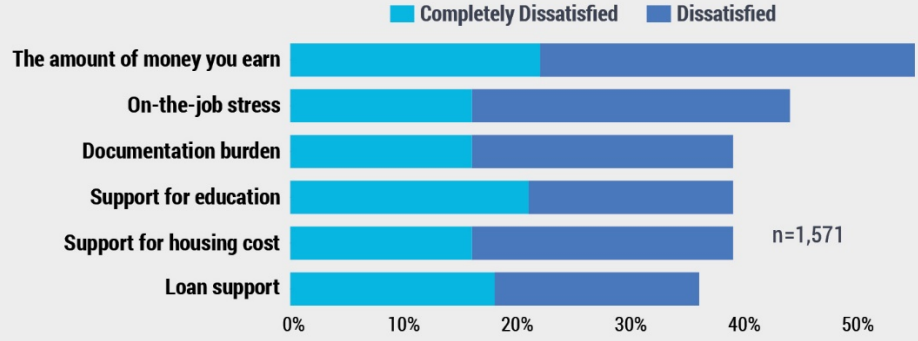
8,100
more workers needed to meet **today's** demand

7,800
to replace those leaving in next 5 years

2,600
to meet growth in demand by 2027

	2022 Workers	2022 Needed	2027 Needed	# Leaving Profession	Additional Needed 2022-2027
Community Health Worker & Social Service Assistant, including Peer Support Specialist	4,644	6,930	7,588	2,783	5,727
Marriage and Family Therapist	4,443	6,637	7,101	2,111	4,770
Substance Abuse and Behavioral Disorder Counselor	2,566	3,631	4,248	1,270	2,952
Mental Health and Substance Abuse Social Worker	1,283	1,913	2,142	616	1,476
Psychologist (Clinical, Counseling, and School)	1,603	2,401	2,522	533	1,451
Psychiatric Technician	789	1,181	1,334	292	837
Registered Nurse working in BH settings	1,040	1,548	1,641	56	656
Psychiatric Aide	129	192	248	89	208
Psychiatrist	265	396	431	37	204
Psychiatric Mental Health Nurse Practitioner	159	238	297	46	184
Physician's Assistant working in BH settings	28	42	48	8	28
Totals	**16,949**	**25,109**	**27,600**	**7,841**	**18,493**

WHY DO BEHAVIORAL HEALTH WORKERS LEAVE JOBS?



44% likely to search for a job in the next 12 months, vs 18-37% nationally

45% turnover for San Diego behavioral health workers, vs. 42% in the rest of California.

WHAT CAN BE DONE TO ADDRESS THIS SHORTAGE?

Invest in Competitive Compensation

San Diego BH professionals are paid less than other CA counties. **55% of workers surveyed were dissatisfied with pay**.

Pursue Administrative Relief

Streamlining documentation is a top concern for BH professionals. Explore **12 issue areas and 29 opportunities** to reduce administrative requirements.

Build Regional Workforce Training Fund

This report provides a financial framework for a **$128M** down payment to train **4,250** more professionals.

Establish Regional Training Centers of Excellence

Sites would **deliver services**, **expand training and supervision** opportunities, and provide **research** opportunities focused on integrated care, workforce optimization, and training best practices.

Continue Listening to Workers

Input from **1,600 San Diego workers and students** informed this report. Levels of job satisfaction, burnout, intent to leave, and other factors driving career decisions should be surveyed annually to inform implementation and measure progress.

$98M for scholarships, stipends, loan forgiveness, and expanding programs.

$30M first-in-the nation renewable training fund providing 0% interest loans to students and financing to establish training and supervision programs.

Sample projects for $128M Fund

- **$6M** to recruit, place, certify and provide on-the-job-training for **600 certified peer support specialists**.
- **$3M** for a regional apprenticeship program to train **600 community health workers**.
- **$8.5M** in scholarships and 0% interest loans to recruit, train, place and certify **1,150 substance use disorder counselors**.
- **$1.3M** to establish a **psychiatric technician** program with regional community colleges.
- **$7.8M** for stipends for **260 master of social work student**s to complete paid internships in BH settings.
- **$7M** to create **280 new supervision slots** for associate social workers to accrue the 3,000 hours for LCSW licensure.
- **$64M** to train **84 psychiatrists** and **200 psychiatric mental health nurse practitioners** to work in integrated teams in community settings.
- **Loan forgiveness** and **down-payment assistance** in exchange for public service for diverse professionals to build wealth, live and work in San Diego long term.

WHAT ARE WORKERS SAYING?

> **I have had to take out personal loans to cover my groceries. Rent is a whole paycheck. I've thought about going to grad school, but is it worth it to go thousands in debt for two more dollars an hour? I want to do this for the rest of my life, I love it. It makes me sad, but I don't think I will be able to.**
>
> – SUD Counselor, Female

> **I just I want to help people. But being extremely short-staffed—feeling the pressure, it's brutal. I'm really burned out and I'm white knuckling it. Being hyper-vigilant in that way is not conducive to being a good clinician. It's pretty maddening to be honest. I'm disillusioned.**
>
> – Pre-Licensed Counselor, Female

Section 2: Project Implementation

The County is pleased to select the San Diego Workforce Partnership to manage implementation of the recommendations outlined in the Behavioral Health (BH) report. The Workforce Partnership will develop and manage the overarching work plan, establish and report regularly on key performance indicators, lead ongoing steering committee meetings and plan additional behavioral health convenings to discuss progress.

From September through October 2022, the Workforce Partnership will:

- Create and issue an RFP and identify a project management consulting partner (consultant) to manage the day-to-day efforts proposed in the BH report recommendations
- Coordinate the development of a fundraising strategy with the County, current steering committee members and other key stakeholders for the initial $128 million workforce training fund

From November through April 2023, the Workforce Partnership will:

- Design an outcomes-based loan plan with Social Finance
- Determine program-specific design and funding needs for programs managed directly by the Workforce Partnership: peer support specialist, community health worker and substance use disorder counselor programs
- In partnership with consultant:
    - Develop overarching tactical plan to establish one, three, and five+ year priorities
    - Identify key working committee participants for each recommendation and overall steering committee members
    - Define tangible goals & KPIs
    - Issue RFPs for key recommendation areas

Each recommendation outlined in the report will have its own working committee comprised of key stakeholders who provide oversight of the development and issuance of competitive bids and tracking of performance. An overall steering committee will be created to ensure the working committees are meeting their objectives and course-correcting as necessary. All committees will be managed by the consultant.

Behavioral Health Report Recommendations

1. Invest in competitive compensation – San Diego County must offer behavioral health professionals competitive pay.
    a. The County will lead this recommendation with input from the Workforce Partnership's research team as needed
2. Pursue administrative relief – San Diego County must streamline documentation requirements.
    a. The consultant will develop a RFP with input from the working committee. Once the RFP is issued and the vendor selection is made, the consultant will manage the subcontractor(s).
3. Build regional workforce training fund –San Diego County must invest $128 million to train 4,250 more professionals.

   a. The Workforce Partnership will design, implement and report on outcomes related to the peer support specialist, community health worker and substance use disorder counselor training programs.
   b. The Workforce Partnership will contract with Social Finance to design and manage the workforce training fund. In partnership with the County, steering committee, and other key stakeholders, the Workforce Partnership will work with stakeholders to identify fundraising ideas for the initial $128 million training fund.
   c. The consultant will develop RFP(s) with input from the working committee for the remaining six occupational training recommendations outlined in the report.
4. Establish regional training centers of excellence – San Diego County must establish sites to deliver services and expand training and supervision opportunities focused on integrated care, workforce organization and training best practices.
   a. The consultant will develop RFP(s) with input from the working committee. Once the RFP is issued and a vendor selection is made, the consultant will manage the subcontractor(s).
5. Continue listening to workers – Continue surveying workers annually to inform implementation and measure progress.
   a. The Workforce Partnership's research department will execute the outcomes related to this recommendation. Activities include conducting annual surveys, producing additional highlights via continued research and developing partnerships with centers of excellence and universities.

Recommended Steering/Working Committee Groups

As discussed above, each of the five recommendation areas will have its own working committee. There will also be an overall steering committee that guides the working committees. Below are organizations that should be engaged as part of either the working or steering committees, depending on their area of expertise.

- County Health & Human Services
- Cities – All cities in the region
- Community Psychiatry – UCSD San Diego Health, Family Health Centers of San Diego, San Diego Youth Services, Survivors of Torture International, Deaf Community Services, Community Research Foundation, San Diego Center for Children, San Ysidro Health, Vista Hill
- Training Providers – SDSU, UCSD College of Extended Studies, Cal State San Marcos, Grossmont College, Cuyamaca College, Southwestern College, San Diego City College, San Diego Continuing Education, Mesa College, Mira Costa College, Palomar College, National University, Futuro Health, Alliant International University, NAMI
- Behavioral Health Employers - NAMI, San Diego Center for Children, McAlister Institute, Interfaith Community Services, Casa De Amparo, Community Research Foundation, Deaf Community Services, Episcopal Community Services, Harmonium, YMCA, Jewish Family Services, Planned Parenthood of the Pacific Southwest, Father Joe's Villages, North County Lifeline, San Diego Youth Services, South Bay Community Services, Union of Pan Asian Communities, Survivors of Torture International, Catholic Charities, Mental Health Systems, MAAC, Veterans Village, Alvarado Parkway Institute, The San Diego LGBT Center, Neighborhood House
- Labor – SEIU, UNAC, UPTE-CWA, Health Center Partners of Southern California

- Philanthropy – Alliance Healthcare Foundation, Burnham Center, Conrad Prebys Foundation, Catalyst of San Diego & Imperial Counties, Irvine Foundation, San Diego Foundation, Price Philanthropies
- Hospitals and Hospital Systems- Rady Children's Hospital, Sharp, Scripps, UCSD Health, Palomar Health, Kaiser, VA Healthcare System
- MediCal Plans- Health Net, Molina
- Federally Qualified Health Centers – Family Health Centers of San Diego, Vista Community Clinic, San Ysidro Health, True Care, La Maestra, American Indian Health Center
- Associations and Consortiums – Hospital Association of SD & Imperial Counties, Health Center Partners of Southern California, SD Psychological Association, Alcohol and Drug Services Providers Association, Mental Health Contractors Association, SD and Imperial Counties Community Colleges Association, Behavioral Health Advisory Group, San Diego Medical Society, Black Nurses Association, Hispanic Nurses Association, California Association of Nurse Practitioners- San Diego, San Diego Psychiatric Society

The Workforce Partnership looks forward to collaborating with this larger community on the important effort of addressing the behavioral health workforce shortage in San Diego. We thank all stakeholders for their contributions in developing this report and in helping us implement the recommendations.

Section 3: Understanding San Diego's Behavioral Health Worker Shortage

Today, there are approximately 17,000 professionals working in a BH setting across 12 key occupations. By 2027, the San Diego region needs to produce, attract, or retain an additional 18,500 behavioral health professionals to meet the need for services from San Diego residents, replace existing workers that will leave the industry and keep up with population growth. This section provides a detailed methodology for these estimates for 12 key occupations, listed in Figure 1.

Figure 1: Occupations included in the workforce needs assessment

SOC Code(s)	Description[3]	2022 Professionals in San Diego
21-1094	**Community Health Workers:** Promote health within a community by assisting individuals to adopt healthy behaviors and advocate for the health needs of individuals by assisting community residents in effectively communicating with healthcare and social service agencies.	4644

[3] Descriptions were based on standard O*NET occupational descriptions and may not reflect every aspect of the professional's job.

SOC Code(s)	Description[3]	2022 Professionals in San Diego
21-1093	Social and Human Services Assistants (includes Peer Support Specialists[4]): Assist other social and human service providers in providing client services in a wide variety of fields, such as psychology, rehabilitation, or social work, including support for families. May assist clients in identifying and obtaining available benefits and social and community services. May assist social workers with developing, organizing, and conducting programs to prevent and resolve problems relevant to substance abuse, human relationships, rehabilitation, or dependent care.	
31-1133	Psychiatric Aides: Assist mentally impaired or emotionally disturbed patients, working under direction of nursing and medical staff. May assist with daily living activities, lead patients in educational and recreational activities, or accompany patients to and from examinations and treatments. Includes psychiatric orderlies.	129
21-1011	Substance Abuse and Behavioral Disorder (SUD) Counselors: Counsel and advise individuals with alcohol, tobacco, drug, or other problems, such as gambling and eating disorders. May counsel individuals, families, or groups or engage in prevention programs.	2566
29-2053	Psychiatric Technicians (multiple related job titles): Care for individuals with mental or emotional conditions or disabilities, following the instructions of physicians or other health practitioners. Monitor patients' physical and emotional well-being and report to medical staff. May participate in rehabilitation and treatment programs, help with personal hygiene, and administer oral or injectable medications.	789
21-1013	Marriage and Family Therapists / Professional Counselor: Diagnose and treat mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems. Apply psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders.	4443
21-1023	Mental Health and Substance Abuse Social Workers: Assess and treat individuals with mental, emotional, or substance abuse problems, including abuse of alcohol, tobacco, and/or other drugs. Activities may include individual and group therapy, crisis intervention, case management, client advocacy, prevention, and education.	1283
19-3033 19-3034	Psychologists (Clinical and Counseling and School): Assess, diagnose, and treat mental and emotional disorders of individuals through observation, interview, and psychological tests. Help individuals with distress or maladjustment understand their problems through their knowledge of case history, interviews with patients, and theory. Provide individual or group counseling services to assist individuals in achieving more effective personal, social, educational, and vocational development and adjustment.	1603
29-1141 29-1141 (02)	Registered Nurses working in BH settings: Assess patient health problems and needs, develop and implement nursing care plans, and maintain medical records. Administer nursing care to ill, injured, convalescent, or disabled patients. May advise patients on health maintenance and disease prevention or provide case management. This report used national estimates that 4% of all RN's work in BH settings.	1040
29-1171	Psychiatric Mental Health Nurse Practitioner: Diagnose and treat acute, episodic, or chronic illness, independently or as part of a healthcare team. May focus on health promotion and disease prevention. May order, perform, or interpret diagnostic tests such as lab work and x rays. May prescribe medication. Must be registered nurses who have specialized graduate education.	159
29-1071	Physician's Assistant working in BH settings: Provide BH services typically performed by a physician, under the supervision of a physician. Conduct complete physicals, provide treatment, and counsel patients. May, in some cases, prescribe medication.	28
29-1223	Psychiatrists: Diagnose, treat, provide medication management, and help prevent mental disorders	265
Total		16,949

[4] While peer support specialists do not have specific Bureau of Labor Statistics (BLS) Standard Occupational Classification (SOC) code, their job titles are commonly found in the broader Social and Human Service Assistants category.

To estimate the need for behavioral health workers across occupations in 2022, we used staffing level estimates and estimates of unmet need in San Diego for BH professionals. For future years (2027 and 2032), we used estimates of growth and rates of workers leaving the profession (referred to hereafter as "replacement") to project numbers of jobs and the number of new providers needed to fill those jobs. This section will review the sources and methods for each of these estimates.

Step 1 – Calculating unmet need: We started by finding estimates of unmet need for behavioral health and substance use disorder. The most recent available substate estimates of mental disorders by The National Survey on Drug Use and Health (NSDUH) at the time of analysis were 2016-2018[5]. They indicate that 18.36% of adults had a mental illness, but only 12.28% received care, leaving an unmet need for mental health services for 6.08% of San Diego's population. Given that 12.28% of the population is receiving care with our current number of service providers, we would need 49.51% additional service providers to reach the 6.08% of San Diego's population who needs but does not receive mental health treatment.

We determined the unmet need for substance use disorder in collaboration with subject matter experts, who noted that a small percentage of people determined to need substance use treatment as measured by the NSDUH ever sought treatment. According to the 2019 NSDUH national data[6], we would need to increase substance use providers by 411% to have enough providers available for every person who needs substance use disorder treatment. However, NSDUH reports that 97.5% of respondents classified as having a substance use disorder in 2020 did not feel they needed treatment[7]. Recognizing San Diego County initiatives to expand the reach of substance use disorder treatment[8] and in conversation with epidemiologists engaged with this question, we decided to aim for an increase of 10% of the unmet need for substance use disorder treatment, resulting in a shortage of 41.19% of providers that treat substance use disorder exclusively.

For professions that treat both mental health and substance use disorders, we set our goal to increase service provision by the larger amount (49.51%).

To account for the outdated unmet need estimates, we started with the number of jobs in each occupation in 2017 using labor market information from the Bureau of Labor Statistics (BLS), supplemented by data from State of California licensing boards. Where possible, we used BLS employment numbers because they are consistently measured year over year. However, BLS numbers are collected by Standard Occupational Classification Codes, some of which are broad enough to include workers outside of behavioral health (e.g., registered nurses). In those cases, we used methods modeled by the HealthForce Center at UC San Francisco from their "California's

[5] Substate Estimates of Substance Use and Mental Illness from the 2016-2018 NSDUH: Results and Detailed Tables | CBHSQ Data. (n.d.). Retrieved June 14, 2022, from https://www.samhsa.gov/data/nsduh/2016-2018-substate-reports
[6] Sub-state estimates of the NSDUH report unmet need for SUD directly without including number of people who receive treatment; we used the most recent available national numbers that do include the number of people currently receiving treatment to estimate the needed increase of providers.
[7] Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health. (2020). 156.
[8] Alcohol and Drug Services (ADS). (n.d.). Retrieved June 14, 2022, from https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/alcohol_drug_services/prevention_services.html

Current and Future Behavioral Health Workforce" report to estimate the number of professionals in the occupation working in behavioral health settings in San Diego[9].

We then applied unmet need for 2017 to the number of jobs in 2017, assuming that our current workforce is serving our current *met* need we would need a proportionate increase in the workforce to meet unmet need. The resulting values represent the number of workers needed in 2017.

Step 2-Estimating BH employment numbers in 2022, 2027 and 2032 to meet unmet need: To understand what that workforce would look like in 2022, we applied the growth rate for each occupation from 2017 to 2022. This gives us an estimate of the workforce required to meet local needs in 2022, if the need during that period grew linearly, proportionately to the occupation growth. This assumption can be evaluated when the NSDUH releases more recent substate estimates.
To estimate the number of jobs and new professionals needed for future years (2027 and 2032), we used growth projections based on Bureau of Labor Statistics[10] to predict the change in the number of jobs in the county for each occupation.

Step 3-Accounting for separations and retirements: To mitigate the shortage from steps 1 and 2, recruiting and retaining the difference between the current workforce and the future workforce over that time would be insufficient. We also need to account for outflows from each profession due to people leaving the occupation (e.g., to retire or leaving the industry) or moving out of the region. We used the occupational replacement rate–this includes people leaving the profession entirely. Workers leaving their job for another in the same occupation (e.g., a SUD Counselor leaving one employer for another) are not included in this analysis because that move does not reduce the number of workers in the occupation. Each occupation has a different replacement rate and demographic distribution, and so some professions will need to hire faster to replace workers leaving the profession than others. This method gives us the following estimates of interest for each occupation:

- The number of workers needed to meet the existing demand in 2022.
- The total number of jobs needed in 2027 and 2032 (considering growth and unmet need).
- The number of workers who need to enter the profession in 2027 and 2032 (to meet growth, unmet need, and to replace workers leaving the profession).

Figure 2 estimates the San Diego regional behavioral health worker shortage is 8,160 professionals, assuming existing staffing patterns and caseload sizes. Note that the following results include everyone in these occupations working in San Diego BH settings, regardless of whether they work in private practice or the public behavioral health system.

[9] Particularly, registered nurses (RNs) and nurse practitioners SOC codes include nurses across specialties. Further complicating this issue, Advance Practice Psychiatric Nurses are counted under the Registered Nurses parent code, rather than with the rest of Nurse Practitioners. For registered nurses, we used the estimate from the 2018 report that 4% of registered nurses are RNs working in behavioral health settings. For Nurse Practitioners, we multiplied the number of actively licensed professionals statewide by 8.4%, the most recent available ratio of San Diego County's population to California's (2020 San Diego Population 3.324 million: 2020 California population 39.35 million). Where needed, we adjusted data from these professions using estimates from the 2018 report of the proportion of Nurse Practitioners (6.9%) and Registered Nurses (4%) working in behavioral health. For both of these professions, we used Emsi growth and replacement estimates for the closest available professions (Registered Nurses and Nurse Practitioners).

[10] provided by Emsi Burning Glass, 2022

Figure 2: 2022 Professionals Needed

Occupation	2022 BH Professionals	Total Professionals Needed	2022 Worker Shortage
Community Health Workers & Social Service Assistants, including Peer Support Specialists	4644	6930	2286
Psychiatric Aides	129	192	63
Substance Abuse and Behavioral Disorder (SUD) Counselors	2566	3631	1065
Psychiatric Technicians	789	1181	392
Marriage and Family Therapists	4443	6637	2194
Mental Health and Substance Abuse Social Workers	1283	1913	630
Psychologists (Clinical, Counseling, and School)	1603	2401	798
Registered Nurses working in BH settings	1040	1548	508
Psychiatric Mental Health Nurse Practitioner	159	238	79
Physician Assistant	28	42	14
Psychiatrists	265	396	131
Totals	**16,949**	**25,109**	**8,160**

We then take the "total professionals needed" number and add 5-year occupational growth rates and replacement rates to get a sense of the total number of professionals the region needs to attract and/or retain (below benchmark replacement rates). This analysis shows an additional 10,333 professionals are needed between 2022-2027 to continue to meet existing and unmet need (figure 3).

Figure 3: Replacement and occupational growth rates from 2022-2027

Occupation	Prof. Needed (2022)	Growth Rate 2022- 2027	Prof. needed (2027)	Replacement rate[2]	Replace-ments	New Prof. Needed 2022-2027
Community Health Workers & Social Service Assistants, including Peer Support Specialists	6930	9%	7588	11.3%	2783	3441
Psychiatric Aides	192	29%	248	12.1%	89	145
Substance Abuse and Behavioral Disorder Counselors	3631	17%	4248	9.2%	1270	1887
Psychiatric Technicians	1181	13%	1334	7%	292	445
Marriage and Family Therapists	6637	7%	7101	9.2%	2111	2576
Mental Health and Substance Abuse Social Workers	1913	12%	2142	9.2%	616	846
Psychologists (Clinical, Counseling, and School)	2401	5%	2522	6.5%	533	653
Registered Nurses working in BH settings	1548	6%	1641	5.2%	56	148
Psychiatric Mental Health Nurse Practitioner	238	25%	297	5.2%	46	105
Physician's Assistant	42	13%	48	5.5%	8	14
Psychiatrists	396	9%	431	2.7%	37	73
Totals	**25,109**		**27,600**		**7,841**	**10,333**

The final step in estimating the total number of BH professionals needed in San Diego over the next 5 years combines the total number of workers to meet unmet need and the 5-year projected growth and replacement rates to give the total number of workers that need to be trained, attracted, placed, and retained at levels below estimated replacement rates (figure 4).

Figure 4: Total number of additional professionals needed in San Diego (2022-2027)

Occupation	2022 BH Prof.	Prof. Needed (2022)	Prof. Needed (2027)	2022 Shortage	New Prof. Needed 2022-2027	Total Additional Needed (2022-2027)
Community Health Workers & Social Assistants, including Peer Support Specialists	4644	6930	7588	2286	3441	5727
Psychiatric Aides	129	192	248	63	145	208
Substance Abuse and Behavioral Disorder Counselors	2566	3631	4248	1065	1887	2952
Psychiatric Technicians	789	1181	1334	392	445	837
Marriage and Family Therapists	4443	6637	7101	2194	2576	4770
Mental Health and Substance Abuse Social Workers	1283	1913	2142	630	846	1476
Psychologists (Clinical, Counseling, and School	1603	2401	2522	798	653	1451
Registered Nurses working in BH settings	1040	1548	1641	508	148	656
Psychiatric Mental Health Nurse Practitioner	159	238	297	79	105	184
Physician's Assistant	28	42	48	14	14	28
Psychiatrists	265	396	431	131	73	204
Totals	**16,949**	**25,109**	**27,600**	**8,160**	**10,333**	**18,493**

Limitations

Because of limitations on available data, this analysis has some weaknesses.

First, BLS Standard Occupation Classifications (SOC) are broad and do not change often. Several occupations in our analysis (for example, registered nurses, nurse practitioners, and physician's assistants) are employed throughout the health system; behavioral health is only one of several specialties or work settings. To include them in our analysis, we used statewide estimates, as explained above. The validity of those estimates rests on several assumptions: 1) that San Diego has a similar proportion of each of these professions working in behavioral health as California at large and 2) that key features, like turnover and replacement rates, are similar across specialties within professions. Additionally, a handful of high-priority occupations for San Diego BH leaders, such as peer support specialists, do not have a designated SOC code and their job titles are included in the SOC code for social and human service assistants and community health workers, making it difficult to estimate how many peer support specialists are needed.

Second, our analysis rests primarily (and necessarily) on historical data, but recent and anticipated changes impact the reliability of our estimates. First, coming changes to the statewide public behavioral health system through CalAIM will extend and change Medi-Cal eligibility and service provision over the course of the next 10 years. Second, the COVID-19 pandemic has changed the

demand and supply for behavioral health services. We cannot predict what long term impacts these changes will have.

Third, this analysis does not consider opportunities to use telehealth providers that do not live in San Diego. Further inquiry is needed to see how telehealth operational capacity, policy changes, and technology advancements can allow for professionals living outside San Diego County to meet local needs.

Finally, our analysis does not include workforce optimization modeling. Currently, federal, state and county policies constrain the scope of practice for professions and in many cases dictate staffing models by regional BH employers. These scopes are changing. For example, nurse practitioners will be able to practice independently in California by 2023[11] and peer support specialists will soon be certified and their services eligible for Medi-Cal coverage[12].

Section 4: Frontline Perspectives

> "If I could stay, I would – I love my job so much. But I got to this point where I felt like I could not possibly stay."
>
> – Former Peer Support Specialist, currently re-training for a technology career

The previous section highlighted an existing worker shortage of more than 8,000 professionals across 11 key occupations and the need to attract or retain an additional 18,500 professionals between 2022–2027. Of those 18,500 new professionals needed, 7,800 of them will leave the profession by 2027.

A combination of both new talent development and attraction and existing talent retention strategies and investments will be necessary to meet the region's goals. Strategies to do this should be informed by the voices, perspectives and experiences of current and future workers themselves.

This section highlights what we heard from over 1,600 San Diego BH workers about their career goals, burnout out, intent to leave and job satisfaction between February and May 2022 through focus groups and direct surveys.

Methodology

We took a two-phase approach to understanding the experiences of behavioral health workers, their perspectives on job quality and job satisfaction, and the drivers of burnout, intent to leave and turnover.

First, we conducted semi-structured focus groups and interviews with 30 workers. Discussions were conducted over video calls in February 2022. The moderator referred to a script written in advance to

[11] AB-890 Nurse practitioners: Scope of practice: Practice without standardized procedures. (n.d.). Retrieved May 20, 2022, from https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB890

[12] California Mental Health Services Authority | Peer Certification. (n.d.). Retrieved May 20, 2022, from https://www.calmhsa.org/peer-certification/

ensure that privacy disclosures were consistent among participants and to focus the conversation on topics of interest. Among participants who provided job information were eight licensed clinicians, nine certified workers, six licensed prescribers, three people who described themselves as site supervisors or program managers, and one psychologist[13], all working in San Diego County. Focus groups and interviews were automatically transcribed, then labelled with qualitative codes. Codes included concepts from the literature review, topics of interest and topics that emerged after analysis of the qualitative data.

Second, we conducted a survey of behavioral health workers in San Diego County. We developed a survey based on our findings in focus groups, our past surveys and findings in workforce development and a review of relevant literature. The survey was distributed through the following partners in San Diego County:

- The Alcohol and Drug Service Providers Association (ADSPA)
- The San Diego County Mental Health Contractors Association (MHCA)
- The Hospital Association of San Diego & Imperial Counties (HASDIC)
- Health Center Partners (HCP)
- The San Diego Imperial County Community Colleges (SDICCC)
- Deans, department chairs, and executives with the region's universities
- The San Diego Psychiatric Society (SDPS)
- The 13-member steering committee that advised on this project.

The survey used a branching design to collect relevant data from students, workers and those who are both students and workers. In April and May of 2022, our survey collected 1,571 responses. The median response time was 13 minutes and 2 seconds.

Figure 5: Survey respondents' occupations, gender identity, and race/ethnicity

Occupations (select all that apply)		Gender Identity		
	N		%	N
Administrator	192	Women	55%	871
Case Manager	176	Men	16.7%	262
Certified SUD Counselor	125	Non-Binary	0.8%	13
Licensed Clinical Social Worker	114	A Gender not listed	.06%	1
Associate Social Worker	122	Unspecified or Prefer not to say	27.0%	424
Licensed Marriage and Family Therapist	118	**Total**		**1571**
Peer Support	113			
Registered SUD Counselor	94	**Race/Ethnicity**	**%**	**N**
Associate MFT	81	White	29.2%	458
Community Health Worker	66	Hispanic or Latino/a/x	22.4%	352
Psychologist	46	Multi Racial	5.9%	93
Psychiatrist	39	Asian	5.2%	82

[13] Certified workers included 1 case manager, 1 gambling and alcohol addiction counselor, 1 peer support worker, and 6 substance use disorder counselors. Prescribing participants included 1 Nurse Practitioner and 5 Psychiatrists. Licensed clinicians included Licensed Clinical Social Workers, Marriage and Family Therapists, and Licensed Clinical Counselors. These can't be split out because we asked them about their job, not licensure, and some employers hire all of the above under the title "social worker." We spoke to at least four pre-licensed workers for these occupations as well.

Associate PCC	36	Black or African American	4.8%	76
Registered Nurses	35	Middle Eastern or North African[14]	1.0%	16
Outreach worker	24	Pacific Islander	0.7%	11
Nurse Practitioner	19	American Indian or Alaska Native	0.4%	7
Licensed Professional Clinical Counselor	13	Other	1.0%	16
Psychiatric Aide	9	Unspecified or Decline to State	29.3%	460
Nurse Practitioner Trainee	2	**Total**		**1571**
Interpreter	3			
Psychiatric Technician	1			
Physician's Assistant	1			
Other Non-certified Professional	79			
Other Certified Professional	14			
Other Occupation	102			
Students only	20			

Our focus group highlighted industry, occupational and local factors driving workers to and away from their jobs in behavioral health. The survey allowed us to ask workers about their burnout, intent to leave and satisfaction with each of the aspects of work revealed in the focus groups, along with other features of work generally that the literature has shown to push workers away from their jobs or make those jobs more appealing. This section will review our findings about burnout, intent to leave, factors that push workers away from working in behavioral health and factors that attract workers to behavioral health using insights from focus groups, our survey and context from other studies and industries.

Burnout

Burnout is conceptualized as "prolonged response to chronic interpersonal stressors on the job" including exhaustion, cynicism, detachment and lack of accomplishment or ineffectiveness at work[15]. Burnout has long been a concern in behavioral health, prompting several studies to understand[16] and reduce[17] burnout among behavioral health providers. COVID-19 may be exacerbating burnout among public sector employees,[18] health care workers[19] and behavioral health care providers[20]. Burnout has been associated with intent to leave among mental health providers[21]. We elected to include burnout alongside intent to leave for two reasons. First, research suggests that

[14] In the census, Middle Eastern and North African are considered part of the category "White," but that may obscure valuable information and fails to reflect this community's contemporary self-identification, so we include it (Maghbouleh et al., 2022). In this report, where we compare to Census data, we collapse this category with "White" to maximize comparability.

[15] Maslach, C., & Leiter, M. P. (2017). Understanding burnout: New models. In The handbook of stress and health: A guide to research and practice (pp. 36–56). Wiley Blackwell. https://doi.org/10.1002/9781118993811.ch3

[16] Paris, M., & Hoge, M. A. (2010). Burnout in the Mental Health Workforce: A Review. The Journal of Behavioral Health Services & Research, 37(4), 519–528. https://doi.org/10.1007/s11414-009-9202-2

[17] Rollins, A. L., Kukla, M., Morse, G., Davis, L., Leiter, M., Monroe-DeVita, M., Flanagan, M. E., Russ, A., Wasmuth, S., Eliacin, J., Collins, L., & Salyers, M. P. (2016). Comparative Effectiveness of a Burnout Reduction Intervention for Behavioral Health Providers. Psychiatric Services, 67(8), 920–923. https://doi.org/10.1176/appi.ps.201500220

[18] Liss-Levinson, R. (2022). Survey Results: Continued Impact of COVID-19 on Public Sector Employee Job and Financial Satisfaction, and Retention. https://slge.org/wp-content/uploads/2022/03/public-workforce-and-covid-march2022.pdf

[19] Amanullah, S., & Ramesh Shankar, R. (2020). The Impact of COVID-19 on Physician Burnout Globally: A Review. Healthcare, 8(4), 421. https://doi.org/10.3390/healthcare8040421

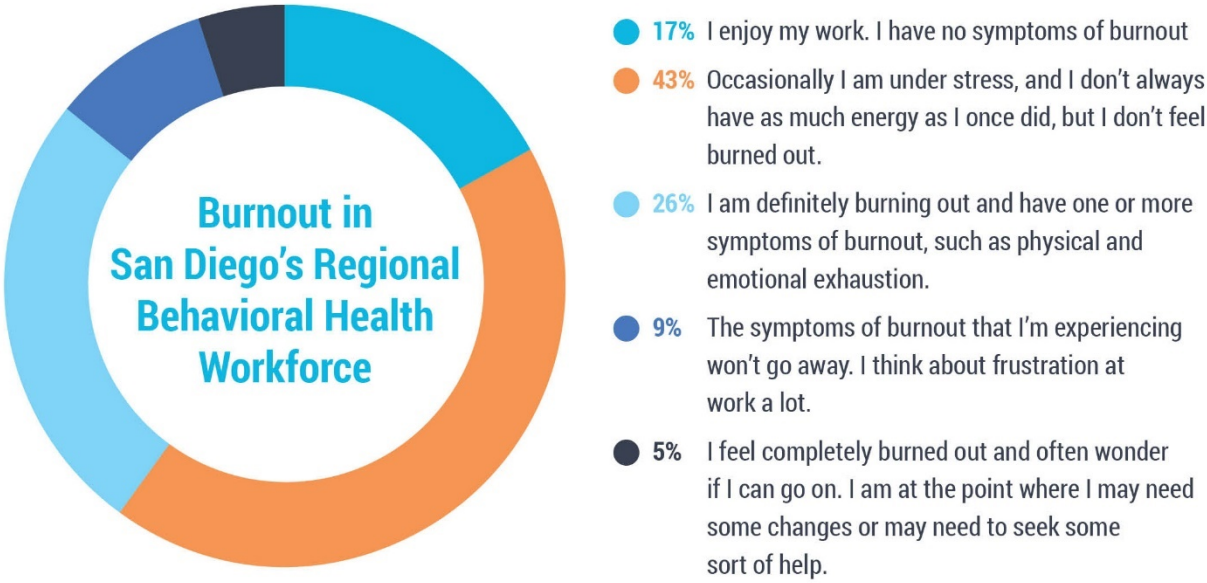
[20] Joshi, G., & Sharma, G. (2020). Burnout: A risk factor amongst mental health professionals during COVID-19. Asian Journal of Psychiatry, 54, 102300. https://doi.org/10.1016/j.ajp.2020.102300

[21] Sklar, M., Ehrhart, M. G., & Aarons, G. A. (2021). COVID-related work changes, burnout, and turnover intentions in mental health providers: A moderated mediation analysis. Psychiatric Rehabilitation Journal, 44(3), 219–228. https://doi.org/10.1037/prj0000480

burnout is one of many factors contributing to workers leaving their jobs, including pay and lack of advancement[22]. Second, burnout may be associated with worsening quality of care among healthcare providers[23].

In our survey, 39% of respondents reported some burnout, with 25% reporting some symptoms, 9% reporting persistent burnout, and 5% indicating, "I feel completely burned out and often wonder if I can go on." Sadly, this is a relatively low burnout number across healthcare, with post-COVID studies finding burnout rates around 50%[24]. Nevertheless, burnout drives turnover, occupational replacement rates, and may hurt quality of care [25].

Figure 6: Burnout among San Diego behavioral health professionals



In the survey data burnout was best predicted by stress on the job. Other than stress, burnout was correlated by satisfaction with respondents' relationship with their boss, caseload, pay, licensure cost and documentation. The strong relationship between burnout and relationships with supervisors is not surprising, but it is encouraging. Many workers in our focus groups mentioned relationships with their supervisors as a strength of San Diego's behavioral health system.

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[22] Parker, K., & Horowitz, J. M. (2022, March 9). Majority of workers who quit a job in 2021 cite low pay, no opportunities for advancement, feeling disrespected. Pew Research Center. https://www.pewresearch.org/fact-tank/2022/03/09/majority-of-workers-who-quit-a-job-in-2021-cite-low-pay-no-opportunities-for-advancement-feeling-disrespected/

[23] Tawfik, D. S., Scheid, A., Profit, J., Shanafelt, T., Trockel, M., Adair, K. C., Sexton, J. B., & Ioannidis, J. P. A. (2019). Evidence Relating Health Care Provider Burnout and Quality of Care. Annals of Internal Medicine, 171(8), 555–567. https://doi.org/10.7326/M19-1152

[24] Prasad, K., McLoughlin, C., Stillman, M., Poplau, S., Goelz, E., Taylor, S., Nankivil, N., Brown, R., Linzer, M., Cappelucci, K., Barbouche, M., & Sinsky, C. A. (2021). Prevalence and correlates of stress and burnout among U.S. healthcare workers during the COVID-19 pandemic: A national cross-sectional survey study. EClinicalMedicine, 35. https://doi.org/10.1016/j.eclinm.2021.100879
Linzer, M., Smith, C. D., Hingle, S., Poplau, S., Miranda, R., Freese, R., & Palamara, K. (2020). Evaluation of Work Satisfaction, Stress, and Burnout Among US Internal Medicine Physicians and Trainees. JAMA Network Open, 3(10), e2018758. https://doi.org/10.1001/jamanetworkopen.2020.18758

[25] Tawfik, D. S., Scheid, A., Profit, J., Shanafelt, T., Trockel, M., Adair, K. C., Sexton, J. B., & Ioannidis, J. P. A. (2019). Evidence Relating Health Care Provider Burnout and Quality of Care. Annals of Internal Medicine, 171(8), 555–567. https://doi.org/10.7326/M19-1152

Stress builds up over time to cause burn out. Stress is a serious problem among our focus group respondents. Behavioral health workers across occupational groups face vicarious trauma from their patients, a pattern especially salient among SUD counselors.

Participants in focus groups noted that caseloads, pay and documentation were primary contributors to their stress. They also mentioned several mitigating factors for stress: supportive management, cooperative culture among peers, small breaks in their schedule for a walk or conferring with a colleague, pay and paid time off (PTO).

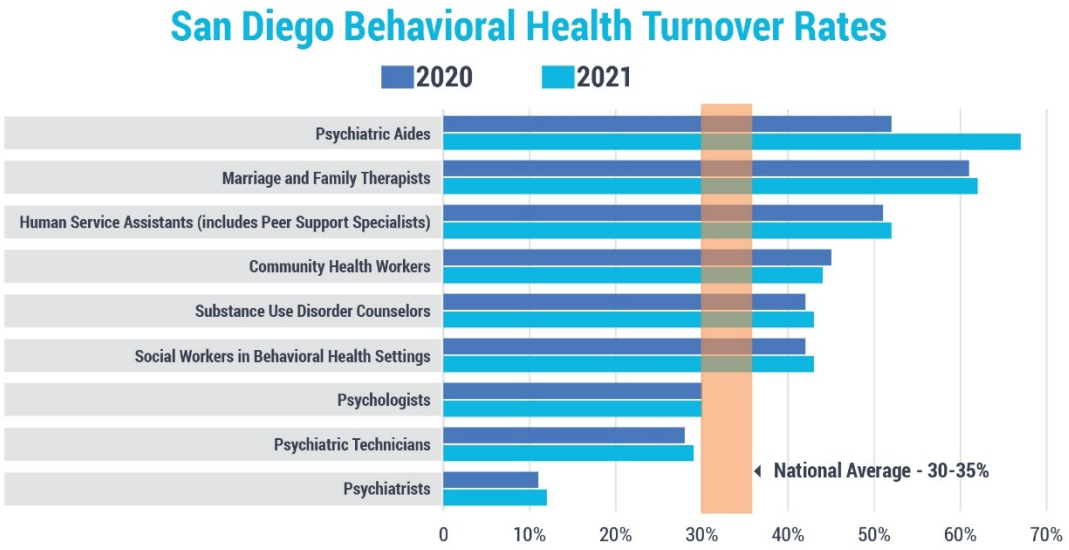
Turnover and intent to leave

In our survey, 44% of respondents indicated that they were somewhat likely (25%) or extremely likely (19%) to search for a job in the next 12 months. This is high compared to historical measures of intent to leave in the field (for example, 18%-25% in substance abuse disorder treatment[26], 22-33% in public health[27]). Data after the onset of the pandemic started is harder to find, but one study found 37% intent to leave among psychiatric nurses.[28]

Turnover is a substantial problem around the country: national annual turnover in behavioral health is between 30% and 35%[29]. In San Diego, many behavioral health occupations meet or exceed that average, and eight San Diego behavioral health occupations saw increases in turnover in 2020. Turnover includes workers leaving their employer for any reason, including to retire, leave the profession, or move to another employer within the same profession. Figure 9 shows 11 behavioral health occupations and their turnover rates in 2019 and 2020 compared to national behavioral health turnover rates.

[26] Rothrauff, T. C., Abraham, A. J., Bride, B. E., & Roman, P. M. (2011). Occupational turnover intentions among substance abuse counselors. Journal of Substance Abuse Treatment, 40(1), 67–76. https://doi.org/10.1016/j.jsat.2010.08.008
[27] Leider, J. P., Sellers, K., Owens-Young, J., Guerrero-Ramirez, G., Bogaert, K., Gendelman, M., & Castrucci, B. C. (2021). Determinants of workplace perceptions among federal, state, and local public health staff in the US, 2014 to 2017. BMC Public Health, 21(1), 1654. https://doi.org/10.1186/s12889-021-11703-x
[28] de Cordova, P. B., Johansen, M. L., Grafova, I. B., Crincoli, S., Prado, J., & Pogorzelska-Maziarz, M. (n.d.). Burnout and intent to leave during COVID-19: A cross-sectional study of New Jersey hospital nurses. Journal of Nursing Management, n/a(n/a). https://doi.org/10.1111/jonm.13647
[29] Johnson-Kwochka, A., Wu, W., Luther, L., Fischer, M. W., Salyers, M. P., & Rollins, A. L. (2020). The Relationship Between Clinician Turnover and Client Outcomes in Community Behavioral Health Settings. Psychiatric Services, 71(1), 28–34. https://doi.org/10.1176/appi.ps.201900169

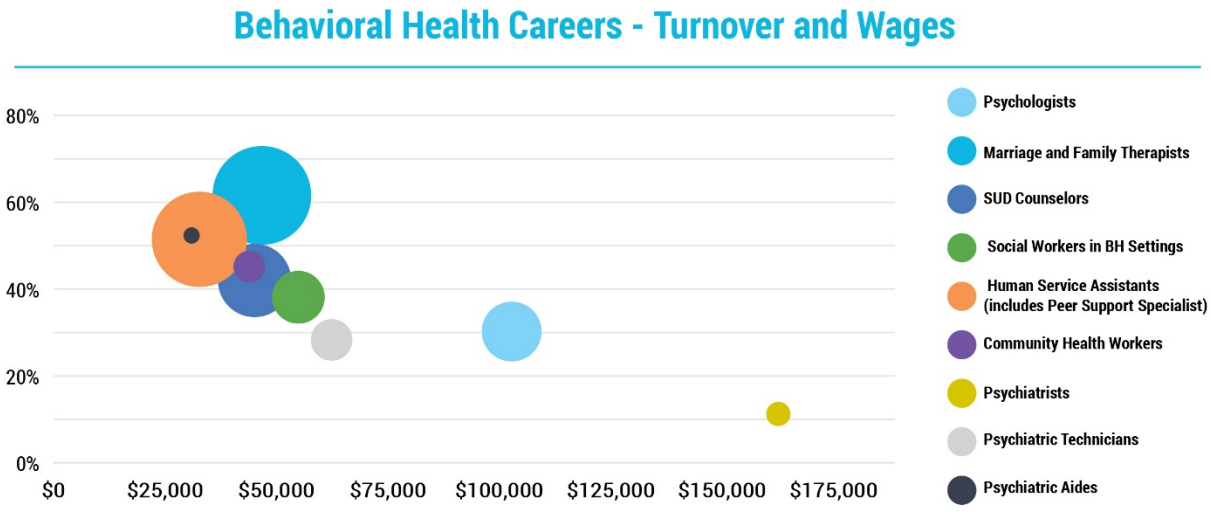
Figure 7: San Diego behavioral health turnover rates



Pay appears to be negatively associated with turnover. The higher the pay, the less likely an individual is to leave their job. Figure 10 shows the pay and turnover rates of 11 behavioral health occupations in San Diego County, with the size of each bubble reflecting the number of workers. Research has noted many factors associated with intent to leave jobs in other industries, including job satisfaction, supervisor support, structural & contextual factors of the work setting or employer[30]. Because several studies identified contextual factors of work as drivers of turnover intent, we used focus groups to surface contextual factors that may be particular to behavioral health, the San Diego region, or the behavioral health system in San Diego.

[30] Hellman, C. M. (1997). Job Satisfaction and Intent to Leave. The Journal of Social Psychology, 137(6), 677–689. https://doi.org/10.1080/00224549709595491
Cho, S., Johanson, M. M., & Guchait, P. (2009). Employees intent to leave: A comparison of determinants of intent to leave versus intent to stay. International Journal of Hospitality Management, 28(3), 374–381. https://doi.org/10.1016/j.ijhm.2008.10.007
Coomber, B., & Louise Barriball, K. (2007). Impact of job satisfaction components on intent to leave and turnover for hospital-based nurses: A review of the research literature. International Journal of Nursing Studies, 44(2), 297–314. https://doi.org/10.1016/j.ijnurstu.2006.02.004

Figure 8: San Diego behavioral health turnover and wages



It's important to note that turnover intent does not perfectly predict turnover: many who want to leave may not be able to find another job that meets their needs, and many who leave do so unexpectedly, for example leaving for family related reasons. However, turnover intent is correlated with turnover and can be measured by survey[31].

We asked about respondents' intent to leave their jobs and intent to move out of San Diego County. 11% of survey respondents indicated that they were likely to move away from San Diego in the next 12 months. Most of those who are likely to move selected "Switching to a similar job in a location with higher pay or lower cost of living as their reason for an anticipated move" (67% of those likely to move, 9.5% of all respondents).

The relatively low burnout paired with high intent to leave suggests that, although burnout may drive a large portion of turnover intent among behavioral health workers in San Diego, there are other job quality factors at work that may contribute to San Diego behavioral health workers intent to leave.

Job quality features making talent attraction and retention difficult (push factors)

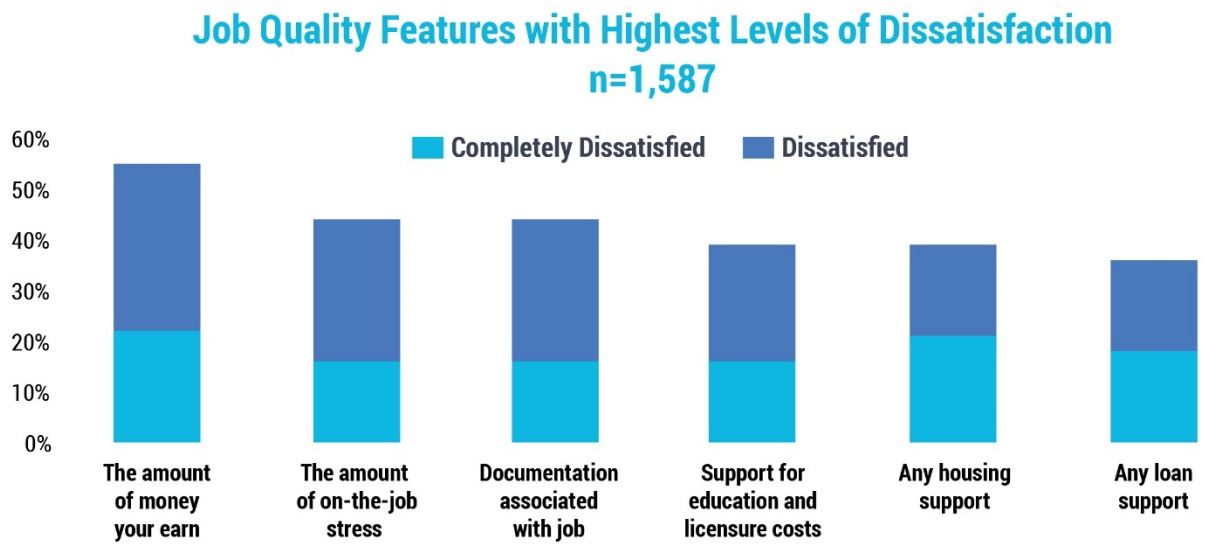
To better understand worker intent to leave, we asked about workers relative levels of satisfaction against 35 different job quality features related to economic stability and security, economic mobility and wealth building opportunities, meaningful work, schedules, vacation, rest and relationship with coworkers.

In exploratory data analysis, intent to leave was best predicted by dissatisfaction with pay, workers relationship with their boss, job security, licensure cost, stress and documentation. Pay was by far the strongest predictor and contributed to intent to leave more than it contributed to burnout. This

[31] Fukui, S., Wu, W., & Salyers, M. P. (2019). Impact of Supervisory Support on Turnover Intention: The Mediating Role of Burnout and Job Satisfaction in a Longitudinal Study. Administration and Policy in Mental Health and Mental Health Services Research, 46(4), 488–497. https://doi.org/10.1007/s10488-019-00927-0

suggests that although focusing intervention on manager's relationships with their workers may mitigate burnout, pay increases are the best strategy for reducing intent to leave.

Figure 9: Job quality features with highest levels of dissatisfaction



- Participants across the board assess pay to be too low. In our survey, 55% respondents were dissatisfied with their pay, with 23% reporting they were "completely dissatisfied." This compares unfavorably with US workers overall: in 2021, a Gallup survey asking a similar question found that 24% were dissatisfied with their pay and 75% were somewhat or completely satisfied with their pay[32]. Pay dissatisfaction cut across all occupations surveyed; no occupation had 50% or more workers answering "completely" and "somewhat" satisfied.

  Participants used several additional factors to assess whether they felt their pay is fair: they noted their level of education and training, loans (especially student loans), experience, average pay in San Diego, supervisory responsibilities, how stressful their job is, their skills and competencies, known pay in other careers, known wages of others in their workplace and the ability of their pay to support the future they want (e.g. can they afford to have kids, own a home, or retire). One SUD Counselor put it like this:

> "Two of my clients died of overdoses in the last year . . . you go through a lot emotionally. And then on top of it, I have to know the documentation. . . you have certain competencies that are hard to develop. And it's just weird to me that that doesn't equate to an average [living] wage. I don't understand."
> – SUD Counselor, Male

[32] https://news.gallup.com/poll/1720/work-work-place.aspx Both dissatisfaction numbers were found by adding the proportion of respondents who answered "somewhat dissatisfied" and "completely dissatisfied."

- Required documentation was one of the focus group participants' biggest sources of frustration and concern. This sentiment was validated in the survey. 39% of respondents were dissatisfied with documentation requirements, the third highest job feature behind only pay and stress on the job. 23% of respondents were dissatisfied and 16% were completely dissatisfied with the documentation requirements of their jobs. Respondents reportedly understood why some paperwork is necessary for compliance, but point to the effort and time required, frequency of changes, redundancy, priorities reflected in enforcement, inconsistency in enforcement by different auditors year to year, consequences of errors and disconnection of documentation requirements from the reality of care as major points of frustration. Participants referred to the documentation as "impossible," "unsustainable," and the audit process as "merciless," "pathological," "demoralizing" and "brutal."

  While this sentiment is not unique to San Diego and is common across publicly funded health and human service programs, section 4.2 addresses specific opportunities to streamline documentation requirements in San Diego County and to advocate for statewide opportunities for administrative relief.

- Licensed and prescribing focus group participants frequently mentioned access to additional treatment and wraparound services for clients as a high priority that is often not met, especially for clients experiencing homelessness. Participants cited long wait times, lack of case management, lack of walk-in or appointment services, difficult to navigate networks of resources and absence specific referral services as limitations. In addition to long wait lists for affordable housing, participants mentioned the lack of credit recovery options for high school students, a shortage of inpatient psychiatric beds and a desire to expand assertive community treatment teams as examples. In these conversations, participants cited the importance of other workers on their teams, including administrators, case managers, and peer support workers, and the benefits of co-occurring programs with many services in-house. In our survey psychologists, psychiatrists, RNs, and LMFTs expressed their dissatisfaction with access to continuum of care and wraparound services.

While it is out of scope of this report to evaluate the feasibility, policy, or service implications of the frustrations described above, we highlight it here because issues related to their ability to provide effective care were consistently mentioned by licensed professionals (psychiatrists, psychiatric mental health nurse practitioners, LCSWs, phycologists, LMFTs) that have options to work in private practice or non-public BH settings as a reason to leave their jobs.

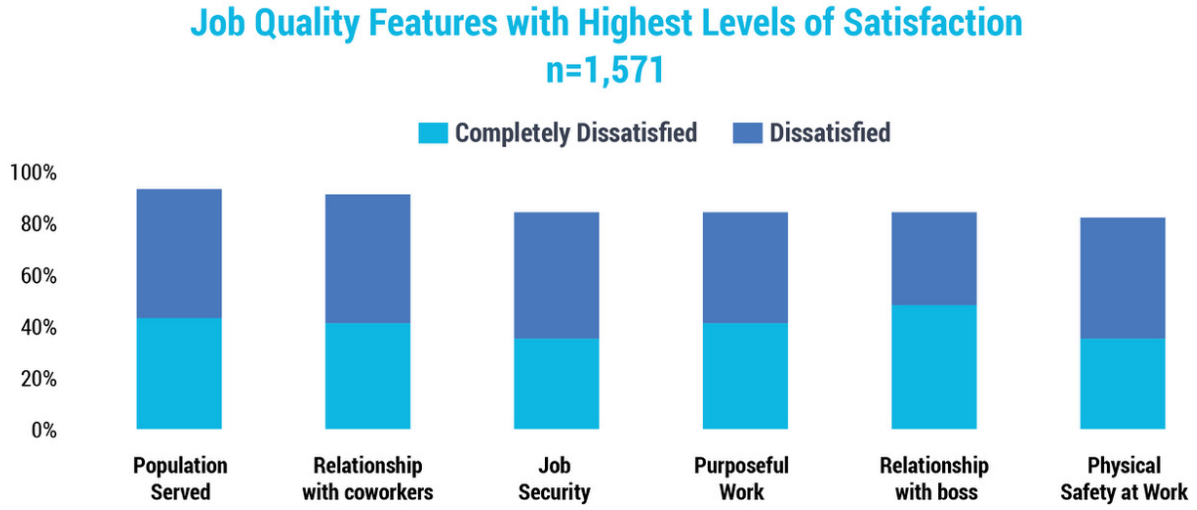
No occupation reported more than 50% satisfaction with staffing (in their own roles, support roles, or management roles), their caseload, pay, retirement plans, stress at work, or recognition for their work. Workers were largely unsatisfied with support for education and licensure (39%) costs, learning and development opportunities, and access to external and internal wraparound services.

Job quality features driving talent attraction and retention (pull factors)

We also wanted to understand what features attract and retain workers to BH professions in San Diego. Top job quality features were job security, physical safety conditions in the workplace,

purposeful work, connection to the population served and relationships with supervisors and coworkers (figure 12).

Figure 10: Job quality features with high levels of satisfaction



- Meaningful and purposeful work appears to be the number one factors helping attract and retain BH professionals: 93% of survey respondents felt strongly connected to the populations they serve and 84% reported either they were completely satisfied (41%) or satisfied (43%) with the way in which their jobs contribute to a purpose they care about. Workers connect the challenges of a given population to their professional identity, purpose and personal dreams or lived experience, and that connection can extend to pride for working in the public behavioral health system.

> "Helping people who have been saddled with decades of institutional neglect is something I find personally rewarding."
> – Psychiatrist, Male

> "I did a little private practice on the side for a while. I was paid four times as much there and we had a full caseload, but I love working with low income, diverse families."
> – Psychologist, Female

- Positive relationships with coworkers and supervisors were also a consistent "pull factor" across survey and focus group participants. 84% of survey respondents were completely satisfied (48%) or satisfied (36%) with their relationships with their managers and 91% were completely satisfied (41%) or satisfied (50%) with relations with coworkers.

Supportive management as described in focus groups included taking time to check in on workers, helping to manage the workers' caseloads and stress, helping make decisions and manage crises, evaluating workers not solely on productivity metrics, supporting workers' career growth within and outside their current employer, verbal affirmations and listening to and valuing workers' concerns and ideas.

> "It's a very beautiful place to work. My employer allows a lot of autonomy, I feel very supported. If I have an idea, I feel heard, and they will try to carry out some sort of programming that's related to that idea."
>
> – SUD Site Supervisor

Participants mentioned relationships with coworkers and the diversity in race, gender, culture, disciplinary backgrounds, ethnicity, and language proficiency as important in staffing. They made special note of needing more Black workers and more male workers, and where language services were lacking their absence was noted. When language services for clients were present, they were cited as a point of pride in the workers' employer.

> "I've worked for multiple organizations where I was the only bilingual person. They would put me in with anyone who didn't speak English, thinking I guess that because I spoke Spanish, it would be easier for me to figure out how to translate in a third language. One of the things that drew me to my current employer is that they offer services in over 30 languages."
>
> – SUD Counselor

- Participants desire autonomy over their treatment approach. Licensed clinicians and prescribing participants wanted to be able to use their expertise to decide whether telehealth or in-person visits are better for a patient, how many visits the client needs, and what treatment modality they should use (e.g., cognitive behavioral therapy or eye movement desensitization and reprocessing). In our survey, 86% of workers were satisfied with their autonomy at work.

- Where loan forgiveness is offered and participants believe they have hope of receiving it, it is a substantial draw for focus group participants. Participants appreciated the support their employers offered for continuing education and license renewal, but consistently redirected questions about tuition assistance to student loan assistance. Licensed focus group participants generally did not anticipate returning for a PhD but did want student loan forgiveness. Some participants mentioned the federal government's student loan assistance program, either because they were planning on using it, or because they felt they had no hope of getting it. Among workers who did not select "not applicable" for loan support, workers reported dissatisfaction with the loan support available to them. This reflects longstanding issues with the Public Service Loan Forgiveness program that many behavioral health workers qualify for and reflects the frustration some of our focus group participants have faced trying and failing to receive the loan forgiveness.

> I had a bad experience dealing with public loan forgiveness. It was so much work. Its almost like having a second job. To get it, I would have to start over and do another 10 years. At this point, making more money is a better solution for me.
>
> – Nurse Practitioner Female

In addition to the themes that emerged in the focus groups, respondents to our survey working in most occupations reported satisfaction with their relationships with coworkers, the physical safety of their workplace, the security of their job, the mastery they feel they can get over their work tasks and their sense of work contributing to an important purpose. Students across occupations expect that they will feel they are helping those who need it, they will have opportunities to advance, they will be able to master the skills and tasks required of them and their work will be contributing to a purpose they care about. Students in no occupations expected good pay or autonomy, although they rated those features of work to be highly important to them.

Overall, the process of asking, listening and responding to the job quality features most important to workers in each BH occupation will be critical to refining and measuring the effectiveness of a regional BH workforce strategy. Insights from the focus groups and surveys described in this section informed the recommendations in sections 4 and 5 of this report. Occupation by occupation survey response data are available in section 5 and the project research team will be doing deeper analysis, including multi-variate regression analysis, to draw deeper insights from the survey data.

Addressing the job features pushing people out of the industry like pay, documentation requirements and on-the-job stress will be critical in attracting new workers to the field and retaining some of the 7,800 workers expected to leave the profession in the next five years. Finally, and as described in section 4.5, the goal of this initial survey is to be a starting point in using the voices and perspectives of workers to center the region's BH workforce strategy and serve as a benchmark for future surveys to understand trends and progress.

Section 5: Recommendations

This report outlines five recommendations that together make up a regional strategy designed to attract and retain the most resilient, representative, skilled and qualified behavioral health workforce in the United States.

1. Invest in competitive compensation
2. Pursue administrative relief opportunities
3. Establish regional training hubs
4. Build a regional workforce training fund
5. Continue listening to workers

While these recommendations are presented in separate subsections, they are parts of a single vision. If implemented in isolation, they will have less than desired results.

5.1: Invest in Competitive Compensation

> "I look at coworkers who have more experience and I'm getting the message. There's not a future in this. And I'm still young – I'm in my early 30s and my life really got sidetracked when I was younger but I'm on track now. Saving for retirement and growing a family seems totally unworkable in this job."
>
> – Peer Support Specialist, Male

Focus groups, survey data and labor market data analysis highlight pay as a significant problem in attracting and retaining behavioral health workers in San Diego. Among workers responding to our survey, 55% were dissatisfied with their pay more than all other 34 job quality features we asked about. This compares unfavorably with US workers overall: in 2021, a Gallup survey found 24% were dissatisfied with their pay and 75% were somewhat or completely satisfied with their pay[33]. Pay dissatisfaction cut across all San Diego BH occupations surveyed; no occupation had 50% or more workers answering "completely" and "somewhat" satisfied.

To contextualize the widespread dissatisfaction with pay, we used labor market information, focus group data, and reported pay from employers and survey respondents to understand how pay in San Diego's BH system compares to workers' other options.

[33] https://news.gallup.com/poll/1720/work-work-place.aspx Both dissatisfaction numbers were found by adding the proportion of respondents who answered "somewhat dissatisfied" and "completely dissatisfied."

> First, we found workers in San Diego's public behavioral health system are paid poorly compared to workers in behavioral health in other California counties. We also found that workers compare their pay unfavorably to local workers in other industries, workers in other healthcare and social service settings, and workers in private practice.

Comparing San Diego compensation to other California counties

To compare wages across California Metropolitan Statistical Areas (MSAs), we took the following steps:

1. Compiled a list of relevant Standard Occupational Classification (SOC) Codes

To identify relevant occupations, we used the definition of "behavioral health" from the "About Behavioral Health Services" section of the County BHS website: "provision of mental health and substance use disorder services." We reviewed the descriptions of Bureau of Labor Statistics (BLS) Standard Occupational Classification (SOC) codes and identified those that include treating either or both of substance use disorder and mental health. To confirm our target SOC codes, a steering committee of 13 behavioral health experts were surveyed to rank highest occupations of concern. Figure 13 reflects the SOC codes selected.

2. Gathered wage data for those occupations from San Diego and 33 other California MSAs

The research team used the economic data aggregation tool EMSI to compile average 2021 compensation data from the Bureau of Labor Statistics Quarterly Census of Employment and Wages (QCEW) for each SOC code for each of the 33 MSAs.

3. Adjusted wages for all occupations and locations by cost of living

For each MSA we identified the cost-of-living (COL) index,[34] a value that reflects the cost of living in a region as a percentage of the average cost of living in the US. We then calculate COL-adjusted wages for each MSA by adjusting the nominal wage by the COL. For example, the San Diego COL index is 142.2, meaning that the expense of living in San Diego is 42.2% higher than the national average. More information about the cost-of-living adjustment is available here.

4. Ranked San Diego by COL-adjusted wages among comparison MSAs for each occupation

At this stage, for each occupation, we had a list of median wages in each of 33 MSAs. We then identified the top and 75th percentile of each occupation's list. We used the cost-of-living adjustment and inflation data to determine how much a worker in San Diego would have to earn to meet the 75th percentile and top COL-adjusted pay for each occupation. We reported San Diego's percentile rank as well—for each occupation and among 33 other California MSAs, how do San Diego's COL-adjusted wages compare? Zero would mean that we are the worst paying among the set of comparison MSAs for that occupation (e.g., peer support specialists); our best rank is 48: we pay our psychiatric

[34] The Cost of Living Index is produced by the Council for Community and Economic Research.

technicians better than 48% of the MSAs on our list. A full listing of all nominal and COL adjusted wages for each MSA by occupation can be found in the Appendix (Figure A.6).

5. Calculated 2021 wages that would meet the top wage (and 75th percentile wage) in the comparison set, adjusted for cost of living and inflation.

6. Adjusted the 2021 wages identified in Step 5 for inflation between 2021 and 2022

Results

In Figure 11 we report the percentile, the current (unadjusted) wages in San Diego, what we would have to pay (unadjusted) to meet the 75th percentile and top pay considering cost of living differences and inflation.

> **Behavioral health workers in San Diego County are significantly underpaid compared to their peers in other California MSAs. In all 10 occupations, wages in San Diego County are lower than those in the median MSA (adjusted for cost of living). In 6 of the 10, wages are in the bottom 20%.**

Social and human services assistants, which includes peer support specialists, is one of the largest occupations of interest and San Diego pays the lowest wages of all comparison MSAs. Pay for psychiatrists is also surprisingly low, but a plurality of local psychiatrists (34%) work in independent offices where wages may be influenced by factors outside the labor market (e.g., other costs associated with the practice may be high, or a clinician may prefer to work part time).

Figure 11: Wage recommendations for 10 BH professionals

SOC Code	Occupation	San Diego Percentile rank of 34 CA MSAs	Average 2021 San Diego Wage	Match median wage in highest-paying MSA	Match median wage in 75th percentile MSA
21-1093	Social and Human Services Assistants (Includes Peer Support Specialists)	1%	$32,620	$73,340	$51,067
29-1223	Psychiatrists	4%	$165,386	$383,773	$329,385
31-1133	Psychiatric Aides	11%	$31,176	$66,957	$42,956
21-1094	Community Health Workers	12%	$43,892	$73,882	$55,669
21-1013	Marriage & Family Therapists	12%	$46,944	$98,632	$69,319
21-1023	Mental Health and Substance Use Disorder Social Workers	17%	$56,216	$119,113	$93,362
19-3033	Clinical, Counseling, and School Psychologists	45%	$103,811	$153,474	$140,097
21-1014	SUD Counselors	27%	$45,590	$85,947	$63,837

SOC Code	Occupation	San Diego Percentile rank of 34 CA MSAs	Average 2021 San Diego Wage	Match median wage in highest-paying MSA	Match median wage in 75th percentile MSA
29-1141	Registered Nurses[35]	33%	$112,222	$175,701	$138,380
29-2053	Psychiatric Technicians	48%	$62,656	$96,016	$80,543

San Diego professionals across all 10 occupations looked at in the compensation analysis need significantly higher salaries to have the same purchasing power of their colleagues in other parts of the state. A full listing of all competitor MSAs actual and COL adjusted salaries by occupation can be found in the appendix (Figure A.4).

While dramatic increases are needed to get San Diego professionals up to the same levels as these peers, it is important to understand not only that our workforce was significantly underpaid in 2021, but also that San Diego County experienced 8.2% inflation over the past year—one of the highest rates in the country, in a year when the national rate was the highest in 40 years. In other words, anything less than an 8.2% raise would constitute a reduction in the purchasing power of behavioral health workers.

Additional perspectives on compensation

While the above analysis uses IRS payroll tax record data as reported by the BLS and is an "apples to apples" comparison with other MSAs, there are several difficulties with labor market information for use in compensation studies for behavioral health. The remaining portion of this section attempts to reconcile these difficulties and provide additional data points and perspectives on how workers consider pay when making career decisions.

The Bureau of Labor Statistics uses SOC codes to categorize reported wages. Some of these SOC codes are not closely scoped to the jobs we are interested in, collapse nuances within professions that are essential to understanding pay and fail to reflect job structures that influence pay. These nuances are discussed in further detail below:

- Settings and Scope of Practice: SOC codes don't reflect settings of employment for some professions. Notably, nurses are grouped together across specialties or departments. Because there is a lot of diversity between, for example, neonatal intensive care, home health care and nurses working in behavioral health, information about how behavioral health nurses are paid is obscured in BLS data by aggregating all nurses together. Further confusing the issue is BLS classifying psychiatric nurse practitioners not under the nurse practitioner classification, but under registered nurses. BH nurses in our survey reported pay on the lower end of the spectrum for nurses overall; if these self-reported wages are accurate, nurses in training deciding how to specialize may perceive behavioral health to be an unattractive option. This difference across settings was validated by expert interviews for

[35] Note: we ran this analysis for Registered Nurses because, confusingly, Advanced Practice Psychiatric Nurses are included under that SOC Code. However, the analysis should be interpreted with caution: we cannot distinguish our population of interest from the larger group of Nurses in this SOC code and we do expect their wages to vary.

nurses, as well as social workers, psychiatric mental health nurse practitioners and physician's assistants.

Figure 12: San Diego BH nurses in survey make less than non-BH settings

Occupation Name	SOC Code	Wages by SOC (25th – 75th Percentile)	Employer Reports (Public)	San Diego BH Survey Respondents Median
Registered Nurses	29-1141	$90,730 to $134, 805	$98,400	$90,000
Nurse Practitioners	29-1171	$133,266 to $232, 452	Insufficient Data	$125,000

- Collapsed distinctions in education and training: Even within occupations that are well described by the scope of their SOC codes, the wage estimates collapse distinctions with the occupation that influence pay. For example, the mental health and substance abuse social worker classification will include fully licensed social workers and associate social workers. Our survey gives us a view into that distinction: there is a $19,000 difference between registered and certified SUD counselors in our survey and more than $27,000 between the associate and licensed social workers who responded to our survey.

- Part time vs full time: Two professions show average reported wages outside the 25th-75th percentile band of wages reported by BLS. Because the reported wages of psychiatric aides were not only below the 25th percentile wage (which is annualized) and below the minimum wage, we suspect that a substantial contingent of our survey respondents work part-time or worked part of the year[36]. Employers reported hourly rates for psychiatrists that would, if annualized, vastly exceed the self-reported wages from the survey, indicating either that psychiatrist working for these employers were not well-represented in the survey or that psychiatrists are not working 40 hours per week at those wages. BLS data, which is annualized, for this profession better aligns with the self-reported wages. This could indicate that many psychiatrists in the county are working for themselves, working part-time, or have other work arrangements that make their annualized salary lower than expected. To better understand how psychiatrists are being compensated, we would need a focused study that includes contextual information like job structure.

Figure 13: Wage nuance likely caused by job structure

Occupation Name	SOC Code	Wages by SOC (25th – 75th)	Employer Reports (Public)	San Diego BH Survey Respondents Median
Psychiatric Aides	31-1133	$29,295 to $36,801	Insufficient Data	$21,014
Psychiatrists	29-1223	$133,265 to 232,452	*$170-220 per hour ($349,400 to $457,600 annually)*	$237,299

- Private vs public sector: The lengthier and costlier the education pathway for a given profession, the more likely they are to be "locked in" to the occupation and think about pay and career moves by type of employer (e.g., private, or public sector). The most common

[36] To solicit grounded wage data rather than speculated wages for the current year, following survey best practices, we asked respondents "What was your approximate individual income from your primary job last year?" The BLS, on the other hand, annualizes wages of part-time or part-year workers based on detailed tax information for comparability in aggregate.

comparison that licensed and prescribing focus group participants made when discussing their wages were to workers in their same occupation that were working in private practice. The BLS data used does not distinguish between these two settings, and secondary data was not sufficient to make estimates across these two settings but focus group discussions confirmed this pay gap was top of mind for these professionals.

> "Increasing the pay—it's a big deal. We have a mental health therapist position that has been open for a year. It's just really hard to compete. Compared with private practice, or even for-profits, it's hard to keep up."
>
> – Program Manager

- Across locations: In focus groups and in our survey, among those who planned or considered moving from San Diego to do behavioral health work in another location, most expressed considering alternate locations within California unless they had family connections in other states. We can make direct comparison between pay in San Diego and other MSAs in California. Although BLS data has evident problems classifying workers as described, we would expect the direction and scale of comparisons among counties to be similar. Therefore, this analysis contributes a high-level view of how behavioral health pay in San Diego County compares to pay in other California MSAs.

- Across industries: It's worth noting that, for prospective workers who may be considering a career in behavioral health, some workers are comparing their wages across industries. This is particularly true in lower-paid occupations with shorter educational requirements and lower barriers to entry including community health workers, peer support specialists, and SUD counselors.

Figure 14: BH occupations competing on wage with entry level jobs in other industries

Occupation Name	SOC Code	Wages by SOC (25th – 75th percentile)	Employer Reports (public)	San Diego BH Survey Respondents Median
Community Health Workers	21-1093	$36,670 to $68,764	Insufficient Data	$44,045
Peer Support Specialists	21-1093 (Social and Human Service Assistants)	$29,141 to $45,156	$36,000 to $47,000	$36,784
Substance Abuse Counselors	21-1018	$36,379 to $57,491	$31,200 to $62,400	$52,223

For comparison, Target recently announced a minimum wage of up to $24 (over $50,000 a year) in markets like San Diego where the cost of living is high. In focus groups, San Diego behavioral health workers described how demoralizing it was to discover that they earned less than the starting salary at many fast-food chains, and they described wanting to continue working in their fields but feeling forced out because they could not afford the cost of living on a behavioral health salary.

One interviewee, who had worked as a substance use disorder counselor and a peer support specialist, discussed how he thought about wages:

> At Panda Express they were hiring someone at the exact same wage. And like here I was: I completed a two-year certificate, I had done hundreds of hours of an unpaid internship, and I had years of experience. I've been trained on medical documentation. I helped the interns in my program, I was training. I helped with the entry level staff, right? And it really felt demeaning.
>
> – SUD Counselor & Peer Support, Male

- Retention and upskilling decisions: Multiple professionals in lower wage BH occupation described their internal dialogue about the tradeoffs between upskilling, career growth and retention in the BH field. In many cases, their outlook on career growth within the industry was more negative the longer they had worked in the field. Less experienced professionals in these lower paid occupations looked at the wage growth opportunities for more experienced and education colleagues to help inform their decisions.

> There is a counselor who had 10 years' experience and he spoke a foreign language and English. He's the only counselor in the county fluent in this language. No one else was both credentialed and bilingual. And they pay him $18.50. They wouldn't even pay him 20 bucks an hour with 10 years' experience. And that was what got me to go back to school to change professions.
>
> – SUD Counselor, Male

- Professionals newly entering the field in the lower wage BH occupations tend to be the most optimistic about their wage and career advancement prospects.

  When we asked current students, 43% (108 respondents) expressed their intention to "to pursue further clinical education in behavioral health (for example, a higher level of certification or licensure)" compared to 33% (84 respondents) who intend to pursue the career until they retire, 17% (42 respondents) who want to advance into administration, 4% (9 respondents) who plan to leave behavioral health for another type of job, and 4% (9 respondents) who intend to work for a period of time and then become a full-time parent or caregiver.

While this report does not examine the reasons behind low compensation in San Diego, it is important to note that BH services delivered in the public system are largely funded by federal, state, and local dollars that have complex requirements and rate-setting structures. In addition, most (but not all) of San Diego's public BH services are delivered through contracted providers. Efforts to address compensation must consider this context.

5.2: Pursue Administrative Relief Opportunities

> 39% of San Diego Behavioral Health workers surveyed were either dissatisfied of completely dissatisfied with the documentation, paperwork, and administrative requirements in their jobs. Of the 34 job quality features asked about, this ranked third behind pay (55%) and stress on the job (44%).

Qualitative data from focus groups with frontline staff working in public behavioral health settings described documentation as "impossible," and "unsustainable," and monitoring as "merciless," "brutal," and "incredibly demoralizing."

In response, this report recommends establishing a task force with sufficient expertise, resources, and decision-making authority to prioritize and pursue solutions to reduce administrative burdens for frontline workers as much as possible. The task force would develop an administrative relief workplan and lead implementation against specific, measurable, attainable, relevant, time-based (SMART) goals and report back to County leadership at regular intervals. The task force administrative relief recommendations should focus on:

- Advancing CalAIM reform efforts to reduce or streamline documentation
- Conducting a comparative analysis of documentation practices across other counties, care settings, payors, and regulatory entities
- Reviewing County of San Diego contracting and monitoring policies and practices
- Supporting electronic health record integration and technology solutions that reduce redundancies

To help advance this recommendation, *Appendix A.5: Administrative Relief Issue Areas and Opportunities* includes 12 issue areas and 29 opportunities that should be reviewed and prioritized for action. This report acknowledges the issues related to administrative requirements are complex, systemic, and historical. Pursuing meaningful action on the below items will require thoughtful, collaborative, and ongoing efforts from leaders at the County of San Diego, provider organizations, state agencies, elected leaders, and – critically – behavioral health care workers, as well as significant project and change management expertise and resources.

Reducing administrative burden (combined with the recommendation in *section 4.1: Invest in Competitive Compensation*) represent an opportunity to address current workers' top areas of dissatisfaction, increasing retention and reducing the number of professionals leaving public service, leaving BH in favor of other healthcare settings, or leaving their occupations all together.

5.3: Establish Regional Behavioral Health Training Centers of Excellence

> "I just want to help people. Dealing with all this big systemic stuff, being extremely short staffed and feeling the pressure, it's brutal. I'm really burned out; I'm white knuckling it (and still just getting supervision hours). Its not conducive to being a good clinician."
>
> – Pre-Licensed Clinician, Female

While competitive compensation and administrative relief is the most direct (and important, according to workers) retention strategies, the behavioral health training and education pipeline must also expand to meet the region's needs. Licensing requirements add complexity to these investments. Many of the occupations profiled in this report require thousands of hours of internships, residencies, and other forms of on-the-job, supervised clinical experience in addition to education to sit for licensure with the Board of Behavioral Sciences (BBS) or other licensure organizations.

Behavioral health training and education programs have identified the lack of quality training sites as one of the primary obstacles to increasing the number of students and graduates in their programs. A shortage of structured, paid, quality internship and supervision slots are limiting the region's ability the produce the number and diversity of professionals the region needs.

This need, coupled with the current unmet demand for access to behavioral health services, provides an opportunity to envision and develop a regional solution that more effectively addresses access to services and training. In addition, educational institutions recognize the inherent value of providing interprofessional training opportunities for students that are more reflective of the experiences they will have on interprofessional teams in their careers.

This report recommends the County of San Diego establish a partnership with educational institutions (mental health undergraduate and graduate programs including through community colleges), community based organizations delivering behavioral health services (CBOs), health systems, community colleges, and the San Diego Workforce Partnership, to develop multi-agency partnerships at existing service sites that develop core competencies in integrated training and supervision program design, operations, BH training financing and public sector retention, all while providing much needed services to the public.

Specifically, this recommendation is to establish a working group with sufficient expertise, decision making authority, and conduct further diligence on this concept, with a focus on:

- Further diligence on potential sites, locations, and priority specialty areas to establish COEs
- Develop a draft MOU template for core partners interested in establishing a COE

- Creating a competitive grant program to establish COEs
- Establishing key performance indicators for COEs
- Developing a financial model to sustain CEO activities
- Opportunities of alignment of the COE concept with existing initiatives and investments.

Figure 15: Vision for regional training centers of excellence (COEs)

As presently envisioned, the COEs will be where community resources and partnership come together to deliver on four primary functions:

- Provide behavioral health services to the public: COEs would be established within existing service programs providing a range of behavioral health services to be delivered by a multidisciplinary team of certified peer support professionals, non-certified behavioral health professionals, practicum students, associates/interns and prescribing professionals under supervision. COEs would target primarily underserved populations and individuals covered by Medi-Cal. The range of services provided could include screenings and assessments, preventative supports focused on promotion of psycho-social strengths, social-emotional health wellness screenings, as well as a full range of outpatient services, crisis response, intensive clinical services and other elements of the continuum of care as needed by the population to be served.

- Develop and host training programs: COEs will expand on and develop shared core competency in designing, administering, and financing BH training and clinical supervision programs. Trainees will develop the skills necessary to effectively deliver high quality and evidence-informed behavioral health services in public mental health settings, with CBOs,

FQHCs and other clinical and educational sites. In addition, trainees will receive the training and supervision necessary to successfully complete all the requirements for certification and/or licensure. The COEs will be designed to provide an interdisciplinary experience to trainees by including the following disciplines:

- Non-certified/non-licensed professionals
- Certified peer support and substance use disorder counselors
- Practicum students (MSW, MFT, PCC, psychology)
- Interns and associates (MSW, MFT, PCC, psychology)
- Psychology post-doctoral fellows
- Nursing, medical assistants and nurse practitioners
- Community psychiatry
- Speech language pathologists and occupational therapists

This could also include job shadows, externships, and other career exposure events for K-12 students to help them learn about BH career paths in partnership with public school systems.

- Technical assistance: The core competencies in designing, executing, and financing behavioral health training and supervision programs will be available as a resource to support and provide technical assistance to other community-based organizations (CBOs) interested in developing or expanding behavioral health training programs. CBOs in underserved communities could be identified to explore the possibility of starting training programs that could serve as satellite behavioral health sites in partnership with the COE in the given region (e.g., HHSA South, Central, North, or East) or specialty or target population (pediatric, unhoused, immigrant and refugee, geriatric). COEs would also help with clinical supervision and will provide professional development to ensure quality supervision is available in the community for university and community college students and graduates.

  To enhance the quality of training and better understand and respond to community needs, regional convenings of CBOs and faculty will be sponsored by the COE to identify and share best practices and respond to challenges or unmet needs. The site could also provide shared services for specific elements related to training and supervision that a smaller organization may not be able to provide, such as stipend disbursement, navigation of student loan forgiveness programs, didactic curriculum, supervision staff and other back-office support.

- Research: In collaboration with faculty from academic institutions placing students and graduates, research can be done to bridge the gap between educational programs and practice, training and supervision best practices, and services outcomes. The COEs could also provide opportunities to evaluate strategies for workforce optimization and integrated staffing patterns to maximize the case load size of prescribing professionals such as psychiatrists and the role non-licensed professionals may play along the continuum of mental health services.

The COEs will also develop expertise in funding strategies that promote diversity, inclusion, accessibility, earn and learn opportunities, and affordability for trainees. Ongoing operating revenue would come from:

- Federal and state workforce investments: the San Diego Workforce Partnership would dedicate existing resources for wage subsidies and cohort training programs to support ongoing training programs. This could including exploring registered apprenticeships that would provide federal and state supplemental instruction (SI) revenues for various roles as well as a portion of its $35M-$40M annual allocation from funding streams like the Workforce Innovation and Opportunity Act (WIOA) funds, State of California Employment Training Panel (ETP) funds, Temporary Assistance for Needy Families (TANF) subsidized employment funds, CalFresh Employment and Training (CFET) reimbursements, competitive philanthropic and government grants.

- Ongoing federal and state (HRSA, WIOA, MHSA, ETP, HCAI) competitive grants and funding opportunities.

- Medi-Cal reimbursement from patient encounters, including CA's implementation of SB 855 that will allow associates under supervision to be credentialed and bill Managed Care Medi-Cal (as they can in specialty mental health programs),

- Medi-Cal reimbursement through County Specialty Mental Health contracts.

The BH regional training COEs will be critical beachheads in the regions effort to expand the capacity of the region's talent development system. The infrastructure described in this section will be anchors in effectively deploying the recommend capital in section 4.3: Regional Behavioral Health Workforce Fund.

5.4: Build a Regional Behavioral Health Workforce Training Fund

> "I have had to take out personal loans to cover my groceries. Rent is a whole paycheck. I've thought about going to grad school, but is it worth it to go thousands in debt for two more dollars an hour? I want to do this for the rest of my life, I love it. It makes me sad, but I don't think I will be able to."
>
> – SUD Counselor, Female

While investing in competitive compensation will help attract and retain more behavioral health professionals and the training COEs will provide additional delivery and partnership infrastructure, strategic cash investments along the education, training, job placement and retention pipeline is also needed to produce the additional 18,500 BH professionals needed over the next five years.

This report estimates approximately $425M in additional investments in the training and education pipeline is needed to meet the workforce needs. This estimate came from cost estimates with specific vetted programs and initiatives listed in section 5 and the workforce needs assessment in section 2.

Figure 16: Investments in the training and education system to meet 2027 worker shortage

Occupation / Job Title	Estimated Additional Cost Per Person Trained	Additional Workers Needed (2022-2027)	Total Investment Needed ($)
Community Health Workers & Certified Peer Support Specialists	$7,561	5727	$43,301,707
Certified Substance Use Disorder Counselors	$7,391	2952	$21,819,130
Psychiatric Technicians	$6,397	837	$5,353,914
Licensed Clinicians (LCSW / LMFT/ LPCC)	$31,905	6246	$152,185,714
Psychologists (Clinical, Counseling and School)	$41,125	1451	$59,672,375
Registered Nurses in Behavioral Health Settings & Psychiatric Mental Health Registered Nurses	$31,603	656	$20,731,282
Psychiatric Mental Health Nurse Practitioners & PAs	$99,000	212	$20,988,000
Psychiatrists**	$493,810	204	$100,737,143
Total		18,285*	$424,789,266

*These numbers do not include the 208 psychiatric aides including in the regional needs assessment in section 2.
**Across four-years of post-graduate residency training per person.

However, this report does not recommend an initial investment of this full amount; programs cannot scale overnight. The recruitment, education, training, supervision and placement needed, and public service incentive system infrastructure (such as the COEs described in section 4.3) are not yet in place to effectively manage this size of investment. Curriculum needs to be approved and validated. Policies and procedures need to be worked out for public service incentives. Based on discussions

with universities, community colleges, employers and workforce agencies, this report recommends an initial $128 million "down payment" in this regional training strategy to establish key infrastructure and processes. Once established, a larger investment to meet the full need can be considered.

Getting Started: A framework for an initial $128 million down payment

This $128 million fund would expand the regional BH education and training pipeline by approximately 4,250 individuals over the next 5-10 years.

- $98 million would braid together new and existing public and private/philanthropic funding sources in the region to support scholarships, stipends, in-school support, expanding and creating evidenced-based programs, loan forgiveness, tuition reimbursement, relocation and other incentives for public service.

- $30 million of philanthropy and flexible public dollars would capitalize a first-in-the nation, regional BH revolving training fund the provides 0% interest loans to students entering specific programs and upfront financing for organizations providing clinical supervision hours.

All investments of the fund would expand regional education and training capacity for the long term and be done with partners and programs with demonstrated track-records of outcomes, diversity, inclusion, accessibility and affordability. Initial investments will focus on programs with clear paths to financial sustainability from existing federal and state revenue streams for healthcare, behavioral health, education and job training programs to address financial barriers at three key pain points:

- Improving access to education and training. Some potential behavioral health workers cannot afford to enter training programs; they lack the financial resources to pay tuition, are ineligible for further grants or financial aid and can't access reasonable financing to cover costs. This limits the pipeline of trainees, especially among communities of color.

- Helping improve persistence and completion. For those learners who do enter training and education, graduation is far from assured. School often means lower earnings, which can strain household finances; even small financial shocks – car repairs, childcare gaps – can disrupt progress.

- Retention in public service. After graduating and finding a job in behavioral health, employees may feel pressure to transition to higher-paid roles in the private sector, leave the region for areas with higher salaries and/or lower costs of living to keep up with debt obligations, and to position themselves for career advancement opportunities.

Funding tools

- Scholarships, living stipends and in-school support. Grants – to cover tuition, fees, materials, transportation, childcare, living stipends and other critical needs – can help open the door for

people with limited assets to enter training and education for in-demand behavioral health jobs. These are especially important for people preparing for lower-wage occupations, which wouldn't allow them to afford to take on further debt burdens or quit their current jobs to further their education or training.

- Loan forgiveness, down payment assistance, tuition reimbursement and relocation allowance: These incentives would be used to keep behavioral health workers to public settings.

  While federal and state loan forgiveness programs currently exist for behavioral health workers in the public workforce, many eligible workers never receive loan forgiveness as (a) forgiveness programs are underfunded relative to the need, and (b) often require stringent and difficult to achieve eligibility requirements, such as substantial years of service. For example, 98% of workers (164,000 of 168,000 applicants) had their loan forgiveness applications rejected from the Public Service Loan Forgiveness (PSLF) program between November 2020 and April 2021[37].

- Outcomes-based financing: For occupations that place students into higher-paying jobs, innovative student financing mechanisms can help increase access, affordability and completion for students. Outcomes-based tools require students to pay little or nothing upfront to attend a program and to repay the cost of tuition only if they land a job paying above a certain income (e.g., over $50,000 per year). The model is most applicable to occupations with 1) scalable, short-term training programs and more commensurate starting salaries and career advancement opportunities; and 2) higher paying occupations that require longer and more expensive education, with subsequently larger student debt burdens[38]. Examples of workforce funds leveraging outcomes-based financing to expand access to good-paying jobs include the Workforce Partnership's Renewable Training Fund, the Google Career Certificates Fund, and Pay it Forward Funds (PIFFs). As students find good-paying jobs and pay back into the fund, those payments can be used to support others.

The below chart outlines a funding allocation for this $128 million investment. Recommended allocations are based on number of additional workers needed in the region (section 2) and expert input on priorities in San Diego.

Figure 17: A financial framework for a $128 million BH education and training investment

[37] "If You Are Denied Student Loan Forgiveness, Do This," Forbes, September 2021

[38] Such as psychiatric registered nurses and nurse practitioners, psychologists, and licensed professionals. In combination with in-school support, the Fund would provide financing to students as a "completion play" in their last or second to last year of an undergraduate or graduate degree program and to replace higher interest rate student debt.

Occupation / Job Title	Public Service Attraction & Retention Investments	Outcomes-Based Loans and Supervision Fund (OBF)	Total ($)	Total Served	Additional Needed Next 5 Years	% of Additional Workers Needed
Certificated Community Health Workers & Certified Peer Support Specialists	$9,000,000	$300,000	$9,300,000	1,230	5,727	21%
Certified Substance Use Disorder Counselors	$7,000,000	$1,500,000	$8,500,000	1150	2952	39%
Psychiatric Technicians	$1,455,000	$400,000	$1,855,000	290	837	35%
Licensed Clinicians (LCSW / LMFT/ LPCC)	$12,800,000	$14,000,000	$26,800,000	840	6,246	13%
Psychologists (Clinical, Counseling and School Psychologists)	$5,000,000	$4,870,000	$9,870,000	240	1,451	17%
Registered Nurses in Behavioral Health Settings & Psychiatric Mental Health Registered Nurses	$5,395,000	$2,000,000	$7,395,000	234	656	36%
Psychiatric Mental Health Nurse Practitioners & PAs	$12,000,000	$7,800,000	$19,800,000	200	212	94%
Psychiatrists	$44,480,000		$44,480,000	84	204	41%
Total	**$97,130,000**	**$30,870,000**	**$128,000,000**	**4,268**	**18,285**	**23%**

The $128M fund is broken down into two funding buckets:

- Public service attraction and retention ($97,130,000): Most of the fund would be used for scholarships, stipends, loan forgiveness, fellowships, and launching and expanding education and residency programs that have demonstrated, or promising, outcomes to attract, support, and retain diverse workers to the public sector and to the San Diego region. Some of these interventions are designed to partially offset the need to leave the behavioral health workforce or enter the private sector for higher wages. Post-education support should be viewed as a worker benefit in addition to compensation increases. An initial list of "shovel-ready" investments can be found in section 5.

- Outcomes-based financing ($30,870,000): These funds will establish the first national revolving financing fund exclusively designed for BH professionals. Products offered by the fund will provide student-friendly financing options to help fill talent gaps within the workforce and upfront financing for community-based organizations to begin or expand supervision programs. These funds are designed to recycle capital. Though the rate of repayment varies significantly based on design decisions, we envision recouping ~60% of each initial investment, increasing the number of students the fund will reach for each dollar investment. Financing options would focus on higher-paying non-certified, non-licensed professionals' occupations, licensed and certified counselors, nurses and psychologists. Trainings for these roles typically require significant tuition costs and fees, which lower-income students can't afford. Available financing alternatives overburden such students with higher debt to income ratios.

For these roles, we would propose a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training if students make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven.[39]

The fund will also finance "last mile" educational needs as a "completion" play. This might include providing financing for the fourth year of a bachelor's program or the final years of a master's after a student has exhausted federally subsidized student loan products and grants, which is often when students drop out due to financial hardship because lack of a co-signer on a Parent Plus loan and/or other unfavorable and expensive options (Source: Better Future Forward, 2022). We envision the following payment terms:

- Minimum income threshold of $50,000 per year (i.e., workers only repay if earning above $50,000)
- A flat monthly payment indexed to a sustainable debt to income ratio
- Five-year payment term without extensions
- 0% interest rate applied to the principal amount
- Loan forgiveness at the end of five years for any unpaid principal, if the worker remains in the public sector workforce
- Borrowing amount will vary by occupation (details in section 5)

While the individual will enter into the financing agreement, there is a clear opportunity for employers to assume their employee's monthly payment as a retention tool. As an example, Social Finance's Career Impact Bond (CIB) for diesel technicians – an industry facing similar workforce shortages – has structured outcomes–based financing whereby employers repay the employee's monthly cost of training if they remain with the organization.

In this model, a $128 million fund with a $30 million outcomes-based financing allocation and conservative education and employment assumptions over a five-year enrollment period[40], will recycle a projected $20 million[41] in capital over 10 years through student repayment. The $20 million can be retained within the fund to support future students and workers or be directed towards other behavioral health workforce initiatives.

Implementation considerations

Specific projects in these three categories for each occupation group can be found in section 5. As regional leaders evaluate the viability, scale and scope of the Behavioral Health Workforce Fund, the following is a non-exhaustive list of key considerations to move from concept to launch.

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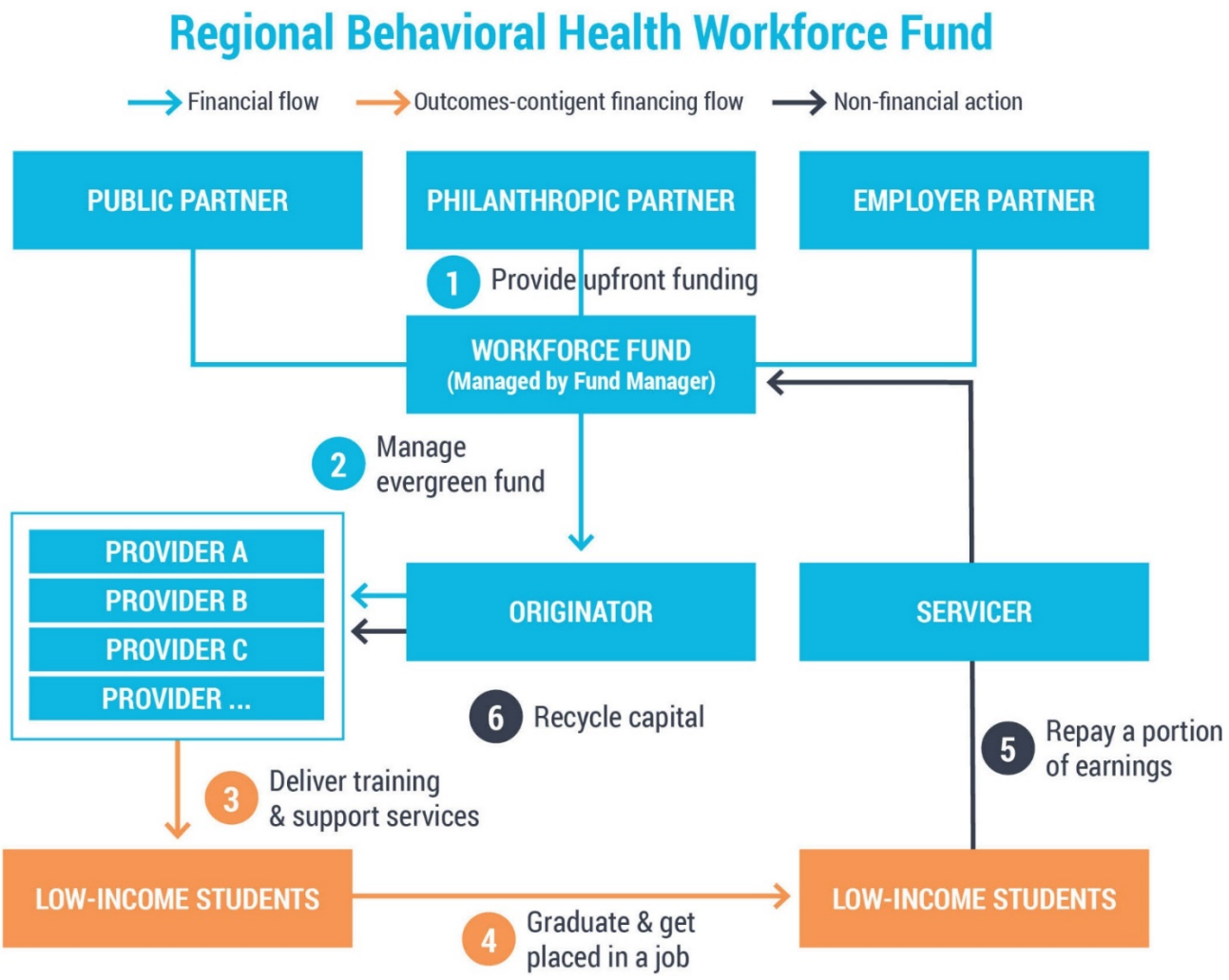
[39] Additional payment terms may include a 3-month grace period, a tuition refund guarantee, a 1.0x maximum payment cap, and no extensions

[40] Current, non-exhaustive, assumptions include education outcomes (95% graduation rates, 90% placement rates), student repayment terms (flat monthly repayment, 0% interest rate and 1.0x payment cap, $50,000 minimum income thresholds), and student repayment (90% payment compliance).

[41] Assuming placement rates of 90%. Phase 2 of this work will include further work on fund design and implementation with more detailed projections on fund recyclability, through detailed conversations with education institutions and employers.

- Eligibility criteria: Occupation and population eligibility and priority for funding and financing (e.g., non-certified, non-licensed professionals and certified scholarships focused on the County's underemployed, unemployed, dislocated workers, opportunity youth, people of color, women, and those without college degrees).
- Outcomes-based fund sustainability & timeline; The duration of the fund and expected return profile (e.g., 10-year fund earning 50 cents back for future workforce initiatives for every $1 spent through the fund on outcomes-based financing)
- Fund structure & manager: The structure of the fund (e.g., County administered, an LLC, Trust, etc.) and the organization(s) responsible for fund management (e.g., braiding capital, legal entity, disbursing funds, conducting diligence of prospective partners, etc.)
- Fund governance, reporting, and active performance management (APM): The organization(s) responsible for general oversight of the fund, in addition to the fund manager, identifying the key performance indicators to track, and the data collection and reporting procedures (e.g., reporting on equity and disparate impact, education outcomes and public sector retention outcomes).The APM process of (1) analyzing data and education, employment and retention outcomes to evaluate the fund's impact, (2) reallocating funding and financing as needed, and (3) course correcting in real time to address underperformance
- Loan forgiveness & tuition reimbursement: Designing and administering the process for behavioral health workers to apply for loan forgiveness and tuition reimbursement (e.g., eligible occupations, tenure requirements, maximum funding per worker, etc.).
- Outcomes-based financing mechanism, student repayment terms, & payment structure: The fund's underlying outcome-based financing mechanism (e.g., outcomes-based loan, income share agreement, etc.), the student repayment terms (e.g., minimum income threshold for repayment at $50,000 per year, 5 year payment terms, maximum loan amount, 0% interest rate, no extensions, etc.), and the payment structure to prospective training provider partners to financially incentivize completion and employment outcomes (e.g., 50% at enrollment, 30% at graduation, 20% at placement)
- Origination & servicing: Outcomes-based financing will require an originator to create and countersign the OBF contracts with students and a servicer to manage student repayment.
- Education and outreach: To ensure San Diegans and current behavioral health workers have equitable and inclusive access to capital, the fund manager will need to partner with community leaders to raise awareness and help counsel workers to navigate their career and funding options.
- Timeline to launch: Developing and launching the fund will likely require nine to twelve months.

Figure 18: Operational and governance model for a regional behavioral health workforce fund



HOW IT WORKS & QUESTIONS

1. Public, philanthropic, and employer partners commit funds to see Workforce fund.
2. An entity manages the fund; contracts with selected training providers; contracts with other vendors (i.e., servicer); manages provider disbursements and repayment from students.
3. Participants enroll at no upfront costs. They participate in the program and receive wraparound services and career support services.
4. Participants graduate and obtain employment in public behavioral health workforce.
5. If students maintain employment with income above a threshold (i.e., $50K) they repay programs cost as a flat monthly payment at 0% interest.
6. Students repayments are recycled into the fund to train more students.

5.5: Continue Listening to Workers

> Thank you for asking about all this. These are conversations we need to be having more of.
>
> – Peer Support Specialist, Male

Through this project the San Diego region has established a network, local expertise, and regional infrastructure to center BH workforce initiatives on the experiences and perspectives of workers themselves. This report should be a starting point in establishing San Diego as national leader in BH workforce development applied research and frontline worker survey work focused on improving the quality of jobs for current and future public sector BH professionals. To do this, the region should regularly survey workers, improve on methods, track trends and progress toward goals, and regularly report back to the local community of practice on findings and insights that can inform job quality investments for BH workers at all levels.

Existing survey and research data is either focused on a specific occupation, often led by an industry or professional association, or is led by a university or research institution using state-wide licensure and certification data. While these national and state level research efforts are important, the on-the-ground solutions to workforce challenges often happen regionally with local partners from government, education and community-based organizations. This initial effort brought together these local partners who are now all connected and well-prepared for local action. Partnerships and assets developed in this project that can be built upon to continue to center workforce voice in local BH workforce strategies include:

- Elected and executive leadership support to champion the cause and communicate a regional vision to address BH workforce challenges and solutions.
- Baseline survey data with year 1 high response rates (1571) from Spring of 2022 with replicable, field-tested survey instrument. Established network of survey dissemination partners.
- The San Diego Workforce Partnership, a public regional agency, can subsidize intermediary and research work with core funding aligned with its mission.
- Engaged advisory committee of key education, healthcare, BH professionals and BH service provider executives committed to supporting these activities.

- Ability to translate research into specific local projects with local partners in ways that national and state level research centers and survey providers cannot.

Continued focus and investment in the research, goal setting and measurement, listening to worker perspectives and regional network management is a critical step in advancing the recommendations above.

Addressing the job features pushing people out of the industry like pay, documentation requirements and on-the-job stress will be critical in attracting new workers to the field and retaining some of the 7,800 workers expected to leave the profession in the next five years. Finally, and as described in section 3, the goal of this initial survey fielded in 2022 is to inform the initial vision and serve as a benchmark for future surveys to understand trends and progress

Section 6: Occupational Profiles and Initial Workforce Development Projects

This section provides a deeper dive into the projected shortages, survey responses, proposed workforce training fund allocations and justifications, and the initial set of workforce development projects and interventions the training fund would finance to help expand the size, diversity and skills of the San Diego BH professionals, all with a focus on retention in public service. Below are a few important considerations when reviewing this section:

- Cost and person served estimates for projects are based on subject matter expertise, the project team's field experience, internet searches and feedback from local education leaders. Please consider these high-level estimates as an initial starting point. Funders and partners interested in advancing these programs should conduct their own detailed budgeting and due diligence to develop the most accurate and up to date information related to program design, persons served and costs.

- In cases where partners are identified in general terms (e.g., local universities and community colleges) the project team assessed there are multiple organizations capable of providing the programming described and further assessment, competition and/or due diligence is needed to select the right partner(s).

- In some cases, the project team identified a partner as uniquely positioned to provide the education or training program or service (e.g., UCSD is the only medical school in San Diego). This report names those organizations for clarity purposes only. To the best of our knowledge, the project team could not find another program or partner positioned to provide similar education or training services. However, if other entities capable of providing similar services exist, these examples should not influence or preclude named or unnamed organizations from related procurements. Funders should follow their procedures related to competitive procurements, single-source awards, and other purchasing requirements.

6.1: Community Health Workers and Certified Peer Support Specialists

Community health workers (CHWs) promote health within a community by assisting individuals adopt healthy behaviors, serve as an advocate for the health needs of individuals by assisting community residents in effectively communicating with healthcare providers or social service agencies and act as liaison or advocate and implement programs that promote, maintain and improve individual and overall community health.

Note: Effective July 1, 2022, the Medi-Cal program launched a new benefit that includes services provided by Medi-Cal Managed Care Plans. This will further drive demand for community health workers in all healthcare settings.

Social and human service assistants assist other social and human service providers in providing client services in a wide variety of fields, such as psychology, rehabilitation, or social work, including support for families. They may assist clients in identifying and obtaining available benefits and social and community services and social workers with developing, organizing and conducting programs to prevent and resolve problems relevant to substance abuse, human relationships, rehabilitation, or dependent care.

Certified peer support specialists do not have specific Bureau of Labor Statistics (BLS) Standard Occupational Classification (SOC) code, their job titles are commonly found in the broader community health worker and social and human service assistants' categories. Senate Bill 803 (SB 803), the "Mental Health Services: Peer Support Specialist Certification Program Act of 2020," sets a standard of 17 core competencies that every peer support specialist is required to know to be certified as a practitioner. In California, this creates a new provider and service type eligible for Medi-Cal reimbursement through the county mental health and behavioral health plans, making it a key occupation of focus in this report.

Figure 19: Community health workers & social and human services assistants' occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
4644	6.87%	6930	7588	51%	11.3%	5727

** Common job titles include Care Coordinators, Outreach Worker, and Peer Support Specialist*

Of the 66 community health workers and 113 peer support specialists in our survey:

- Representation

Peer support worker respondents (64% women, 31% men, 3% non-binary, 2% unspecified) were more often women than men, but had a higher proportion of men than community health worker respondents (74% women, 18% men, 4% non-binary, and 5% unspecified).

Figure 20: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals in San Diego County[42]	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022)
Asian / Pacific Islander	5.9%	10.8%	12%	7%
Black	4.8%	9.6%	5%	5%
Hispanic	22.4%	32.4%	31%	39%
Native American	0.4%	.6%	.4%	.4%
White	30.2%	34.5%	45%	18%
Multi-racial	5.9%	12.2%	7%	
Other	1%		.2%	
Not Reported	29.3%			30%

[42] These proportions are based on the 5-year 2020 American Community Survey respondents who indicated they worked in the occupation "Social and Human Service Assistants," the parent category that includes Peer Support Workers. Community Health Workers were not counted in the 2020 American Community Survey

- Salaries: Respondents reported a median salary of $36,784 (peer support) and $50,000 (community health workers). Peer support workers do not have their own classification from BLS, but reported salaries are somewhat below the salaries for the comparison category we use in this report: the median salary among social and human service assistants is $32,573. Reported salaries among community health workers are higher than the median salary of $43,908 for community health workers ($53,248 mean) from the BLS.

- Student loans: community health workers reported a much higher debt load ($63,000 median initial balance (n=7), $55,500 median remaining balance (n=6)). The median monthly payment was $400. Peer support workers had more workers who reported zero loans (20 with zero initial loan balance). Among the rest, however, the median initial loan balance was $25,000 (n=25). Among those who had a remaining balance, the median was $30,000 (n=25). 25 peer support workers reported a monthly payment of zero and the median payment among those who had one (n=15) was $200.

- Burnout: 39% of community health workers respondents and 28% of peer support workers reported some level of burnout. Persistent burnout was reported by 5.5% of peer support workers and 5.1% of community health workers, with 4.6% of peer support workers and 8.5% of community health workers reporting complete burnout. This is similar to the 39% burnout among all 1,572 survey respondents and lower than the 50% of all mental health professionals reporting burnout.

- Intent to leave: 51% of community health workers and 42% of peer support specialists reported they were either somewhat likely (22.7% community health workers; 18.6% of peer support specialists) or extremely likely (28.8% community health workers; 23% of peer support specialists) to leave their job in the next 12 months. Community health workers are more likely to report some intent to leave (51%) than the 44% of all 1572 survey respondents and much more likely than the 18%-37% reported among mental health workers. Community health workers and peer support workers reported similar likelihood of leaving San Diego: 10.6%, compared to 11% in our survey overall.

- Job quality and job satisfaction: Non-certified professionals were overall satisfied with their managers, relationships with co-workers, the population they work with and the sense of autonomy and purpose they have at work. They were dissatisfied with pay, support staffing and loan support (where it exists).

Figure 21: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	Establish Community Health Worker Apprenticeship Program	$5,000	600	**$3,000,000**
2	On-the-Job Training, Support, & Certification of Peer Support Specialists	$10,000	600	**$6,000,000**
3	0% Outcomes Based Loan (OBL) Fund	$10,000	30	**$300,000**
Totals			**1230**	**$9,300,000**

Program 1: Establish a regional community health worker apprenticeship program

This recommendation would expand the regions CHW output by 600 workers over the next 10 years. With an initial investment of $3,000,000 with a community-based non-profit and a partnering local education agency (LEA), the program lead would work with employer partners to validate curriculum, get the program registered with the California Division of Apprenticeship Standards (DAS), establish MOUs with hiring partners and begin recruiting and operating the program. The $3,000,000 would cover start-up and operating costs for the first five years, serving at least 300 CHWs. After that, ongoing revenues from DAS, ETP, WIOA and education partner enrollment revenues can sustain the program to serve an additional 300 over the next five years.

Establishing a CHW registered apprenticeship program (RAP) with a BH emphasis would provide regional standards, a curriculum and competency advisory structure and a structured pathway for professionals to become CHWs while earning wages at each step of the process. The recommendation would also position the region for long-term training revenue through Related Supplemental Instruction (RSI) and Employment Training Panel (ETP) funds, and competitive grants from multiple federal and state agencies focused on expanding "earn & learn" opportunities.

Expanding and funding healthcare RAPs has been a big priority for the US Department of Labor. The Urban Institute and the US DOL published this report to help local jurisdictions set up CHW apprenticeship programs in 2018. In Riverside County, local employers have partnered with community colleges to offer a 12-month registered apprenticeship program that starts workers at $17.00 per hour with step-raises after specific training milestones are completed. San Francisco City College offers a 16-month CHW program in partnership with the Homeless Pre-Natal Program (HPP). During the apprenticeship, participants receive a minimum of 250 hours of education and receive customized related instruction to fit their roles at HPP as they advance through their training. The apprenticeship combines classroom instruction with on-the-job training working with clients, reception skills, performing client intakes, use of the HPP database and other computer applications, learning about local resources, skills for outreach and other client-centered professional skills. Establishing a RAP would also create the formal structure for partner employers that hire CHW apprentices to review and update curriculum, which may be particularly important as the CalAIM rollout may impact job functions over the next 10 years.

Program 2: On-the-job training subsidy for certified peer support specialists ($6,000,000)

$6,000,000 would establish a regional system that provides outreach, case management, job placement, supportive services (e.g., transportation, childcare assistance), on-the-job training subsidies and certification exam fees to recruit, train, place, and certify 600 peer support specialists over a 10-year period. This system would leverage existing workforce development infrastructure and funds, including those provided by WIOA and Temporary Assistance for Needy Families (TANF) Expanded Subsidized Employment (ESE) funds. In San Diego County, these funds are administered by the San Diego Workforce Partnership who have committed $3,000,000 of the $6,000,000 recommended over the next 10 years to stand up and operate this regional program.

Certified peer support specialist programs are currently offered for zero cost and are likely to remain low cost. Individual career coaches based in the region's American Job Centers (AJCs) would be

available to support individuals qualified and interested in becoming a certified peer support specialist through job-readiness training, coaching and financial assistance to arrange child care, transportation, help getting laptops/internet and a job placement with partner employers.

Employers that hire from this regional system and support peer supports specialists through the certification process, would get 50% of the employees' wages reimbursed by the San Diego Workforce Partnership for the first six months of employment though the On-the-Job Training (OJT) program ($8,000 – $12,000) in cases where the individual is enrolled in the Temporary Assistance for Needy Families program (TANF), the employer subsidy may be more generous through the Expanded Subsidized Employment (ESE) program.

This recommendation would allow organizations to continue hiring peers that are not certified, train and pay them on the job, and receive reimbursement for the time required to support the individuals in the certification process. Effectively, this recommendation bridges a financial gap between date of hire until the individual begins generating Medi-Cal reimbursements post-certification and helps participating employer partners establish and scale peer training and onboarding programs aligned to CalMHSA core competencies.

Program 3: Outcomes-based financing ($300,000)

This program will set aside $300,000 to provide 0% interest loans to peer support specialists interested in upskilling. This dollar amount is relatively small and will be used as an innovation pilot to see if a larger investment would be beneficial.

The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven. This product would finance peer specialists to pursue education to become SUD Counselors, psychiatric technicians, and licensed clinician roles that require four-year and advanced degrees.

Loan repayments will be used to support future students and workers or be directed towards other behavioral health workforce initiatives. $300,000 in 0% outcomes loans would serve an estimated 30 students over the first five years, with cashflows from these first 30 students serving another 10-15 students after that. More information about the renewable loan product and proposed fund mechanics can be found in section 4.4.

6.2: Certified Substance Use Disorder Counselors (SUD Counselors)

SUD counselors: These professionals counsel and advise individuals with alcohol, tobacco, drug, or other problems, such as gambling and eating disorders. They may counsel individuals, families, or groups or engage in prevention programs.

SUD counselors must complete minimum education requirements, plus register as a SUD counselor with one of three state accrediting bodies and pass a certification exam after education plus 2,000 hours of supervised work experience. Navigating this system, covering all course fees and tuition, and successfully completing all requirements can be challenging. Considering that well over 50% of SUD counselors are in active recovery, investing in infrastructure to help these individuals enter and advance in BH careers will expand the number of professionals with lived experience.

Figure 22: Substance use disorder (SUD) counselor occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
2566	7.66%	3631	4248	43%	9.2%	2952

Of the 121 substance abuse counselors in our survey:

- Representation: 60% were women, 36% were men, and 4% declined to state.

Figure 23: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals in San Diego County[43]	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022)
Asian / Pacific Islander	2.3%	11.6%	12%	7%
Black	9.4%	9.7%	5%	5%
Hispanic	22.7%	22.9%	31%	39%
Native American	3.9%	.07%	.4%	.4%
White	39%	41.2%	45%	18%
Multi-racial	8.6%	14.5%	7%	
Other	.8%		.2%	
Not Reported	13.3%			30%

- Salaries: Respondents to our survey reported a median salary of $47,500. These reported salaries are similar to the median salary of $44,470 ($50,876 mean) for all SUD Counselors in San Diego.

- Student loans: 17 SUD counselors reported zero debt loads and 22 reported some loan information. The median initial balance among all SUD counselors who reported taking out

[43] Based on Census American Community Survey 2020 5-year data respondents who indicated they worked as "Substance Use, Behavioral Health, and Mental Health Counselors."

loans was $39,000 (n=20) the median remaining balance was $32,500 (n=22), and the median monthly payment was $275.

- **Burnout:** 27% of respondents reported some level of burnout, with 7% reporting persistent burnout and 4% reporting complete burnout. This is below the 39% of all 1,572 survey respondents and 50% of all mental health professionals.

- **Intent to leave:** 31% reported they were either somewhat likely (22%) or extremely likely (9%) to leave their job in the next 12 months. This is below the 44% of all 1,572 survey respondents and slightly above the 18%-25% among substance abuse disorder treatment workers in the United States. 6% reported they intended to leave San Diego, compared to 11% in our survey overall.

- **Job quality and job satisfaction**: SUD counselors were satisfied with their relationships with coworkers, population and managers. They were dissatisfied with pay, documentation requirements, support staffing levels and loan support (where it exists).

Figure 24: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	Regional SUD Recruitment, Case Management, and Scholarship Program	$6,000	500	**$3,000,000**
2	Establish the State of California's first SUD Registered Apprenticeship Program	$10,000	400	**$4,000,000**
3	0% Outcomes Based Loan (OBL) Fund	$6,000	250	**$1,500,000**
Totals			**1150**	**$8,500,000**

Program 1: Regional SUD recruitment, case management, and scholarship program ($3,000,000)

This recommendation would train, certify and place an estimated 500 SUD counselors over a 10-year period. This system would leverage existing infrastructure and funds, including those provided by the Workforce Innovation and Opportunity Act (WIOA), administered by the San Diego Workforce Partnership who have committed $3,000,000 over the next 10 years to stand up and operate this regional program.

This recommendation would establish a regional system that provides scholarships, case management, course fees, supportive services (e.g., transportation, childcare assistance) and job placement and mentorship support to local jobseekers interested in becoming SUD counselors.

The first step requires getting high-quality, affordable substance use disorder training programs with demonstrated completion and placement outcomes onto the San Diego Workforce Partnership's Eligible Training Provider List (ETPL). Initial partner programs include San Diego City College, Palomar Community College, and UCSD Extension. Once these programs are on the ETPL, WIOA eligible jobseekers and students would be enrolled in the American Job Center network, assigned a career coach that specializes in supporting the SUD counselor career path, and provided with a full scholarship (including fees and books) to their preferred program on the ETPL.

Individual career coaches would be available to support them through their program, provide coaching and financial assistance to arrange childcare, transportation, help getting laptops/internet and anything else the individual needs to successfully complete their education in partnership with the training provider.

After graduation, the American Job Center staff would work with the individual to place them in a job and provide 180 days of post-placement retention and supportive services (coaching on work-place dynamics, fees for taking certification exams, checking in on supportive service needs, etc.).

Programs and training providers would be added to the ETPL based on their eligibility and accreditation, ability to report outcomes (completion, placement, wage at placement, ideally disaggregated by key demographics such as race/ethnicity and gender), and curriculum validation by key employers from San Diego's Alcohol and Drug Service Provider Association (ADSPA), which includes over 15 agencies that employ the majority of SUD counselors in the region.

Within this system there is an opportunity to contract with community-based organizations (CBOs) to provide recruitment, outreach, case management and career support, paid work experience and other career navigation in lieu of and/or in addition to the American Job Center. For example, the San Diego Refugee Communities Coalition (SDRCC) recently received a 3-year, $400,000 grant from the CA Department of Health Care Services (DHCS) through the Sierra Health Foundation to provide scholarships and wages to 10 employees of SDRCC member organizations to participate in SUD counselor certification programs. Partnership with these equity-based CBOs will help ensure there is sufficient diversity, cultural, and language competency in the SUD training pipeline.

Program 2: Establish SUD registered apprenticeship program ($4,000,000)

This recommendation would create one of the first SUD counselor registered apprenticeship program (RAP) in the United States and train an additional 400 trained professionals over the next 10 years. With an initial investment of $4,000,000 and a regional lead and local education agency (LEA) identified, partners can validate curriculum, get the program registered with the California Division of Apprenticeship Standards (DAS), establish MOUs with hiring partners, and begin recruiting and operating the program for the first five years, serving at least 200 SUD counselors. At which point, ongoing revenues from DAS, ETP, WIOA and education partner enrollment revenues can sustain the program to serve an additional 200 participants over the next five years.

The apprenticeship would combine classroom instruction (6-12 months) with 2,000 hours of supervised and paid on-the-job training required for certification. At the completion of the 18–24-month apprenticeship, SUD counselors will get a registered apprenticeship certification, a two-year associate degree from the partner community college, and state SUD certification, all with $0 out of pocket cost and earning wages all along the way.

Establishing a RAP would also create the formal structure for partner employers to review and validate curriculum from education partners. In addition to the structured learning and support from the education partner and the employer sponsor(s), apprentices would also get individual career coaches from the American Job Centers to support them through their program, provide coaching

and financial assistance to arrange childcare, transportation, help getting laptops/internet, and anything else the individual needs to successfully complete their education in partnership with the training provider. Many peer support specialists have an interest in becoming certified SUD counselors; this apprenticeship program could tailor recruitment and outreach efforts to peers, creating a clear pathway in the BH system.

Program 3: Outcomes-based financing ($1,500,000)

Some individuals interested in pursuing a SUD counselor career may not qualify for WIOA Adult or Dislocated Funds because they may be currently working and/or their household income is too high, but they do not have money out of pocket and/or want to take out private loans.

This program will set aside $1,500,000 to provide 0% interest loans to those individuals to pursue the vetted programs on the Eligible Training Provider List (ETPL) listed above. The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan would be forgiven.

Loan repayments will support future students and workers towards other behavioral health workforce initiatives. $1,500,000 in 0% outcomes loans would serve an estimated 250 students over the first five years, with cashflows from these first 250 students serving another 60-75 after that. More information about the renewable loan product and proposed fund mechanics can be found in section 4.3.

6.3: Psychiatric Technician

Psychiatric technicians: These professionals care for individuals with mental or emotional conditions or disabilities, following the instructions of physicians or other health practitioners. They monitor patients' physical and emotional well-being and report to medical staff and may participate in rehabilitation and treatment programs, help with personal hygiene and administer oral or injectable medications.

While there are several psychiatric technician training programs across Southern California, the project team did not identify any active programs in San Diego.

Figure 25: Psychiatric technician occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
789	6.08%	1181	1334	29%	7%	837

There were insufficient responses from psychiatric technicians to make inferences. This report recommends making a concerted effort to increase psychiatric technician's survey participation in future years.

Figure 26: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	Establish local Psychiatric Technician Program	$9,550	200	**$955,000**
2	Relocation Payment	$10,000	50	**$500,000**
3	0% Outcomes Based Loan (OBL) Fund	$10,000	40	**$400,000**
Totals			**290**	**$1,855,000**

Program 1: Establish local psychiatric technician program ($955,000)

San Diego County does not have a psychiatric technician training program in the region. According to the California department of consumer affairs, there are 13 psychiatric technician training programs across California that prepare students for licensure as a psychiatric technician. Southern California programs include San Bernardino Valley College and Cypress College.

San Diego's cost of living is making it increasingly difficult to attract psychiatric technicians from out of the region.

With multiple planned and active health system infrastructure projects that will increase the number of beds for in-patient psychiatric patients, establishing at least one local program for San Diego residents from the community to get trained, licensed and placed in in-patient settings is the highest priority investment for this occupation.

A one-time grant of $955,000 delivered through a regional RFP process could identify the institution best positioned to establish this program for the region. The selection criteria could be focused on domain expertise, demonstrated partnerships with psychiatric hospitals (the primary employer of psychiatric technicians), track record of diversity, equity, inclusion, and accessibility, program affordability, demonstrated outcomes with like programs and a model for financial sustainability.

Funds would be used to develop curriculum, hire faculty, get approval from the state, and begin outreach and recruitment activities. The investment would generate at least 200 psychiatric technicians regionally over the next ten years.

Program 2: Hiring and retention bonuses ($500,000)

In the short term while the local program described above is being established, this report recommends $500,000 for hiring and retention bonuses and relocation incentives local employers of psychiatric technicians can use to attract graduates from the 13 other California programs. Employees receiving these funds would make three-year commitments to their employers. In the event these funds are not spent on hiring or retention bonuses in the short term, funds could be reallocated to either program #1 or program #3 in this section.

Program 3: Outcomes-based financing ($400,000)

High-performing psychiatric technicians' programs are good candidates to outcomes-based financing because they are relatively short-term, low-cost, and salaries at placement are well above the $50,000 minimum income threshold that triggers repayment. In short, the economics of these programs are well suited for the loan product we have described in this report.

The loan fund would set aside $400,000 to provide 0% interest loans to those individuals to pursue the local psychiatric training program once established. This tool would help the new program generate enrollments, reduce student acquisition costs, and potentially be a source of early revenue while the program is getting off the ground.

The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven.

Loan repayments will be used to support future students and workers or be directed towards other behavioral health workforce initiatives. $400,000 in 0% outcomes loans would serve an estimated 40 students over the first five years, with cashflows from these first 40 students serving another 15-25 after that. More information about the renewable loan product and proposed fund mechanics can be found in section 4.4.

6.4: Licensed Clinicians (LCSWs, LMFTs, LPCCs)

Licensed clinical social workers assess and treat individuals with mental, emotional, or substance abuse problems, including abuse of alcohol, tobacco, and/or other drugs through individual and group therapy, crisis intervention, case management, client advocacy, prevention and education.

Figure 27: Licensed clinical social workers working in behavioral health settings occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
1283	6.87%	1913	2142	39%	9.2%	1476

Licensed marriage and family therapists: These professionals diagnose and treat mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems and apply psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders.

Figure 28: Licensed marriage and family therapist (LMFT) / licensed professional clinical counselor (LPCC) occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
4443	6.87%	6637	7101	62%	9.2%	4770

Of the 248 Licensed Clinicians in our survey:

- Representation: 80% were women, 18% were men, and 3% declined to state.

Figure 29: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals in San Diego County[44]	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022)
Asian / Pacific Islander	5.6%	14.4%	12%	7%
Black	2.8%	8.1%	5%	5%
Hispanic	25.8%	20.8%	31%	39%
Native American	.04%	.06%	.4%	.4%
White	48%	44.2%	45%	18%
Multi-racial	6.9%	12.0%	7%	
Other	0%	.3%	.2%	
Not Reported	10.5%			30%

- Salaries: Respondents reported a median salary of $75,000. These reported salaries are higher than the median salaries of $55,099 for mental health and substance abuse social workers and $46,779 for marriage and family therapists from the BLS. We expect this is because trainees seeking licensure hours and sole proprietors are included in the BLS data.

- Student loans: 24 licensed clinicians who reported loan data took out no student loans. The median initial loan amount reported was $82,000 (n=148) and among those who reported a remaining balance, the median was $80,000. Among the 110 students who reported a payment, the median monthly payment was $400 (32 reported $0 payments).

- Burnout: 42% of respondents reported some level of burnout, with 11% reporting persistent burnout and 3% reporting complete burnout. This is above the 39% of all 1,572 survey respondents and 50% of all mental health professionals

- Intent to leave: 40% reported they were either somewhat likely (27%) or extremely likely (13%) to leave their job in the next 12 months. This is 44% of all 1,572 survey respondents and higher than the 18%-37% among mental health workers in the United States. 8.6% reported they intended to leave San Diego, compared to 11% in our survey overall.

- Job quality and job satisfaction: Workers in these occupations were most satisfied with their autonomy, relationships with coworkers and the populations they work with. They were dissatisfied with pay, support staffing, documentation and (where it exists) loan support. LCSWs were satisfied with more aspects of their jobs than other Licensed clinicians.

Figure 30: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	BH MSW Stipend Program	$30,000	260	**$7,800,000**
2	Upskilling Scholarships for Public BH Workers	$50,000	100	**$5,000,000**
3	0% Outcomes Based Loan (OBL) Fund	$35,000	200	**$7,000,000**
4	Renewable Supervision Fund	$25,000	280	**$7,000,000**
Totals			**840**	**$26,800,000**

[44] Based on Census American Community Survey 2020 5-year data respondents who indicated they worked as "Mental Health and Substance Abuse Social Workers and Marriage and Family Therapists."

Program 1: BH Master of Social Work stipend program ($7,800,000)

This intervention is modeled after the discontinued Mental Health Services Act Stipend Program for MSW Students. The UC Berkeley California Social Worker Education Center (CALSWEC) recently completed a retrospective study of the program that demonstrated positive outcomes related to program completion, fulfillment of public service, retention in behavioral health professions, and high levels of diversity, lived experience, and cultural and linguistic competency among program completers.

Under this program, MSW students from Cal State University San Marcos (CSUSM) and San Diego State University (SDSU) will be provided stipends of $15,000 if enrolled part-time and $30,000 if enrolled full-time. These funds can be used for living expenses (gas, rent, food) at the student's discretion. Trainees will be required to complete advanced-year field training at public behavioral health sites, advanced-year clinical courses focused on applying the recovery model and other MHSA principles in clinical practice and specialized symposia, capstone projects and other consumer-focused learning experiences designed by their MSW programs. After graduation, all trainees will be required to complete 24 months of full-time paid work (or equivalent part time service) in a public behavioral health setting in San Diego County. Graduates who fail to complete this service obligation and who are not entitled to a waived repayment will repay stipend funding, prorated to reflect any service fulfilled.

A $7.8 million investment would provide an estimated 200 full-time students with $30,000 stipends, 60 part-time students with $15,000 stipends and have $900,000 available for SDSU and CSUSM for coordination, matching and placement activities, community-based organizations internship supervision costs, wrap around career coaching/supportive services, and stipend origination, disbursement and servicing fees.

Program 2: Upskilling scholarships for public BH workers ($5,000,000)

This program would provide full-tuition scholarships for CSU San Marcos and SDSU's Bachelor of Social Work (BSW) and/or Master of Social Work programs for incumbent-behavioral health workers in San Diego. The program could specifically target unlicensed professionals that have worked for the County of San Diego, and/or a County of San Diego Behavioral Health Services (BHS) contracted provider, and/or an FQHC for 5 or more years. Applicants not meeting those criteria could be evaluated on a case-by-case basis to provide flexibility while still ensuring the spirit of the program is achieved (for example, a peer-support specialist working on a philanthropic or city funded program to reduce homelessness may be eligible, but an administrative support professional at a cash-only psychiatry practice would not be).

Applicants would include case workers, eligibility workers, outreach workers, certified SUD counselors, certified peer support specialists, and other unlicensed professionals working in the public system that are looking for an opportunity to advance their education and training but may not have the disposable income, ability to finance education, and/or willingness to take on additional student debt loads. The program could prioritize individuals with lived experience and cultural and linguistic competencies.

Long term, the scholarship program could focus on advanced standing and/or accelerated programs and will work with the CSUSM, SDSU, and the San Diego Imperial County Community College Association (SDICCA) colleges to expand opportunities for accelerated programs and consideration of work-experience for entry into advanced standing programs.

After graduation, all trainees could be required to complete between 3-5 years (depending on scholarship amount) of full-time paid (or equivalent part time service) in public behavioral health settings in San Diego County. Graduates who fail to complete this service obligation and who are not entitled to a waived repayment would repay scholarship funding in cash, prorated to reflect any service fulfilled.

If funded, a $5M investment would provide an estimated 100 full time students with $40,000 scholarships. There would also be $1M set aside for colleges to expand faculty and administrative support to expand slots. The program application, fund distribution, reporting, and repayment servicing for recipients that do not fulfil their public service obligation can be handled centrally by a regional organization to reduce administrative burden for participating employers. Once launched, the program could also be expanded to programs training LMFTs and LPCCs.

Program 3: 0% Outcomes based loan (OBL) fund ($7,000,000)

To expand education access, outcomes-based financing would cover the upfront cost of master's degree or gap financing for the fourth year of a bachelor's degree programs in San Diego that have strong completion data, a track record of diversity and inclusion, and data supporting their graduates are likely to enter the San Diego behavioral health workforce upon completion and work toward licensure as an LCSW, LMFT, or LPCC.

This financing would focus specifically on students and programs that provide advanced standing and/or accelerated programs by considering undergraduate and associate level coursework and/or work experience to reduce required credit hours and would be available for students' pursuing careers in the public behavioral health system.

The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven.

While the individual will enter into the financing agreement, there is a clear opportunity for employers to assume their employee's monthly payment as a retention tool. Hospitals, FQHCs, the County and its contractors could develop policies and practices to pay off these loans early as a signing bonus.

Loan repayments will support future students and workers or other behavioral health workforce initiatives. $7,000,000 in 0% outcomes loans averaged at $35,000 each would serve an estimated 200 students over the first five years, with cashflows from these first 200 students serving another 75-100 after that. More information about the renewable loan product and proposed fund mechanics can be found in section 4.3.

Program 4: Renewable supervision fund ($7,000,000)

This recommendation would provide upfront financing for FQHCs and CBOs to provide structured supervision to professionals that need to accrue hours to sit for LCSW, LMFT, and LPCC licensure exams with the Board of Behavioral Sciences. The funding would cover the following costs:

- Setting up/expanding supervision infrastructure
- 3,000 hours of supervision over a minimum of 104 weeks
- Application fees, test preparation and test fees
- Incidentals/support for all other CA Board of Behavioral Sciences (BBS) requirements

Below is how the fund could work, with example financing terms for demonstration purposes only:

- Step 1: The fund provides $200,000 - $300,000 to a qualified FQHC or community-based organization over a two-to-three-year period. The FQHC/CBO provides supervision to 8-12 ASWs, AMFTs, or APCCs and helps them prepare for and complete their licensure exams.

- Step 2: Each quarter post licensure (minimum of two years after step 1 begins) the participant remains in good standing with employer, the employer sponsor pays back the fund.

Figure 31: Example Payment Terms with Employer Sponsor

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Total
Trainee 1	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 2	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 3	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 4	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 5	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 6	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 7	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
Trainee 8	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$40,000
	$40,000	**$40,000**	**$40,000**	**$40,000**	**$40,000**	**$40,000**	**$40,000**	**$40,000**	$320,000

If a student does not complete licensure, the employer sponsor is not responsible for payment. If a trainee is separated from employment from the employer sponsor for any reason before eight full quarters (two years) of post-training program retention commitment, the employer sponsor no longer makes payments back to the fund. If the trainee leaves the employ of the client mid-quarter, the quarterly invoices for that trainee will be pro-rated based on the percentage of the quarter trainee remained in employ of employer sponsors.

The aim of the fund is to create a renewable supervision fund that reaches financial self-sufficiency. Returns over and above break-even will be used to support either the expansion of program to serve additional individuals, employers, or occupations.

Figure 32: Potential new billable revenue for employer sponsor generated by graduates (LCSW)

Assumption = $80 per hour through the Prospective Payment System (PPS) @ 30 billable hours per week (13 weeks per quarter)

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Total
Trainee 1	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 2	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 3	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**

Trainee 4	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 5	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 6	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 7	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
Trainee 8	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	$31,200	**$249,600**
	$249,600	**$249,600**	**$249,600**	**$249,600**	**$249,600**	**$249,600**	**$249,600**	**$249,600**	$1,996,800

Note: $1,996,800 also represents local economic impact of new billable funding brought into San Diego local economy for health care services for vulnerable populations from federal government.

- Step 3: Outcomes based repayment agreement

If, and only if, the trainee leaves the employ of the employer sponsor during the program or before the two-year post licensure employment commitment is complete, the trainee will be required to repay the fund. This is an important retention tool to encourage continued employment with the FQHC or community-based organization. The repayment agreement will include a $50,000 minimum income threshold to protect trainees who may become un/underemployed as well as a flat, affordable monthly payment plan similar to the outcomes-based loan outlined above. These terms would be disclosed to the trainee prior to initiating the program.

A note on the licensed clinician pathway: careful attention and discussion is required with the CSU Schools of Social Work, community colleges and participating CBOs about ensuring sufficient resources for faculty, coordination, project management and intermediary support, and administrative costs are provided to support each proposal. Additionally, clinicians servings as supervisors must be compensated accordingly for additional scope and requirements.

In proposals #1 and #2, a total of $1.9 million is recommended for this activity but should be validated at the project level to avoid pushing more students through the pipeline without expanding the number of slots available at each step of the career pathway. Proposals #3 and #4 include these costs generally but do not itemize a specific amount.

If faculty and administrative support is not sufficiently resourced, the result of these investments would be longer waitlists for students, not more throughput in the regional education system for licensed clinicians.

6.5: Psychologist

Clinical and counseling psychologist: These professionals assess, diagnose, and treat mental and emotional disorders of individuals through observation, interview and psychological tests. They help individuals with distress or maladjustment understand their problems through their knowledge of case history, interviews with patients and theory. They provide individual or group counseling services to assist individuals in achieving more effective personal, social, educational, and vocational development and adjustment and may design behavior modification programs and consult with medical personnel regarding the best treatment for patients.

School psychologists: These professionals diagnose and implement individual or schoolwide interventions or strategies to address educational, behavioral, or developmental issues that adversely impact educational functioning in a school. They may address student learning and behavioral problems and counsel students or families. These professionals are required to get a doctoral degree from an approved or accredited program in clinical or counseling psychology and complete 3,000 hours (two years) of supervised clinical experience.

Figure 33: Clinical, counseling and school psychologists occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
1603	6.08%	2401	2522	30%	6.5%	1451

Of the 47 psychologists in our survey:

- Representation: 77%% were women, 19% were men, and 5% declined to state.

Figure 34: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals in San Diego County[45]	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022)
Asian / Pacific Islander	4.3%	7.4%	12%	7%
Black	0%		5%	5%
Hispanic	8.5%	11.9%	31%	39%
Native American	0%		.4%	.4%
White	48.9%	76.9%	45%	18%
Multi-racial	12.8%	1.6%	7%	
Other	2.1%	2.1%	.2%	
Not Reported	23.4%			30%

- Salaries: Respondents reported a median salary of $100,000. These reported salaries are similar to the median salary of $102,502 ($121,493 mean) from the BLS for clinical, counseling, and school psychologists.

- Student loans: 19 psychologists reported the median initial student loan balance of $195,000 and median remaining balance of $180,000. The median monthly payment was $800 per month among those with a payment.

- Burnout: 58% of respondents reported some level of burnout, with 18% reporting persistent burnout and 7% reporting complete burnout. This is above 39% of all 1,572 survey respondents and above the approximately 50% of all mental health professionals experiencing burnout reported in the survey.

- Intent to leave: 26% reported they were either somewhat likely (6.5%) or extremely likely (19.6%) to leave their job in the next 12 months. This is below 44% of all 1,572 survey

[45] Based on Census American Community Survey 2020 5-year data respondents who indicated they worked as "Clinical, Counseling, and School Psychologists."

respondents and similar to other mental health workers in the United States. Psychologists are the only profession with respondents answering "somewhat" less than "extremely." One of our focus group participants mentioned that she had one foot out the door of public behavioral health but was trying to see if she could bring her staff with her. Having almost 20% of the psychologist workforce "extremely likely" to leave their jobs is highly concerning. Psychologist do not appear to be planning to leave the County: 4.6% reported they intended to leave San Diego, compared to 11% in our survey overall.

- Job quality and job satisfaction: Psychologists in our survey were most satisfied with their relationships with and emotional support among co-workers, their managers, their sense of purpose at work and perceived job security. They were most dissatisfied with their pay, licensure costs, documentation requirements and on-the-job stress.

Figure 35: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	Loan Forgiveness for Public Service	$50,000	80	**$4,000,000**
2	Homeownership Incentive Fund	$40,000	25*	**$1,000,000**
3	0% Outcomes Based Loan (OBL) Fund	$40,000	60	**$2,370,000**
4	Renewable Supervision Fund	$25,000	100	**$2,500,000**
Totals			**240**	**$9,870,000**

*Individuals served would be in one of the other programs.

Program 1: Loan forgiveness for service in public behavioral health settings ($3,000,000)

Psychologists have many options post licensure, including working in research settings and private practice. To attract these professionals to public service in behavioral health settings, this program will provide additional short term loan forgiveness incentives to help bridge the pay gap and connect recent graduates and licensure recipients to organizations serving the behavioral health needs of the community.

Based on focus group and survey feedback, existing federal loan forgiveness programs are very difficult to navigate, reflecting larger national challenges. While federal and state loan forgiveness programs currently exist for behavioral health workers in the public workforce, many eligible workers never receive loan forgiveness as (a) forgiveness programs are underfunded relative to the need, and (b) often require stringent and difficult to achieve eligibility requirements, such as substantial years of service. For example, 98% of workers (164,000 of 168,000 applicants) had their loan forgiveness applications rejected from the Public Service Loan Forgiveness (PSLF) program between November 2020 and April 2021.[46]

Focus group respondents indicated a loan forgiveness program that forgave a set amount per year of public service in behavioral health settings (e.g., $10,000 per year for up to five years) would be a more effective talent attraction and retention tool than a more complicated, longer-term formula.

[46] "If You Are Denied Student Loan Forgiveness, Do This," Forbes, September 2021

The infrastructure established through the Southern Counties Regional Partnerships (SCRP) to administer WET funds could be used to administer this loan forgiveness program.

Program 2: Home ownership incentives for public service ($2,000,000)

While psychologists make starting salaries of at or near $100,000 per year could service home loans, they typically graduate with significant negative net worth. Psychologists that reported student debt in our survey had a median balance of $180,000 and struggle to make down-payments on homes in expensive markets (like San Diego) for their first 5-10 years practicing.

To address this, we also recommend offering beneficiaries that complete or are near completion of the programs listed in this section and are in good standing with all obligations and repayments incentives to live and work in San Diego for the long term through home ownership.

A portion of funds could be combined with homeownership programs like Landed for down-payment assistance to incent living in San Diego and working in public behavioral health settings by helping them get to 20% for a down payment on a median priced home. The fund itself could also take an equity stake in the home and be repaid through appreciation and refinance, creating a public renewable homeownership fund for public behavioral health professionals working in multiple settings including schools, hospitals, FQHCs, the County, and community-based organizations contracted with the County BHS.

By strategically stacking programs, a psychologist committed to working in public behavioral health settings would only need to come up with $40,000 (compared to $160,000) for a 20% down-payment on a near-median priced home to avoid paying Private Mortgage Insurance (PMI). The down-payment assistance program would come with requirements for San Diego public service in behavioral health settings (3-5 years) and could be targeted to first-generation college students and/or other professionals from backgrounds underrepresented in the field. Below is a sample model of what this package could look like.

Figure 36: Sample down payment assistance program

Approximate Median Priced Home in SD County	20% needed for down payment to avoid PMI	10% provided by Landed	5% provided by fund	% provided by individual
$800,000	$160,000	$80,000	$40,000	$40,000

Program 3: 0% Outcomes based loan (OBL) fund ($2,370,000)

To expand education access, outcomes-based financing would cover the upfront cost of a doctoral degree or gap financing for the final year of a master's/bachelor's degree programs in San Diego that have strong completion data, a track record of diversity and inclusion, and data supporting their graduates are moving toward licensure and community practice in San Diego. Programs with high pass rates with focus on clinical and community service in San Diego include Alliant University and programs at San Diego State University.

This financing would focus specifically on students and programs that provide advanced standing and/or accelerated programs by considering undergraduate and associate level coursework and/or

work experience to reduce required credit hours and would be available for students pursuing careers in public behavioral health system.

The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven.

While the individual will enter into the financing agreement, there is a clear opportunity for employers to assume their employee's monthly payment as a retention tool. Hospitals, FQHCs, the County and its contractors could develop policies and practices to pay off these loans early as a signing bonus.

Loan repayments will support future students and workers or other behavioral health workforce initiatives. $2,370,000 in 0% outcomes loans averaged at $40,000 each would serve an estimated 60 students over the first five years, with cashflows from these first 60 students serving another 20-30 after that. More information about the renewable loan product and proposed fund mechanics can be found in section 4.3.

Program 4: Renewable supervision fund ($2,500,000)

Similar to the model described for licensed clinicians, this fund would provide upfront financing for community focused clinics such as SDSUs Psychology Clinic, FQHCs and CBOs to provide structured supervision to professionals that need to accrue the 3,000 hours needed to sit for licensure. The hosting site, such as an established regional training hub, would provide best-in-class supervision training and the fund would be repaid over time by the employer sponsor each quarter the licensed psychologist retains employment with their sponsor. This $2,500,000 investment would create an additional 100 additional community-focused psychology supervision slots over a ten-year period.

6.6: Registered Nurses Working in BH Settings

Registered nurses in behavioral health settings (RNs): This occupation group refers to registered nurses that do not possess advanced degrees but may work across various behavioral health settings. These professionals assess patient health problems and needs, develop and implement nursing care plans, and administer nursing care to ill, injured, convalescent, or disabled patients. An estimated 4% of all RN's in California work in Behavioral health settings.

Psychiatric mental health registered nurses (Psych RNs): This occupation group refers to advanced practice registered nurses listed with the California Board of Registered Nursing as a psychiatric mental health registered nurse. To be eligible for this listing, registered nurses must possess a master's degree in psychiatric/mental health nursing and complete two years of supervised clinical experience.

Figure 37: Registered nursed working in BH settings occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
1040	6.87%	1548	1641	21%	5.2%	656

Of the 36 registered nurses in our survey:

- **Representation:** 61% were women, 29% were men, and 10% declined to state.

Figure 38: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals in San Diego County[47]	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022)
Asian / Pacific Islander	30.6%	27.9%	12%	7%
Black	2.8%	3.3%	5%	5%
Hispanic	2.8%	10.7%	31%	39%
Native American	0%	0%	.4%	.4%
White	30.6%	51.6%	45%	18%
Multi-racial	2.8%	6.3%	7%	
Other	0%	0.2%	0.2%	
Not Reported	30.6%			30%

- **Salaries:** Respondents reported a median salary of $90,000. These reported salaries are lower than the median salary of $112,507 ($111,613 mean) from the BLS for all RNs, potentially reflecting lower pay for RNs working in Behavioral Health settings.

- **Student loans:** Among RNs who responded to student loan questions, two reported 0 initial balance, and the median among those who reported taking out loans was $52,500 initial balance (n=10), a $48,000 remaining balance (n=9), and $600 monthly payment (n=8).

- **Burnout:** 32% of respondents reported some level of burnout, with 13% reporting persistent burnout and 0% reporting complete burnout. This is below 39% of all 1,572 survey respondents and 50% of all mental health professionals.

- **Intent to leave:** 43% reported they were either somewhat likely (26%) or extremely likely (17%) to leave their job in the next 12 months. This is similar to the 44% of all 1,572 survey respondents and slightly above the 18%-37% across mental health workers in the United States. 3% reported they intended to leave San Diego, compared to 11% in our survey overall.

- **Job quality and job satisfaction**: RNs we surveyed were most satisfied with their relationships with co-workers, the population they work with and their mastery over job tasks. They were most dissatisfied with self-care opportunities at work and support staffing. RNs were the most dissatisfied with their caseloads out of all professions we surveyed.

Figure 39: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	Scholarships for RNs committing to public BH settings	$30,000	67	**$2,000,000**

[47] Based on Census American Community Survey 2020 5-year data respondents who indicated they worked as Registered Nurses across specialties and departments

Program		Avg. Amount Per Worker	Est. # Served	Funding Total
2	Expanding BH clinical site slots for RN students	$33,950	100	**$3,395,000**
3	0% Outcomes Based Loan (OBL) Fund	$30,000	67	**$2,000,000**
Totals			**234**	**$7,395,000**

Program 1: Scholarships for RNs committing to public BH settings ($2,000,000)

This recommendation would provide $30,000 scholarships to 67 RNs to pursue their master's degree and get their license and be listed as a psychiatric mental health registered nurses through local programs such as Cal State San Marcos, San Diego State University and the University of San Diego.

The Board of Registered Nursing maintains a list of registered nurses who are eligible for direct reimbursement by some health care plans for providing psychiatric/mental health services to insured persons. To be eligible for the listing, the California Registered Nurse must possess a master's degree in psychiatric/mental health nursing and complete two years of supervised clinical experience in providing psychiatric/mental health counseling services. The master's degree in nursing must be directly related to mental health, such as psychiatric/mental health nursing or community mental health nursing.

Scholarships will come with five-year commitments to serve in public behavioral health settings post-graduation in San Diego County. This investment will help increase the number of RNs with specialized skills working in behavioral health settings and be used by employers as both a retention and upskilling strategy.

Program 2: Expanding BH clinical site slots for RN students ($3,395,000)

This intervention will be modeled after the Mental Health Services Act Stipend Program for MSW Students. The UC Berkeley California Social Worker Education Center (CALSWEC) recently completed a retrospective study of the discontinued program that demonstrated positive outcomes related to program completion, fulfillment of public service, retention in behavioral health professions, and high levels of diversity, lived experience, and cultural and linguistic competency among program completers.

Under this program, RN students from Cal State University San Marcos (CSUSM), University of San Diego (USD), Point Loma Nazarene University and San Diego State University (SDSU) will be provided stipends of $15,000 if enrolled part-time and $30,000 if enrolled full-time. These funds can be used for living expenses (gas, rent, food) at the student's discretion. Trainees will be required to complete their 800 hours of advanced-year field training at public behavioral health sites[48], advanced-year clinical courses in behavioral health specialties and specialized symposia, capstone projects, and other consumer-focused learning experiences designed by their RN programs. After graduation, all trainees will be required to complete either six or 12 months (depending on stipend amount) of full-time paid (or equivalent part time service) in public behavioral health settings in San Diego County.

[48]The full range of providers that serve the Behavioral Health needs of people who may be eligible for public health insurance based on economic need. This includes County employees, contractors, FQHCs, hospitals, providers in education settings, and private organizations that serve people who may be eligible for public health insurance.

Graduates who fail to complete this service obligation and who are not entitled to a waived repayment will repay stipend funding in cash, prorated to reflect any service fulfilled.

A $3,395,000 investment would provide an estimated 50 full time students with $30,000 stipends, 50 part-time students with $15,000 stipends and have $1,145,000 available for coordination, matching, and placement activities, community-based organizations internship supervision costs, wrap around career coaching/supportive services, and stipend origination, disbursement and servicing fees.

Program 3: 0% Outcomes based loan (OBL) ($2,000,000)

To expand education access, outcomes-based financing would cover the upfront cost of master's degree or gap financing for the fourth year of a bachelor's degree programs in San Diego that have strong completion data, a track record of diversity and inclusion, and data supporting their graduates are likely to enter the San Diego behavioral health workforce upon completion of their graduate or undergraduate coursework.

This financing would focus specifically on students and programs that provide advanced standing and/or accelerated programs by considering undergraduate and associate level coursework and/or work experience to reduce required credit hours and would be available to students pursuing careers in public behavioral health system.

The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven.

While the individual will enter into the financing agreement, there is a clear opportunity for employers to assume their employee's monthly payment as a retention tool. Hospitals, FQHCs, the County and its contractors could develop policies and practices to pay off these loans early as a signing bonus. Loan repayments will be used to support future students and workers or be directed towards other behavioral health workforce initiatives.

Loan repayments will support future students and workers or other behavioral health workforce initiatives. $2,000,000 in 0% outcomes loans averaged at $30,000 each would serve an estimated 67 students over the first five years, with cashflows from these first 67 students serving another 25-35 after that. More information about the renewable loan product and proposed fund mechanics can be found in section 4.3.

6.7: Psychiatric Mental Health Nurse Practitioner (PMHNNPs)

Psychiatric mental health nurse practitioner (PMHNPs): These professionals are master's level RNs who also possess a nurse practitioner certification and are therefore able to prescribe medication. While a master's degree is currently required to become a nurse practitioner, by 2025 a Doctor of Nursing practice (DNP) may be required.

Many healthcare leaders believe increasing the number of advanced practice nurses is the only realistic way to mitigate the physician shortage. Typically, advanced practice nurses are trained in a narrow clinical area and work in partnership with a supervising physician. The advanced practice nurse manages more routine, stable cases while the physician focuses on more complex, challenging cases. Ultimately, this partnership model expands the practice's total patient capacity.

Assembly Bill 890 allows NPs to work to the full extent of their license, including seeing mental health patients, without a physicians' supervision. This report recommends a strategic investment to expand the pipeline for PMHNPs to take advantage of these changes and position San Diego County to be a national leader PHMHNPs and psychiatrist integrated team to expand community psychiatry capacity.

Figure 40: Occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
159	6.87%	238	297	22%	5.2%	184

Of the 20 nurse practitioners in our survey:

- **Representation:** 95% were women, 0% were men, and 5% declined to state.

Figure 41: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals in San Diego County[49]	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022[50])
Asian / Pacific Islander	20%	5.5%	12%	7%
Black	5%	4.7%	5%	5%
Hispanic	5%	5.3%	31%	39%
Native American	0%		.4%	.4%
White	40%	75.8%	45%	18%
Multi-racial	5%	8.7%	7%	
Other	5%		.2%	
Not Reported	20%			30%

- **Salaries:** Respondents reported a median salary of $115,500. These reported salaries slightly below the median salary of $124,612 ($126,110 mean) from the BLS.

- **Student loans:** Two respondents reported not taking out student loans. Among those who reported taking out loans, the median initial loan amount was $100,000 (n=9), the median remaining balance was $90,000 (n=8). Three respondents reported $0 student loan payments, and the median payment among those who reported paying was $1000 (n=7).

[49] Based on Census American Community Survey 2020 5-year data respondents who indicated they worked as Nurse Practitioners across specialties and departments

[50] California Health and Human Services Open Data Portal (link) showed 991,503 Medi-Cal eligibles for the April 2022.

- **Burnout:** 45% of respondents reported some level of burnout, with 6% reporting persistent burnout and 22% reporting complete burnout. This is above 39% of all 1,572 survey respondents and 50% of all mental health professionals. Nurse practitioners in our survey had one of the highest rates of complete burnout.

- **Intent to leave:** 32% reported they were either somewhat likely (26%) or extremely likely (5%) to leave their job in the next 12 months. This is less than the 44% of all 1,572 survey respondents similar to the 18%-37% among behavioral health workers in the United States[51]. 5.6% reported they intended to leave San Diego, compared to 11% in our survey overall.

- **Job quality and job satisfaction**: These professionals were most satisfied with the autonomy they have at work, their relationships with their managers and coworkers and the emotional support they get from their peers. They were least satisfied with support staffing and (when applicable) loan support available to them.

Figure 42: Regional training fund project recommendations

	Program	Avg. Amount Per Worker	Est. # Served	Funding Total
1	Expanding UCSD's School of Medicine Community Psychiatry Programs for Nurse Practitioner Students and Graduates	$140,000	50	**$7,000,000**
2	Establish a Doctor of Nursing Practice PMHNP Program at San Diego State University	$60,000	50	**$3,000,000**
3	Home Ownership and Loan Forgiveness Incentives for Public Service	$40,000	50*	**$2,000,000**
4	0% Outcomes Based Loan (OBL) Fund	$65,000	100	**$7,800,000**
Totals			**200**	**$19,800,000**

*Individuals served would be in one of the other programs.

Program 1: Expanding UCSD's School of Medicine Community Psychiatry Programs for nurse practitioner students and graduates ($7,000,000)

This investment would expand two of the UCSD School of Medicine's Community Psychiatry Program (CPP) innovative nurse practitioner training programs that are demonstrating both capacity to scale and promising results in attracting nurse practitioners to San Diego and to public service in behavioral health settings.

The Nurse Practitioner Student Rotation program takes students from local psychiatric mental health nurse practitioner (PMHNP) programs including San Diego State University, Cal State University San Marcos and the University of San Diego as well as UCSF students and provides clinical training and rotations at Federally Qualified Health Centers (FQHCs) (such as Family Health Centers of San Diego and San Ysidro Health), County-supported Behavioral Health clinics and programs such as the Jane

[51] Rothrauff, T. C., Abraham, A. J., Bride, B. E., & Roman, P. M. (2011). Occupational turnover intentions among substance abuse counselors. Journal of Substance Abuse Treatment, 40(1), 67–76. https://doi.org/10.1016/j.jsat.2010.08.008
Leider, J. P., Sellers, K., Owens-Young, J., Guerrero-Ramirez, G., Bogaert, K., Gendelman, M., & Castrucci, B. C. (2021). Determinants of workplace perceptions among federal, state, and local public health staff in the US, 2014 to 2017. BMC Public Health, 21(1), 1654. https://doi.org/10.1186/s12889-021-11703-x

Westin Center and South Bay Guidance Center, and specialty programs with County of San Diego contractors, such as Survivors of Torture International.

The program began in 2014 and takes eight students per year from a pool of over 40+ qualified applicants. Cohorts are 18 months long with new cohorts starting each January. The students rotate through a variety of community sites focusing on underserved populations with Serious Mental Illness (SMI). Students receive didactics through their primary nursing programs/schools. Since 2014 when NP students first started there have been 30 graduates and an estimated >90% accepted community/public sector jobs as their first positions post-graduation.

The primary barrier to scaling this program is faculty supervisor salaries, administrative costs and clinical placement coordination. A $2 million, five-year investment would provide an estimated 10 additional slots for this program per year (50-75 total). These funds would go to faculty supervisor salaries, and administration and supervision site coordination.

Additionally, there is an opportunity to scale the PMHNP New Graduate Fellowship program. UCSD's School of Medicine currently offers the only post-graduate fellowship program in California for nurse practitioners to gain experience in community psychiatric settings working with SMI populations. The 12-month program runs from November to October every year and currently offers a pediatric specialization serving children/adolescents (generously supported by Price Philanthropies) and one specializing in adult services (funded through a time-limited HRSA grant). Both funding streams are designed to gradually decrease, with Price Philanthropies funding slated to end in Summer of 2024 and HRSA funding slated to end in August 2023. Both tracks provide placements in community settings in many of the same FQHCs and County BHS contractors and community-based partners as the residency program.

The program is currently on its third cohort of pediatric fellows and second cohort of adult fellows. The program has nine graduates so far and 100% accepted community/public sector positions as their first jobs post-graduation.

The primary barrier to scaling this program is faculty salaries, PMHNP salaries and clinical placement coordination. A $5 million, five-year investment would provide an estimated four additional slots for this program per year (20 overall). These funds would go to resident salaries (est. $120,000 + benefits per year), faculty salaries and administration and supervision site coordination.

The services provided by fellows would be billable to Medi-Cal and recoverable by the FQHC and/or County provider, which could be reinvested into the program to create long-term financial sustainability after the initial $5M investment.

Program 2: Establish a Doctorof Nursing practice PMHNP program at San Diego State University ($3,000,000)

San Diego State University's School of Nursing has received approval to begin conferring Doctor of Nursing Practice (DNP) degrees and could stand up the program with a specialty in psychiatric mental health by the Fall of 2024. The program would begin with an initial 10 students and would increase enrollment annually, hitting 15-20 students per year by 2030. This program would create

additional nurse practitioner slots in the San Diego community and position San Diego's regional education system to be responsive to a potential new requirement for nurse practitioners to have doctorate degrees. Public investments in this program would be explicitly focused on producing PMHNPs that will be patient-seeing practitioners, as opposed to PMHNP's pursuing research or other careers in academia.

Starting this program would require a one-time investment of $100,000 to write and submit the curriculum by October 2023 (per CSU guidelines), $2,600,000 to hire four program instructors/faculty for the initial five years while the program gets off the ground and an additional $300,000 for administration and set-up costs (coordinating clinical sites, etc.).

After this initial five-year investment, the program would reach 20-25 enrolled students and be financially self-sufficient through standard tuition costs, including through outcomes loan fund. SDSU would enroll students from San Diego as well as Imperial County residents, where 96% of students in current nursing programs identify as Hispanic, while most of those individuals being bi-lingual in Spanish and English. This new SDSU program will partner with UCSD to ensure clinical placement sites with UCSD clinical faculty members.

Program 3: Home ownership and loan forgiveness incentives for public service ($2,000,000)

While PMHNP/DNPs make starting salaries of $110,000 - $150,000 per year and could potentially service home loans, they typically graduate with significant negative net worth. PHMNPs in our survey had a median student debt load of approximately $100,000.

To address this, we also recommend offering beneficiaries that complete or are near completion of the programs listed above and are in good standing with all obligations and repayments incentives to live and work in San Diego for the long term through home ownership. A portion of funds could be combined with homeownership programs for down-payment assistance to incentivize living in San Diego and working in public behavioral health settings by helping them get to 20% for a down payment on a median priced home. The fund itself could also take an equity stake in the home and be repaid through appreciation and refinance, creating a public renewable homeownership fund for public behavioral health professionals working in multiple settings including schools, hospitals, FQHCs, the County, and community-based organizations contracted with the County BHS.

By strategically stacking programs, a PMHNP committed to working in public behavioral health settings would only need to come up with $40,000 (compared to $160,000) for a 20% down-payment on a near-median priced home to avoid paying Private Mortgage Insurance (PMI). The down-payment assistance program would come with requirements for San Diego public service in behavioral health settings (3-5 years) and could be targeted to first-generation college students and/or other professionals from backgrounds underrepresented in the field. Below is a sample model of what this package could look like.

Figure 43: Sample down payment assistance program

Approximate Median Priced Home in SD County	20% needed for down payment to avoid PMI	10% provided by Landed	5% provided by fund	% provided by individual

$800,000	$160,000	$80,000	$40,000	$40,000

Additionally, these funds could be used for loan forgiveness for public service. Focus group respondents indicated a loan forgiveness program that forgave a set amount per year of public service in behavioral health settings (e.g., $10,000 per year for up to five years) would be a more effective talent attraction and retention tool than a more complicated, longer-term formula. The infrastructure established through the Southern Counties Regional Partnerships (SCRP) to administer WET funds could be used to administer this loan forgiveness program.

Program 4: 0% Outcomes based loan (OBL) fund ($7,800,000)

To expand education access, outcomes-based financing would cover the upfront cost of tuition for the last 1-2 years of future DNP programs in San Diego, master's degree costs, or gap financing for the fourth year of an RN bachelor's degree programs in San Diego that have strong completion data, a track record of diversity and inclusion, and data supporting their graduates are likely to enter the San Diego behavioral health workforce upon completion and work toward PNP/DNP degrees and licensure.

This financing would focus specifically on students and programs that provide advanced standing and/or accelerated programs by considering undergraduate and associate level coursework and/or work experience to reduce required credit hours and would be available for students pursuing careers in public behavioral health system.

The loan product proposed would be a zero-interest outcome-based loan (OBL), repaid as a flat monthly payment over five years following training when participants make over $50,000 per year. At the end of that period, regardless of the remaining balance, the loan will be forgiven.

While the individual will enter into the financing agreement, there is a clear opportunity for employers to assume their employee's monthly payment as a retention tool. Hospitals, FQHCs, the County and its contractors could develop policies and practices to pay off these loans early as a signing bonus and/or annual retention strategy.

Loan repayments will support future students and workers or other behavioral health workforce initiatives. $7,800,000 in 0% outcomes loans averaged at $65,000 each would serve an estimated 100 students over the first five years, with cashflows from these first 100 students serving another 40-50 after that. An additional 1.3 million in this category set aside for additional clinical supervision slots.
More information about the renewable loan product and proposed fund mechanics can be found in section 4.3.

6.8: Psychiatrists

Psychiatrist: Diagnose, treat, and help prevent mental disorders.

Figure 44: Psychiatrist occupational data

2022 Professionals	Unmet need	2022 Professionals needed	2027 Professionals Needed	Turnover (2021)	Annual Replacement Rate	Total Additional Workers Needed (2022-2027)
265	6.08%	396	431	11%	2.7%	204

Of the 42 psychiatrists in our survey:

- **Representation:** 50% were women, 44% were men, and 6% declined to state.

Figure 45: Race & ethnicity of survey respondents and professionals

	Survey Respondents	All San Diego Professionals	San Diego Population	San Diego's Medi-Cal Eligibles (April 2022)
Asian / Pacific Islander	16.7%	12.9%	12%	7%
Black	2.4%	1.9%	5%	5%
Hispanic	4.8%	2.8%	31%	39%
Native American	0%	0.6%	.4%	.4%
White	33.4%	68.1%	45%	18%
Multi-racial	7.1%		7%	
Other	4.8%		.2%	
Not Reported	30.9%	12.6%		30%

- **Salaries:** Respondents reported a median salary of $250,000. These reported salaries are higher than the median salary of $162,718 ($191,880 mean) from the BLS. We believe this difference is a sampling difference: we did not actively recruit sole proprietors, whom we expect to make less take home pay due to overhead costs and part time hours.

- **Student loans:** 14 psychiatrists reported loan amounts. Four reported not taking out loans; the median initial balance among those who reported taking out loans was $232,500 (n=10). Seven reported having no student loan balance remaining; among those with a remaining balance, the median was $280,000 (n=7). Five reported no monthly payment; among those who had a payment reported a median of $1,700 per month (n=8).

- **Burnout:** 36% of respondents reported some level of burnout, with 14% reporting persistent burnout and 4% reporting complete burnout. This is below 39% of all 1,572 survey respondents and 50% of all mental health professionals.

- **Intent to leave:** 43% reported they were either somewhat likely (22.5%) or extremely likely (20%) to leave their job in the next 12 months. This is near the 44% of all 1,572 survey respondents and slightly above the 18%-37% among behavioral health workers in the United States. 6% reported they intended to leave San Diego, compared to 11% in our survey overall.

- Job quality and job satisfaction: These professionals were most satisfied with their autonomy at work, relationships with coworkers and flexibility in treatment modality. They were least satisfied with their on-the-job stress and lack of access to continuum of care and wraparound services for their patients.

Figure 46: Regional training fund project recommendations

Program		Avg. Amount Per Worker	Est. # Served	Funding Total
1	Make strategic investments in Community Psychiatry Program Residency Programs	$493,809*	84	**$41,480,000**
2	Home Ownership and Loan Forgiveness Incentives for Public Service	$40,000	75**	**$3,000,000**
Totals			**84**	**$44,480,000**

*Cost includes four year of residency salary, benefits, and faculty and administration costs, on average across the two programs described in 1a and 1b below.
**Individuals served would be in one of the other programs.

Program 1a: Expand the community psychiatry program residency track at UCSD School of Medicine

UCSD's School of Medicine Community Psychiatry Program (CPP) Residency Track, within the General Psychiatry Residency, was developed in partnership with the County of San Diego's Health and Human Services Agency. This specialized track trains providers to address the mental health needs of the community working in public behavioral health settings at rotation sites that treat underserved communities. This allows residents to develop an understanding of the public mental health system and the skills necessary to provide quality patient care to each unique population.

In addition to clinical rotations within the UCSD Medical Center, residents rotate through community-based organizations (CBOs) for training sites including San Ysidro Health , Family Health Centers of San Diego, San Diego Youth Services, Survivors of Torture International, Deaf Community Services, Community Research Foundation, San Diego Center for Children and Vista Hill.

The pediatrics residency track is hosted by Rady Children's Hospital and provides residents with best-in-class pediatric care facilities and supervising psychiatrists.

CPP Residents also have a special didactic seminar series in their third and fourth year, every Thursday afternoon, focused on learning about population health, advocacy, healthcare leadership, program design, finance, budgeting, collaborative care and outcomes-based research.

The CPP track is a four-year program and opens two slots per year (eight total residents). In 2021, the program had nearly 500 applicants from top medical schools across the United States. This program has demonstrated evidence of attracting psychiatrists to public sector settings. Of the 25+ graduates dating back to 2012-13, 100% have taken jobs in community/public sector or academic positions as their first job out of residency or fellowship.

Increasing from two slots to four slots per year would provide an additional 20 psychiatrists and psychiatrist resident students trained and connected to San Diego's public behavioral health system over a 10-year period, increasing the services provided in the community through residents and maximizing faculty placements. The cost of expanding to two additional slots is estimated to be $3

million in the first three years, and $1.74 million for each year after that (15 million over 10 years). Primary expense categories include faculty placements, administration and coordination with clinical sites, and supervision and resident salaries and fringe.

After the initial expansion, the program will be funded by ongoing revenues generated through patient and third-party encounters.

Program 1b: Support the launch of a new 8x4 community psychiatry residency program at a San Diego FQHC

The proposed psychiatry residency program would address the growing need in San Diego County for accredited community-based primary care residency programs in psychiatry, to address the physician workforce shortages and challenges faced by rural and underserved communities in San Diego County. The program would include a four-year psychiatry residency for adult and pediatric psychiatric residents that includes community clinic-based experience, inpatient rotation at a new, state-of-the-art psychiatry hospital, robust experience treating underserved patient populations and didactic sessions including interprofessional training and care of special populations.

The program would train eight psychiatry residents each project year and will host 32 psychiatry residents in total, once the program reaches a four-year maturity (eight slots per year for four years). The program would track residents' career outcomes for a minimum of five years post-graduation from the residency program, including retention in San Diego County and with underserved areas and equity populations.

Financial support against the $26,480,000 estimated cost of launching the program would create eight additional four-year residency slots per year (32 residents when the program is at year four). Over a 10-year period, this would create 64 new psychiatrist graduates connected to and experience and training working in the San Diego community health system.

Residents will serve the medically underserved populations presenting for care in San Diego County's Health and Human Services Central, East, North and South Regions. Residents also will complete clinical experiences at FQHC clinics located in underserved communities and Mental Health HPSAs across San Diego County. The proposed psychiatry residency program will help meet a critical need for training programs in our region, as there is currently only one other psychiatry residency program accepting non-military applicants.

The FQHC would need well-developed partnerships with academic institutions and clinical training sites to provide community-based clinical experiences and didactic education to psychiatry residents and psychiatric mental health nurse practitioners fellows. This experience can be leveraged alongside integrated and interprofessional care delivery and the tremendous and diverse needs of FQHC patients to develop a new Accreditation Council for Graduate Medical Education (ACGME)-accredited psychiatry residency program that leads to successful board certification and readiness for clinical practice.

Medical and executive leadership from the FQHC and psychiatric hospital partners would establish mutually agreed upon rotation schedule, identified board-certified faculty and subject matter experts to contribute toward curriculum development in all sub-specialties and/or to provide administration and supervision, and have agreed upon the clinical training sites. The FQHC and its partners would also need to determine adequate patient care volumes and interprofessional care teams across training sites and identified the high-need special populations in the region, including patients who are uninsured, undocumented, non-English speaking, living with HIV/Hep C, experiencing homelessness, lesbian, gay, bisexual, and/or transgender (LGBT), veterans, refugee/asylees, people who inject drugs, and experiencing substance use disorder, for whom residents will build relationships and provide longitudinal management and follow-up for during year three continuity clinic.

One example of an FQHC that has made significant progress toward expanding the psychiatry training pipeline is Family Health Centers of San Diego (FHCSD). FHCSD has a planned 25,000 square foot multi-cultural mental health complex in the City Heights neighborhood in the City of San Diego. The project has broken ground and is under-construction and consists of a parking garage, mental health clinic and 170 units of housing for formerly unsheltered people. FHCSD and its partners are currently developing the program curriculum and infrastructure in order to achieve ACGME accreditation by November 30, 2023, with resident matriculation planned for July 1, 2024.

FHCSD is one of the nation's ten largest Federally Qualified Health Centers (FQHC) and is the largest health center system serving low-income and uninsured San Diegans. In 2020, FHCSD provided primary health care services to 160,902 unduplicated patients through 995,125 visits at 25 community-based health center sites situated in Health Professional Shortage Areas (HPSA) across San Diego County, California. FHCSD currently operates a Family Medicine Residency in which five of six graduates have stayed working in community health in San Diego (above national average).

After initial launch, and once the program is functioning at a four-year level of maturity, the program will be funded by ongoing revenues generated through patient and third-party encounters. The program will then be able to tap into federal and state residency funding to support on-going operations.

Program 2: Home ownership and loan forgiveness incentives for public service ($3,000,000)

While psychiatrists make high-starting salaries of $250,000 - $350,000 per year and could potentially service home loans, they typically graduate with significant negative net worth. Of the 18 physiatrists that took our survey, their average reported debt at graduation was $350,000 and focus group participants reported challenges making down-payments on homes in expensive markets (like San Diego) for their first 5-10 years practicing. Focus groups with psychiatry chairs/directors charged with recruiting and retaining psychiatrists have indicated that getting a professional connected in the local community is critical in the first 1-3 years post residency to keep them living and working in San Diego.

To address this, we also recommend offering beneficiaries who complete the residency programs listed above and are in good standing with all obligations and repayments incentives to live and work in San Diego for the long term through home ownership.

A portion of funds could be combined with homeownership programs like Landed for down-payment assistance to incentivize living in San Diego and working in public behavioral health settings by helping them get to 20% for a down payment on a median priced home. The fund itself could also take an equity stake in the home and be repaid through appreciation and refinance, creating a public renewable homeownership fund for public behavioral health professionals working in multiple settings including schools, hospitals, FQHCs, the County, and community-based organizations contracted with the County BHS.

By strategically stacking programs, a psychiatrist committed to working in public behavioral health settings would only need to come up with $40,000 (compared to $160,000) for a 20% down-payment on a near-median priced home to avoid paying Private Mortgage Insurance (PMI). The down-payment assistance program would come with requirements for San Diego public service in behavioral health settings (3-5 years) and could be targeted to first-generation college students and/or other professionals from backgrounds underrepresented in the field. Below is a sample model of what this package could look like.

Figure 47: Sample down payment assistance program

Approximate Median Priced Home in SD County	20% needed for down payment to avoid PMI	10% provided by Landed	5% provided by fund	% provided by individual
$800,000	$160,000	$80,000	$40,000	$40,000

Additionally, these funds could be used for loan forgiveness for public service. Focus group respondents indicated a loan forgiveness program that forgave a set amount per year of public service in behavioral health settings (e.g., $10,000 per year for up to five years) would be a more effective talent attraction and retention tool than a more complicated, longer-term formula. The infrastructure established through the Southern Counties Regional Partnerships (SCRP) to administer WET funds could be used to administer this loan forgiveness program.

Section 7: Moving Forward

This report provides a deeper understanding of San Diego's behavioral health worker shortage and provides concrete recommendations - informed by the perspectives and experiences of workers – to address it. With a regional vision and framework for action, the people, organizations, systems, and policies that drive the behavioral health system will determine if and how that vision is carried out in San Diego. Below are four considerations focused on implementation:

- Invest in the project management and technical resources necessary to execute

Designing and executing against the regional vision outlined in this report will require significant project management and technical resources. The time and expertise needed cannot be undervalued and will require a senior leader with budget authority and a team of managers and subject matter experts with clear lines of accountability and significant time dedicated to these efforts will be required to make meaningful progress.

- Establish a California legislative agenda

The recommendations in this report require both local and state action. Members of the steering committee and other key stakeholders should develop a San Diego County policy brief to compliment this report, providing local elected officials, advocacy groups, employers, and professional associations with a clear, concise platform to engage California policy makers and administrators.

- Build a broad coalition and provide regular updates on progress

Executing on the recommendations outlined in this report will require partnerships with colleges, universities, healthcare providers, workforce development and nonprofit organizations, foundations, state and local government, health plans, elected officials, professional associations, and workers themselves. Hosting an annual symposium to introduce this vision and providing regular updates to communicate progress will help grow the size and strength of this coalition.

- Set metrics and provide regular updates on progress

This report outlines significant public and private investment to address a regional problem. The implementation team should work with key stakeholders to establish key metrics for workforce retention, talent attraction, diversity, equity, and inclusion, and ultimately, how the investments impact quality and availability of care to San Diego residents.

Understanding the worker shortage, hearing from frontline professionals, and detailing regional recommendations is an important step in San Diego's efforts to address the Behavioral Health staffing shortage. The considerations above will help facilitate the next steps toward implementing the vision of the most resilient, representative, and skilled and qualified BH workforce in the United States.

Appendix

Figure A.1: Replacement and occupational growth rates from 2022-2032

Occupation	Prof. Needed (2022)	Growth Rate (%) 2022- 2032	Prof. needed (2032)	Annual Replacement rate	Replace-ments 2022-2032	New Prof. Needed 2022-2032
Community Health Workers & Social and Human Service Assistants, including Peer Support Specialists	6930	17%	8087	11.3%	5854	7011
Psychiatric Aides	192	48%	284	12.1%	196	288
Substance Abuse and Behavioral Disorder Counselors	3631	30%	4720	9.2%	2716	3805
Psychiatric Technicians	1181	21%	1429	7%	613	861
Marriage and Family Therapists	6637	12%	7433	9.2%	4339	5135
Mental Health and Substance Abuse Social Workers	1913	21%	2315	9.2%	1292	1694
Psychologists (Clinical, Counseling, and School	2401	9%	2618	6.5%	1088	1304
Registered Nurses working in BH settings (4% of all RNs)	1548	10%	1702	5.2%	570	724
Psychiatric and Mental Health Nurse Practitioner	238	44%	342	5.2%	100	205
Physician's Assistants	42	24%	52	5.5%	17.352	27
Psychiatrists	396	14%	451	2.7%	77	132
Totals	**25,109**		**29,433**		**16,862**	**21,186**

Figure A.2: Total number of behavioral health professionals needed in San Diego by 2032

Occupation	2022 BH Prof.	Prof. Needed (2022)	Prof. Needed (2032)	2022 Regional BH Worker Shortage	New Prof. Needed 2022-2032	Total Additional Workers Needed (2022-2032)
Community Health Workers & Social and Human Service Assistants, including Peer Support Specialists	4644	6930	8087	2286	7011	9297
Psychiatric Aides	129	192	284	63	288	351
Substance Abuse and Behavioral Disorder Counselors	2566	3631	4720	1065	3805	4870
Psychiatric Technicians	789	1181	1429	392	861	1253
Marriage and Family Therapists	4443	6637	7433	2194	5135	7329
Mental Health and Substance Abuse Social Workers	1283	1913	2315	630	1694	2324
Psychologists (Clinical, Counseling, and School	1603	2401	2618	798	1304	2102
Registered Nurses working in BH settings (4% of all RNs)	1040	1548	1702	508	724	1232
Psychiatric and Mental Health Nurse Practitioner	159	238	342	79	205	284
Physician's Assistants	28	42	52	14	27	41
Psychiatrists	265	396	451	131	132	263
Totals	**16,949**	**25,109**	**29,433**	**8,160**	**21,186**	**29,346**

Figure A.3 San Diego BH professionals' satisfaction with job quality features

Green Text = Top Talent Attraction and Retention Feature (Pull Factor)
Red Text: Top Driver of Intent to Leave (Push Factor)

	n	Completely Satisfied	Satisfied	Dis-satisfied	Completely Dissatisfied	No Opinion
Economic Stability & Security						
The amount of money you earn	1238	11%	32%	33%	22%	2%
Your job security	1238	35%	49%	10%	3%	4%
The paid sick leave available to you	1238	28%	40%	18%	9%	6%
The physical safety conditions of your workplace	1198	35%	47%	11%	4%	3%
The retirement plan your employer offers	1238	22%	44%	15%	8%	11%
Economic Mobility & Wealth Building						
Learning and development opportunities provided by your employer	1198	25%	46%	18%	6%	5%
The frequency of feedback on your job performance	1238	27%	47%	16%	6%	3%
Support for education or licensure costs	1198	15%	29%	23%	16%	17%
Support for continuing education	1198	22%	42%	15%	10%	11%
The mastery you have over the skills and tasks required of at work	1198	35%	54%	7%	2%	2%
The recognition you receive at work for your work accomplishments	1198	25%	43%	20%	8%	3%
Any loan support available to you (e.g., student loan assistance or forgiveness)	1198	9%	19%	18%	18%	36%
Any housing support available to you (e.g., rent or mortgage assistance)	1198	5%	12%	18%	21%	44%
Meaningful Work						
The ways in which your job contributes to a purpose you care about	1198	41%	43%	9%	3%	3%
The sense that your work is valued	1238	34%	39%	18%	6%	2%
The population you work with	1198	43%	50%	4%	1%	2%
The autonomy you have at work	1198	36%	50%	8%	3%	4%
Mandates and regulations that you must follow in the course of your work	1198	19%	53%	17%	8%	4%
The documentation associated with your job	1238	17%	40%	16%	23%	2%
In-house wraparound services or resources for clients	1198	16%	40%	20%	7%	16%
Support for warm handoffs to external wraparound services or resources for clients	1198	17%	42%	22%	7%	13%
Your caseload	1238	19%	45%	16%	7%	12%
Schedules, Vacation, and Rest						
The amount of on-the-job stress in your job	1198	11%	41%	28%	16%	3%
The paid vacation days available to you	1198	27%	41%	17%	8%	7%
The flexibility of your hours	1198	30%	47%	15%	5%	3%
Support for working caretakers (e.g., parental leave, schedule flexibility, childcare)	1238	21%	39%	15%	6%	19%
Available modality options (i.e., flexibility to see clients in person or telehealth)	1238	30%	44%	8%	5%	13%
The self-care time available at work (e.g., time between clients, team meetings)	1238	19%	37%	26%	14%	4%
Self-care resources available from your employer	1238	18%	41%	26%	10%	5%
Relationship with Coworkers						
Your boss or immediate supervisor	1198	48%	36%	9%	4%	3%
Your relations with coworkers	1198	41%	50%	6%	2%	2%
The social and emotional support provided by your peers	1238	37%	46%	11%	4%	3%
The social and emotional support provided by your manager or immediate supervisor	1238	39%	37%	15%	7%	3%
The number of people working in positions similar to yours	1238	20%	43%	21%	10%	7%
The number of staff working in support roles	1238	20%	40%	27%	9%	4%
The number of staff working in management roles	1238	27%	47%	16%	6%	3%

Figure A.4: Compensation analysis using California Metropolitan Statistical Areas (MSAs)

For each MSA we identified the cost-of-living (COL) index,[52] a value that reflects the cost of living in a region as a percentage of the average cost of living in the US. We then calculate COL-adjusted wages for each MSA by adjusting the nominal wage by the COL. For example, the San Diego COL index is 142.2, meaning that the expense of living in San Diego is 42.2% higher than the national average. More information about the cost-of-living adjustment is available here.

	Cost of Living Adjustment	Social Services Assistants (includes Peer Support)		Psychiatrists		Psychiatric Aides	
California MSA		**2021 Avg Wage**	**COL Adj. Avg**	**2021 Avg Wage**	**COL Adj. Avg**	**2021 Avg Wage**	**COL Adj. Avg**
Bakersfield	119.1	$ 38,966	$ 32,717	$ 241,967	$ 203,163	$ 32,032	$ 26,895
Chico	128.2	$ 39,591	$ 30,882	Insf. Data	Insf. Data	Insf. Data	Insf. Data
Clearlake	130.3	$ 34,342	$ 26,356	Insf. Data	Insf. Data	Insf. Data	Insf. Data
Crescent City	126.9	$ 33,824	$ 26,654	Insf. Data	Insf. Data	Insf. Data	Insf. Data
El Centro	103.5	$ 45,115	$ 43,590	Insf. Data	Insf. Data	Insf. Data	Insf. Data
Eureka-Arcata	130.1	$ 37,454	$ 28,789	$ 290,816	$ 223,533	$ 29,940	$ 23,013
Fresno	122.5	$ 36,252	$ 29,593	$ 199,263	$ 162,664	$ 38,846	$ 31,711
Hanford-Corcoran	122.2	$ 36,861	$ 30,164	$ 188,103	$ 153,931	$ 30,001	$ 24,551
LA-Long Beach-Anaheim	157.6	$ 39,807	$ 25,258	$ 274,289	$ 174,042	$ 33,390	$ 21,186
Madera	124.1	$ 37,843	$ 30,494	$ 276,609	$ 222,892	Insf. Data	Insf. Data
Merced	121.0	$ 52,230	$ 43,165	$ 187,058	$ 154,593	Insf. Data	Insf. Data
Modesto	124.8	$ 39,556	$ 31,696	$ 182,630	$ 146,338	$ 29,941	$ 23,992
Napa	144.3	$ 39,346	$ 27,266	$ 259,429	$ 179,785	Insf. Data	Insf. Data
Oxnard-Thousand Oaks-Ventura	135.3	$ 44,595	$ 32,960	$ 275,000	$ 203,252	$ 30,956	$ 22,879
Red Bluff	125.9	$ 50,859	$ 40,397	Insf. Data	Insf. Data	Insf. Data	Insf. Data
Redding	128.2	$ 37,605	$ 29,333	Insf. Data	Insf. Data	Insf. Data	Insf. Data
Riverside-San Bernardino-Ontario	127.9	$ 38,608	$ 30,186	$ 319,020	$ 249,429	$ 55,659	$ 43,518
Sacramento-Roseville-Folsom	136.0	$ 46,654	$ 34,304	$ 181,603	$ 133,532	$ 32,941	$ 24,221
Salinas	132.2	$ 39,719	$ 30,044	$ 263,067	$ 198,992	$ 34,517	$ 26,109
San Diego-Chula Vista-Carlsbad	**142.2**	**$ 32,620**	**$ 22,940**	**$ 165,386**	**$ 116,305**	**$ 31,176**	**$ 21,924**
San Francisco-Oakland-Berkeley	164.8	$ 45,260	$ 27,464	$ 280,534	$ 170,227	$ 36,774	$ 22,314
San Jose-Sunnyvale-Santa Clara	145.3	$ 55,886	$ 38,463	$ 288,709	$ 198,699	$ 36,866	$ 25,372
San Luis Obispo-Paso Robles	134.3	$ 36,297	$ 27,027	$ 278,186	$ 207,138	$ 37,735	$ 28,097
Santa Cruz-Watsonville	137.8	$ 41,523	$ 30,133	$ 195,393	$ 141,795	$ 36,056	$ 26,165
Santa Maria-Santa Barbara	134.6	$ 41,773	$ 31,035	$ 290,661	$ 215,944	$ 37,569	$ 27,912
Santa Rosa-Petaluma	138.7	$ 40,289	$ 29,048	$ 294,736	$ 212,499	$ 30,101	$ 21,702
Sonora	132.7	$ 42,654	$ 32,143	$ 185,378	$ 139,697	Insf. Data	Insf. Data
Stockton	125.7	$ 41,817	$ 33,267	$ 248,276	$ 197,515	$ 37,244	$ 29,629

[52] The Cost of Living Index is produced by the Council for Community and Economic Research.

	Cost of Living Adjustment	Social Services Assistants (includes Peer Support)		Psychiatrists		Psychiatric Aides	
Susanville	129.8	$ 50,202	$ 38,677	Insf. Data	Insf. Data	Insf. Data	Insf. Data
Truckee-Grass Valley	136.6	$ 56,735	$ 41,534	$ 120,369	$ 88,118	Insf. Data	Insf. Data
Ukiah	131.1	$ 38,386	$ 29,280	$ 282,733	$ 215,662	Insf. Data	Insf. Data
Vallejo	131.8	$ 36,758	$ 27,889	$ 294,283	$ 223,280	$ 36,823	$ 27,939
Visalia	118.2	$ 38,720	$ 32,758	$ 263,854	$ 223,227	$ 29,945	$ 25,334
Yuba City	126.2	$ 60,155	$ 47,667	$ 189,203	$ 149,923	Insf. Data	Insf. Data

	Cost of Living Adjustment	Community Health Workers		Marriage and Family Therapists		Social Workers (in BH Settings)	
California MSA		2021 Avg Wage	2021 Avg Wage	2021 Avg Wage	COL Adj. Avg	2021 Avg Wage	COL Adj. Avg
Bakersfield	119.1	$ 57,190	$ 48,019	$ 49,111	$ 41,235	$ 54,663	$ 45,897
Chico	128.2	$ 30,519	$ 23,806	$ 47,213	$ 36,828	$ 39,876	$ 31,104
Clearlake	130.3	$ 41,320	$ 31,711	$ 52,115	$ 39,996	$ 49,793	$ 38,214
Crescent City	126.9	Insf. Data	Insf. Data	$ 51,301	$ 40,426	Insf. Data	Insf. Data
El Centro	103.5	Insf. Data	Insf. Data	$ 42,516	$ 41,079	$ 30,795	$ 29,754
Eureka-Arcata	130.1	$ 43,404	$ 33,362	$ 52,955	$ 40,704	$ 52,719	$ 40,522
Fresno	122.5	$ 40,878	$ 33,370	$ 40,302	$ 32,900	$ 49,145	$ 40,119
Hanford-Corcoran	122.2	$ 43,392	$ 35,509	$ 62,907	$ 51,478	$ 91,854	$ 75,167
LA-Long Beach-Anaheim	157.6	$ 46,811	$ 29,702	$ 46,789	$ 29,689	$ 71,160	$ 45,152
Madera	124.1	$ 43,396	$ 34,968	$ 58,340	$ 47,011	$ 95,941	$ 77,310
Merced	121.0	$ 43,885	$ 36,269	$ 42,406	$ 35,047	$ 59,567	$ 49,229
Modesto	124.8	$ 45,778	$ 36,681	$ 36,009	$ 28,854	$ 64,594	$ 51,758
Napa	144.3	$ 47,889	$ 33,187	$ 40,519	$ 28,080	$ 93,285	$ 64,646
Oxnard-Thousand Oaks-Ventura	135.3	$ 48,294	$ 35,694	$ 57,042	$ 42,160	$ 87,540	$ 64,701
Red Bluff	125.9	Insf. Data	Insf. Data	$ 59,726	$ 47,439	Insf. Data	Insf. Data
Redding	128.2	$ 46,273	$ 36,095	$ 64,728	$ 50,490	$ 57,055	$ 44,504
Riverside-San Bernardino-Ontario	127.9	$ 49,069	$ 38,365	$ 51,801	$ 40,501	$ 65,350	$ 51,094
Sacramento-Roseville-Folsom	136.0	$ 59,762	$ 43,942	$ 51,268	$ 37,697	$ 62,699	$ 46,102
Salinas	132.2	$ 39,155	$ 29,618	$ 58,192	$ 44,018	$ 74,974	$ 56,712
San Diego-Chula Vista-Carlsbad	**142.2**	**$ 43,892**	**$ 30,867**	**$ 46,944**	**$ 33,013**	**$ 56,216**	**$ 39,533**
San Francisco-Oakland-Berkeley	164.8	$ 55,999	$ 33,980	$ 65,187	$ 39,555	$ 86,641	$ 52,573
San Jose-Sunnyvale-Santa Clara	145.3	$ 60,881	$ 41,900	$ 57,560	$ 39,614	$ 61,276	$ 42,172
San Luis Obispo-Paso Robles	134.3	$ 43,461	$ 32,361	$ 59,752	$ 44,491	$ 91,744	$ 68,313
Santa Cruz-Watsonville	137.8	$ 47,892	$ 34,755	$ 64,807	$ 47,030	$ 50,124	$ 36,375
Santa Maria-Santa Barbara	134.6	$ 43,796	$ 32,538	$ 48,021	$ 35,677	$ 88,207	$ 65,533

	Cost of Living Adjustment	Community Health Workers		Marriage and Family Therapists		Social Workers (in BH Settings)	
Santa Rosa-Petaluma	138.7	$ 54,665	$ 39,413	$ 52,479	$ 37,836	$ 105,280	$ 75,905
Sonora	132.7	Insf. Data	Insf. Data	$ 48,974	$ 36,906	$ 57,388	$ 43,247
Stockton	125.7	$ 44,169	$ 35,139	$ 43,212	$ 34,377	$ 59,044	$ 46,972
Susanville	129.8	Insf. Data	Insf. Data	$ 58,184	$ 44,826	Insf. Data	Insf. Data
Truckee-Grass Valley	136.6	Insf. Data	Insf. Data	$ 60,229	$ 44,091	$ 63,386	$ 46,403
Ukiah	131.1	$ 44,179	$ 33,699	$ 59,314	$ 45,243	$ 56,046	$ 42,751
Vallejo	131.8	$ 43,657	$ 33,124	$ 83,940	$ 63,687	$ 102,035	$ 77,416
Visalia	118.2	$ 40,447	$ 34,219	$ 53,342	$ 45,129	$ 66,459	$ 56,226
Yuba City	126.2	Insf. Data	Insf. Data	$ 80,900	$ 64,105	$ 36,489	$ 28,914

	Cost of Living Adjustment*	**Psychologists**		**SUD Counselors**		**Registered Nurses**		**Psychiatric Technicians**	
California MSA		2021 Avg Wage	COL Adj. Avg	2021 Avg Wage	COL Adj. Avg	2021 Avg Wage	COL Adj. Avg	2021 Avg Wage	COL Adj. Avg
Bakersfield	119.1	$ 106,987	$ 89,829	$ 51,362	$ 43,125	$ 95,640	$ 80,302	$ 74,324	$ 62,405
Chico	128.2	$ 91,867	$ 71,659	$ 51,451	$ 40,133	$ 87,287	$ 68,087	$ 49,543	$ 38,645
Clearlake	130.3	$ 104,765	$ 80,403	$ 40,493	$ 31,077	$ 94,645	$ 72,636	Insf. Data	Insf. Data
Crescent City	126.9	Insf. Data	Insf. Data	$ 40,390	$ 31,828	$ 92,326	$ 72,755	Insf. Data	Insf. Data
El Centro	103.5	$ 98,924	$ 95,579	$ 57,815	$ 55,860	$ 84,757	$ 81,891	Insf. Data	Insf. Data
Eureka-Arcata	130.1	$ 95,433	$ 73,353	$ 42,749	$ 32,859	$ 88,909	$ 68,339	$ 54,351	$ 41,776
Fresno	122.5	$ 117,238	$ 95,705	$ 49,463	$ 40,378	$ 97,134	$ 79,293	$ 63,522	$ 51,855
Hanford-Corcoran	122.2	$ 114,839	$ 93,976	$ 62,376	$ 51,044	$ 112,038	$ 91,684	$ 49,100	$ 40,180
LA-Long Beach-Anaheim	157.6	$ 106,714	$ 67,712	$ 48,769	$ 30,945	$ 113,004	$ 71,703	$ 43,833	$ 27,813
Madera	124.1	$ 120,443	$ 97,053	$ 53,377	$ 43,012	$ 62,117	$ 50,054	$ 46,879	$ 37,775
Merced	121.0	$ 102,574	$ 84,772	$ 53,498	$ 44,213	$ 103,542	$ 85,572	$ 49,430	$ 40,851
Modesto	124.8	$ 114,668	$ 91,882	$ 54,528	$ 43,692	$ 110,049	$ 88,180	$ 48,602	$ 38,944
Napa	144.3	$ 123,537	$ 85,611	$ 49,781	$ 34,498	$ 116,147	$ 80,490	$ 55,853	$ 38,706
Oxnard-Thousand Oaks-Ventura	135.3	$ 103,081	$ 76,187	$ 40,795	$ 30,152	$ 105,220	$ 77,768	$ 71,731	$ 53,016
Red Bluff	125.9	$ 96,315	$ 76,502	$ 37,467	$ 29,760	$ 102,911	$ 81,740	Insf. Data	Insf. Data
Redding	128.2	$ 70,607	$ 55,075	$ 44,197	$ 34,475	$ 115,731	$ 90,274	$ 51,615	$ 40,261
Riverside-San Bernardino-Ontario	127.9	$ 103,811	$ 81,166	$ 53,537	$ 41,858	$ 109,068	$ 85,276	$ 62,925	$ 49,199
Sacramento-Roseville-Folsom	136.0	$ 111,561	$ 82,030	$ 53,114	$ 39,055	$ 136,697	$ 100,513	$ 46,677	$ 34,321
Salinas	132.2	$ 103,845	$ 78,551	$ 47,968	$ 36,285	$ 132,385	$ 100,140	$ 73,354	$ 55,487
San Diego-Chula Vista-Carlsbad	**142.2**	**$ 102,185**	**$ 71,860**	**$ 45,590**	**$ 32,060**	**$ 112,222**	**$ 78,919**	**$ 62,656**	**$ 44,062**
San Francisco-Oakland-Berkeley	164.8	$ 101,234	$ 61,428	$ 57,764	$ 35,051	$ 154,193	$ 93,564	$ 58,049	$ 35,224
San Jose-Sunnyvale-Santa Clara	145.3	$ 111,222	$ 76,546	$ 62,218	$ 42,821	$ 155,576	$ 107,072	$ 68,341	$ 47,034
San Luis Obispo-Paso Robles	134.3	$ 124,436	$ 92,655	$ 64,494	$ 48,022	$ 105,091	$ 78,251	$ 63,460	$ 47,252
Santa Cruz-Watsonville	137.8	$ 78,692	$ 57,106	$ 40,223	$ 29,190	$ 131,385	$ 95,344	$ 51,235	$ 37,180

	Cost of Living Adjustment*	Psychologists		SUD Counselors		Registered Nurses		Psychiatric Technicians	
Santa Maria-Santa Barbara	134.6	$ 116,765	$ 86,749	$ 54,360	$ 40,386	$ 110,027	$ 81,744	$ 71,392	$ 53,040
Santa Rosa-Petaluma	138.7	$ 128,913	$ 92,943	$ 41,261	$ 29,748	$ 119,188	$ 85,932	$ 65,274	$ 47,062
Sonora	132.7	$ 114,629	$ 86,382	$ 46,644	$ 35,150	$ 93,182	$ 70,220	$ 70,919	$ 53,443
Stockton	125.7	$ 107,310	$ 85,370	$ 43,502	$ 34,607	$ 114,898	$ 91,407	$ 73,919	$ 58,806
Susanville	129.8	Insf. Data	Insf. Data	$ 38,465	$ 29,634	$ 110,898	$ 85,438	Insf. Data	Insf. Data
Truckee-Grass Valley	136.6	$ 100,081	$ 73,266	$ 42,241	$ 30,923	$ 116,032	$ 84,943	Insf. Data	Insf. Data
Ukiah	131.1	$ 108,884	$ 83,054	$ 46,893	$ 35,769	$ 83,672	$ 63,823	Insf. Data	Insf. Data
Vallejo	131.8	$ 119,646	$ 90,779	$ 42,321	$ 32,110	$ 150,509	$ 114,195	$ 69,125	$ 52,447
Visalia	118.2	$ 117,903	$ 99,749	$ 38,425	$ 32,508	$ 84,170	$ 71,210	$ 61,524	$ 52,050
Yuba City	126.2	$ 81,873	$ 64,876	$ 45,535	$ 36,081	$ 112,232	$ 88,932	Insf. Data	Insf. Data

Figure A5: Administrative Relief Issue Areas and Opportunities

Issue Area	Opportunities
A. According to local focus group data from individuals working in behavioral health positions funded by the County of San Diego, documentation burden is the primary driver of dissatisfaction and staff turnover. Respondents cited: • Effort and time required • Frequency of changes • Redundancy • Priorities reflected in enforcement • Inconsistency in enforcement by different auditors • Consequences of errors • Disconnection of documentation requirements from the reality of care	1. Advance CalAIM documentation reform. a. Work with County leadership to champion a culture change that accepts some risk in order to prioritize the triple aim of improving clinical care, promoting better outcomes, and reducing costs. Even when there is a lack of clarity or State guidance, embrace the opportunity presented by CalAIM and maximize all opportunities to reduce documentation. b. Limit disallowances to instances where there is fraud, waste, or abuse. c. Work with California Department of Healthcare Services (DHCS) to clearly define "fraud, waste, and abuse," advocating for a high threshold that focuses on patterns of fraud, waste, and abuse and ensures issues such as incorrect billing codes, missed timelines, or minor human errors do not result in recoupment. 2. Resolve competing sets of requirements (e.g., Drug Medi-Cal and Substance Abuse Prevention and Treatment Block Grant) and require consensus among regulatory agencies prior to enforcement. a. Where necessary, seek legislative reform to align requirements. b. Standardize forms at the state level to simplify chart review, reduce administrative burden, and ensure consistency. 3. Simplify clinical and administrative documentation. a. Identify areas where standardized language would be allowable (e.g., utilizing drop-down menus to select criteria) so that staff can focus on individualizing relevant components of documentation. b. Reduce the information required for progress notes, eliminating the need to repeat components when there has been no change. c. Eliminate requirements to document how every note and intervention ties to a treatment plan and medical necessity. d. Reduce the number of data fields that must be repeated across forms. e. Remove client signature requirements on problem lists and/or treatment plans. f. Eliminate documentation redundancy such as completing Discharge Summary and Discharge Progress Note. g. Reduce admission paperwork and leverage the ability to bill prior to establishing a diagnosis to create a low barrier intake process that better reflects the realities of care, which prioritizes access, and that improves the client experience. h. Add flexibility to deadlines where justified. i. Eliminate change of provider letters. j. Reduce documentation associated with credit cards and mileage.
B. In addition to state requirements, county programs can add additional requirements for behavioral health professionals.	4. Retain a professional consultant to evaluate San Diego County's documentation and monitoring practices. a. Align County requirements with minimum State standards b. Conduct a comparative analysis of documentation requirements in other counties and other specialty mental health plans, other payors, and other settings (including FQHCs). c. Identify and seek to replicate reform efforts that have been successful in other states. d. Advocate for parity across settings and regulatory entities, aligning to minimum requirements accepted for physical health providers such as FQHCs and Managed Care Plans.
C. The County has two separate electronic health records (EHRs) for specialty mental health and substance use disorder services. Providers are required to submit clinical and billing information	5. Explore the current EHR structure with contracted providers. a. If the County continues to build its own electronic health record(s), identify resources to increase the internal capacity of BHS for data management and systems architecture.

Issue Area	Opportunities
into each respective system; however, the two systems are not able to share data. This leads to challenges with care coordination, duplicative disclosures for clients who are served in both systems, and duplicative data entry for clinicians working across both systems. Moreover, because these EHRs lack interoperability, programs with their own EHR must enter the exact same data twice.	6. Reduce redundant data entry by prioritizing interoperability with other systems and only utilize the County's systems where necessary.
D. Clinical staff who entered the field to provide direct care are increasingly required to do administrative functions that take away time from direct care/services. • The County's Organizational Provider Operations Handbook states that "the ratio of actual total Indirect Cost to actual total Gross Cost shall not exceed the ratio of budgeted Indirect Cost to budgeted Gross Cost." This policy exacerbates the negative impacts of staffing shortages, such that administrative staff cannot be hired to support programs when there are vacancies in direct service positions. As a result, even when there is money in the contract budget to hire administrative support, already-overwhelmed clinicians are forced to take on duties that could be performed by non-clinical staff. • In Drug Medi-CAL (DMC) programs, licensed and license-eligible clinicians (known as Licensed Practitioners of the Healing Arts) are required to review and sign off on documentation done by SUD counselors. This review usually does not involve the client and is not considered clinical care, nor does it contribute to integrated service delivery. Instead, this administrative function makes these positions less attractive to license-eligible individuals who need 3,000 hours of clinical experience. In the short-term, this creates shortages of individuals to fill these positions. In the long-term, this negatively impacts the pipeline of individuals who will gain the hours needed to achieve licensure.	7. Retain a consultant to conduct a formal analysis of what documentation and monitoring contributes to improved clinical outcomes and advocate to the State and CMS to align requirements to support the triple aim. 8. Re-evaluate current ratios that limit contractors' admin-to-clinical staff allowances. 9. Work with DHCS to limit documentation that must be reviewed and signed by LPHAs in SUD programs. Where LPHAs must still review and sign documentation, extend the timelines for acquiring such signature(s).
E. Focus groups conducted by SDWP show that frontline workers feel demoralized and overwhelmed by the level of scrutiny, describing audits as "merciless," "self-defeating," "unfair," "brutal," and "catastrophic," citing examples such as using the verbiage "client will provide physical exam results" rather than "client will obtain physical exam" on a DMC treatment plan and having *all* subsequent services associated with that treatment plan disallowed. While the prospect of recoupment does inform monitoring priorities, it is important to note that frontline staff report clinically insignificant documentation contributes to feelings of reduced dignity and respect in the workplace.	10. In addition to the documentation reforms mentioned above, simplify chart review processes. 11. Defer to contractors to internally monitor compliance issues. a. Eliminate "double jeopardy" wherein providers are required to self-audit and self-disallow, only to be re-audited by the County and have their self-disallowances count towards disallowance rates. 12. Implement a simple process that allows for corrections to minor compliance issues at the program level, ensuring that monitoring prioritizes clinical care and that corrective action plans do not place a significant burden on staff. 13. Establish a Tier System for medical record reviews and compliance monitoring based on contract performance (i.e., reduce the frequency of reviews for programs that demonstrate strong compliance and/or internal capacity for monitoring). Form an ad hoc workgroup to determine details regarding timelines, items monitored, sample sizes, continuous improvement plans and ongoing monitoring requirements.

Issue Area	Opportunities
F. County-contracted providers are required to submit duplicative, time-consuming information, frequently requiring the same information to be sent multiple times, to multiple people, in multiple formats. • *Example*: A Contractor that offers services at five school sites under a single contract may be asked to complete the exact same Site Visit Tool for all five locations as part of the annual contract monitoring process. This can require sending the same contract monitor identical information such as policies and procedures five times. Any requests for clarification or revisions must then be done and resubmitted five times. • *Example*: The same or similar staffing information may be required to be reported and regularly updated/corrected on: o Annual budgets and subsequent AARs o Monthly invoices / labor distributions o Monthly Staffing Status Reports (SSR) o Credentialing o System of care (SOC) application o SanWITS/CCBH registration o DHCS audits o Medi-Cal provider enrollment (PAVE) o Site visit reports G. In addition to duplicating work, such processes reveal the significant discrepancies in County review practices and inconsistent expectations across the system. *Example*: The County recently implemented a legal entity-level review tool for Article 14 compliance; however, it is reviewed each year by multiple BHS divisions (i.e., CYF and AOA) such that the exact same policy may be deemed compliant by one contract monitoring team and non-compliant by another.	14. Implement provider audits at the legal entity-level where possible and identify a streamline review process across County departments/divisions. 15. Identify opportunities for reporting efficiencies and/or technology solutions to share data across reports. a. Consider creating a portal for contractors to submit and upload required documents to a single place, in a single format. This could also include applicable policies and procedures, cost allocation plans, attestations, etc. b. Utilize data from the SOC application to auto-populate other reports that require staffing information. 16. Allow exceptions to requirements for obtaining a minimum of three bids for certain purchases when it may unnecessarily result in having to seek duplicative bids or where it may defeat organizational efficiencies. 17. Use existing structures and agencies for oversight and monitoring where possible (i.e., defer to licensing boards to monitor annual CEU requirements) and encourage the State to do so as well. 18. Consider the benefits of a statewide credentialing process and advocate accordingly.
H. The State has three distinct contracts with the County for behavioral health services, each of which entails extensive monitoring that can result in corrective actions for inconsequential findings. Many such findings are subject to interpretation of the reviewing entity and may vary from year-to-year or from auditor to auditor. Importantly, most audits do not focus on direct services and client records; rather, they are audits of County BHS as the pass-through entity. In turn, findings must be passed down to Contractors and monitored, even if they have no bearing on clinical care.	19. Advocate for simplified, reduced oversight of the County at Federal and State levels which will, in turn, be passed on to contractors and direct service staff. a. Limit pass-through auditing to focus on those items expressly required by CMS and Mega Regs. b. Similar to Specialty Mental Health Services, request a clear list of reasons for recoupment for services billed to Drug Medi-Cal. c. Eliminate scrutiny over word choice and phrasing to ensure documentation can reflect and elevate the client voice. d. Only disallow billing directly attributable to fraud, waste, and abuse, ensuring that subsequent services appropriately rendered and documented are reimbursable. e. Reduce the frequency of changes and consider limiting such changes to a predictable schedule (i.e., at the beginning of the fiscal year) and eliminate retroactive compliance with changes. 20. Advance CalAIM efforts towards administrative behavioral health integration. 21. Advocate for consistent understanding and application of regulations at the State level. 22. Establish a structure that allows the County and contractor representatives to directly and collaboratively problem solve with the State.

Issue Area	Opportunities
I. County BHS and, by extension, BHS contracts are funded by multiple, complex funding sources such as Medi-Cal, SABG, MHSA, Realignment, etc., and each may have its own set of restrictive and sometimes even conflicting requirements. *Example*: Even as Medi-Cal payment reform looks to implement simplified CPT codes, other primary sources of BHS funding like SABG and MHSA continue to require competing cost reimbursement requirements.	23. Evaluate and consider opportunities to simplify and/or "unbraid" funding and/or seek legislative reform to align requirements across funding streams and regulatory entities. 24. Participate in statewide efforts to integrate MH and SUD administrative functions.
J. BHS contractors are required to submit time-consuming administrative authorization requests (AARs) for nearly every change to their budgets. Despite ongoing efforts to create thresholds for "materiality," contractors still must submit and resubmit AARs (which often requires resubmitting revised budgets and invoice templates) numerous times throughout the fiscal year.	25. In place of the current AAR process, implement a quarterly or semi-annual process to submit budget changes, with a final true-up at the end of the fiscal year.
K. The administrative burdens placed on clinical and accounting staff when administering Flex Funds reduces client access.	26. While some level of tracking is important to reduce fraud and waste, revise requirements and approvals depending on amount of spending.
L. Most BHS contracts are awarded for one (1) year with four (4) one-year option terms. In addition, this usually includes the option to extend the term in one or more increments for a total of no less than one (1) and no more than six (6) calendar months with at least fifteen (15) calendar days' notice. Especially in the wake of COVID, numerous BHS contracts have been renewed beyond their intended terms – often multiple times, in small increments, with little notice, and at the same funding level, contributing to: • High levels of staff anxiety about job security and difficulty retaining valuable staff • Vacant positions that cannot be filled due to uncertainty about future employment • Budget stagnation that does not allow for competitive compensation • Unrealistic timelines for staffing programs and other start-up activities that contribute to lapses in care when a contract transitions to a new provider • Contracting practices that do not account for operational realities such as lease terms	27. Require a minimum of 60 days' notice to exercise extension options. 28. Require contract extensions to occur in a minimum of one-year increments. 29. As a standard procurement practice, include a transition period of at least 30 days when there is a change in provider for a direct service contract to prevent any lapse in services and workforce transition.

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