Washington State Behavioral Health Workforce

Policy Recommendations – Straw Proposals

Topic I: Reimbursement & Incentives for Supervision of Interns & Trainees

Proposal 1.1: **With Health Care Authority (HCA) expertise, develop a plan for creation and implementation of a funding mechanism that recognizes and supports community behavioral health agencies for performing a significant training function that is required for behavioral health workers to obtain clinical licensure.**

- **Policy Action**: Create a teaching clinic enhancement rate for clinical supervision provided in community behavioral health agencies/facilities, consistent with specified standards. Planning, development, methodology, and implementation processes should include relevant stakeholders, including HCA, to provide additional context and guidance of actuarial decisions which impact rate determinants.
- **Rationale**: Community behavioral health agencies are important sources of supervised training for students completing credential degree requirements, and for post-graduate professionals seeking clinical licensure. Supervision of these trainees is expensive and cost burden is placed upon the community behavioral health agencies providing this training. A teaching clinic enhancement rate, similar to the rate provided to the forthcoming behavioral health teaching hospital, would allow supervising agencies to improve capacity, while avoiding the administrative burdens of a more complex time-tracking system. A teaching clinic enhancement rate for qualifying agencies would also allow the state and community behavioral health agencies to avoid expenses associated with more complex funding structures.

Proposal 1.2: Create a bonus payment for clinical supervision of students, based on patient encounters lost.

- **Policy Action**: Compensate clinical training sites providing supervision/precepting of behavioral health students for decreased number of patient encounters that result from supervision/precepting activities. Compensation should occur at a rate equivalent to direct service reimbursement.
- **Rationale**: Educational institutions face challenges in finding sites to host students for clinical internships, in part due to the burden supervision of students/interns places on the host site, which is not eligible for billable reimbursement. A bonus payment or vehicle to bill for student supervision would incentivize potential or existing sites to provide supervision and, if structured correctly, could allow for tracking of payments used for supervision, through tracking of submitted claims. Unlike Proposal 1.1, this proposal is limited to students because tracking of student supervision is already required of clinical training sites by education programs, and building on this existing structure would not create a new administrative burden for supervisors and supervising agencies.
    - *Note: This uses a FFS model, which has benefits and drawbacks.*

Proposal 1.3: Building on the established Washington Health Corps model, ensure that loan forgiveness programs incentivize direct (clinical) behavioral health service provision.

- **Policy Action**: Strengthen and fund loan forgiveness programs that focus on direct (clinical) behavioral health service provision. This would include tying loan forgiveness to the *nature of services* a worker is providing and seeks to increase financial support for direct service roles.

  - *Important Questions*: Should there be a service obligation? Could this be for pre-licensure, post-licensure, or both? Which positions would qualify?
- **Rationale**: At present, direct service (clinical) behavioral health positions in community-based settings tend to receive lower annual salaries than for the same the behavioral health occupations when serving in administrative roles at state agencies/MCOs, which discourages seasoned behavioral health professionals from remaining community-based clinical positions. Support for concentrated loan forgiveness programs for behavioral health workers in direct service could help alleviate this barrier to long-term retention in the community practice setting. Careful consideration should be made regarding the unique circumstances of rural behavioral health settings, where direct care providers are more likely to have additional administrative duties compared with counterparts in more densely populated areas.

Proposal 1.4: Expand geographical reach of and scale up programs that promote behavioral health supervision.

- **Policy Action**: Support, pilot, evaluate, and scale quality supervision programs, like the Greater Columbia Accountable Community of Health (GCACH) Internship & Training Fund, in cooperation with direct service organizations.
- **Rationale**: The GCACH Internship & Training Fund co-creates and funds programs that support quality supervision and good training experiences for behavioral health professionals, in partnership with regional behavioral health organizations. The funding supports supervision of baccalaureate, masters-level, and post-doctoral behavioral health trainees. Co-creation of similar programs with direct service organizations ensures that funding is directed towards needs and potential solutions identified by the beneficiary organizations, which often have a detailed understanding of specific community needs and efficient solutions to address those needs.

Topic II: Supervision Requirements

Proposal 2.1: Remove barriers to effective tele-precepting for supervision in clinical education and pre-licensure settings.

- **Policy Action**: Support the use of tele-precepting for clinical supervision, including but not limited to:
  a. Amending relevant laws and policies to allow tele-supervision hours to apply towards a greater percentage of the overall supervision hours required for clinical education requirements, and for licensure requirements.
  b. Address barriers in student access to electronic health records (EHRs) in tele-precepting, such as supports for secure remote access to the EHR for students/trainees, with appropriate data privacy protections and oversight in place.
- **Rationale**: As with provision of behavioral health services via phone- and video-based telehealth, provision of clinical supervision via telephonic or video interaction has become necessary, widespread, and is reported to be beneficial to clinicians and supervisors alike. Current laws limit the number of tele-supervision hours which can apply towards clinical education requirements and licensure requirements. Some students and trainees lack access to EHR patient information due to security and/or IT funding concerns, which is disrupting training and creating additional work for supervisors/preceptors of these students.

Proposal 2.2: Create a task force to assess the impact of, and potentially propose revisions to, current supervision requirements on the size, distribution, and availability of the behavioral health workforce in Washington.

- **Policy Action**: Form a specialized workgroup to investigate the extent to which and reasons why supervision requirements vary by behavioral health occupation, and the history and impact of the statutory authority. Taskforce could include experts in legal/judicial matters, behavioral health quality assurance, and behavioral health credentialing to examine options for how different types of supervisors (clinical, administrative, etc.) could work in concert to support more efficient and effective training for behavioral health trainees.
- **Rationale**: Changes to supervision requirements should involve behavioral health, legal, quality assurance, and credentialing experts to determine and develop consensus around recommendations for improving supervision requirements. A dedicated, member-assigned taskforce could ensure the necessary expertise is included. Considerations for the taskforce could include:
    - Why must different supervision requirements be completed for different behavioral health occupations to gain licensure?
    - Why are there significant limitations to which professional credentials are eligible to provide supervision for licensure hours? Both clinical and administrative skills are important for training pre-licensure clinicians, yet not all are equally valued.
    - There is a "career cul-de-sac" issue for some occupations which prevents experienced behavioral health workers from providing clinical supervision to trainees; e.g. mental health professionals (MHPs) may not be eligible to ascend the credential ladder and are not eligible for to provide clinical supervision for licensure, despite their significant experience in the field.
    - Some professions have stricter requirements than others (e.g. years in practice, occupation of supervisor) – what is the rationale/basis for this, and could these requirements be made more rational and consistent between professions that are providing similar services?
    - Consider standardization of terms related to supervision in behavioral health. For example, alignment of language, including language that translates beyond behavioral healthcare settings; "trainees" (post-graduate, pre-licensure) would be referred to as "residents" or "fellows" in other healthcare settings.

Proposal 2.5: Identify and provide support for ideas that make supervision easier.

- **Policy Action**: Structure funding supports to promote new models of supervision which allow for division of labor and multiple pathways to working as a supervisor. For example: some sites divide roles into (1) clinical supervision and (2) administrative supervision, which allows supervisors to specialize and master different content areas while distributing the burden of supervision.
- **Rationale**: Some stakeholders reported using bifurcated supervision roles (clinical and administrative) to help improve both quality and ease of supervision, and other stakeholders expressed interest in implementing a similar model. This model may be available without additional legislation.

Note: Proposals 2.3 and 2.4 were paused by the stakeholder group and not advanced into the drafting process, and have subsequently been omitted from this document.

Topic III: Competency-Based Training

Proposal 3.1: Support development of a registered apprenticeship model for behavioral health professions.

- **Policy Action**: Continue to work with SEIU 1199NW Training Fund, SEIU 1199NW, and Behavioral Health Institute (BHI) to develop and implement behavioral health registered apprenticeship models, with legislative support.
- **Rationale**: Registered apprenticeships promote an "earn-while-you-learn" model, which reduces direct costs and student loan debt risk to workers, and may reduce cost barriers to education required for a career in behavioral health. These features promote increased access to behavioral health professional training for marginalized and under-represented groups, help improve diversity of the behavioral health workforce, and potentially increase availability of patient-provider background-concordant care.

Proposal 3.2: Develop a workgroup to investigate competency-based behavioral health training in Washington.

- **Policy Action**: Form a workgroup to investigate whether or not competency-based training could be used to replace the existing hours-based education/licensure requirements among behavioral health specific occupations, if this would be a more efficient use of resources, and what the alternative requirements would be. The workgroup should engage, or have expertise in, professional bodies and governance, as these organizations set competency requirements.
- **Rationale**: Rather than relying on a set number of hours to graduate or qualify for licensure, should supervision measure actual competency and clinical skills? Equity between different credentials might also be useful, including a focus on clarifying discrepancies between hourly requirements across behavioral health professions and understanding why such variation exists.
    - *Note*: A competency-based training model may have the potential to create a barrier to licensing reciprocity between states, if states cannot agree on the role and value of competency-based training in behavioral health.

Proposal 3.3: Promote increase in acquisition of ongoing credentialed skill sets in behavioral health.

- **Policy Action**: Develop credential add-ons for behavioral health workers.
- **Rationale**: Behavioral health workforce members would benefit from additional clinical training, and the professional recognition that stems from achieving an additional credential.
    - *Note*: the degree to which workforce members are directly indebted for this additional training would require ongoing scrutiny, given the already high debt-to-earnings ratio among many behavioral health occupations, and the possibility that credential add-ons could become de-facto job requirements and responsibilities without enhanced pay. Stakeholders expressed concern that, without employer/payer buy-in and enhanced payment for services rendered by those with credential add-ons, this idea would likely not improve access to behavioral health services, and may distract from other important objectives.

Note: This section is currently light on recommendations – are the other ideas we can recommend? Is there some occupation that would naturally allow for competency-based training in the short-term? If so, should a pilot be recommended?

Topic IV: Licensing Reciprocity & Interstate Agreements

Proposal 4.1: Continue to support Department of Health's work implementing licensing reciprocity.

- **Policy Action**: Support expanding lists of substantial equivalency based on *both* licensing requirements (e.g. hours of supervision, years of practice, etc. required for license) and scope of practice (e.g. what can the licensee legally do in practice). Encourage development of a "missing requirements" crosswalk, which would allow behavioral health practitioners interested in relocating to Washington (and their prospective employers) identify missing educational and hourly practice requirements.
- **Rationale**: SB 5054 required DOH to expand lists of substantial equivalency based on a scope of practice comparison for psychologists, social workers, marriage & family therapists, mental health counselors, and substance use disorder professionals. DOH conducted this work following the passage of SB 5054 and has indicated interest in expanding the lists to eventually include all 50 states.

Proposal 4.2: Engage educational institutions to fill gaps in professional development, both for existing and prospective Washington-licensed behavioral health professionals.

- **Policy Actions**:
    - Identify, disseminate, and create (as necessary) opportunities and pathways for out-of-state behavioral health professionals to become licensed by relevant Washington agencies.
    - Create online evidence-based practices (EBPs) training for community behavioral health staff, conducted by Washington experts in EBPs.
- **Rationale**: Stakeholders expressed a need for professional development and reduction of barriers to licensure for out-of-state behavioral health professionals. Established behavioral health professionals seeking to transfer existing licensure into Washington could be moved through the licensing process more quickly. Stakeholders also desire online EBP training for their staff from experts in Washington.

Proposal 4.3: Reduce paperwork requirements for established professionals.

- **Policy Action**: Consider easing academic transcript requirements and/or clinical supervision documentation for providers who meet certain criteria indicating they have been previous licensed by a determinant number of years in good standing.
- **Rationale**: Individuals who have a strong record of providing high quality behavioral healthcare, and wish to work in Washington, should be encouraged to provide these services to Washingtonians. Stakeholders reported difficulty transferring licensure or hiring employees who require licensure reciprocity due to challenges in documenting initial supervision hours/academic requirements. Specific barriers reported include: difficulty finding and making document requests to previous clinical supervisor(s) and engaging educational institutions from past decades.

Proposal 4.4: Encourage messaging that licensing portability is the goal and that interstate agreements are one possible mechanism to support licensing portability, with upsides and downsides.

- **Policy Action**: Encourage development of a workgroup, led by DOH, to consider and evaluate ways to support ongoing Congressional efforts aimed at improving interstate license portability, without reducing state autonomy.
- **Rationale**: Interstate agreements have upsides and downsides, which must be carefully evaluated. Agreements like PSYPACT have relevance during a pandemic, but local control and

accountability may be attenuated under an interstate agreement framework. If increased access to care is the goal, a clear pathway from licensing portability to increased access needs to be established. Available research from nursing suggests that states joining interstate compacts may not experience a significant inflow of nurses following compact implementation.

Proposal 4.5: Develop a crosswalk of licensing portability/reciprocity requirements.

- **Policy Action**: With funds allocated, DOH should develop a crosswalk of reciprocal licensing requirements for licensed behavioral health workers moving to Washington, including education, supervised hours, and specialized training.
- **Rationale**: Workers, who are entering jobs and relocating to Washington with existing clinical licensure, need clarity on what they are permitted to do with which degrees/credentials. For example: MFTs moving from California to Washington need additional coursework to meet Washington requirements, and a crosswalk would help clarify which missing licensing requirements (course completions, supervision hours, etc.) are required for them to achieve licensure and practice in Washington.

Proposal 4.6: Engage with and consider tribal perspectives regarding reciprocity.

- **Policy Action**: Engage with tribal leaders and experts regarding how these nations address the challenges of licensing and recognition of behavioral health licensing across jurisdictional boundaries, with an eye towards learning approaches to licensing portability that could be tailored to non-tribal jurisdiction.
    - *Note: What would concrete policy action look like here? Who should be included, what format should conversations take, etc.?*
- **Rationale**: Tribal nations have laws, regulations, and policies specific to their jurisdictions. As a community, tribes are acutely affected by behavioral health concerns, at disproportionately high rates compared to non-tribal counterparts, and have specific experience working to improve access to behavioral health services, due to its longstanding concern within these communities.

Topic V: Background Checks

Proposal 5.1: Conduct an evidence-based review of the Department of Social and Health Services (DSHS) Secretary's Disqualifying List of Crimes & Negative Actions.

- **Policy Action**: Use an evidence-based risk assessment framework to review and potentially amend the DSHS Secretary's Disqualifying List of Crimes & Negative Actions, with an eye towards: optimizing reduction of risk to patients; reducing opportunities for direct or disparate impact discrimination against legally protected groups; and improving opportunities for lawful work and income among those with a criminal record.
    - The assessment should consider whether the Secretary's Disqualifying List is protecting patients or unnecessarily limiting the pool of qualified workforce applicants, particularly among peer counselors with lived experience.
    - The assessment should examine possible negative implications and barriers to employment caused by the Secretary's Disqualifying List, and should consider if DSHS should transition to an individual review system, similar to that used by DOH, and what barriers such a transition would produce.
    - The assessment should consider and address of the role of stigma of a criminal record, in addition to risk assessment.

- **Rationale**: Stakeholders repeatedly wished to know more about the DSHS Secretary's Disqualifying List of Crimes & Negative Actions. While DOH, which licenses most behavioral health professions, conducts an individual review process (without a disqualifying list), workers whose criminal and/or substance use disorder background did not preclude them from licensure may be prohibited from gaining employment at a DSHS-licensed facility, due to the Secretary's Disqualifying List.
    - *Note*: approximately 1 in 3 adults in the U.S. have a criminal record, indicating that hiring individuals with a criminal record is, in some cases, a business necessity, particularly in sectors with high turnover and low pay. About 95% of offenses leading to a criminal record are for non-violent crimes, and some criminal records remain visible for many years. The risks to patients associated with hiring individuals who have a criminal record may be overstated.

Proposal 5.2: Anticipate possible increase in behavioral health workers in emergency services/first responder roles.

- **Policy Action**: Identify ways to expand behavioral health workforce in Washington to address potential increase in need for workers as behavioral health workers are brought in to fill reconfigured emergency services/first responder departments.
- **Rationale**: With possible increases to the role of behavioral health workers in emergency services and first responder positions, the existing workforce shortage of behavioral health workers in Washington will be further exacerbated.

Proposal 5.3: Evaluate Certificate of Restoration of Opportunity (CROP) and consider updates to the program or ways to expand community awareness of its benefits.

- **Policy Action**: Convene a workgroup to evaluate CROP, including identification of how it is currently used in Washington, who has benefited from the program, and what changes are necessary to expand access and participation statewide.
- **Rationale**: Since its implementation in 2017, applications to CROP have been extremely low when compared with individuals who may be eligible for the program. Carve-outs introduced into the law prior to passage may have reduced the effectiveness of CROP's intended purpose. For example, CROP legislation as passed allows discretion to disregard an applicant's CROP when making some decisions, such as licensing or employment decisions. A workgroup could consider what changes to CROP are feasible and could help make this program more widely available, accessible, and acceptable for legislative action.

Proposal 5.4: Expand community awareness and engagement with CROP and its potential benefits.

- **Policy Action**: In partnership with the relevant entities, develop an educational pilot program for incarcerated individuals approaching release, which provides information and resources for participating in the CROP process and potential career opportunities in behavioral health, such as peer counseling. Pilot could focus on participants with non-violent, SUD-related offenses, who are interested in entering the behavioral health workforce.
- **Rationale**: As stated above, CROP applications since its 2017 introduction have been significantly low in comparison to the population of potentially eligible participants. Stakeholders and experts on CROP have speculated that this may be due to a lack of education and awareness among potentially eligible participants. Direct engagement with soon-to-be released incarcerated individuals could provide an opportunity to expand awareness as individuals prepare to transition to life post-incarceration, and could also provide a unique

opportunity to engage potential behavioral health workers with valuable lived experience in both justice system involvement and substance use disorder.

Proposal 5.5: Convene leadership of state agencies with jurisdiction to reduce barriers to behavioral health employment related to criminal background checks.

- **Policy Action**: Create a taskforce comprised of representatives from the office of the Attorney General, DOH, DSHS, office of the Governor, and others to examine impacts and changes proposed to the use of criminal background checks in employment in behavioral health settings, with the goal of reducing barriers to developing and retaining a robust behavioral health workforce.
- **Rationale**: Existing background check requirements are preventing workforce development in behavioral health. Taking into account new scientific evidence on relevant risk, a taskforce with the necessary jurisdictional oversight could examine legal requirements of and risks posed by existing background check policies and propose changes to the RCW and WAC.