

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.

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.

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?

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.

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.

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.

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.

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.

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.

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.

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.

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.

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 previously licensed by a determinant number of years in good standing.

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.

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.

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.?*

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.

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.

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.

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.

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.