

## 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.