

Washington's Behavioral Health Workforce Assessment: Project Phase I

Project Team

Nova Gattman, Workforce Board

Rebecca Reule, Workforce Board

Agnes Balassa - Agnes Balassa Solutions, LLC

Susan M. Skillman, University of Washington Center for Health Workforce Studies

Rachelle L. McCarty - University of Washington Center for Health Workforce Studies

Malaika Schwartz - University of Washington Center for Health Workforce Studies



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Executive Summary

Throughout Washington, the demand for behavioral healthcare is outstripping the availability of services. The challenge of meeting the demand is likely to not only persist, but to become more acute due to difficulties recruiting, educating, training, and retaining a skilled behavioral healthcare workforce, negatively affecting the state's ability to deliver on its goal of integrating behavioral healthcare and primary care in 2020.

In 2016, Washington's Governor and Legislature chartered a number of efforts to improve access to and the effectiveness of behavioral health care in the state, including this assessment of Washington's Behavioral Health Workforce. This report represents the completion of Phase I of a 22-month project, and focuses on initial findings regarding barriers and short-term solutions related to ensuring a comprehensive and effective behavioral health workforce. 171 stakeholders and 41 key informants participated in the development of this report via a combination of interviews, four large group meetings, or written input.

Phase II will focus on longer-term solutions to the barriers identified in Phase I, and will culminate in a final report and recommendations to policymakers by December 15, 2017 for the 2018 Legislative Session and beyond.

Key Findings

The challenges to ensuring adequate access to behavioral healthcare are complex; while workforce shortages exist in a variety of occupations at all levels of delivery, simply increasing the pipeline will not resolve all of the challenges. A number of underlying systemic, structural, and perceptual challenges affect the ability to recruit, educate, train, certify, and retain a sufficiently large and adequately skilled workforce to provide access to behavioral health services for those who need these most. These challenges fall into four categories (for more details on these barriers, see page 8).

- Recruitment and retention, including the need to increase workforce diversity, in an environment at times characterized by heavy caseloads, patients with high acuity of behavioral health and other healthcare needs, time-consuming documentation requirements, relatively low pay, and cultural stigma.
- Insufficient skills and training, especially "real world" training opportunities, to meet the changing behavioral healthcare environment, and increase integration of behavioral health and physical healthcare. This includes the need to work effectively in inter-professional teams using new models of practice and evidence-based skills, to make effective use of current health information technology systems, and to efficiently meet documentation requirements.
- Credentialing, licensing and related policy issues that influence the number, distribution, and scope of practice of the occupations that comprise the behavioral health workforce.
- Paperwork and documentation burdens that take considerable workforce commitment and reduce time spent with patients, contributing to lower morale, and driving behavioral health clinicians out of the field.

Recommendations

Recommendations were developed by and vetted with stakeholders to identify those mostly like to have an impact on the issues identified above. Stakeholders also began work on developing potential recommendations that will be considered further in Phase II of the project in 2017.

The recommendations for Phase I of the report are:

1. Adjust reimbursement rates to better support competitive recruitment and retention of a skilled behavioral health workforce.
2. Promote team-based and integrated (behavioral and physical health) care.
 - 2-a. Support the use of/expansion of the Healthier Washington Practice Transformation Hub efforts to promote adoption and training of team-based integrated behavioral health and primary care.
 - 2-b. Consider expanding the list of professions eligible to bill as mental health providers.
 - 2-c. Train and deploy entry-level providers in both primary care and behavioral health to support health team efforts in community health settings.
 - Items for further study to promote team-based and integrated (behavioral and physical health) care that will require further research or additional stakeholder input during Phase II.
3. Increase access to clinical training for students entering behavioral health occupations.
 - 3-a. Recognize and compensate the function that community-based settings play in training new behavioral health professionals and paraprofessionals in their first year of practice.
 - 3-b. Increase the ability of behavioral health clinical training sites to accept students/trainees by incentivizing and supporting clinical training sites.
 - 3-c. Encourage payers (Managed Care Organizations (MCOs)/health plans and (BHOs)) to contract with licensed community behavioral health agencies, as well as individual licensed clinicians.
 - 3-d. Increase funding to expand behavioral health education programs and graduate more professionals.
4. Expand the workforce available to deliver medically-assisted behavioral health treatments.
 - 4-a. Increase primary care providers' (physicians, ARNPs, PAs, pharmacists) confidence to use their full prescriptive authority for psychiatric medications.
 - 4-b. Expand telehealth reimbursement to include any site of origination.
5. Increase diversity in the behavioral health workforce.
 - 5-a. Improve behavioral health literacy as a foundation for healthcare careers.
 - 5-b. Increase the use of peers and other community-based workers in behavioral health settings.
 - 5-c. Expand access to the I-BEST core curriculum, and encourage additional programs that include behavioral health occupations.
 - 5-d. Reduce care worker turnover, improve diversity by creating career pathways and opportunities for certification of behavioral health and other paraprofessional roles.
 - 5-e. Support continued funding for the state's health professionals loan repayment program, and consider strategies to expand the program and its applicability to behavioral health occupations.
 - 5-f. Expand the state Work Study program.

Methods and Process

In July 2016, Governor Inslee tasked the Workforce Training and Education Coordinating Board (Workforce Board) to assess workforce needs across behavioral health disciplines and charged the Workforce Board with creating an action plan to address these needs. The Workforce Board assembled a project team that included the University of Washington Center for Health Workforce Studies and Agnes Balassa Solutions to collect and analyze quantitative and qualitative data to identify occupational shortages, assess the range of workforce-related barriers to improving access to behavioral health in Washington, and identify recommendations for solutions. The behavioral workforce assessment is one of a number of efforts initiated by the Governor and Legislature to improve access to and effectiveness of behavioral healthcare in the state. The Behavioral Health Workforce Assessment team has been in contact with and tracking the activities of the other workgroups in the state focusing on behavioral health to eliminate duplication of effort and align research and analysis where possible.

Previous work in Washington related to the behavioral health system was reviewed for recommendations relevant to this workforce assessment, including the 2015 Adult Behavioral Health System Task Force Final Report to the Governor and Legislature¹ and the Washington State Behavioral Health Workforce Recommendations from the Workforce Development Subgroup.²

Research for this phase of the project focused on stakeholder input as the primary vehicle for developing recommendations to address workforce issues impacting access to behavioral health services. The Workforce Board provided staff for the project management of this initiative, policy analysis, and administrative support. Stakeholder meeting planning and facilitation was provided by Agnes Balassa Solutions. Research and key informant work that also informed the recommendations was provided by the University of Washington Center for Health Workforce Studies.

Stakeholder engagement meetings

171 stakeholders from a broad cross-section of healthcare stakeholders including providers, facilities, educational institutions, state and county agencies, tribes, labor organizations, and settings with expertise in behavioral healthcare participated in the development of recommendations in this report. Stakeholders were invited to participate in four meetings in 2016 between July and October – one in Olympia, two in Renton, and one in Cheney. Stakeholders participated in these meetings in person or by phone, and many more provided information and feedback via email. These meetings helped the project team identify occupations with shortages, workforce-related barriers to increasing access to behavioral health, recommendations to address the barriers, and potential key informants and promising practices. A list of these stakeholders is provided in Appendix A.

Key informant interviews

Between August 19th and October 6th, 2016, 41 interviews with “key informants” were completed by phone (34) or using an online instrument (7) by researchers at the University of Washington Center for Health Workforce Studies. The 78 candidate key informants who were invited to participate in the

¹ Washington State Legislature. Adult Behavioral Health System Task Force Final Report to the Governor and Legislature, December, 2015. Available from: <http://leg.wa.gov/JointCommittees/Archive/ABHS/Documents/ABHS%20TF%20Final%20Report.pdf>.

² Avalos J, Ratzliff A., Washington State Behavioral Health Workforce Recommendations. Workforce Development Subgroup to the Steering Committee for Second Substitute Senate Bill 5732 “An Act relating to improving behavioral health services provided to adults in Washington state.”

interviews were drawn from an initial list of nearly 300 potential key informants drawn from various sources assembled for this project. Candidates for interviews were selected to represent a broad cross-section of occupations, behavioral health settings, and geographic areas across the state. Appendix B includes a full list of participant organizations. A semi-structured interview guide addressed themes consistent with those used to guide stakeholder conversations. While much of the feedback from key informants is integrated into this report, the full results and report of the key informant interviews have been posted online. An executive summary of the key informant report can be found in Appendix C.

- **Key Informant Report:** <http://depts.washington.edu/fammed/chws/wp-content/uploads/sites/5/2016/11/WA-BH-Key-Informants-FR-2016-Nov.pdf>.

Washington's Health Workforce Sentinel Network

A parallel activity funded by Healthier Washington (through the Health Care Authority) and conducted by the Workforce Board and the University of Washington Center for Health Workforce Studies is tracking changes in health workforce demand across the state through the *Washington Health Workforce Sentinel Network* (<http://www.wtb.wa.gov/healthsentinel/>).

This survey of healthcare employers was launched in July of 2016, and will be collecting data on changes in the workforce occupations, and skills and roles needed by healthcare employers as healthcare transformation takes place in the state. Initial results from the survey included a high response from behavioral mental health clinics and other outpatient mental health and substance abuse clinics. These results, generally consistent with the stakeholder and key informant input, have been considered in developing the recommendations in this report.

Key findings from behavioral/mental health, outpatient mental health and substance abuse clinics include:

Which occupations did your facility recently experience exceptionally long vacancies for open positions?

- Mental health counselors, clinical social workers, and substance abuse/behavioral disorder counselors were cited most often.
- Reasons included not having enough qualified applicants; issues with salaries or benefits; and recruitment and retention issues not related to salaries or benefits (such as rural location).

For which occupations did your facility recently experience an increase in demand?

- Mental health counselors and substance abuse/behavioral disorder counselors were cited most often.
- Having more clients and greater community need were commonly-cited reasons for this demand increase.

What were recent training and skills development needs for new and incumbent workers?

- The top training needs reported by sentinels included building skills in evidence-based practices, use of medically-assisted treatments, suicide prevention, meeting regulatory and administrative requirements, and effective use of electronic health records and health information technology.

Limitations

The short amount of time available for Phase I of this project limited the options for obtaining and analyzing data on the behavioral health workforce. The most efficient approach for this phase was to conduct the assessment primarily using qualitative (verbal) input through stakeholder meetings and key informant interviews from those with the most experience and interest in the issue across the state.

Analysis of available quantitative data to better describe workforce supply and demand, such as from state professional licensing records and labor statistics, could also help inform the assessment. The tight timeline for Phase I, however, made it unfeasible to obtain and analyze quantitative data across the multiple occupations that comprise behavioral health workforce supply and the varied settings in which workforce demand data are drawn. In addition, typical state-level labor market data are limited, and do not provide information about the changing skills and roles of the healthcare workforce, such as those needed by the workforce delivering integrated behavioral and physical healthcare. That type of information is largely uncovered through interviews and conversations (such as through stakeholder meetings and key informant interviews) and through surveys specifically designed for that purpose (such as Washington’s Health Workforce Sentinel Network).

During Phase II of this assessment (January –December, 2017), the project team will examine, in more depth, the highest priority issues identified in Phase I, most likely using a combination of quantitative and qualitative methods.

Findings and Recommendations

Overview

The challenges to ensuring adequate access to behavioral healthcare are complex; while workforce shortages exist in a variety of occupations at all levels of delivery, simply increasing the pipeline will not resolve all of the challenges. A number of underlying systemic, structural, and perceptual challenges affect the ability to recruit, educate, train, certify, and retain a sufficiently large and adequately skilled and diverse workforce to provide access to behavioral health services for those who need these most.

Barriers

Barriers identified by stakeholders and key informants fall into four categories:

- Recruitment and retention: The behavioral health work environment, especially in settings serving low-income populations, is at times characterized by heavy caseloads, patients with high acuity of behavioral health and other healthcare needs, time-consuming documentation requirements, and relatively low pay. Cultural stigma related to behavioral health was identified by stakeholders and informants as an additional challenge to workforce supply for this field. As a result, recruiting and retaining a skilled and diverse workforce across the range of occupations required to deliver appropriate behavioral health services is difficult.
- Skills and training: The changing behavioral healthcare environment, including moving toward the goal of integration of behavioral health and physical healthcare, increases the need for the behavioral health and physical health workforce to work effectively in inter-professional teams, be up-to-date with new models of practice and evidence-based skills, have access to and demonstrate proficiency using current health information technology systems, and efficiently meet documentation requirements. The opportunities and resources to meet these training needs are not adequate to meet demand, both in initial education programs as well as for incumbent workers. Stakeholders and key informants identified concerns not only with the availability of “real world” training opportunities, but also with the ability of new and incumbent workers to keep up with the competencies needed to deliver evidence-based and integrated behavioral healthcare.
- Credentialing, licensing and related policy issues: Numerous policies and regulations influence the number, distribution, and scope of practice of the occupations that comprise the behavioral health workforce. These include what were described by stakeholders as overly burdensome requirements for credentialing some occupations, limited opportunities for dual credentialing or the addition of endorsements to those with credentials, and long timelines to receive some types of credentials.
- Paperwork and documentation burdens: The healthcare system, including behavioral health, must respond to requirements of multiple payers/insurers and oversight organizations. Responding to these reporting requirements takes considerable workforce commitment to keep up with the paperwork and to respond to documentation and audit requirements. These processes can be duplicative and inconsistent. In addition, compliance with these requirements requires considerable resources to train clinicians and staff to use the different systems for reimbursement and compliance. Stakeholders identified these administrative burdens as contributing to lower morale and driving behavioral health clinicians out of the field.

Recommendations

1. Adjust reimbursement rates to better support competitive recruitment and retention of a skilled behavioral health workforce

Workforce-related barrier: *A low behavioral health reimbursement rate has created a ripple effect that impacts recruitment and retention of the behavioral health workforce, and as a result, impacts services for clients.* Current reimbursement practices, particularly the reimbursement differential between Medicaid and other insurance programs, were consistently identified by stakeholders and informants as a root cause of challenges to recruiting, educating, training, and retaining a skilled behavioral healthcare workforce, especially in settings with large numbers of Medicaid-insured patients. Medicaid expansion, increased emphasis on primary and behavioral health integration, and growing awareness of behavioral health needs among the public and the medical profession increase the need for skilled behavioral health workers throughout the healthcare system. Because Medicaid is the primary funder of community mental health³ services, Medicaid capitation rates are a primary determinant of community-based Medicaid providers' ability to recruit and retain a qualified workforce. In 2015, due to concern that funds appropriated for mental health services were sitting in reserve accounts of the Regional Support Networks, the Legislature passed ESSB 6052, which reduced community mental health Medicaid capitation rates to the bottom of the actuarial rate bands at the 25th percentile of clinical salary levels. Although the impact may have been unintentional, stakeholders and key informants emphasized that as a result, community providers cannot compete effectively with hospital, health system, managed care organization (MCO), or government salaries. Additionally, low Medicaid reimbursement rates—both Behavioral Health Organizations (BHOs) and Apple Health—cause fewer providers to accept Medicaid patients, which in turn burdens the public behavioral health system that is already stretching to meet high demand from highly acute patients with co-occurring disorders and health challenges. Low reimbursement rates translate directly into reduced capacity for outpatient treatment, which overloads the crisis, inpatient, and criminal justice components of the healthcare system.

To illustrate the impact on recruitment and retention, the Department of Social and Health Services noted in feedback to an earlier draft of this report that it faced challenges in finding adequate forensic evaluators because the reimbursement rate is 1/3 of what could be charged in the private sector. An October 24, 2016 job posting for a Case Manager in a community setting further illustrates the challenge. The position is expected to work with persons who have experienced “chronic or multiple episodes of severe mental illness, co-occurring substance use disorders and homelessness” and provide “intensive wrap-around services” including a shift every weekend and rotation in 24-hour crisis coverage. The position provides ongoing assessment of mental health symptoms, changes to treatment plans, individualized support therapy and psychotherapy, and support in community activities including housing, grocery shopping, and job coaching. The position, in Seattle, requires a Master’s Degree in the field and state licensure and pays \$32,546 - \$36,680, or \$15.64 - \$17.63/hour before taxes.⁴ The HUD “Very Low Income Level” for Seattle in Fiscal Year 2015 was \$31,400 for one person; for a family of three it was \$40,350.⁵ The high cost of education compared to wages in community settings makes it difficult

³ Note that while we are working toward an integrated behavioral health system, in this section we are specifically talking about the impact of reimbursement rates for mental health services. To that end, we have been specific in referring to mental health in this section, but it is not out of step with the overarching content of this report related to full behavioral health workforce issues.

⁴ The full job posting can be accessed at:

<http://chm.tbe.taleo.net/chm02/ats/careers/requisition.jsp?org=DESCSEA&cws=41&rid=1539>

⁵ <http://www.huduser.gov/portal/datasets/il/il2015/2015ILCalc.odn>

for behavioral health providers to repay student loan debt, contribute to retirement savings, or start families.

Because Medicaid rates reflect current system capacity (i.e., historical use), not service need or demand, or the desire to actively engage people in treatment further upstream, low rates perpetuate the problem. If rates remain low, capacity continues to fall, producing fewer encounters and even lower rates (and therefore capacity) in successive actuarial cycles. Timely community treatment becomes even less available, putting further pressure on crisis and inpatient providers.

ESSB 6052, Sec. 204(1)(q), which passed in 2015, decreases **both** Medicaid funds available to community mental health, and state-only non-Medicaid dollars. This adds to the challenge; one-third of the funding for crisis services must come from state dollars, because Medicaid doesn't pay for everything or for everyone. For example, Medicaid covers room and board for patients in hospitals, but doesn't cover these for the growing number of free-standing evaluation and treatment facilities, because inpatient beds in these facilities are classified as residential mental health services. While clinical services are covered by Medicaid, the wraparound services needed to get seriously mentally ill individuals into the clinic are not covered—a therapy session may be one hour, but it takes many hours to establish the rapport, locate the person as they move between unsheltered sleeping locations, or connect them to community services that will meet their basic needs between sessions.

Finally, any update to increase reimbursement rates needs to be sufficiently high enough to achieve the desired effect of increasing pay and capacity. For example, stakeholders reported that a recent rate increase for Substance Use and Dependency (SUD) programs helped absorb some of the administrative costs caused by additional documentation and data requirements associated with healthcare integration, but was insufficient to increase pay for workers.

The Legislature's Children's Mental Health Work Group reported similar findings: "Low rates paid to providers (or to BHOs who then pay providers) for serving children/families on Medicaid lead to poor access, low pay, provider turnover, and the potential for lower quality services. Because Medicaid is the main funder of community mental health services, Medicaid capitation rates are a primary determinant of community-based Medicaid providers' ability to recruit and retain a qualified workforce. This is even more apparent in rural areas. Qualified people choose to opt out of serving Medicaid clients, and many are taking private pay only. Medicaid rates are only about 2/3 of Medicare rates for the same units of service, highlighting care inequities between children and adults within our system." The Children's Mental Health Work Group recommended moving Medicaid rates from the bottom of the rate bands so providers can offer competitive clinical salaries to support recruitment and retention⁶.

Action required: In order to better support competitive recruitment and retention of a skilled behavioral health workforce, policymakers, Department of Social and Human Services, and the Health Care Authority would need to:

- Make the placement of Medicaid rates at the bottom of the rate bands as per ESSB 6052, Sec. 204(1)(q) a one-time response to excess Regional Support Networks reserves, rather than ongoing policy.
- Adjust Medicaid capitation rates from the bottom of the rate bands to a level sufficient to positively influence wages.

⁶ <http://leg.wa.gov/JointCommittees/CMH/Pages/default.aspx>

- Update clinical salary assumptions to reflect current competitive market salaries, in order to prevent additional negative impact on the behavioral health workforce.

Item for further study regarding adjusting reimbursement rates to better support competitive recruitment and retention of a skilled behavioral health workforce that will require additional research to be conducted in during Phase II of this project:

- *Examine the salaries/wages and other employment incentives of behavioral health providers in different employment settings to assess the range and variability of these incentives in order to assess possible impact on workforce recruitment and retention.* The University of Washington Center for Health Workforce Studies (UW CHWS) will conduct this behavioral health workforce wage and salary study in Phase II of this project by reviewing existing studies and conducting new analyses using relevant data available from state and national sources. This examination will be conducted as part of their current contract with the Workforce Training and Education Coordinating Board to assess Washington's behavioral health workforce. Where data to inform the topic are not available from existing sources, the UW CHWS will recommend strategies to obtain additional data and studies that would help determine where significant salary, wage and other employment benefits disparities exist that could deter workforce recruitment and retention, as well to describe potential solutions.

2. Promote team-based and integrated (behavioral and physical health) care

Workforce-related barrier: *Too little education and training in team-based and integrated (behavioral and physical health) care is available for the incumbent workforce and for students entering clinical occupations.* Providing more team-based integrated training could be one of the most effective solutions for putting healthcare integration on a faster track. While there are examples of a common skill set for team-based care, such as the Wraparound with Intensive Services (WiSe) and Program of Assertive Community Treatment (PACT) teams that can be used for trainings, there is not enough cross-training, common language/approaches, or understanding of how to communicate with and work in cross-disciplinary teams generally. A recent E3SHB 1713 Task Force report draft references the complexity of integrating primary and behavioral healthcare, not just funding, as well as the delivery of substance abuse disorder and mental health services so that they are not fragmented.

RECOMMENDATIONS:

2-a. Support the use of/expansion of the Healthier Washington Practice Transformation Hub efforts to promote adoption and training of team-based integrated behavioral health and primary care. Key informants expressed strong desire for training resources and practical information to support their agencies' success in moving toward integration. The Healthier Washington Practice Transformation Hub is currently working to support overall healthcare practice transformation to achieve the reform goals of better healthcare quality, greater patient satisfaction, more efficiency, and more satisfied practitioners in the state. The Department of Health has contracted to develop the Hub.

The Hub will provide coaching and regional health connectors to support moving both behavioral health and primary care practices along the continuum of integration. The project will target behavioral health and primary care practices of fewer than 20 providers for enrollment in intensive coaching services. Recruitment will begin in November of 2016, prioritizing the regions stepping up for early and mid-adopter status for Fully Integrated Managed Care (FIMC). The Hub will also stand up a Web-Based Resource Portal that will hold curated resources related to behavioral health integration as well as practice transformation resources related to readiness for value based payment, population health, and improving community-clinical linkages.

As created, there are not incentives for practices to participate in the coaching beyond their desire to improve patient care. Full financial integration will happen by 2020, and this will provide a foundation for clinical integration and changes in service delivery. The practice transformation needed for clinical integration is anticipated to continue several years past 2020. The Healthier Washington support for the Hub will end in December 2019.

Action Required: To implement this recommendation, the Washington Department of Health through the Practice Transformation Hub as part of “Healthier Washington” initiative would need to take the following actions:

- Examine payment incentives to make sure they are properly aligned to support workforce integration efforts. If the Hub identifies misalignments, there will need to be a state-level discussion about how to shift payments to incentivize integrated behavioral and primary care.
- Ensure practice coaches located in each region of the state.
- Support training of team-based integrated care in behavioral health as well as in primary care settings.
- Create a sustainability plan to support the practice integration support work needed after the conclusion of the Healthier Washington initiative and funding period.

2-b. Consider expanding the list of professions eligible to bill as mental health providers. One possible way to support team-based and integrated care is to expand the list of professions able to perform and bill for behavioral health functions. For example, stakeholders and key informants recommended adding Occupational Therapists (OTs), to the list of professions allowed to bill for behavioral health services, as is allowed in Oregon, Pennsylvania, Minnesota, Tennessee, Massachusetts, Maine, and Illinois. OTs are currently only able to bill for services when working with behavioral health clients if there is a *medical* reason for that service. Stakeholders noted that a number of recent actions at the federal level also recognize an expanded role for OTs in behavioral healthcare:

- The Substance Abuse Mental Health Services Administration (SAMHSA) included OTs in the staffing suggestions for new Certified Community Behavioral Health Centers (CCBHC) in Section 1.b.2 in the CCBHC criteria, along with other professionals currently eligible for training grants in Section 211 of S. 1945.⁷
- The Center for Medicare and Medicaid Services (CMS) included OTs as a core component of quality mental health by requiring that occupational therapy services be offered at any community mental health center that wishes to bill under Medicare partial hospitalization.⁸
- SAMHSA included OT in their list of suggested staff for programs receiving Primary Behavioral Health Care Integration grants; recognizing the important role of occupational therapy in bridging physical and behavioral healthcare services⁹.
- The Senate Health Education Labor and Pensions committee passed the “Mental Health Reform Act” (S 2680), which, if passed by Congress would add OT higher education programs to the list of professional programs eligible to receive training grants from Health Resources Services Administration (HRSA). The grants can be used to help provided training and field placements, recruit students with an interest in behavioral health, and provide interprofessional training and integration with primary care.

⁷ http://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-001_0.pdf

⁸ <http://www.gpo.gov/fdsys/pkg/FR-2013-10-29/pdf/2013-24056.pdf>

⁹ <http://www.samhsa.gov/sites/default/files/grants/pdf/sm-15-005.pdf>

In order for OT's or other healthcare professions to bill for the provision of mental health services in Washington, a change to the community mental health definition of a mental health professional found in the mental health RCW and WAC would need to be made. For example, Massachusetts defines a professional staff member authorized to render billable Mental Health Center Services as "a person trained in the discipline of psychiatry, clinical or counseling psychology, social work, psychiatric nursing (includes a psychiatric clinical nurse specialist), counseling, or occupational therapy as described in 130 CMR 429.424."¹⁰ If Washington was to consider expanding the definition of mental health professionals, including OTs, language specific to Washington would need to be developed. Research and stakeholder input would help to determine which professions should be added to yield the greatest expansion at the lowest risk to patient safety.

Stakeholder Concerns: The Washington State Society for Clinical Social Work objected to including OTs in the definition of mental health providers. The Society noted that OTs cannot bill as mental health providers under Medicare and are not "trained specifically to create differential diagnoses in mental health or the counseling and psychotherapy to alleviate these conditions." Some stakeholders suggested that additional research should be conducted to determine whether there is sufficient capacity within the OT workforce to add behavioral health work, as some parts of the state, especially rural areas, report difficulty recruiting OTs, and questioned whether OT mental health billing would significantly increase access for clients.

Action Required: In considering whether to expand the definition of mental health professionals to allow more occupations to provide and bill for behavioral health services, the following actions could be considered:

- Policymakers could request that the Department of Health conduct a Sunrise Review of the professions able to bill for mental health services.
- The Behavioral Health Workforce Assessment Phase II could assist with research as requested to determine whether additional efforts are needed to expand the supply of occupational therapists and other professions impacted by this recommendation that may be listed in short supply.

2-c. Train and deploy entry-level providers in both primary care and behavioral health to support health team efforts in community health settings. To support health team efforts, community health settings need new ways to train and make use of entry-level staff positions to triage, do brief interventions, screening, motivational interviewing, and support the care coordinator, allowing more time for providers in higher demand (e.g., psychiatrists, child psychologists, psychiatric advance practice registered nurses) to carry out work at the top of their scope of practice and training. This recommendation would allow facilities to triage primary and behavioral healthcare more efficiently. Models are currently in development in Washington State. The Washington Association of Community and Migrant Health Centers (WACMHC) is conducting a needs assessment within the Federally Qualified Health Centers (FQHCs) and rural and tribal clinics to develop a behavioral health apprenticeship program for integrated care implementation. The behavioral health apprenticeship program will train incoming and current support staff in the aforementioned skills, using didactic and clinical training at participating FQHCs and rural clinics. WACMHC is also working to partner with the University of Washington Advanced Integrated Mental Health Solutions (AIMS) Center to provide hybrid modular learning models for incumbent workers to build the skills necessary to effectively work in integrated team-based models of care.

¹⁰ <http://www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-mentalhealthctr.pdf>

Action Required: This is a low-cost recommendation. WACMHC will need assistance with outreach to the behavioral health community to recruit for, and support, staff in the use of the apprenticeship and incumbent worker trainings once they are complete, assist with curriculum review and sharing of expertise to ensure cross-coordination in model dissemination, as well as collaboration with the University of Washington AIMS Center to develop appropriate curriculum.

Items for further study to promote team-based and integrated (behavioral and physical health) care that will require further research or additional stakeholder input during Phase II.

- *Create a public relations campaign for health educators, healthcare professionals, and the general public describing integrated care and how it is delivered.* A public awareness campaign could increase awareness to improve recruitment to professions, reduce stigma for both patients and the profession, and provide public recognition for the important service that behavioral health practitioners provide. This campaign would also help to promote understanding that physical health is affected by behavioral health issues and vice versa.
- *Review the use and success of evidence-based practice (EBP) curriculum and team health skills in education and training programs.* The traditional behavioral health treatment model of hourly 1-on-1 therapy visits for 12 weeks is less applicable in a primary care setting. Education and training should emphasize needed clinical skills that can be performed to fidelity such as motivational interviewing, SBIRT (screening, brief intervention, and referral to treatment), Cognitive-Behavioral Therapy, the Collaborative Care Model, and other interventions. In addition, team-based clinicians in integrated settings need daily skills of writing and communicating effective clinical notes, working with other providers efficiently and flexibly, and protecting confidentiality while also maximizing system efficiency.
- *Provide the incumbent medical and behavioral health workforce with additional training in effective practices in integration.* Further research could review options to incentivize additional training on best practices in integration, such as with suicide assessment and management training. Encourage additional training to staff who participate in care coordination, screening, etc. to identify potential behavioral health issues earlier. Potential models are in development. For example, the University of Washington AIMS Center resource library is working to provide modules for teaching integrative care to a variety of practitioners in the Collaborative Care model and to turn 20 minutes of didactic training of each University of Washington Psychiatry and Addictions Case and Conference (PACC) telepsychiatry session into an open-access podcast. Washington Association of Community Migrant Health Center is working to develop stand-alone training for incumbent workers, and offer an array of modular online and in-person trainings on behavioral health and integration relevant topics.
- *Initiate a “call out” for best practices around team-based/inter-professional education.* A workgroup or additional research could identify and collect information on best practices in team-based/interprofessional education, reviewing “centers of excellence”, research, and other funded work by HRSA, SAMHSA and others. One suggestion would be to consult leaders in hospice, as they were an early adopter of multidisciplinary work. This information could be helpful in exploring how to improve existing programs in Washington, or developing new programs, such as creating pilot projects to refine programs, or developing learning collaboratives.

3. Increase access to clinical training for students entering behavioral health occupations

Workforce-related barrier: *Too few resources and opportunities are available to meet the clinical training needs of the behavioral health workforce.* Too few internships, residencies, other clinical training, and “real-world” placement opportunities are available to provide the necessary experience for behavioral health workforce development. According to the 2013 Multi-Discipline Clerkship/Clinical Training Site Survey on recruiting and maintaining U.S. clinical training sites¹¹, the most important factors influencing the ability to develop new sites and preserve existing sites were: training and orientation of preceptors, security and legal issues (e.g., common affiliation agreements, immunizations, background checks), and administrative elements. Training in sites that mirror environments where service demand is greatest reinforces the skills needed for successful and fulfilling work in those types of practices and can improve students’ interest in working in similar practice environments.

Stakeholders noted that community-based sites that serve clients with the greatest needs are disproportionately used as clinical training sites. There are too few incentives to encourage and support clinical training, such as reimbursement for supervision and training functions, which places heavy burdens on preceptors and administrative staff responsible for the training. Stakeholders and key informants report that many who complete their training at these high-impact sites seek employment in private practice or other better paid and less challenging settings after licensure requirements are fulfilled. This high turnover adds to the already heavy workloads and stress among staff at these organizations, increasing their workforce recruitment and retention problems. According to the 2013 Multi-Discipline Clerkship/Clinical Training Site Survey on recruiting and maintaining U.S. clinical training sites, the top-rated incentives to recruit community-based sites as clinical training sites were non-monetary¹²: offering faculty positions, providing library access, and public recognition.

RECOMMENDATIONS

3-a. Recognize and compensate the function that community-based settings play in training new behavioral health professionals and paraprofessionals in their first year of practice. While the primary mission of these organizations is to provide behavioral healthcare services, they are also playing an important role in the training of the behavioral healthcare workforce. Community mental health agencies, substance use disorder treatment agencies, and federally-qualified health centers (FQHCs) often serve the most complex and chronically ill behavioral health clients, which can be a challenging population for new entrants to the workforce. Often due to the reimbursement issue covered in recommendation #1, many providers leave for more highly paid opportunities as soon as they become available; it is typical for these organizations to lose workers after only one year of employment. Recognizing the critical role community mental health agencies play in training healthcare workers by compensating them for this function or incentivizing them to provide internship programs and be clinical sites may help community agency providers to retain workers. Additionally, this would also at least partially address reductions in standard clinical productivity as a result of time spent supervising new workers, enabling better absorption of the costs of high turnover, and/or allow for these settings to staff appropriately to support a training function.

¹¹ Erikson C, Hamann R, Levitan T, et al. Recruiting and Maintaining U.S. Clinical Training Sites: Joint Report of the 2013 Multi-Discipline Clerkship/Clinical Training Site Survey. Association of American Medical Colleges. 2014. http://members.aamc.org/eweb/upload/Medicaid_Graduate_Medical_Education_Payments--A_50_State_Survey.docx.pdf

¹² Figure 6 from above reference.

Action Required: In order to implement this recommendation, the Washington Association of Community and Migrant Health Centers (WACMHC) and the Washington Council of Behavioral Health (WCBH) would need to:

- Charter/convene a work group of community mental health agencies and federally qualified health centers to determine which incentives would be useful, and identify the level of funding needed if financial incentives were recommended.
- Once the work group has concluded its review, the next step could be to work with policymakers to establish and obtain funding for incentives for community mental health agencies and federally qualified health centers with existing training programs.

3-b. Increase the ability of behavioral health clinical training sites to accept students/trainees by incentivizing and supporting clinical training sites. Key informants have emphasized that trainees gravitate to where they had positive clinical training experiences and role models, and that competence gained in challenging settings/populations increases job satisfaction. Appropriate clinical training prior to credentialing is necessary not only to effectively teach real-world practice, but also to ensure that skills that were introduced in school programs are mastered. Informants have expressed concern that too few clinical training sites with appropriately trained preceptors are available to adequately support existing behavioral health education programs and future expansion, and have requested incentives for training sites and preceptors. Some informants noted that this approach could lead to primary care providers asking for similar incentives.

Action Required: In order to implement this recommendation, WACMHC, universities and colleges with behavioral health programs, and clinical training sites (such as FQHCs) will have to work together on the following tasks:

- Develop and implement a readiness assessment to support clinics in assessing their capacity and ability to implement long-term residency and training programs.
- Promote increased collaboration between universities/colleges and clinics for clinical training of behavioral health professions. Examine the approach used by Clinical Placements Northwest as a potential model for expanding coordination across the state.
- Consider legislative and funding support that provides financial incentives for current and potential clinical training sites to make up for the time and money that is lost while training new healthcare workers.
- Review opportunities to provide additional incentives for clinical training sites to send their preceptors to get training as supervisors.

3-c. Encourage payers (MCOs/health plans and BHOs) to contract with licensed community behavioral health agencies, as well as individual licensed clinicians. Most insurance companies' payments are directed to a specific licensed clinician. In addition to contracting with individual licensed clinicians, another approach that could better expand the behavioral health workforce and support training needs is to direct payments to a licensed organization, enabling that organization to use their resources to pay for the team required, which could include interns, paraprofessionals, and others, to deliver the services needed to achieve the desired outcomes. This approach incorporates several workforce development strategies and could be implemented quickly and without additional resources. It 1) maximizes direct service capacity by using licensed positions 'at the top of their credential' to oversee the work of non-licensed individuals, thus expanding the overall behavioral health workforce pool and 2) provides entry-level opportunities to expand workforce diversity by employing non-licensed individuals who work within an organizational and supervisory structure that ensures appropriate standards and protections. These organizations would also have the necessary flexibility to develop internal career pathways to support these employees to pursue professional education and licensure.

Encouraging payers to contract with licensed community behavioral health agencies, in addition to individual licensed clinicians, could encourage a systemic shift toward value-based, integrated delivery of care models by providing the financial flexibility for community health center organizations, as well as private practices, hospitals, etc., to employ and adequately compensate “care-teams” as opposed to individual provider “fee for service” visits. The implementation of this recommendation would be fairly simple – all it requires is for the state to amend the applicable contracts – and the cost is minimal. No statutory or rulemaking action would be required.

Additional research to identify any negative, unintended impacts for individual practitioners who are not part of the managed care system, and how these contracts would function in an integrated care environment where more mental health services are provided at traditional primary care sites may help with implementation.

Action Required: In order to implement this recommendation, the Health Care Authority (HCA) could lead a process to work with payers to update/create contracts with licensed community behavioral health agencies in addition to individual licensed clinicians. Alternately, policymakers could direct the HCA to move toward renegotiating the current contracts and consider requiring future payer contracts to include licensed community behavioral health agencies, in addition to individual licensed clinicians.

3-d. Increase funding to expand behavioral health education programs and graduate more professionals.

Although a number of professions could have been included in this recommendation, advanced registered nurse practitioners (ARNPs) in psychiatric roles were specifically identified by the Washington State Hospital Association (WSHA). In stakeholder meetings, WSHA has identified that universities offering psychiatric advanced practice nurse programs could accept more qualified candidates if they had more funding to recruit faculty to teach the courses and to increase the number of clinical preceptorship placements. Leaders of psychiatric ARNP programs have identified two areas of concern about expanding their programs. The first is a limit on the numbers of qualified applicants that schools can accept because of difficulties attracting faculty to teach the courses. The second is difficulty placing psychiatric ARNPs in preceptorships to gain the necessary clinical hours. A preceptor’s productivity is reduced while educating students, meaning the clinician’s billable clinic hours decline without compensation. The path toward the state’s goal of behavioral and physical health integration has just begun and will continue to grow and drive the demand for behavioral health professionals in a variety of settings.

Action Required: In order to implement this recommendation, one suggested approach would be for policymakers to create a grant program for universities with psychiatric ARNP programs in Washington state to apply for and receive funds to pay for faculty positions and preceptorship placement. A pool of \$5 million would allow universities to apply for single or multiple \$400,000 grants for a 2-3 year cycle to educate and train additional psychiatric ARNPs. A minimum number of student slots, above previous enrollment, should be identified for grants (for example, eight students per grant award). This proposal would result in an approximately 80 additional psychiatric ARNPs to be educated and clinically trained over the next two to three years.

Items for further study to increase access to clinical training for students entering behavioral health occupations that require further study by the project team and stakeholder group:

- Work toward a standardized core curriculum for entry-level workers across behavioral health professions. Development and implementation of a common curriculum could encourage and expedite behavioral health training across a range of entry level occupations. The stakeholder group

will explore the potential of convening a work group composed of education/training program and employer stakeholders to identify curriculum objectives and specifics, as well as implementation barriers and facilitators.

- Support coordination of clinical training among education programs and delivery sites to reduce the burden of identifying and enlisting sites, as well as delivering and supervising clinical training. Most health professions, including behavioral health, require students to complete some clinical training in care delivery sites before becoming fully credentialed to practice. Identifying, contracting with, and supervising training at sites can be administratively burdensome. Making the process as efficient as possible could benefit sites' willingness to participate in clinical training. Key informant and stakeholders recommended education institutions with behavioral health occupation programs be encouraged to increase coordination of their clinical training efforts. Although there is cost to provide this type of coordination, the resulting savings of time and effort for both students and training sites may outweigh the cost of coordination. Clinical Placements Northwest (CPNW) was offered as one example of how this function could work. CPNW is the umbrella of three clinical placements consortia (East, North & South); representing thirty-four healthcare organizations and thirty-five nursing education programs working to consolidate into a single organization. CPNW negotiates nursing student clinical placements between healthcare partners and education programs and identifies additional placements when there is shortfall. CPNW is working to provide "one-stop shopping" and an automated placement grid to allow a clinical placement coordinator to work on placements for all healthcare students. There are likely other providers and models that should be included in this discussion.
- Increase the number of psychiatric residencies, especially in rural and other underserved communities. There are not enough psychiatric residencies to support the workforce needs of the state. Research shows, and key informants have observed, that physicians and other doctorate-level providers are more likely to stay with an organization or in sites similar to where they complete residency training (such as rural locations) when they enter practice. In 2014, 43% of psychiatrists practicing in Washington State had completed a residency in Washington¹³. To encourage more psychiatrists to practice in Washington, the state should support expansion of the number of psychiatric residencies in the state. The Children's Mental Health Workgroup also supported increased psychiatric residencies, particularly child psychiatric residencies.
- Host a forum on employer/educator behavioral health occupations. Encouraging connections between the employers and educational system is a best practice to align training programs with the needs of employers, and a key component of the Governor's cluster strategy. Postsecondary education has hosted forums with employers focused on topics such as the value of a liberal arts education and STEM literacy. A behavioral health occupations forum would consist of convening regional or statewide conversations between behavioral health employers, professional associations, and education institutions at the K-12 and postsecondary level to allow for better understanding of employer needs for these occupations, and encourage partnerships between industry and education. A team would need to be put together to identify the specific outcomes to be achieved, identify a lead organization(s), and otherwise organize the event.

¹³ Skillman SM, Stover B. Washington State's physician workforce in 2014. Seattle, WA: WWAMI Center for Health Workforce Studies, University of Washington, Aug 2014.

4. Expand the workforce available to deliver medically-assisted behavioral health treatments

Workforce-related barrier: *Too few providers have the prescribing authority needed to deliver medically-assisted behavioral health treatment.* Currently, physicians (including primary care physicians and psychiatrists), advanced registered nurse practitioners (ARNPs), including psychiatric ARNPs, physician assistants (PAs), and pharmacists working under a physician's prescriptive authority may prescribe medications for behavioral health conditions. Only licensed physicians with specific certification can currently prescribe drugs such as buprenorphine to treat opioid addiction. There are too few of these professionals available to efficiently serve the needs of all behavioral health service sites in the state. This is a supply shortage issue, and a recruitment/retention issue.

RECOMMENDATIONS

4-a. Increase primary care providers' (physicians, ARNPs, PAs, pharmacists) confidence to use their full prescriptive authority for psychiatric medications. Stakeholders and key informants cited a lack of comfort or confidence regarding prescription of behavioral health medications as a challenge to current prescribers' willingness to practice to the full scope of their licenses, including prescribing psychiatric medications. Providing training and support within integrative collaborative systems is ideal, but challenging, due to the shortage of psychiatrically trained providers. This barrier could be mitigated by providing reimbursable, interactive consultations with psychiatrists within or outside of Washington via telehealth, such as UW's Partnership Access Line (PAL) telephone consultative service. The UW's AIMS Center is also working to expand the reach and availability for consultation of Washington's psychiatric prescribing workforce. Current UW AIMS Center programs provide residency training and fellowships to train psychiatrists to work in integrated care settings, train primary care physicians how to work with psychiatrists in an integrated clinical model, and provide telepsychiatry services. Additionally, Columbia Health is testing a model that partners with a managed care organization to fund a nurse care manager to allow for the monitoring that is critical to prescribing. The Children's Mental Health Work Group¹⁴ also recommended providing psychiatric care consultations via telemedicine

Action Required: In order to Increase capacity to support the comfort of primary providers prescribing psychiatric medications several actions should be considered:

- Adjust the Medicare, Medicaid, PEBB, commercial insurance, and other relevant payment models to provide greater support for and sustainability of telepsychiatry and other consultation methods to support primary care providers via tele-consulting services with a psychiatrist.
- Continue funding beyond 2018 for the University of Washington Integrated Care Training Program (ICTP) and Psychiatry and Addictions Case Conference (PACC), and the University Washington's Project ECHO program that provides weekly didactic education and case consultation to any primary care provider in Washington.
- Expand MCOs/BHOs providing telepsychiatry networks for contracted provider networks, by supporting options such as the model being developed by North Sound BHO.
- Consider removing the 100 patient cap for telemedicine.
- Continue support for psychiatrist training through the UW Integrated Care Training Program (through the UW AIMS Center), and consider expansion of this program to support all psychiatric prescribing providers (e.g., ARNPs), with a plan for ongoing investment in such training beyond 2018.

¹⁴ <http://leg.wa.gov/JointCommittees/CMH/Pages/default.aspx>

4-b. Expand telehealth reimbursement to include any site of origination as well as consultation services.

Expanding the use of telehealth, including telepsychiatry, is dependent on providing reimbursement for telehealth at any organization or site addressing behavioral health needs, including consultation services. This approach is especially important for rural areas. Policymakers have made many improvements to increase access to telemedicine across the state, amending RCW 48.43.735, 41.05.700, 74.09.325, and 70.41.230. RCW 48.43.735 includes homes as originating sites for health carriers starting January 1, 2018. RCW 41.05.700 is identical, but for health plans. Stakeholders were very supportive of changing the statute to allow telehealth services to be delivered **at any site** of the provider and patient's choosing, such as a community library or senior center, increasing access to service delivery for rural patients and others who may lack reliable internet access in the home.

Action Required: In order to expand telepsychiatry access to any site of the provider's and patient's choosing, including access to consultation services, policymakers would need to update telemedicine RCWs to allow access and reimbursement from any site of origin.

Items for further study to expand the workforce available to deliver medically-assisted behavioral health treatments:

- *Provide prescriptive training/examination/credentialing to a broader range of behavioral practitioners.* While some states address this issue by allowing clinical psychologists with additional training to become prescribers for psychiatric medication, stakeholders cautioned against providing prescriptive training/examination/credentialing to a broader range of behavioral healthcare practitioners without careful consideration. As one stakeholder stated: "...because medical complications can arise from the administration of medications, and medical training currently consists of four years, please keep in mind any adverse outcomes that might arise if the approaches are not thoughtful." In order to implement such an approach, a Sunrise Review and legislative action would be required, and research into what other states are doing is strongly recommended.
- *Encourage RNs to increase their training to become ARNPs.* Supporting a career ladder by supporting both costs and time for RNs to advance their training would increase the number of ARNPs and the availability of prescribers, and could create other efficiencies in the delivery of behavioral healthcare. It should be noted that at least one stakeholder cautioned that as ARNP programs are moving from Masters level toward doctoral level training, fewer ARNPs may enter the workforce over the next several years.
- *Increase the number of psychiatrist prescribers by:* 1) Increasing the number of residencies and encouraging medical school graduates in Washington to enter psychiatric residencies in Washington; and 2) Consider developing a Psychiatric ARNP residency program and expanding the behavioral health training slots in the current ARNP training programs. Washington is facing a major shortage of psychiatrists, as those currently in the field are aging out and demand for these services is increasing. Encouraging psychiatrists to complete their residencies in Washington could help to address this shortage while increasing the pool of prescribers, but is an expensive proposition. Another, less costly option might be to develop a psychiatric ARNP residency and increase the behavioral health training slots in current ARNP programs.
- *Identify and resolve barriers to community-based facilities to host psychiatry residents for rotations.* For example, it was noted by a stakeholder that community-based sites are charged to host a psychiatry residents; creating a disincentive to training psychiatrists in underserved settings.

5. Increase diversity in the behavioral health workforce

Workforce-related barrier: *The behavioral health workforce does not reflect the diversity of the population wanting to access services.* As a result, it is difficult to provide culturally appropriate care early and in a proactive way that reduces the need for addressing behavioral and physical healthcare issues when they become more acute. For the purposes of this report, the term diversity is used to focus on the broad category of underserved populations, included but not limited to providers representing various genders, class, sexual orientation, countries of origin, disabilities, race/ethnicities, and history of substance use disorders. For example, one key informant was concerned with the ability to replace a provider for deaf clients were that provider to leave the facility.

The Children's Mental Health Work Group¹⁵ also identified the need for a diverse workforce, stating the importance of ensuring "...that children and families receive the most appropriate services, delivered in a linguistically and culturally competent manner. Many families are reluctant to seek mental health services due to stigma, cultural norms, lack of awareness of available services, etc. It is critical that in addition to having a diverse workforce, services can be provided and billed for in settings that are relevant to the population being served." The workgroup recommended conducting a diversity survey of the public mental health workforce, increase payment for those providing culturally and linguistically appropriate services to Medicaid children/families, ensuring that interpreters are adequately reimbursed, and ensuring that payment can be made when providing services in nontraditional settings by a variety of professionals.

RECOMMENDATIONS

5-a. Improve behavioral health literacy as a foundation for healthcare careers. Stakeholders generally agreed that diversity is a pipeline issue. Earlier mastery of behavioral health concepts and literacy, as well as early opportunities to explore career paths related to behavioral health services leading to targeted post-secondary education and credentialing, will reduce the stigma of behavioral health and allow more individuals to consider these health careers. Focusing on providing this exposure to underserved populations will also increase diversity in the behavioral health workforce. There are a number of models and approaches in Washington and elsewhere that could be expanded.

- Yakima Valley Technical College is using AmeriCorps partners in Toppenish to entice students to consider behavioral health careers.
- Washington State University has a program in partnership with tribal groups focused on nursing, which could be adapted to include behavioral health as well.
- Washington's Office of Superintendent of Public Instruction (OSPI) is implementing Project AWARE (Advancing Wellness and Resilience in Education) to increase awareness of mental health issues among school-aged youth, including training in mental health for school personnel, families and community members, and collaboration to bring mental health literacy curriculum into high school health classes.
- UW Psychiatry and Psychology departments are collaborating to offer a new course and minor in behavioral medicine to UW undergraduate students in pre-health professional training programs (e.g., pre-medicine, pre-nursing, pre-physical therapy, pre-pharmacy).
- Nevada is piloting a high school pre-vocational behavioral health course.
- Nebraska is offering an introduction to behavioral health careers curriculum.
- The Alaska Area Health Education Centers (AHECs) are offering behavioral health career camps.

¹⁵ Ibid.

Action Required: There are a variety of actions that could be taken by various organizations to expand support for behavioral health literacy in Washington State. These include:

- Policymakers could enhance funding for mental/behavioral health literacy education; using models such as the programs listed above, and emphasize support for programs which include training and resources for educators.
- The Professional Educator Standards Board, OSPI, and selected teacher preparation programs could provide mental health literacy for pre-service instructors in teacher preparation programs, as well as in-service mental health literacy training for teachers and school staff.
- Policymakers could consider funding a program manager for mental health literacy efforts at OSPI.
- The OSPI Health Science Program Supervisor, Workforce Board, Educational Services Districts, and local districts, in collaboration with OSPI content specialists and the Health Science Program Supervisor, could create and implement a Behavioral Health career pathway curriculum, based on promising practices in Washington, Nevada, Alaska and Nebraska and others, especially in areas that include rural, underserved, and diverse populations
- Policymakers could increase emphasis in state funding for Washington AHECs to continue and expand their health career pathway programs, particularly those focused on behavioral health careers.

5-b. Increase the use of peers and other community-based workers in behavioral health settings. By their very nature peer specialists in the behavioral health workforce reflect the diversity of their communities. The peer role involves having some personal experience with behavioral health recovery. However, according to stakeholders, a major hurdle to becoming certified as a peer specialist in Washington is the availability of training spots and oral examinations required for certification. According to the Department of Behavioral Health and Recovery (DBHR), there are considerably more applicants than training spots available, and training opportunities and examination location sites are limited. Expanding access to training and certification examinations would allow more people to become peers and reduce the barrier caused by the cost of travel associated with earning the certification. A number of other states, including Oregon, are working to increase the use of peers and other community-based behavioral support providers.

Action Required: In order to increase the number of sites delivering peer counselor training in Washington, DBHR would need to increase the number of training sessions throughout the year, and could consider use of video or virtual training and examination to increase access to the certification.

5-c. Expand access to the I-BEST core curriculum, and encourage additional programs that include behavioral health occupations. Washington's Integrated Basic Education and Skills Training Program (I-BEST) quickly teaches students literacy, work, and college-readiness skills so they can move through school and into living wage jobs faster. Some I-BEST programs focus on healthcare occupations, and there are a few programs in the state that include a focus on behavioral health. For example, Grays Harbor Community College has an I-BEST for their Human Services program that admits 40 students per year, and generally has a waiting list of students. The program has a generalist track and a track that leads to the CDP. Expanding I-BEST programs to include more information on behavioral health occupations could provide the state an untapped resource of diverse entry-level and paraprofessional providers, such as CDPs (one of the most highly in-demand occupations according to Key Informants), medical assistants with integrative skills, and peer specialists, as well as provide a step forward for these students towards transfer degree programs to develop additional skills in areas such as psychology, human services, and community health.

Action Required: Increased funding support of policymakers for the I-BEST program. The State Board for Community and Technical Colleges has a funding request that would increase access to I-BEST programs for an additional 900 students, which includes healthcare programs.

5-d. Reduce care worker turnover and improve diversity by creating career pathways and opportunities for certification of behavioral health and other paraprofessional roles. Underrepresented minorities, immigrants and refugees, and others from diverse population groups often work at the entry and middle-skilled positions across the healthcare sector. Viable pathways to better paying healthcare positions are limited, especially for those with barriers to traditional education and training programs. The development of career lattices, with wage and job progression across the full spectrum of the healthcare workforce, can help support the retention and advancement of these workers, result in a more diverse healthcare workforce, and potentially improve patient outcomes as a “reflective workforce” develops from within communities being served. The Health Workforce Council (HWC), with adequate funding support, could be the logical body to convene a Care Worker Task Force. The Workforce Board, which staffs the HWC, has submitted a decision package for 1.5 FTE to support the HWC's work. If funding is appropriated for this request, the Workforce Board could work with the Council to support a stakeholder process to create a statewide care worker career lattice framework over an 18 to 24-month period.

National and international efforts to stem the loss of care workers by using career pathway development and increased autonomy over the work have shown success. These efforts have generally been focused on one or a couple aspects of caregiving, like long-term care, with limited position or wage growth. Even so, Pennsylvania, Massachusetts, New York, Oregon, North Carolina, Georgia, Florida, and Vermont all had successful long-term care career pathway efforts, and have been able to show significant turnover reductions. Massachusetts, the only state that looked at the effect of workforce development interventions on federal patient care quality indicators, showed a significant increase in certain quality indicators, and positive changes in revenues that were transferred to direct patient care and care worker wage increases. The five states that participated in Robert Wood Johnson Foundation's "Better Jobs for Better [long-term] Care Initiative" were able to show reductions in worker turnover. The United Kingdom, anticipating an almost double digit increase in the need for care workers has begun an effort to look across the caregiving subsectors to improve front-line worker recruitment and retention. They are looking at career pathways, portable and stackable credentials, and customer-endorsed badges.

Action Required: The Workforce Board, with funding from the state budget to support 1.5 FTE, could work with the Health Workforce Council to establish a Care Worker Task Force and develop a care worker career lattice over the next 18-24 months.

5-e. Support continued funding for the state's health professionals loan repayment program, and consider strategies to expand the program and its applicability to behavioral health occupations. Stakeholders were very interested in using loan repayment with possible enhancements and incentives to recruit and retain diverse and skilled behavioral health workers, particularly in rural and other underserved areas. Recent updates to the program added four behavioral health occupations to the program – Clinical Psychologist, Licensed Independent Clinical Social Worker, Marriage & Family Therapist, Mental Health Counselor – for licensed providers with a minimum of a Master or Doctoral Degree level education who are working in an integrated setting/system of care. Stakeholders voiced a primary interest in expanding the resources available for loan repayment.

Stakeholders also made several recommendations that could expand the use of the program in the behavioral health sector. These included: 1) Better marketing of the newly eligible professions – many stakeholders were unaware of the addition of behavioral health occupations to the program; 2) Exploring options such as the Alaska SHARP program¹⁶ to provide support-for-service to practitioners in the form of either repayment of qualifying education loans and/or payment of direct incentive for practicing in underserved sites; 3) Expanding the types of job sites and job classes for which loan repayment could be provided; and 4) Changing the definition of health professional shortage areas (i.e., expanding beyond the federal HPSA designations, though this is only an issue for the limited federal loan repayment program), which prevents some key parts of the state from accessing the program. Additional concerns were raised regarding the financial penalties for those who do not fulfill their service commitment, deemed as excessive by some stakeholders, and creating a disincentive for those who might otherwise benefit from the program.

The topic of loan repayment is a complicated one. Expanding access to loan repayment opportunities was one of the recommendations most frequently cited by stakeholders. Better marketing the opportunities for graduates of the four behavioral health occupations recently added was also supported by all stakeholders. Many agencies that employ behavioral health providers are not aware that they are eligible sites for state Health Professional Loan Repayment program assistance, and in many cases for National Health Service Corps providers. Facilities with more administrative resources tend to submit more applications for loan repayment slots than less-resourced facilities, but the ability to submit more applications does not necessarily indicate greater need. The Children’s Mental Health Work Group also identified the need for increasing the sites able to take advantage of loan repayment opportunities to include BHO- or MCO-funded agencies that serve a high percentage of Medicaid children/youth/families.

A significant and vocal but not unanimous set of stakeholders are also extremely interested in addressing the other challenges to the program identified above as a lever to increase diversity in the behavioral health workforce.

Stakeholder Concerns: The Washington Association of Community and Migrant Health Centers (WACMHC) expressed serious concerns about creating any new program or prioritization for specific professions within the current loan repayment budget.

Action Required: In order to make better use of the loan repayment program to expand diversity in the behavioral health care workforce, the Washington Student Achievement Council (WSAC), which administers the program, should be encouraged to increase outreach to sites and graduates to access the program. Expansion of loan repayment awards would require policymakers to increase the program’s appropriation. Another option would be for the Department of Health to consider convening a workgroup or task force to explore a new direct incentive program, since the current loan repayment program doesn’t directly target providers with educational debt.

5-f. Expand the state Work Study program. The state work study program is the only state student financial aid program that includes graduate and professional students, as well as undergraduates. Work Study is a critical approach to reduce barriers to higher education in the state. Student participants are placed with employers that meet their career interests. There are many work study sites at behavioral health service providers across the state, largely in community health centers, which

¹⁶ <http://dhss.alaska.gov/dph/HealthPlanning/Pages/sharp/default.aspx>

increases exposure to behavioral health career paths which serve a diverse clientele. At one time, Washington had the largest state Work Study program in the country; however, it's been cut by two thirds since the Great Recession. The Washington Student Achievement Council is requesting an additional \$10 million for the program next session to serve an additional 3,000 students.

Action Required: In order to expand Washington's Work Study Program to serve additional students, including those training for behavioral healthcare occupations, policymakers would need to appropriate additional funding to the program.

Items for further study to increase diversity in the behavioral health workforce that require additional research and/or stakeholder engagement:

- *Explore options for incentives to recruit and retain a more diverse workforce.* Look into tax incentives such as providing a B&O tax exemption for businesses that use the program to offer retention bonuses.
- *Develop a position at the Department of Health to provide behavioral health provider recruitment support for underserved communities.* This position could supplement the current resources provided at DOH dedicated to recruitment of primary care physicians, dentists and PA/ARNPs recruitment support. A similar program recently implemented in New Hampshire could be considered as a possible model.
- *Expand the Welcome Back Center program to additional sites.* Several colleges in Washington provide this program to help foreign-trained professionals enter careers in the U.S. Further study could examine the applicability of this program to address behavioral health workforce needs.
- *Review King County's approach to addressing direct service level racism for potential expansion as a model for replication in behavioral health.* King County's Early Learning division is working to uncover and tackle institutional racism and implicit bias at the direct service level.
- *Consider the recommendation of the Children's Mental Health Work Group¹⁷ to increase payment for providers offering interventions in community locations.* The interventions may include primary care, education, child welfare, and juvenile justice. The Work Group also called for ensuring that payment can be made when providing services in non-traditional settings by a variety of professionals.

6. Increase the number of dually-certified behavioral healthcare providers

Workforce-related barrier: *Not enough providers have dual training and certification in mental health and chemical dependency treatment to meet system needs.* Key informants and stakeholders routinely mentioned the prevalence of co-occurring disorders (mental health and chemical dependency) seen in clinical practice. Providing opportunities for dual or "add-on" certification would allow interested clinicians to maximize their effectiveness in treating patients with dual diagnoses, and provide for increased access to needed services, especially if salaries reflected this higher level of training.

Items for further study to increase the number of dually-certified behavioral healthcare providers:

¹⁷ <http://leg.wa.gov/JointCommittees/CMH/Pages/default.aspx>

- *Support career ladders for peer support specialists, medical assistants, and other entry-level staff, such as community health workers, to acquire behavioral health coordinator training with CDP and additional training and certifications.* This includes supporting training time and costs. As a model, the Washington Association of Community and Migrant Health Centers provides a paid 12 month apprenticeship program for medical assistants and others which offers didactic and clinical instruction.
- *Reduce the cost of maintaining dual licensure.* Maintaining dual licensure is expensive to the individual, and so without incentives to continue one or both licenses, it is possible that some providers let their credentials lapse. Providing a “bundled rate”, dual license discounts, or reimbursement might address this issue, although the Department of Health has noted that current fees are set at the minimum level required to regulate the profession. Implementation would require subsidies to address the cost of licensure. Currently, King County has a model for reimbursing license costs for some employees. Employers who are able could also be encouraged to cover the cost of the second credential for their employees.
- *Review the process for Licensed Mental Health Professionals (LMHPs) to become certified as Chemical Dependency Professionals (CDPs).* A significant portion of the discussion on the topic of dual certification revolved around the challenges faced by mental health professionals interested in becoming dually certified as CDPs to address the needs of patients with co-occurring disorders. The Department of Health adopted new rules in July 2016 to facilitate the expansion of dually-credentialed professionals. The rules require 1000 hours of clinically supervised chemical dependency treatment experience for applicable LICSW, LMHC, and LMFTs, and 1,500 for individuals with a Master’s or doctorate earning a CDP credential. The new WACs were the culmination of a rulemaking process to create an alternative CDP track. Department of Health plans to monitor the use of the new CDP alternative training pathway, working with the CDP Advisory Committee at quarterly meetings, periodically reviewing Department credentialing data, and inviting stakeholders to provide feedback to determine the extent that licensed healthcare practitioners use the alternative training pathway.

Stakeholders also suggested creating more programs to facilitate CDP training for Master’s level mental health counselors. Models include the Healthcare Employee Education and Training (HEET) pilot program that is enabling mental health counselors employed in the North Sound Region to obtain “fast track” CDP training using distance learning through Whatcom Community College in partnership with Spokane Falls Community College (faculty are based at Spokane Falls Community College).

Stakeholder Concerns: The Washington State Society for Clinical Social Work (WSSCSW) expressed concerns about this potential recommendation. The Department of Health recently updated the Washington Administrative Code rules about how licensed mental health clinicians, including LICSWs, can become Chemical Dependency Professionals (CDPs). WSSCSW noted that the practice methodology found in WAC 246-811-010(4) and (5) would need to be changed before they could support this change. The organization stated that nowhere else in the RCWs or the WACs is behavioral health treatment dictated in law. The requirement that all treatment of addictions be based on abstinence only is not only outdated; it ignores the successful use of harm reduction treatment that SAMHSA supports.

7. Address barriers to licensing and credentialing

Workforce-related barrier: *Stakeholders identified lags in the time it takes for newly trained workers to receive licensure, the cost of obtaining/maintaining licensure, and lack of reciprocity with other states and countries as barriers to hiring and retention.* Research identified a number of factors contribute to this challenge; however, additional research would be needed before recommendations for action could be made. For example, the State Office of Financial Management sets a 14-day target for processing of an application for licensure. However, it often takes applicants longer to provide supervision hours, requirements for clinical signoff on the various items, supporting documents, official transcripts from the educational institutions, etc., particularly if training was obtained out of state, due to challenges in tracking down the required documentation and signatures, delaying the process. These challenges increase when licensing providers who were credentialed out of the country, because their educational institutions often don't meet Washington's accreditation requirements. Criminal history can play a major role in delayed time to licensure, particularly for those who fail to disclose this background early in the process. The Department of Health is working with a vendor to implement online licensing applications in the spring of 2017 to reduce the amount of incomplete or substandard applications, thereby speeding up the credentialing process, but this will not reduce the time it takes for applicants to collect their documentation.

Items for further study to address barriers to licensing and credentialing that require more research and stakeholder input to determine which of these might have sufficient impact on this issue.

- *Examine the Department of Health process for monitoring those in recovery working towards a CDP.* Key informants noted that those in recovery who aspire toward a CDP credential are required to adhere to strict Department of Health guidelines for public safety, including counseling/group attendance, regular urinalyses, etc. The monitoring required for those in recovery can be cost prohibitive to applicants, who may instead choose other less onerous career paths, so further research on a potential recommendation is needed before moving forward to address this. However, research showed that these monitoring requirements apply to only about 1% of the profession. Monitoring requirements are based on documented national best practices for substance misuse disorder programs and the program requirements apply equally to all profession types under DOH jurisdiction.
- *Consider increasing occupations with license reciprocity among states to encourage more behavioral health providers to work in Washington.* To address reciprocity issues, the behavioral healthcare community would need to work with the secretaries at Department of Health and the Department of Social and Health Services, as well as various licensing bodies, to determine how to align standards to allow better access to care or moving, in some cases, toward national standards. Washington requirements for educational experience and exams tend to be higher than other states, based on stakeholder and consumers input for the professions. One key informant stated that students get licensed and go to work in neighboring states instead of Washington because it requires less time in supervised clinical training before becoming eligible. Aligning the standards with the national norm for these professions will be challenging, as Washington has always valued vigorous licensing standards. Some of the statutes provide limited flexibility on the requirements, but others are set in rule and could be addressed through rulemaking. Compacts provide a possible solution at least in some cases – the national compacts model used by psychologists or the Interstate Medical Licensure Compact for physicians (although it has not been approved by the Legislature) may be worth considering. Adoption of any compact would require approval by the Legislature and signature of the Governor.

- *Review the timing of background checks in the licensing process.* Documentation of criminal history and conviction is an issue for some applicants, who do not provide this information or do not follow the directions related to this item. Because there is a cost for the background check, it is not conducted until the end of the application process, once all of the other requirements for licensure have been met. However, if an applicant doesn't report their criminal history or doesn't provide court documents before the background check, the licensing process can be delayed considerably. The requirement for disclosing criminal history is worded so it stands out in the application, and there a lot of info about the requirement to disclose on the website. However, not everyone complies with the requirement to disclose this information. More work is needed to determine if there could be updates to either the forms and directions to applicants or the timing of the background check in the process of licensing.
- *Reduce obstacles for behavioral health providers to serve in supervisory roles and provide clinical services needed to attain additional credentials.* Stakeholders noted that some master's level counselors who have been in the field practicing are unable to obtain the LMHC status. They noted challenges for those in a supervisory position who report conflicts maintaining the position – while still obtaining the required hours to become licensed since the direct client contact is minimal – as well as difficulties in paying for the necessary supervision to become licensed. There are options available for providers to address this problem that may just need to be better publicized. For example, the Department of Health noted that some facilities contract for clinical supervision services on-site for a team of clinicians. For individual providers who cannot find a full time job with proper supervision, associates may need to contract out for supervision or take on a second job where there is a supervisor who meets the requirements. Policymakers have increased the number of renewals allowed for an associate license, which allows them to gain the necessary experience through part time work.

8. Increase the efficiency of the behavioral health workforce by streamlining paperwork and reporting requirements.

Workforce-related barrier: *Stakeholders identified the paperwork burden as one of the most significant contributors to low morale and high turnover.* Time spent reporting and dealing with paperwork reduces time with patients. However, a number of reporting requirements are directly linked to the state's ability to maintain waivers that increase practitioner flexibility, so there is no easy answer.

This issue has also come up at a number of different tables. The Children's Mental Health Work Group¹⁸ noted that "in a recent survey of over 200 Master's Level Therapists across Washington State, respondents clearly indicated "too much paperwork" as one of the primary drivers to workforce turnover. In addition, time spent completing excessive paperwork results in reduced time each week doing direct services, reduced availability of staff to be responsive to the needs of their clients, and an inefficient use of existing funding for mental health services. Key Informants noted that, "This overregulation also falls short of ensuring high quality and effective services, as it focuses more on what questions you asked, information you gathered and boxes you checked, rather than on treatment decisions."

The E3SHB 1713 Behavioral Health Regulatory Alignment Task Force emerged from the 2016 session to streamline and reduce these types of administrative barriers. E3SHB 1713 charged the Department of

¹⁸ <http://leg.wa.gov/JointCommittees/CMH/Pages/default.aspx>

Social and Health Services (DSHS) and the Health Care Authority (HCA) to “...align regulations between behavioral health and primary healthcare settings and simplify regulations for behavioral healthcare providers¹⁹.” In its report to the Legislature, the task force identified concerns and recommendations consistent with recommendation to eliminate the need for site-specific policy audits for organizations with multiple sites, and promoting methods to coordinate or eliminate redundant audits.

DSHS has formed an internal workgroup to identify opportunities to make the process of audits and personnel file review more streamlined, outcome-driven, and quality-focused, and will provide the results of audits to the respective behavioral health organizations (BHOs) to assist with their review process. DSHS and the Department of Health are in the process of forming a workgroup to address redundancies in rules and audits that overlap. The goal of this workgroup is a coordinated process that will combine audit activities into a single site visit and ease the burden on providers.

Items for further study to reduce, streamline, and/or eliminate duplicate and conflicting audits that require more research and stakeholder input to determine which of these might have sufficient impact on this issue.

- *Support efforts by the Behavioral Health Regulatory Alignment Task Force, the Health Care Authority and other regulatory agencies to reduce, streamline, and/or eliminate duplicate and conflicting audits.*
- *Consider additional recommendations put forth by the Children’s Mental Health Work Group to further reduce, streamline, and/or eliminate duplicate and conflicting audits. The Children’s Mental Health Work Group²⁰ identified a number of interesting ideas that might further reduce the paperwork and administrative burden in behavioral health and integrated settings. The group specifically called out the paperwork and audit challenges created by current assessment practices, and recommended: 1) In accordance with the Federal Paperwork Reduction Act, replacing current WACs with the following language: Use Best Practices for age-appropriate, strength-based psychosocial assessments, including current needs and relevant history in the following areas: Behavioral/Emotional, Mental Health Safety/Risk, and Functional Impairment (family/relationships, school/work, living skills/self-care, legal, medical/physical, addiction/substance use, and caregiver needs/strengths, as applicable); and 2) Exempting provider agencies using evidence- and research-based practices (EBPs/RBPs) from current documentation WACs when that Evidence-Based Practice already requires documentation of that element of treatment: assessments (except for meeting access to care standards and medical necessity), crisis/safety plans, treatment/service Planning, tracking of progress/outcomes (treatment/service plan review), and discharge/transition plans.*
- *Review documentation requirements for Medicaid to determine whether these are different for Behavioral Health Organizations (BHOs) versus hospitals. While this recommendation does not address the broader issue of whether there is just too much paperwork overall, it does address the perception that hospitals are required to do less paperwork than BHO providers. The recommendation is to review prior work in this area, and determine whether to put together a task force to determine any next steps.*

¹⁹ <http://app.leg.wa.gov/billinfo/summary.aspx?bill=1713&year=2015>

²⁰ Ibid.

9. Additional items for further study.

The following items are policies outside of the main themes from stakeholders and key informants, where there could be potential recommendations, but were not yet ready for full recommendations. Phase II will review these and the other further study items for possible inclusion in the final report to policymakers in 2017.

- *Identify and publicize successful practices for retaining workers in community care settings.* Some community-based behavioral health organizations (BHOs) have found simple, relatively low-cost approaches to increasing worker retention. By identifying aspects of what people find attractive in private care and other settings, and attempting to replicate some of these, BHOs may increase retention. Discovering and publicizing these approaches could help other find similarly effective low cost ways to reduce turn over. The Transformation Hub might be an appropriate place for such a forum to exchange ideas on promising practices in use in Washington. Examples include:
 - One organization provided mental health professionals with offices so the staff would not have to move their files and other materials when meeting with patients.
 - One behavioral health system provides educational reimbursement programs for either continuing education in evidence-based practices or pursuing advanced credentials while employed. Employees are provided part or all of training costs with a contractual obligation to remain with the agency for 2-3 years, or payback the costs. Such as agreement can negate eligibility in formal loan repayment programs, and so should not conflict with this incentive opportunity.
 - SAMHSA and NAADAC (The Association for Addiction Professionals) have recently published a free, publically accessible webinar on promising practices in workforce retention.
- *Support community-based coordination of care.* Many healthcare issues occur at the point of transitions, and may be helped using a community navigator/guide to ensure patients set up and attend appointments, assist with navigating insurance, keeping records, filling prescriptions, and facilitating a stable housing environment. This position may be eligible for funding available through SBIRT grants or other Federal programs. Stakeholder input did not clarify whether the barrier this recommendation was intended to address is a lack of community health workers to provide this function, a lack of training for those professionals or the lack of a license or credential for this function.
- *Re-institute home visits nursing program.* RNs making home visits can ensure clients are taking medication, perform assessments, and prevent crisis situations requiring EMS/emergency room or police/jail intervention. This program has worked very well clinically in the past and delivered a necessary service to patients. However, the costs of the program and travel time for rural areas did not allow the program to break even financially. Under capitated payment, this program could pay for itself; however it will not be able to meet fiscal costs in a fee-for-service model unless offered in a dense urban environment. There are currently some models for maternal child health that would be able to meet pediatric psychiatric needs. This is one option for an expansion that could be cost-effective²¹.

²¹ Washington State Legislature. Adult Behavioral Health System Task Force Final Report to the Governor and Legislature, December, 2015. Available from: <http://leg.wa.gov/JointCommittees/Archive/ABHS/Documents/ABHS%20TF%20Final%20Report.pdf>.

- *Develop an infant/child psychiatric nurse practitioner program.* Both psychiatrists and psychiatric ARNPs are in short supply, but those who are specifically trained and comfortable working with the pediatric population is even more rare, but a critical component of behavioral healthcare delivery for infants and children. Similarly, the Children’s Mental Health Workgroup recommended exploration of a professional infant mental health endorsement.
- *Support increased access to psychiatric Physician Assistant Programs.* Physician Assistants (PAs) are trained at three different levels in psychiatry and other levels of primary care. In addition, PAs may receive certificates of added qualification (CAQ) from the national certifying body. At this time, 100+ PAs in Washington have taken advantage of this certification.
- *Sponsor psychiatric PA residencies.* This position would augment experience by a provider already based in both behavioral health and primary care, and thus ideally poised to work in integrated settings.

Discussion and Policy Implications

Every effort was made to cast a wide net in terms of the inclusion of stakeholders and stakeholder ideas in the development of this report. It is clear that the development of a sufficiently large and skilled behavioral health workforce is complex, and there are many, often conflicting opinions and recommendations about how best to reach the goal. Wherever possible, efforts were made to identify relatively low-cost, but potentially impactful recommendations in addition to those that require additional resources, and to build on efforts already in motion.

However, stakeholder and informants were nearly universally in agreement that improving reimbursement rates for behavioral health providers was the single most significant lever that the state has to address workforce challenges in the field. Informants and stakeholders identified the low reimbursement rates as the root cause of the sectors' challenges recruiting and retaining a skilled workforce, as well as a contributing factor to the challenges of adequately preparing the workforce to serve in the challenging settings that work with populations most at-risk. Recommendations regarding loan repayment and the reduction of administrative burdens also had very strong stakeholder support. Discussions about dual certifications or changes to scope of practice for providers were among the most controversial – clearly there is much more work to be done in this area if consensus is to be reached.

Many of the recommendations in this report overlap with the work of other workgroups. These recommendations were retained and called out, so that policymakers would have the ability to easily identify those that had support beyond the group engaged in the Behavioral Health Workforce Assessment.

Based on the sheer number of recommendations identified in the short window for data collection, many were identified as “items for further study.” These items are not less important than those for which action steps were recommended. However, most of these items require additional research before specific recommendations for implementation can be made.

Finally, it should be noted that upon further research, it turned out that a number of the recommendations stakeholders suggested had already been wholly or partially resolved. For example, many stakeholders recommended reducing the hours needed for Masters-level professionals to earn a chemical dependency professional certification. Research into this topic showed that rules had already been changed to address this issue. However, the rule changes were not widely known among stakeholders, who were clearly highly engaged and very knowledgeable. This points to the fast pace of change within the field, the number of initiatives that are happening simultaneously, and the ongoing challenge to get important information to the field as quickly and effectively as possible. It may be worth considering ways to improve communication about current efforts in order to avoid duplication and help those in the field focus on those things that still need to be addressed.

Next Steps

What will be in the final report (2017)

This report represents the completion of the first phase of an 18-month project, and addresses the initial findings of workforce-related barriers and short-term solutions to accessing behavioral health services in Washington. Phase II will focus on longer-term solutions to the barriers identified in Phase I, and will provide to the Governor's office and appropriate Legislative committees a final report and recommendations by December 15, 2017 for the 2018 Legislative Session and beyond.

Phase II will:

- Determine whether recommendations in the “for further study” sections of this report have actionable next steps that should be called out for future legislative sessions.
- Identify promising practices and models to be considered for adoption in Washington.
- Examine the supply and distribution of, and demand for, behavioral health occupations and occupations that can deliver integrated behavioral and physical/medical health services across Washington. Specific topics, such as a study of the salaries/wages and other employment incentives of behavioral health providers in different employment settings, will be prioritized using the results of Phase I stakeholder and key informant input, and will capitalize on available reports and data.

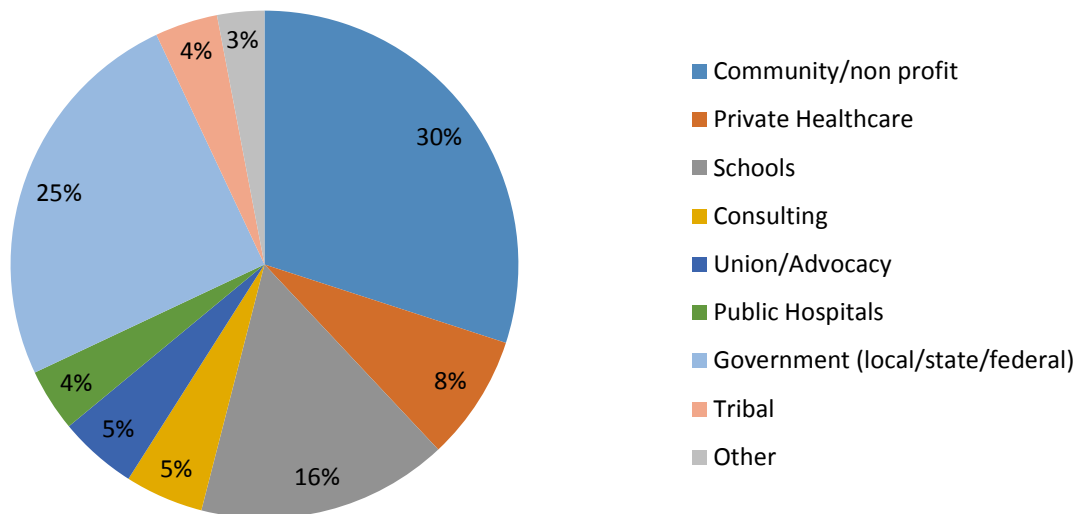
APPENDIX

A: List of participating stakeholders

B: List of key informant agencies

C: Key informant recommendations

Behavioral Health Workforce Stakeholders



Stakeholders & Participants

Aaron Chavez	Wahluke School District	
Abbie Chandler-Doran	Washington Association of Community & Migrant Health Centers	
Adam Marquis	Discovery Behavioral Health	
Agnes Balassa	Agnes Balassa Solutions	
Ahmed Ali	Somali Health Board	
Alexa Silver	Washington State House of Representatives	
Amy Kashiwa	Fairfax Behavioral Health	
Amy Persell	SEIU 775 Healthcare	
Andi Smith	Office of Financial Management	
Ann Christian	Washington Council for Behavioral Health	
Annabelle Payne	Pend Oreille County Counseling Services	
Annette Klinefelter	Daybreak Youth Services	
Avanti Bergquist	Seattle Children's Hospital	
Bea Dixon	Optum Health Services and Innovation Company	
Bob Crittenden	Governor's Office	
Bob Potter	Olympic Workforce Development Council	
Brent Korte	Evergreen Healthcare	
Briana Duffy	Beacon Health Options	
Brigitte Folz	University of Washington	
Caitlin Safford	Amerigroup	
Carl Kester	Lakeside-Milam Recovery Center	
Cassie Undlin	Navos Mental Health Solutions	
Chelene Whiteaker	Washington State Hospital Association	
Cheryl Sanders	Lummi Nation	

Chris Imhoff	Department of Social and Health Services	
Chris Kaasa	Washington Association of Community & Migrant Health Centers	
Christian Jones	Public Consulting Group	
Claudia D'Allegri	SeaMar Community Health Center	
Clifford Thurston	Worldbridgers	
Cody Eccles	Council of Presidents	
Cori Garcia-Hansen	Whatcom Community College	
Dale Sanderson	Sound Mental Health	
Dan Ferguson	Yakima Valley Community College	
Darla Helt	Clark County Parent Coalition	
Dave Wallace	Workforce Training and Education Coordinating Board	
David Bauman	Community Health of Central Washington	
David Lord	Disability Rights Washington	
Devon Nichols	Office of Financial Management	
Diane Norell	Eastern Washington University	
Diane Sosne	SEIU 1199	
Donna Mann	Eastern Washington University	
Donna Patrick	Washington State Developmental Disabilities Council	
Eileen Branscome	Mason General Hospital	
Eleni Papadakis	Workforce Training and Education Coordinating Board	
Elizabeth Krijger	University of Washington	
Emily Gardner	Cowlitz County	
Evan Klein	Washington State Senate	
Georgianna Sedlar	University of Washington - Psychiatry & Behavioral Sciences	
Geri Marcus	Willapa Behavioral Health	
Glenn Czerwinski	Greater Lakes Mental Healthcare	
Grace Creaseman	Eastern Washington University	
Haley Lowe	Department of Social and Health Services	
Heather Stephen-Selby	Washington State Nurses Association	
Ian Goodhew	University of Washington- Government Affairs, School of Medicine	
Ian Harrel	Behavioral Health Resources	
Janice Tufte	Hassanah Consulting (Group Health Research Institute)	
Jason McGill	Office of the Governor	
Jeanne Cushman	AHNE PLLC	
Jeff Thomas	Frontier Behavioral Health	
Jim Adams	Pierce County Careers Connection	
Jim Baumgart	Governor's Office	
Joan Miller	Washington Council for Behavioral Health	
Jodi Perlmutter	Western Washington Area Health Education Center	
Jodi Ryznar	Valley Cities Behavioral Health Care	
Joe LeRoy	HopeSparks	
Joe Roznak	Kitsap Mental Health Services	
John Aultman	Office of the Governor	
John Moren	Community Services Northwest	
Jonathan Anderson	Eastern Washington University	
Joyce Mphande-Finn	City University of Seattle	
Judy Holman	Department of Social and Health Services	

Julie Caruso	Washington State House of Representatives	
Julie Garver	Council of Presidents	
Justin Iwasaki	Lummi Indian Business Council	
Karen Ellis	Kone Consulting	
Katherine Saluskin	Yakama Nation Behavioral Health	
Kathleen Boyle	Amerigroup	
Kathleen Kannenberg	Harborview Medical Center	
Kathy Greco	Kitsap Mental Health Services	
Kathy Schmidt	Department of Health, Office of Health Professions and Facilities	
Kevin McCarthy	Renton Technical College	
Kirsten Wilbur	University of Puget Sound	
Krista Loney	Eastern Washington University	
Laura Collins	University of Washington	
Laura Groshong	Licensed Independent Clinical Social Worker	
Libby Hein	Children's Home Society of Washington	
Lillian Bravo	Washington Association of Community & Migrant Health Centers	
Linda Dale	Heritage University	
Linda Grant	Evergreen Recovery Centers	
Linda Kehoe	Consultant Leadership Development	
Lindsey Grad	SEIU 1199	
Lisa Holt	Jefferson Healthcare	
Liz Stevens	City University of Seattle	
Loni Greninger	Department of Social and Health Services	
Lore Joplan	Lore Joplin Consulting	
Lynda Evans	Employment Security Department	
Mackenzie Dunham	Child and Adolescent Clinic	
Mandy Paradise	Office of Superintendent of Public Instruction	
Marc Bollinger	Great Rivers Behavioral Health	
Margaret Rojas	North Sound Behavioral Health	
Maria Yang	DCHS/Behavioral Health and Recovery Division	
Marianna Goheen	Office of Superintendent of Public Instruction	
Mark Mattke	Spokane Area Workforce Development Council	
Mary Moller	Pacific Lutheran University	
Mary O'Brien	Yakima Valley Farm Workers Clinic	
Mary Stone Smith	Catholic Community Services of Western Washington	
Maureen Kinley	Lummi Nation	
Melanie Gillespie	Foundation for Healthy Generations	
Melet Whinston	United Healthcare	
Melissa Haney	Northwest Physicians Network	
Michelle Mallari	International Community Health Services	
Mike Burke	Yakima Valley Community College	
Mike Watson	Lake Whatcom Residential and Treatment Center	
Nancy Alleman	Washington Rural Health Association	
Nancy Lawton	Greenwood Medical Clinic	
Nancy Salovich	Worldbridgers	
Nancy Tyson	Department of Health	
Nico Janssen	Senator Maria Cantwell's Office	

Nicoleta Alb	Sea Mar Community Health Clinic
Nikki Finkbonner	Lummi Nation
Nova Gattman	Workforce Training and Education Coordinating Board
Pam Brown	Forks Hospital
Pamela Spears	Cowlitz Family Health Center
Pat Beckett	The Children's Center
Patrick Evans	Sound Mental Health
Paul Francis	Council of Presidents
Peter Pastras	Clinical Services Management
Phyllis Cavens	Child and Adolescent Clinic
Rachelle McCarty	UW School of Social Work
Randi Christensen	Kittitas Valley Healthcare
Randon Aea	International Community Health Services
Rashi Gupta	Washington State House of Representatives
Ray Hsiao	Seattle Children's Hospital
Rebecca Bates	Passages Family Support
Rebecca Burch	Health Care Authority
Rebecca Reule	Workforce Training and Education Coordinating Board
Renee Fullerton	Department of Health
Rex Rempel	Lake Washington Technical College
Richard Dietz	Northwest Workforce Council
Richard Stride	Cascade Mental Health
Robin Cronin	Catholic Charities, Diocese of Yakima
Ruth Nash	Columbia River Mental Health Services
Sam Huber	Multicare
Sarah Arnquist	Beacon Health Options
Shaleena Bertram	Lummi Nation
Sharon Shadwell	Department of Health
Shelley McDermott	OTB Solutions
Sofia Aragon	Washington State Nurses Association
Sue Skillman	WWAMI Rural Health Research Center Department of Family Medicine
Susan Chesbrough	Peninsula Community Health Services
Suzan Dula	American Academy of Physicians Assistants
Suzanne Allen	University of Washington School of Medicine
Swatee Surve	LiteSprite
Tammy Moore	Summit Pacific Medical Center
Terri Gushee	Mason General Hospital
Tessa Timmons	Confluence Health
Thomas (Chet) Roshetko	Washington State University
Torri Canda	Amerigroup
Tory Gildred	Coordinated Care Health
Traci Adair	DSHS
Tre Normoyle	Valley View Health Center
Victoria Evans	Molina Healthcare
Wei Yen	Office of Financial Management
Wendy Price	SEIU 1199NW
Zosia Stanley	Washington State Hospital Association

Appendix B – Key Informant Agencies

- American Indian Health Commission for Washington State
- Amerigroup Washington
- ARNPs United of Washington State
- Association of Advanced Practice Psychiatric Nurses
- Central Washington Family Medicine
- Children’s Home Society of Washington
- Clallam County Juvenile & Family Services
- Columbia River Mental Health Services
- Confluence Health
- Cowlitz Indian Tribe
- Department of Health
- Department of Social and Health Services, Eastern State Hospital
- Department of Social and Health Services, Office of Behavioral Health and Prevention
- Educational Service District #112
- Educational Service District #113
- Evergreen Recovery Centers
- Great Rivers Behavioral Health
- Harborview Medical Center
- Kitsap Mental Health
- Lifeline Connections
- Mason General Hospital
- NAVOS
- NeighborCare Clinics
- Office of Superintendent of Public Instruction
- Partners for Our Children
- Pacific Lutheran University School of Nursing
- Private Mental Health Practice
- Seattle Children’s Hospital
- SEIU Healthcare
- Sound Mental Health
- St. Martin’s University
- Sundown M Ranch
- Harborview Medical Center-Psychiatry
- Washington Association of Community & Migrant Health
- Washington Council for Behavioral Health
- Washington State Development Disabilities Council
- Washington State Society for Clinical Social Work
- Willapa Behavioral Health
- Yakima Catholic Family & Child Services
- Yakima Valley Community College

Washington's Behavioral Health Workforce Assessment: Input from Key Informants

November, 2016

Rachelle L. McCarty, Malaika R. Schwartz, Susan M. Skillman
University of Washington Center for Health Workforce Studies

EXECUTIVE SUMMARY

BACKGROUND

In July 2016, Governor Jay Inslee tasked the Workforce Training and Education Coordinating Board (WTECB) to assess the behavioral health workforce in Washington State. As Washington moves toward greater integration of behavioral health and physical/medical care, the WTECB has been charged with creating an action plan to address behavioral health workforce challenges and training needs to facilitate this emerging integrated healthcare model.

The first phase of this assessment identifies barriers and short-term solutions related to Washington's behavioral health workforce. These findings were informed by a series of meetings with stakeholders and interviews with key informants, the latter described in this report. Longer-term solutions to the barriers identified here will be evaluated during the project's second phase in 2017.

The University of Washington Center for Health Workforce Studies (UW CHWS) team conducted the key informants survey in Fall 2016. Potential key informants were identified by the UW CHWS, with input from a wide range of experts. Key informants included clinicians, administrators, advocates, educators, and regulators serving in mental health and chemical dependency inpatient and outpatient facilities, hospitals, schools, and private practice settings. Telephone interviews and online surveys were conducted with 41 key informants over the course of seven weeks. Participants were asked about barriers and solutions, recruitment and retention challenges, and training needs related to the behavioral health workforce in Washington. Additional probes expanded on specific settings, occupations, and incumbent versus new workers' needs.

This report summarizes the common themes related by the key informants, and provides further background to the workforce-related challenges to providing behavioral health care in Washington.

KEY FINDINGS

Barriers: Key informants described a wide range of barriers that affect behavioral health workforce recruitment, retention, and quality in the state. The most commonly mentioned were:

- Limited availability of quality supervision
- Too few professional development opportunities
- Administrative requirements that compete with patient care
- Limited resources to access education and clinical training
- Low reimbursement rates

Continued on back

Challenges in Settings and Occupations: Key informants described many healthcare settings where it is difficult to recruit or retain behavioral health workers, as well as shortages among specific occupations. The most commonly mentioned settings were:

- Rural facilities
- Residential facilities
- Community mental health centers

The most common occupations mentioned were:

- Chemical dependency professionals and addiction specialists
- Psychiatrists
- Other occupations able and trained to prescribe pharmaceutical treatment for mental health and substance use disorders

Challenges in Education and Training: This was an important topic for key informants, who described many barriers and recommended measures for improving workforce education and training. The most commonly mentioned challenges were:

- Education in evidence-based practice and integration of behavioral health with physical health care
- Too few clinical training sites and trained supervisors
- Continuing education opportunities for the behavioral health workforce

Recommendations: Many of the workforce-related recommendations to improve behavioral health care suggested by key informants were specifically targeted to identified barriers. The most common themes were:

- Increase Medicaid reimbursement rates
- Expand opportunities for programs that provide loan repayment in exchange for service
- Better leverage the use of telemedicine and telehealth to address workforce gaps
- Increase access to clinical training sites and residency opportunities
- Increase the availability of quality clinical supervision
- Increase resources for continuing education and training support

SUMMARY

Major workforce-related barriers to providing behavioral health care described by key informants include pay, rural location, quality education and training resources, opportunities for advancement, and general burnout due to high caseloads working with complex, high-need clients. These challenges leave many employers with inadequate resources to attract and retain a high-quality workforce to deliver necessary behavioral health care services.

Several key informants stressed that only by prioritizing behavioral health and recognizing its value can long-term, actionable solutions be effected. This assessment is one among a number of efforts underway in Washington to improve access to and effectiveness of behavioral health care, and should help inform changes to improve the ability of the state to meet increasing behavioral health care needs.

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ACCESS THE REPORT:

The full report "Washington's Behavioral Health Workforce Assessment: Input from Key Informants" can be accessed at:
<http://depts.washington.edu/fammed/chws/wp-content/uploads/sites/5/2016/11/WA-BH-Key-Informants-FR-2016-Nov.pdf>

CONTACT:

Rachelle L. McCarty, Research Scientist | rmccarty@uw.edu | 206-685-1969.
Malaika R. Schwartz, Research Scientist | malaika@uw.edu | 206-685-1990.
Susan M. Skillman, Deputy Director | skillman@uw.edu | 206-543-3557.