

# Washington's Behavioral Health Workforce: Barriers and Solutions



## Phase I Report and Recommendations

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## Executive Summary

As Washington moves forward to achieve integration of its statewide physical and behavioral healthcare systems by 2020, demand for a qualified behavioral health workforce continues to grow. While the state has many highly competent and committed professionals working hard to deliver behavioral health services, barriers to educational attainment, professional recruitment, and long-term retention may prove detrimental to the state's ability to provide sufficient behavioral healthcare—mental health and substance use disorder treatment—to its residents.

The 2019 Washington State Legislature directed the formation of a workgroup, funded by the Health Professions Account,<sup>1</sup> to continue work on select workforce barriers outlined in the Workforce Training and Education Coordinating Board's (Workforce Board) 2017 Washington State Behavioral Health Workforce Assessment. The 2017 assessment described the state's behavioral health workforce landscape, and provided recommendations for research and policy proposals to better understand and address workforce barriers faced by the industry. This new project builds upon that work, and charges the Workforce Board to lead a workgroup to develop recommendations on the following five topic areas:

- a) Reimbursement and incentives for supervision of interns and trainees.
- b) Supervision requirements.
- c) Competency-based training.
- d) Licensing reciprocity or the feasibility of an interstate licensing compact, or both.
- e) Background checks, including barriers to work related to an applicant's criminal history or substance use disorder.

The workgroup is led by the Workforce Board in collaboration with the University of Washington Center for Health Workforce Studies (hereafter "Project Team").

This report represents the first phase of this project. Phase I began September 2019, and ends with this report to the Governor and Legislature on December 1, 2019. Two stakeholder workgroups that included health facility leaders, behavioral health providers, educators, organized labor, not-for-profit organizations, and state and local government agencies shaped the recommendations in this Phase I report. Nearly 100 individuals participated in the development of this report through interviews, large group meetings, and written input.

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<sup>1</sup> Administered by the Washington State Department of Health.

To address shortages in behavioral health professions in Washington, this initial report provides a preliminary analysis of, and recommendations focusing on two of the barrier areas listed in the proviso:

- d) Licensing reciprocity or the feasibility of an interstate compact, or both, and
- e) Background checks, including barriers to work related to an applicant's criminal history or substance use disorder.

As an initial report on the two topics above, this report is not meant to be an exhaustive analysis. The Project Team will continue exploring these topics and more in Phase II of the project.

Phase II of the project will begin in January 2020. The early recommendations made in the Phase I report will be finalized in Phase II, and the three remaining barriers named in the proviso above will be explored in detail in a final report to the Legislature by December 1, 2020.

## Key Findings

When asked about the specific topics covered in this report, stakeholders were consistent in mentioning the following challenges:

### Reciprocity and Interstate Agreements

- The current licensing and credentialing processes for behavioral health professionals and paraprofessionals who have already established licensure and practice outside of Washington are causing problems for workers and employers, and perhaps patients.
- Stakeholders want faster and more efficient processes for licensing and credentialing well-qualified veteran behavioral health professionals and paraprofessionals that are taking up residence in Washington and seeking to work in behavioral healthcare, especially for military spouses/domestic partners.
- Stakeholders viewed interstate variation in clinical practice and licensing requirements for behavioral health professionals and paraprofessionals as a major barrier to licensure reciprocity, and wanted clarity on which behavioral health practitioners were suited for reciprocity.
- Interstate compacts for licensure were generally perceived as impractical for addressing immediate workforce needs, but worth further inquiry as part of a longer-term solution.

### Background Checks

- Background checks are viewed as necessary for public safety, mandated by federal laws, and required to access certain funding. But stakeholders raised some concerns about their application and the time required for completion.
- Some stakeholders were unclear about what types of background checks were required for various occupations.
- Stakeholders desired greater transparency regarding how background check information is used by boards and employers in licensing, credentialing, and employment, as well as consideration of equity in how background checks are applied.
- Stakeholders generally agreed background check use should be regularly reviewed by appropriate authorities to: assess effects of the background check process on efficient licensing and employment; maintain patient safety; and to ensure equitable application with populations disproportionately affected by substance use disorders and/or inherent biases in the criminal justice system.

## Recommendations

*For specific details on each topic area, including the action required for each recommendation, please see page 12.*

### **Topic 1: Increase opportunities for behavioral health professionals relocating to Washington to more easily transfer out-of-state professional credentials through expanded licensing reciprocity.**

- 1) Expand Washington's lists of states with substantial equivalency in licensing requirements to include all credentialed behavioral health professions, in addition to existing lists for psychologists and substance use disorder professionals (SUDPs).
- 2) Identify states with successful behavioral health profession interstate compacts, and the behavioral health occupations to which they apply.
- 3) Increase access of behavioral health professionals who are spouses/registered domestic partners of military personnel to obtain licensure through reciprocity upon moving to Washington.

### **Topic 2: Review and adapt existing background check policies and practices to increase behavioral health workforce entry and retention, while upholding patient protection and safety measures.**

- 4) Clarify and improve consistency in background check use in clinical hiring and education training/admission decisions.
- 5) Evaluate existing scope of background checks for professional licensing, credentialing, and employment, to identify aspects that disproportionately impact certain types of behavioral health providers and demographic populations.

## Background

The 2017 Washington State Behavioral Health Workforce Assessment determined *“the demand for behavioral healthcare—mental health and substance use disorder treatment—exceeds the availability of services throughout the state”* (Gattman et al., 2017, p.1). The assessment went on to detail specific policy recommendations to increase the number of available behavioral health workforce members to provide Washington residents with more timely access and appropriate behavioral healthcare (Gattman et al., 2017). This report expands upon work done in the 2017 assessment.

**The demand for behavioral healthcare exceeds the availability of services throughout the state.**

The behavioral health workforce can be found in a multitude of professional settings including, but not limited to: inpatient and outpatient treatment facilities; physical/medical care delivery locations; educational institutions; community-based behavioral health agencies; drug and alcohol treatment centers; and private practice. Many occupations involved in providing substance use disorder and mental health treatment are recognizable by name and are profiled in the preceding 2017 assessment: psychiatrists, clinical/counseling psychologists, psychiatric advanced registered nurse practitioners, social workers, mental health counselors, marriage and family therapists, substance use disorder professionals, certified peer counselors, and community health workers. In conjunction with their primary medical care roles, many physical medical providers also provide behavioral health services.

## The Burden of Disease and Barriers to Care

Washington residents continue to experience significant disease burden from mental illness and substance use disorders, and difficulty accessing treatment and maintaining recovery. In 2016 and 2017, an estimated 18.8 percent of Washington adults received treatment for mental illness in the preceding year. However, an estimated 7.1 percent (approximately 398,000 Washingtonians) faced an unmet need in their mental health treatment within the past year, and among them, many did not know where to seek treatment (20.6 percent), or thought they could “handle” the challenges without treatment (30.1 percent). In the same span, an estimated 6.2 percent of Washingtonians experienced substance use disorder within the same year, and 8.4 percent reported receiving substance use disorder treatment in their lifetime (Substance Abuse and Mental Health Data Archive, 2019).

Statewide, pregnant or parenting individuals, as well as those who have had involvement with the criminal justice system, face particularly glaring gaps in behavioral

health treatment (McGill, 2019). Sufficient availability of appropriately-trained workers to identify, assess, treat, and monitor these patients is a necessary component to providing high-quality behavioral healthcare and reducing disparities in access to appropriate care.

Washington is not unique in facing the complex challenge of addressing access to appropriate behavioral health services; the problem is equally challenging at the national level. In 2018, an estimated 19.1 percent (47.6 million) of U.S. adults aged 18 years or older lived with a diagnosed mental illness, and 4.6 percent (11.4 million) experienced significant mental illness (SAMHSA, 2019). Of the 11.5 million U.S. adults severely impaired by a major depressive episode, 31.4 percent did not receive treatment, a statistically significant reduction in access to treatment compared with the preceding seven years (SAMHSA, 2019).

**47.6 million**  
**U.S. adults lived with a**  
**diagnosed mental**  
**illness in 2018.**

In 2018, 7.8 percent of U.S. adults (19.3 million) experienced at least one substance use disorder. Within this population, 75.4 percent faced alcohol use disorder, 38.3 percent experienced prescription or other drug use disorder, and 12.9 percent experienced co-occurring alcohol and drug use disorders. In the same year, substance use disorder treatment was provided to 15.3 percent of individuals 18- to 25-years old, 7.0 percent of those 26 years or older, and 3.8 percent of 12- to 17-year-olds. In 2018, among the estimated 9.2 million individuals experiencing co-occurring substance use disorder and mental illness, 48.6 percent did not receive care for either, a statistic unchanged since 2015 (SAMSHA, 2019).

**19.3 million**  
**U.S. adults experienced**  
**at least one substance**  
**use disorder in 2018.**

There is significant variation in the geographic distribution of behavioral health providers, complicating access to care, and creating significant disparities in care for those living in non-metropolitan counties in Washington and throughout the U.S. (Andrilla et al., 2018). The behavioral health workforce shortage in community settings is expected to worsen as experienced behavioral health professionals and paraprofessionals exit for private practice or hospital-based settings with better pay and lighter caseloads, or retire altogether. New entrants to the field, often graduating with large student loan debt, tend to begin their career in a community-based setting. With severe funding limitations because of the large percentage of Medicaid-funded services, these facilities have high worker-to-patient ratios, and lower pay scales than hospital-based facilities or others with a higher proportion of private pay patients. Community-



based workers are assigned large caseloads and field increasing demand for services from the community, adding additional stress to their over-burdened workload (Thompson, Flaum, and Pollack, 2017).

## **Measuring Workforce Demand through Washington’s Health Workforce Sentinel Network**

Measuring health workforce demand involves gathering information, such as the number of available jobs, employed hours, specific needed skills, and changes to workforce roles. Typical workforce demand statistics, such as those maintained by state and federal labor/employment agencies, are represented by job vacancies and turnover measures. It is more difficult to find information describing changes in skills and roles required to meet employers’ needs, and the reasons for gaps between workforce supply and demand.

Washington’s Health Workforce Sentinel Network,<sup>2</sup> an initiative of the Washington Health Workforce Council,<sup>3</sup> in collaboration with the Workforce Board and the University of Washington Center for Health Workforce Studies (UW CHWS), provides qualitative information about health workforce demand in Washington. Through the Sentinel Network, the Workforce Board and the UW CHWS are tracking changes in health workforce demand across the state. The Sentinel Network employs a voluntary short survey of Washington’s healthcare employers which collects data that signal changes in occupations, skills, and roles needed by healthcare employers and employers’ descriptions of the reasons for those needs.

Since its inception in 2016, the Sentinel Network has consistently prompted a relatively high number of responses from behavioral/mental health settings, community health centers, medical clinics, and other settings employing occupations that provide behavioral health services. At every reporting opportunity since 2016, mental health counselors and substance use disorder professionals (formerly chemical dependency professionals) were identified as the top two positions with “exceptionally long vacancies” as reported by behavioral health facilities. Social workers were consistently named among the top four positions with exceptionally long vacancies in these settings since 2016.

More recently, in reporting from summer 2018 and fall 2019, peer counselor positions were among the top four occupations identified with exceptionally long vacancies in these settings. These responses further validate that Washington has a persistent problem accessing the necessary workforce to meet the behavioral healthcare needs of residents. Detailed responses from employers to Washington’s Health Workforce

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<sup>2</sup> <http://wa.sentinelnetwork.org/>

<sup>3</sup> <http://www.wtb.wa.gov/HealthWorkforceCouncil.asp>

Sentinel Network can be examined online. See the chart below for a full list of the top occupations referenced by Sentinels at behavioral health clinics.

Top occupations cited as having exceptionally long vacancies by date of reporting						
Summer 2016	Winter 2016	Spring 2017	Fall 2017	Summer 2018	Spring 2019	Fall 2019
Mental health counselor	Chemical dependency professional	Mental health counselor	Chemical dependency professional	Mental health counselor	Mental health counselor	Mental health counselor Chemical dependency professional
Chemical dependency professional	Mental health counselor	Chemical dependency professional	Mental health counselor	Chemical dependency professional Peer counselor	Chemical dependency professional	Social worker
Social worker	Social worker	Social worker	Social worker Nurse practitioner	Nurse practitioner	Social worker	Peer counselor
Nurse practitioner	Nurse practitioner Psychiatrist	Nurse practitioner	Peer counselor	Social worker Psychiatrist	Marriage & Family Therapist	Psychiatrist Psychologist Nurse practitioner
Registered nurse Psychiatrist	Marriage & Family Therapist	Registered nurse	Registered nurse Psychiatrist Psychologist	Marriage & Family Therapist Medical assistant	Peer counselor	Registered nurse

← Most cited

### Project to Improve Behavioral Health Workforce and Access to Care

As part of efforts to address these persistent challenges, the Washington State Legislature directed the Workforce Board to convene a workgroup to develop policy recommendations on the topics listed below. The barriers and recommendations outlined in the 2017 Washington State Behavioral Health Workforce Assessment provided the starting point for the workgroup.

The workgroup is charged with addressing the following policy topics:

- a) Reimbursement and incentives for supervision of interns and trainees.
- b) Supervision requirements.
- c) Competency-based training.
- d) Licensing reciprocity or the feasibility of an interstate licensing compact, or both.
- e) Background checks, including barriers to work related to an applicant’s criminal history or substance use disorder.

The work involved is divided into two phases. Phase I took place from September through November 2019 and involved researching and gathering stakeholder feedback for early recommendations to policymakers. Phase II begins January 2020 and will involve more in-depth research and stakeholder engagement to further collect input and collaboratively develop policy recommendations on all five barriers to the behavioral health workforce listed above by December 2020.

In Phase I, the Project Team began study activities (detailed in Approach) addressing two of the topics specified in the proviso:

- d) Licensing reciprocity or the feasibility of an interstate compact, and
- e) Background checks, including barriers to work related to an applicant's criminal history or substance use disorder.

This Phase I report details the workgroup findings resulting from research and literature review by the Project Team, and stakeholder input. Specific recommendations for actionable solutions to address these challenges were developed through the stakeholder engagement process and are also detailed in this report.

## **Approach**

The Project Team conducted stakeholder meetings and interviews to identify and report on the problems, barriers, potential solutions, and recommendations for topic areas to be covered in Phase I. Stakeholder input was supplemented with: background research on relevant published findings; reports and guidance by federal and local government agencies; and industry and advocacy reports, among other sources. Formal group stakeholder meetings were conducted in person in Renton, Washington on September 24, 2019 and through an online webinar on October 7, 2019. Meeting participants included a wide range of stakeholders interested in the topics to be covered in Phase I, providing input from a broad range of organizations, facilities, practitioners, and agencies from across the state.

This work was supplemented with interviews with content specialists and key informants. Interviews conducted during Phase I helped provide additional detailed stakeholder input on the topics involved, and build stakeholder engagement for Phase II of the work. (See page 28 for the full list of Phase I participants.) Stakeholder participation was solicited statewide, in order to understand the needs of providers in varying geographies. Outreach garnered representation from central, eastern, and southwest Washington, as well as western Washington.

Background research on federal and other states' policies helped identify important interstate initiatives and relevant state and federal practices and regulations for each topic, and inform policy recommendations.

## Topic I: Reciprocity and Interstate Agreements

### Purpose and Definitions

License reciprocity is a policy that allows a professional who is licensed to practice in one state to gain licensure in another state through recognition of their prior licensure and practice experience. In contrast, a professional licensing interstate agreement or interstate compact allows a professional, who is already licensed to practice in a given state, to practice in other states which are members of the compact, without requiring the professional to apply for and secure an additional license in the other states (Understanding Interstate Licensure, 2003).

To increase availability of behavioral healthcare workers, some states have passed licensing reciprocity agreements and/or interstate compacts into law, with the intention of reducing barriers to licensure or certification when a behavioral health professional—who already holds a license in one state—wishes to practice in another state.

### National Overview of Reciprocity and Interstate Compacts for Behavioral Health Licensure

Scope of practice for each behavioral health occupation varies by state, as do licensing standards. The level of education, training, testing, supervision, and practice experience needed to meet the requirements for licensure are typically set by each profession's state board or commission. This variation in licensing standards would need to be considered for licensing reciprocity or interstate agreements to work in a predictable way for these professions. Some occupations are further along than others; psychologists and licensed clinical social workers typically have less variation in licensing standards among states when compared with specialized behavioral health professions and paraprofessionals such as peer counselors (Page et al., 2017).

Reflecting a need for consistency in behavioral health professional scope of practice, several national professional and certification organizations have developed standardized certifications for specialized licensed professionals treating substance use disorders. The Association for Addiction Professionals (NAADAC) has developed standardized exams used in most states, including Washington, to establish qualifications to practice for some types of substance use disorder professionals (NAADAC, 2019). The International Certification & Reciprocity Consortium (IC&RC) has developed certification standards used by many state licensing agencies – including those in Washington—responsible for oversight of various types of substance use disorder professionals (IC&RC, 2019).

Other mental health professionals also have resources and examples of existing interstate licensing agreements to draw upon. The Psychology Interjurisdictional Compact (PSYPACT) was created in 2015 through the Association of State and Provincial

Psychology Boards (ASPPB) with the initial goal of addressing telepsychology licensing to improve access to care. The compact was later amended to allow psychologists licensed in any member state to practice using in-person interactions, in addition to telepsychology, with patients in any other member state for a limited 30-day period without requiring an additional license (ASPPB, 2019). Washington is not currently a member of PSYPACT.

### **Other Healthcare Licensure Compacts and Agreements**

There are also compacts for licensed healthcare professionals who may provide behavioral health treatment in addition to other services, such as primary or specialty care. For example, the Nurse Licensure Compact (NLC) provides a process for licensed nurses (registered and licensed practical/vocational), including psychiatric nurses, to practice in 36 member states (NLC, 2019). Similarly the Interstate Medical Licensure Compact (IMLC) allows medical and osteopathic doctors, including psychiatrists, to practice in 29 member states (IMLC Commission, 2019). Washington is one of these member states.

Arizona's 2019 deregulation of all occupational licensing represented a major policy shift, with some qualifiers written into the law. The new law permits the issuance of an occupational license *"in the discipline applied for and at the same practice level as determined by the regulating authority to a person"* establishing residence in Arizona. The professional must be currently licensed or certified for a minimum of one year in another state, meeting *"minimum education requirements and, if applicable, work experience and clinical supervision requirements."* The other state must also verify the applicant met their requirements, passed a licensing/credentialing examination, has no unresolved/uncorrected disciplinary action on the previous license, or had the license revoked. Applicants may also be required to pass a state law-specific exam in Arizona (HB 2569 P, 2019).

Other historic compacts focused on mental health treatment provision. Between 1967 and 1980, eight states<sup>4</sup> enacted the Interstate Compact on Mentally Disordered Offenders, through which member states sought to promote: *"research and training of personnel on a cooperative basis, in order to improve the quality or quantity of personnel available for the proper staffing of programs, services, and facilities"* (Interstate Compact on Mentally Disordered Offenders, 2019).

### **Washington's Participation in Compacts Related to Behavioral Healthcare**

Washington enacted the Compact on Mental Health in 1965, joining 44 other states and the District of Columbia to provide mental healthcare for patients *"in need of institutionalization by reason of mental illness or mental deficiency,"* with the

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<sup>4</sup> Delaware, Illinois, Maine, Missouri, New Hampshire, New Mexico, North Dakota, and West Virginia.

understanding that *"community safety and humanitarianism require that facilities and services be made available for all who are in need of them"* (RCW 72.27.01, Article I- Article III (a)).

Although the compact does not contain specific language for staffing, it does grant powers to make rules and regulations to meet the needs of the compact (RCW 72.27.01, Article X). Furthermore, the Compact, as chaptered in Washington law, authorizes party states' administrative authorities to collaborate and take action to improve care collectively (RCW 72.27.01, Article XI).

The Washington State Department of Health (DOH) maintains a list of other states with "substantially equivalent" licensing requirements for psychologists and substance use disorder professionals. For substance use disorder professionals, *"all applicants credentialed in another state can be certified without taking the required exam if the other state's credential standards are equivalent to those of Washington"* (WAC 246-811-060). Applicant substance use disorder professionals are still required to demonstrate they meet education and experience requirements for certification (DOH, 2019).

For psychologists, *"Washington State may issue credentials to applicants with credentials in another state based upon the other state's qualifications. The other state's credentialing standards must be equivalent to Washington State's qualifications"* (DOH, 2019).

In 2019, Washington took action to expand reciprocity for other behavioral health professions. The Legislature enacted Senate Bill 5054, which requires DOH to: *"(1) Establish a reciprocity program for applicants for licensure or certification as a psychologist, chemical dependency professional, mental health counselor, social worker, or marriage and family therapist in the state"* (SB 5054, 2019). This effort is currently in the rulemaking process. The Project Team is closely monitoring and participating in this work to ensure the related activities are complementary.

Given the need for behavioral healthcare workers in most professions across the U.S., it appears reasonable to assume reciprocity agreements alone are unlikely to lead to a sharp increase in the supply of behavioral healthcare workers in Washington. However, by increasing opportunities for license reciprocity, qualified behavioral health professionals who move to Washington or who live and work near state borders may be able to gain licensure more quickly and provide care sooner to Washington residents in need.

## Recommendations

### **Topic 1: Increase opportunities for behavioral health professionals relocating to Washington to more easily transfer out-of-state professional credentials through expanded licensing reciprocity.**

**Workforce-related barrier:** *The complexity and variation of behavioral health profession licenses/certification between states makes hiring trained employees relocating to Washington a difficult, slow, and sometimes impractical undertaking.*

Unlike many physical health occupations, behavioral health professionals experience variety in licensing requirements and scopes of practice from state-to-state, resulting in a patchwork of educational and supervised practice requirements for licensure. For example, both Massachusetts and Washington offer certification for a Licensed Independent Clinical Social Worker, but while Massachusetts requires 3,500 hours of postgraduate supervised practice, accumulated over a minimum of two years, Washington requires 4,000 hours of postgraduate supervised practice, accumulated over a minimum of three years.

Such variation creates significant barriers to transferring behavioral health licensure between states, including but not limited to: challenges applying for and receiving licensure in the new state; cost of additional training education, and/or supervised practice to meet new state requirements; and limited employment opportunities, as many employers require completed licensure. Transitional licenses (such as an associate license) stipulate limitations on where applicants are permitted to work.

Stakeholders voiced concerns regarding the availability of information related to licensing reciprocity, both for job seekers new to Washington and employers recruiting out-of-state workers to Washington. Practitioners holding current licensure from other states cannot practice in Washington until they have been credentialed by the Washington State Department of Health, which oversees licensure and credentialing for all behavioral health professions, with the exception of peer counselors, which are certified by the Washington State Health Care Authority. Delays in this process can lead to employers assuming the financial burden of sponsoring licensure, which may include costs associated with provision of supervision, licensing fees, and paying employee salary and benefit costs until the employee is permitted to engage in billable clinical practice hours.

**Recommendation 1: Expand Washington’s lists of states with substantial equivalency in licensing requirements to include all credentialed behavioral health professions, in addition to existing lists for psychologists and substance use disorder professionals (SUDPs).**

At present, DOH maintains lists of “Substantially Equivalent States/Countries” for psychologists and SUDPs. The lists identify states and other jurisdictions determined to have educational and practice training requirements comparable to Washington. For psychologists, the list notes the date of review for individual states and if the state has been deemed “equivalent.” For states deemed not equivalent, DOH notes how psychologist applicants for Washington licensure who are licensed in the respective state may meet Washington qualifications. Such specifications for additional measures for “non-equivalent” states are not available for SUDPs.

In stakeholder discussions, many participants noted confusion regarding requirements for licensure application in Washington for those practitioners already holding approved licensure in another state. Employers reported lengthy delays in the licensure application process when hiring out-of-state clinicians, resulting in disruption in client care, significant financial burden, and potential loss of workers who may depart in favor of employment in states with a less-challenging process. When asked which behavioral health professions are affected by a lack of licensing reciprocity, stakeholders reported a broad spectrum, with particular emphasis on masters-level clinicians (licensed independent clinical social worker, licensed marriage and family therapist, licensed mental health counselor) and substance use disorder professionals.

**Action Required:** As part of their work in implementing SB 5054, and with resources allocated for this purpose, DOH should expand the existing substantial equivalency lists to include all credentialed/licensed behavioral health occupations. Lists should model the psychologist list, including specifications of necessary measures to meet Washington requirements, and begin by examining and assessing comparability between Washington and the five states with the highest rates of behavioral health professionals relocating to Washington, as well as “neighboring states,” as defined by DOH, with a long-term goal of capturing information for all 50 states.

**Recommendation 2: Identify states with successful behavioral health profession interstate compacts, and the behavioral health occupations to which they apply.**

The complex jurisdictional patchwork of state-regulated behavioral health professional licensure creates a challenging foundation to build an interstate compact. Enacting compacts typically require passage of legislation by each member state, as well as involvement of a broad spectrum of stakeholders, including professional associations, labor unions, licensing authorities, employers, and state agencies.



Each behavioral health occupation has unique education, training, and scope of practice standards, which often vary by state. While the ease of movement afforded by an interstate compact membership is appealing, it is important to assess the impact of such a policy on care quality, workforce access, and employer needs.

To determine the feasibility of Washington's participation in any behavioral health profession compacts, an examination of existing compacts and their member-states would be a necessary first step. From there, successful strategies for legislative development and implementation, challenges faced and overcome by member-states in enacting such legislation, regulatory hurdles, and positive or negative impact on populations served by providers within the compact can be identified.

Similarly, an analysis of existing interstate compacts among behavioral health professions, such as those existing for psychiatrists and nurse practitioners (including psychiatric nurse practitioners), can help to identify aspects of clinical practice that can be standardized, evaluated, and regulated among multiple state authorities, as well as those professions better suited for reciprocity measures such as licensure by endorsement or provisional licensure.

**Action Required:** With resources allocated for this purpose, University of Washington Center for Health Workforce Studies, with consultation from the Workforce Board and Health Workforce Council, should conduct a study to identify states with successful adoption of interstate behavioral health professional compacts, and which occupations have successfully implemented interstate agreements. The goal of this study would be to develop policy considerations for Washington's potential participation in interstate compacts.

**Recommendation 3: Increase access of behavioral health professionals who are spouses/registered domestic partners of military personnel to obtain licensure through reciprocity upon moving to Washington.**

In both workgroup meetings and key informant interviews, stakeholders noted the additional burdens faced by behavioral health practitioners affiliated with the military, particularly spouses and domestic partners of active duty service members. These providers are more likely to move between states due to change in military assignment, and face a unique set of professional licensure hurdles at every new duty station or permanent change of station.

Stakeholders noted that for providers serving within the military community (typically on a base or in a veteran-affiliated capacity), billing permissions are restricted to physicians, nurses, and clinical social workers, limiting employment opportunities for military-affiliated behavioral health professionals who do not fall into these categories.

Establishing a single point of assistance specifically for spouses/registered domestic partners of military personnel to attain employment in Washington and navigate the licensure transition system was identified as a potential solution. DOH currently employs a staff member with the responsibility to help transitioning military members navigate health careers in Washington. Going forward, DOH could determine the feasibility of marketing this service to also connect with military spouses/registered domestic partners seeking employment and licensure reciprocity in Washington.

Similarly, the Washington State Employment Security Department (ESD) operates WorkSource Washington, which functions as an employment and job training resource for employers and potential job seekers in the state. ESD's employment navigation services could provide spouses/registered domestic partners of military personnel with a centralized information source related to behavioral health employment opportunities (and relevant requirements) upon transfer to Washington.

**Action Required:** With resources allocated for this purpose, ESD, in collaboration with DOH, should be charged with developing and implementing an employment navigation program, with a focus on serving all incoming spouses/domestic partners of military personnel seeking behavioral health professional licensure. This should be highlighted on the WorkSource Washington website,<sup>5</sup> and potentially in tandem with an existing initiative on this topic by the Washington State Military Transition Council.

### Items Requiring Further Study for Phase II

- Explore implementing more behavioral health apprenticeship programs.
- Explore a navigation model to support military personnel interested in behavioral health careers as they transition to civilian employment.
- Where appropriate, consider greater use of certification of behavioral health occupations, which stakeholders identified as potentially a faster process than licensure.
- Identify funding sources, such as grants, for offsetting individuals' costs of licensure/credentialing for behavioral health professionals moving into Washington.
- Work with DOH and Health Care Authority to explore alternative pathways to state licensure for behavioral health occupations, including consideration of a "5<sup>th</sup> year" residency option, as is used to evaluate foreign medical school graduates seeking to practice in the U.S. Any related recommendations would need to be feasible for Medicaid reimbursement.
- Investigate strategies to reduce processing time for applications for behavioral health licensure through reciprocity, including exploring the concept of offering provisional license to practice while waiting for administrative processing.

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<sup>5</sup> [www.WorkSourceWA.com](http://www.WorkSourceWA.com)

- Work with appropriate entities, such as Welcome Back Centers and/or Washington Association for Community Health, to develop recommendations for improving the licensure process for internationally trained behavioral health practitioners moving to Washington.
- Create a crosswalk based on licensure/credentialing requirements for specific behavioral health professions across states and military programs to identify areas of alignment with Washington’s requirements, as well as gaps.
- Partner with educational institutions to map stackable education credential additions to meet Washington’s licensure requirements, and use Credential Engine’s<sup>6</sup> existing crosswalk pilot programming to develop behavioral health license/credential crosswalks in Washington.

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<sup>6</sup> [www.credentialengine.com](http://www.credentialengine.com)

## Topic II: Background Checks

### Purpose and Definitions

Background checks are required for licensure and/or employment in many behavioral health occupations. These checks typically examine an applicant's criminal or substance use history, with the goal of preventing risk to vulnerable patient populations, but may also present unnecessary barriers to employment of needed behavioral health professionals. The purpose of this inquiry was to assess how background checks are deployed in licensing and employment of behavioral health occupations in Washington, and recommend opportunities to address issues posing barriers to access to care provision. Any changes in policy regarding the use of background checks for behavioral health workers will need to balance patient safety, workforce availability, and equity.

In this context, stakeholders have expressed concern about the availability of appropriate workforce members likely to have a criminal or substance use history who can help address behavioral healthcare needs. For example, peer counselors provide a recognized therapeutic function in behavioral health treatment because of their prior lived experience, which some patients may identify with and draw support from in their recovery. Peer counselors are a valued part of community behavioral healthcare teams in agencies across the state: they act as guides and role models for those undergoing behavioral health treatment, and provide hope that recovery is possible. However, this lived experience may also include criminal justice involvement, which can put peer counselors at risk for failure to pass background checks required for employment or credentialing.

When background checks are used to unnecessarily exclude individuals from providing behavioral health services due to a criminal or substance use record, the result may reduce patient access to behavioral healthcare. In 2019, the past president of Oregon's Addiction Counselor Certification Board reported that, *"one-in-five behavioral health workers with a criminal history have been denied employment because of that history,"* despite high demand for such workers (Foden-Vencil, 2019).

DOH staff indicated that length of time since an infraction's occurrence and the applicant's self-disclosure of past criminal and/or substance use history is considered when reviewing background check results as part of applications for licensure.

### National Overview of Background Checks

In 2008, a national screening pilot project presented to the U.S. Senate indicated that 9,500 individuals with past convictions for offenses were denied employment in home health settings due to background check results, which used FBI fingerprint data, in addition to other sources (United States Senate, 2008). The FBI is authorized (through public law 92-544) to exchange federal criminal history record information with state

and local government agencies for licensing and employment purposes, and FBI fingerprint data are now used in many state agencies' background checks throughout the United States.

In 2012, the Equal Employment and Opportunity Commission (EEOC) issued specific guidance on the use of background checks under Title VII of the Civil Rights Act, which required employers to meet certain criteria before disqualifying a specific candidate for employment based on criminal history information:

*"There are two ways in which an employer's use of criminal history information may be discriminatory. First, the relevant law, Title VII of the Civil Rights Act of 1964, prohibits employers from treating job applicants or employees with the same criminal records differently because of their race, national origin, or other protected characteristic (disparate treatment discrimination). Second, the law also prohibits disparate impact discrimination. This means that, if criminal record exclusions operate to disproportionately exclude people of a particular race or national origin, the employer has to show that the exclusions are 'job related and consistent with business necessity' under Title VII to avoid liability.' [Doing so] is not burdensome. The employer can make this showing if, in screening applicants for criminal conduct, it (1) considers at least the nature of the crime, the time elapsed since the criminal conduct occurred, and the nature of the specific job in question, and (2) gives an applicant who is excluded by the screen the opportunity to show why he/[she] should not be excluded."* (EEOC, 2012).

Similarly, a 2016 report by the National Employment Law Project (NELP) noted that, *"people with arrest or conviction records are protected under Title VII because the use of criminal background checks has a significant 'disparate impact' on people of color"* (Williams et al., 2016, p. 60). Despite this, employers may circumvent such protections if the applicant's conviction *"would compromise the requirements of the job and there are no alternatives to such exclusions"* (Williams et al., 2016, p. 60).

In an attempt to lessen disparate impact on communities of color, fair-chance laws, which include 'ban-the-box' policies, have proliferated throughout the U.S. As of July 2019, 35 states, including Washington, and 150 cities and counties had implemented some kind of 'ban-the-box' regulation, preventing some potential employers from asking applicants about criminal or arrest history prior to evaluating the candidate on qualifications for the position (Avery, 2019).

Certain occupational settings are exempted from these laws, including those working with vulnerable adults, and the background check can still be applied after offering the position, creating a conditional hiring situation. In some cases, applicants can provide a hiring committee with additional information related to their criminal and/or recovery history, which can be reviewed by the committee. However, the review processes

conducted by agencies or employers may be uneven, varied, and potentially subject to implicit or overt bias, as are other hiring processes throughout the U.S. (Sherman, 2017).

Communities of color in Washington continue to experience disproportionate marginalization and disparate impact. This indicates more robust measures may be needed to prevent intentional and unintentional hiring discrimination on the basis of race.

### **Lack of Clarity of Background Check Application**

Several stakeholders noted confusion resulting from the lack of a centralized “clearinghouse” for all background check-related questions, policies, and processes. Confusion was mentioned specifically regarding which types of checks are conducted (e.g., federal versus Washington versus other states), for which professions or licenses each check is relevant, and what authority is responsible for which check.

Centralization could also contribute to a streamlining of the overall licensure and/or employment application processes, as the administrative timeline followed by the governing body is frequently prolonged by delays related to background check processing. Development of such a policy should include active stakeholder engagement, with particular emphasis on equitable representation of employers (e.g., community behavioral health agencies, hospitals, schools, and treatment facilities).

The Project Team attempted to produce a recommendation intended to reduce difference in conduct and interpretation of background checks between behavioral health agencies, but was unable to reach consensus on the best format for this process. As such, this effort will be included in the items for further inquiry, and will remain a priority as Phase II of the report begins January 2020.

### **Recommendations**

**Topic 2: Review and adapt existing background check policies and practices to increase behavioral health workforce entry and retention, while upholding patient protection and safety measures.**

**Workforce-related barrier:** *The broad scope of background check implementation, utilization, and frequency may pose significant barriers to both entry into, and retention within the behavioral health workforce.*

Background checks function as a mode of consumer protection by identifying individuals with criminal histories that might harm patients and put employers at risk. These checks evaluate authenticity of employment history, education, professional license, driving record, criminal offense history, substance use testing, and fingerprinting, among other items. Considering the potential for frequent contact with vulnerable populations such as children, the elderly, and people with developmental and

physical disabilities, behavioral health employers have a responsibility to conduct comprehensive evaluation of a potential employee's history, to ascertain if the prospective employee will pose significant risk to patients or the employer.

Stakeholders identified specific barriers presented by background checks including: cost of conducting the check(s), particularly to the student/worker; time required, both of employer and worker, to complete the check(s); confusion regarding who is conducting the check, and at what level (e.g., federal/FBI, current state of practice, previous state of residence, etc.); and lack of consistency in how background checks are interpreted, particularly in hiring decisions. Also identified was a lack of communication and/or clear practice standards between agencies and employers in the use of background checks due to variation among professions, different purposes of background checks (e.g., certification vs. for employment), and different levels of risk, among other reasons.

The scope of who is requiring the background checks varies, as well. Checks may be required for licensing/credentialing by state agencies; for education program entry by educational institutions; for assignments to clinical training by the clinical training site; at initial employment by the employer; and occasionally at intervals during employment. Despite the frequent opportunity for conducting background checks, stakeholders reported confusion regarding the existence of a standardized process for which checks are conducted, and for which purpose, at various points in the behavioral health career path.

While the entire behavioral health workforce is affected by barriers related to background checks, certain specific populations within this workforce are more heavily-impacted. Stakeholders noted the particular difficulty faced by previously incarcerated persons to entering behavioral health careers, as employment restrictions and limitations resulting from background check results can prevent eligibility in working with certain populations, such as children and vulnerable adults. Similarly, several stakeholders identified peer counselors, who draw upon lived experience as a central aspect of their behavioral health practice, as likely to face negative impacts of background check results related to hiring decisions.

Current background check use may limit access to employment for historically marginalized communities, such as Native American, African American, and Latino populations. Such populations are more likely to experience prior involvement with the criminal justice system and face low representation within the behavioral health workforce. Another challenge focuses on character competency and suitability reviews, utilized when a potential employee's background check results include non-disqualifying conviction(s), pending charge(s), and/or negative charge(s), and are a subjective measure used by potential employers. Stakeholders identified these reviews

as being inconsistently used, and a related barrier that can lead to bias stemming from institutional racism.

**Recommendation 4: Clarify and improve consistency in background check use in clinical hiring and education training/admission decisions.**

Stakeholders frequently named inconsistent use of background check results as a barrier to both entry and long-term retention/career pathway movement within the behavioral health field. While various reasons were named for such inconsistency, consensus identified a lack of training related to background check reading, interpretation, and implementation as most problematic. Despite the frequency of using background checks in hiring and retention decisions, stakeholders reported that few employers provide related training. Consistency in background check use requires developing guidelines, as well as training and educating hiring managers and others who frequently use and/or interpret background checks.

**Action Required:** As part of its Phase II work, the Project Team, with support of the workgroup, will research and evaluate best practices for consistent background check use, with the intent of informing a curriculum and/or training guidelines for the interpretation and use of background checks in hiring processes and education/training program admissions. The curriculum/training guidelines should consider ways to address disproportionate impact on marginalized populations, such as communities of color, and those with a history of criminal offense and/or substance use disorder.

**Recommendation 5: Evaluate existing scope of background checks for professional licensing, credentialing, and employment, to identify aspects that disproportionately impact certain types of behavioral health providers and demographic populations.**

Stakeholder discussions frequently referenced the potential negative impact of background check results, which may include long-ago incidents and criminal history. While context and severity of past charges and convictions remain important considerations in hiring and/or licensing decisions, the inclusion of some results may contribute to increased stigma and decreased likelihood of employment/licensure, while disregarding the potential for rehabilitative growth (both personal and professional) in the intervening years, particularly for those professions in which lived experience is emphasized.

As mentioned previously, marginalized communities, particularly communities of color, are more likely to have interaction with the justice system, including higher rates of arrest and conviction, and thus are more likely to experience the employment ramifications of background check results noting criminal history. The potential for exacerbation of hiring bias and institutionalized racism presents further barriers to



building and supporting a culturally and linguistically diverse workforce; one which is able to provide culturally-responsive and equitable care.

**Action Required:** With resources allocated for this purpose, the Governor's Interagency Council on Health Disparities should be charged with examining the current role of background checks for professional licensing and employment decisions, and providing recommendations to reduce the potential for negative impact on historically marginalized populations, while maintaining reasonable protections for patient safety and employers.

### **Items Requiring Further Study for Phase II**

- Consider development of model policies, per occupation, for behavioral health agencies and employers to use in determining which background checks are necessary for hiring and retention decisions.
- Examine the Washington State Department of Social and Health Services Secretary's Disqualifying List of Crimes & Negative Actions to understand its role in employment-related actions (i.e., hiring versus not hiring) resulting from background check results, with particular attention to disproportionate impact on underrepresented population groups, including communities of color.
- Research current implementation of Certificate of Restoration of Opportunity to identify potential problems and solutions.

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Christy Curwick Hoff	Washington State Board of Health
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