CYBHWG Workforce & Rates Subgroup

Wednesday, July 21
10:00 am – Noon

Agenda Items	Notes
Workforce priorities poll	**Laurie Lippold** *See page 6 for survey results.* **Discussion** • Insurance-blind coverage – Be specific: Crisis response? Particular settings (e.g., schools)? • It was suggested that we look at small, medium and big issues/items/asks. • Aug. 1 – Sept. 15 – We need to be mindful that all legislative staff are off, not assigned tasks.

Workforce: Identify additional items for possible recommendations	**Laurie Lippold** • Other critical issues to address workforce? **Discussion** • Waiver - MHP oversight, or MHP oversight of a non-MHP? Could someone other than the MHP do the initial appt under the supervision of a MHP? What are the requirements etc? *> Mary – to check if we can already do it.* • It was agreed that it is better to provide services for BIPOC communities by BIPOC themselves. • We should continue to explore Bachelor's level folks as there could be less turnover, more stability. **Straw poll decisions** • Bachelor's level clinicians – put back on list for further exploration. • Focus in on top priorities + bachelors level + **rates** for interim.
Certification Process	**Laurie Lippold** • Issues related to professional certification of clinicians – refer to Workforce Board; continue to participate in their process. • Issues related to HCA Medicaid certification/MCO certification – subgroup led by Joe LeRoy; no administrative support from HCA at this time.
Updates	**Behavioral Health Institute** *See page 8 for more information.*

	• Regarding apprenticeships, they are currently hiring 3 staff members; identifying all 3 pathways; will be focusing on employer engagement/recruitment; met with ACHs in 3 regions; working with DOH on policy issues. **Proviso 60** – **Telehealth** • Close to executing contract with HCA; partnering with the Evidence Based Practices Institute; developed a draft stakeholder list. **Workforce Board** (Julia O'Connor) • Kickoff meeting will be held on Fri., Aug. 6 meeting, 10 to noon – they will provide an overview of charge, and review recs from 2017, 2020. Launch meeting will be followed by a survey. **STEM** • Working closely with the Workforce Board. **BH Council** (Joan Miller) • Teaching clinic rate enhancement - Steve Perry, with Christy Vaughn and Michele Wilsie staffing – (draft) report due mid-October; finish by end of year. • Funding from Balmer Group for pilot. 3 pilot sites. • Will run pilot before asking for permanent funding. • Different strategy than HB 1504. HB 1504 focused on individual clinicians (supervisors). Council not involved in those pilot projects. [Rep. Leavitt will check with staff about the status of implementation.
Rates discussion	**Joan Miller** (WA Council) • 3 asks: • Short-term: Medicaid rate increase – at least 5%. • Long-term: Statewide Certified Community Behavioral Health Clinic (CCBHC) implementation, through the 1115 waiver or a State Plan Amendment. 2022: Funding to amend the waiver or state plan. • Long-term: BH teaching clinic designation/rate enhancement. (after learning from pilot). **Discussion** • Impt to wrap into/link with primary care. • Still in conversation with members. Some BHAs concerned, particularly rural, with CCBHC model and their ability to make linkages. • Legislation/implementation – must be intentional about children/youth. • Include stakeholder requirements in proviso? **Straw poll decision:** • Support Council's CCBHC proposal. **Sarah Rafton** • WCAAP survey + HCA data work on current state (due in August). • Codes underutilized for care coordination – Peds NW/ HopeSparks are implementing the model.

	• Startup funding not available. Places that have gotten programs up and running have had substantial ACH/waiver funding or philanthropic funding. • A lot of what's provided in primary care does not require a LMHP, can be people who support a LMHP. • Implementing the collaborative care model may be more of the focus as opposed to advocating for an increase in the rate for certain psychotherapy codes • Startup costs per practice that wants to implement a collaborative care approach: +$200,000 for one year – credentialing, building workflows and processes, educating your team. What can the MHP invest in their teams? Develop registry. How are you going to bill? • The places that are doing well are yielding benefits from the initial investment. **Discussion** • Figure out what low-level CBT looks like, can we do it with bachelors' level. We are using Masters level and billing agnostically. Others weighed in that we can't bill for bachelors' level. • HopeSparks: Clinical integration is showing financial viability even with Master's level MHCs. Hope: Could replicate – would shorten the runway for startup and costs. • HopeSparks planning on 5 more practices in Pierce Co without additional funding. • Much easier to hire and retain people in a pediatric clinic. • Collaborative care works better for reimbursement for Medicaid; traditional psychotherapy better for private insurers – all goes to the deductible for families. But then they don't get the benefits of the collaborative care model. • What should the ask be? $1M from Leg – startup costs for 5 integrated clinics? **Other comments:** • The WACs are far better than they used to be. Big problem is the administrative overhead/level of documentation for WISe. Lawsuit needs to be settled before changes can be made. **Straw poll decisions:** • Determine path forward re bachelor's level clinicians. • Seek start up funding for collaborative care: credentialing, build the team. Other: The HCA is looking at where and how children/youth are getting care; this should provide more insight than previous looks.
2022 priorities *Straw poll results*	**Overarching:** • Rate increase + other components of the CCBHC proposal **Top 3 in poll:** • Ability to pay master's level interns and post-grads • Fully fund school-based behavioral health providers • Insurance-blinkd behavioral health coverage **Added in meeting:** • Use of bachelor level clinicians and others until Master's level MHPs are available

	Next 3 in poll (just in case): • *Remove barriers to employment-related background checks* • *Fully fund staffing in schools to support students' social-emotional well-being* • *Statewide rapid recruitment, training and placement of care coordinators*
• Access to care discussion	**Hugh Ewart** **Discussion: What does good access to care look like?** • When a family member or youth can talk to someone the same day about what's going on – someone who can do a crisis assessment – even if they can't get services for a week or two. And having someone they can call until services are available.Right now it's not something we can bill for or even include in the actuarial rates. Medicaid rules: Can't bill for anything except crisis until there's been an intake. Can't do intake until you provide services. The person needs to be able to assess risk and engage/develop a relationship with the caller. • Teaching brief interventions. • Happens naturally in PC, not in traditional BH or WISe. • We still need to really understand what good access looks like • Hugh will develop a preliminary survey to send to members for input • Info: What would help private providers? | **Additional next steps:** • We should ask for time on the full WG agenda to discuss the rate approachesl • Do a survey regarding what access looks like? • Capture priorities from survey and find a lead for each. • Lay out where we appear to be on our various likely priority items.

See page 5 for Chat transcription.

Attendees

Rachel Burke, Health Care Authority (HCA)
Mary Clogston, Legislative staff
Christine Cole, HCA
Devon Connor-Green, ARNPs United, AAPPN
Hugh Ewart, Seattle Children's
Kiki Fabian, HCA
Anusha Fernando, Molina Healthcare
Bob Hilt, Seattle Children's
Marissa Ingalls, Coordinated Care
Avreayl Jacobson, King County Behavioral Health & Recovery
Sarah Kwiatkowski, Premera, AWHP
Joe LeRoy, HopeSparks
Representative Mari Leavitt, Washington State House of Representatives
Laurie Lippold, Partners for Our Children
Melody McKee, UW Behavioral Health Institute
Joan Miller, Washington Council for BH
Julia O'Connor, Workforce Board
Sarah Rafton, Washington Chapter of the American Academy of Pediatrics (WCAAP)
Lucas Springstead, HCA
Mary Stone-Smith, Catholc Community Services of Western Washington
Andy Toulon, Legislative staff
Alex Wehinger, Washington State Medical Association
Kristin Wiggins, Perigee Fund

Workforce & Rates Meeting (7/21/2021) – Edited Chat Log

Workforce priorities

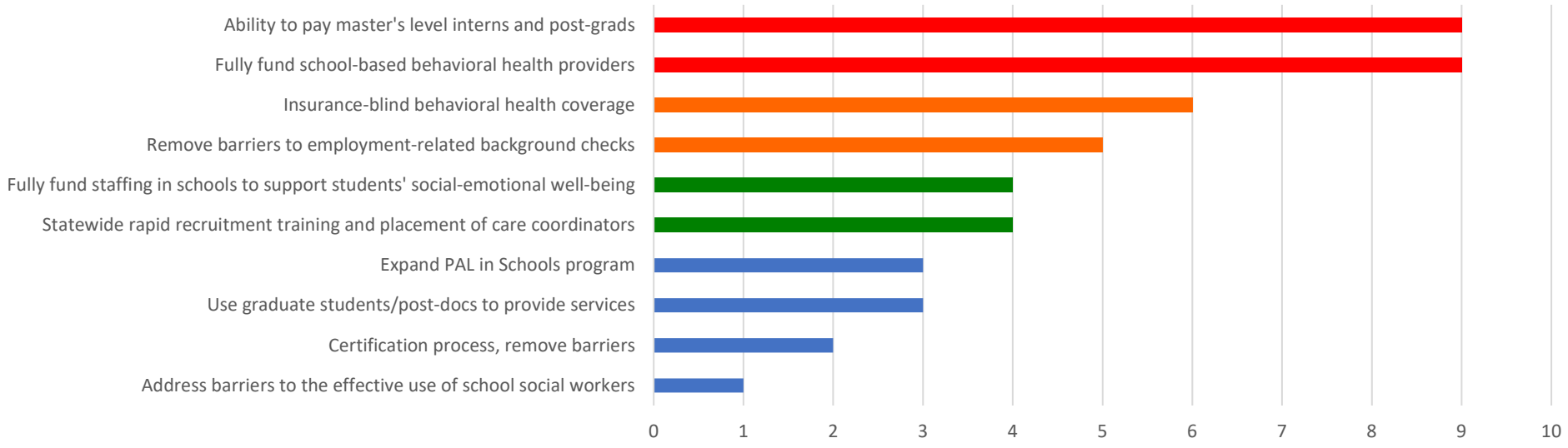
- Last year fully funded staffing in schools for SEL was a key recommendation fo the School-based BH group. I'd anticipate that it will remain on their list.
- *UW Dept. of Psychiatry Grand Rounds video: **Low-Intensity CBT: Driving Revolution in Mental Health Care***

Rates discussion

- Large administrative burden in CoCM which is not necessarily accounted for in the reimbursement, many pediatric patients with BH symptoms are not best served by CoCM, does not address intergenerational component to providing BH care two kids and still does not allow for prevention, positive parenting, ETC...And I know this is not necessarily where HCA is focused, but CoCM for any family with high deductible benefit design are often unable to afford CoCM (Coordinated Care Manager). Can use but cannot bill for their time.
  Melody: That IS the IAPT model that I put in the link for.
- I completely agree with Sarah, lots of operational and administrative implementation support needed - lots of training and education for BH professionals and PCP's.
- I think this is also what we're understanding better in some of the other subcommittees. That a lot of the BH related needs relate to intergenerational issues, prevention, parenting skills, managing stress, ETC. Among other issues, this keeps leading me to an understanding that some of the health care needs we all have are not addressed slash allowed for in our healthcare system. This leads us to needing other funds that aren't healthcare funds to provide health care. It also leads to not needing to pathologically label folks in order to receive needed support, care and connections.
- And the training and education is not one and done.
- In summary: current understanding from the BHI subgroup is. 1) startup costs are significant and not funded 2). CoCM reimbursement is working well from a revenue standpoint when the program is intentionally built towards the CoCM codes and programed intentionally. 3) lay people are not reimburse but key for the coordination children need an LICSW or masters prepared workforce need to work to top of their license. 4) startup administrative and billing burden and ongoing administrative billing burdens are not funded.
- Administrative burden is also significantly present in the New Journeys program, Washington's first episode psychosis program.
  The council actually worked with HCA and Mercer last year to develop a two- tiered case rate for New Journeys. We need to get it certified by CMS but it will help tremendously with the administrative burden.
- I'd love to hear more about the two-tiered rate for New Journeys, particularly if it lessens the administrative burdens. I'm hoping it might be something eventually applicable to WISe.
- This is a really important insight: CoCM not working on commercial side; commercial insurers are on the BH subgroup Sarah K is representing here today.

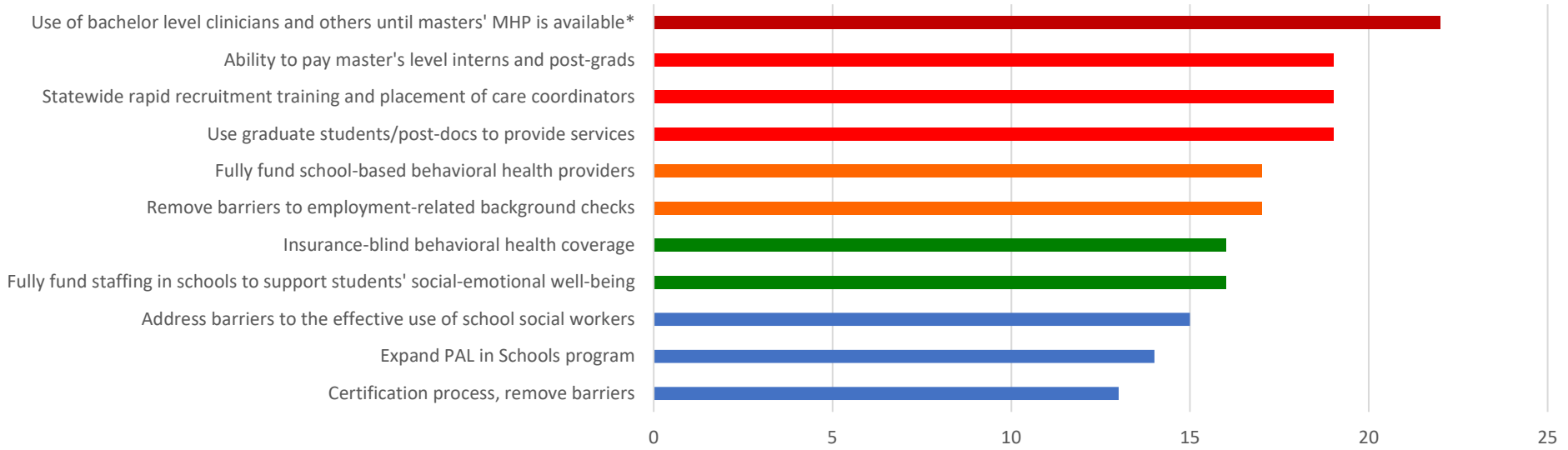
Top 2022 "must keep" priorities - Workforce recommendations - July poll

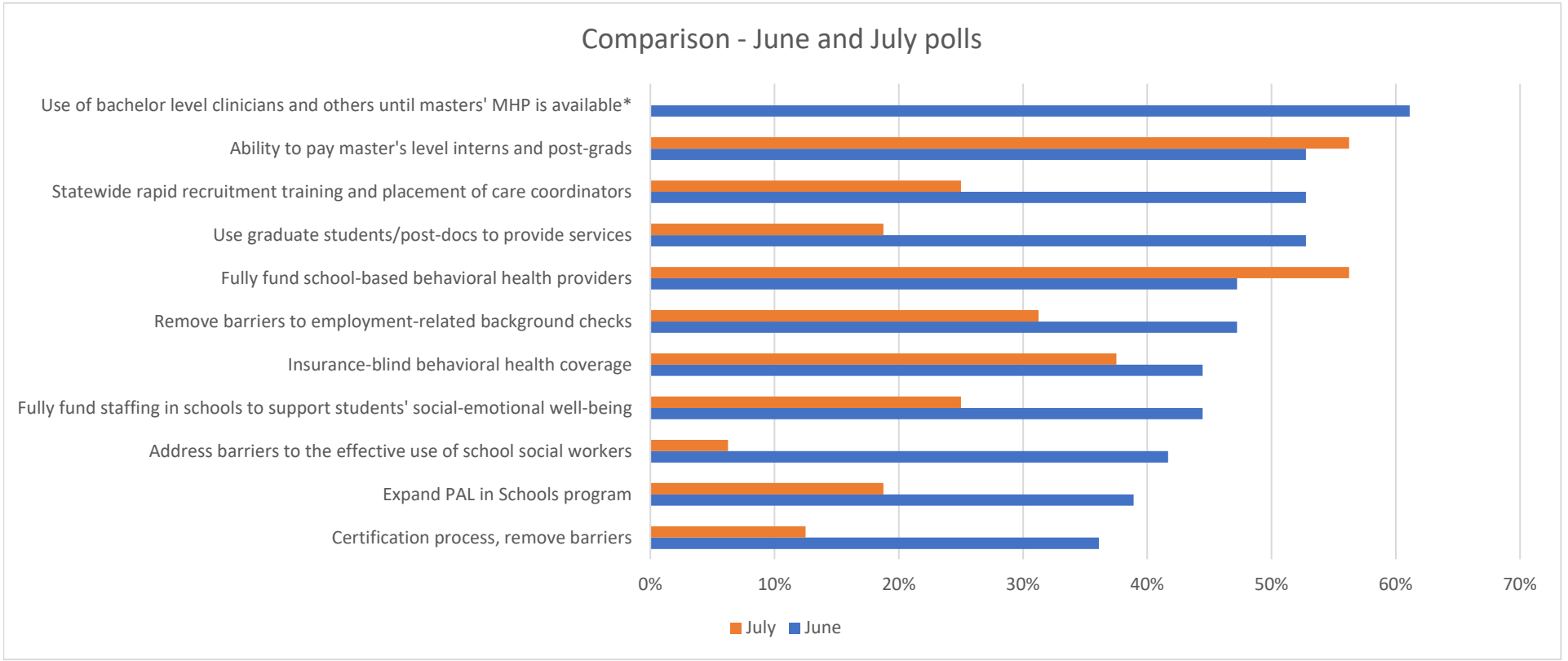
16 respondents - allowed to choose 3 priorities each



Top 2022 priorities - Workforce recommendations - June survey/poll

36 respondents - no limit set on # of selections




Comparison - June and July polls
Use of bachelor level clinicians and others until masters' MHP is available*
Ability to pay master's level interns and post-grads
Statewide rapid recruitment training and placement of care coordinators
Use graduate students/post-docs to provide services
Fully fund school-based behavioral health providers
Remove barriers to employment-related background checks
Insurance-blind behavioral health coverage
Fully fund staffing in schools to support students' social-emotional well-being
Address barriers to the effective use of school social workers
Expand PAL in Schools program
Certification process, remove barriers
0%
10%
20%
30%
40%
50%
60%
70%
July
June

Behavioral Health Apprenticeship Pathways

The Work

Progress:
The consortium has been working for 9 months engaging community experts and key stakeholders to develop (3) initial pathways – Behavioral Tech, Peer Counselor and SUDP.

Timeline:
- Year 1 Early career pathway and occupational competencies documentation. Development and completion of the first 3 apprenticeship pathways.
- Year 2 Begin PC, BH Tech & SUDP apprenticeship implementation and apprentice enrollment. In partnership with higher ed institution(s), develop an apprenticeship that transfers into a baccalaureate level degree program (Baccalaureate Level Apprenticeship: BLA).
- Year 3 Begin BLA apprenticeship implementation

Funding Sources
- Philanthropy
- Washington State Legislature
- King County

Policy Changes
- Via HB 1311: Updating RCW include apprenticeships as an option for certification requirements for SUDP/SUDPT
- WAC 246-811-030/WAC 246-811-046 – Updated to include apprenticeships as an option for educational requirements.

Behavioral Health Workforce Crisis:
Throughout the state, the demand for behavioral healthcare (mental health and substance use disorder treatment) exceeds availability of these vital services. The lack of an adequate, qualified, diverse workforce, coupled with the rapidly increasing need for behavioral health services, means people are waiting too long for services, cannot get services delivered by people who understand their life experiences or speak their language, or cannot access services at all.

Practical Solution:
Building and launching a statewide behavioral health educational pathway infrastructure through apprenticeship opportunities is an innovative, collaborative approach to solving the workforce problem. A registered apprenticeship program supported by the State, and utilized by behavioral health employers across the Washington, would improve accessibility to services, enhance retention, stabilize the behavioral health workforce, and bring necessary diversity to the delivery of behavioral health services.

Three Key Steps to Behavioral Health Apprenticeship
1. Create accessible points of entry into the field: Apprenticeship provides accessible entry points by allowing apprentices to get paid while learning the required skills.
2. Provide clear pathways up the career ladder: Apprenticeships enable access to higher levels of education and experience, including peer options.
3. Establish a continuous cycle of increasing professionalism: through consistent and improved training, which lead to better wages, attracting and retaining stronger and more diverse candidates.

BH Apprenticeship Development Partner Organizations:
- Behavioral Health Institute
- Multi-employer Training Fund
- Health Care Apprenticeship Consortium (HCAC)
- SEIU Healthcare 1199NW
- King County
- Washington Council for Behavioral Health
- Workforce Training and Education Coordinating Board
- Washington State Representative Lauren Davis

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