Behavioral Health Workforce Advisory Committee

Preliminary Report & Recommendations

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Executive Summary

Following the bidirectional integration of Washington's physical and behavioral health systems, the state continues to face a shortage of much-needed healthcare professionals, while demand for behavioral health workers continues to grow. The existing behavioral health workforce encompasses many highly competent, committed professionals working hard to deliver behavioral health services, but barriers to educational attainment needed to enter or advance in the field, along with professional recruitment challenges, and long-term retention issues, hamper the state's ability to meet the behavioral healthcare needs of its residents. The need for this care – defined in this report as mental health and substance use disorder (SUD) treatment – will only grow as the COVID-19 pandemic continues.

The Workforce Training and Education Coordinating Board (Workforce Board) has been leading efforts to address recruitment and retention of the behavioral health workforce since 2016. The 2021 Washington State Legislature formalized the stakeholder workgroup that had informed previous iterations of policy and practice recommendations as the Behavioral Health Workforce Advisory Committee (BHWAC). The BHWAC was charged with assessing the progress of recommendations from the Workforce Board's previous assessments and updating actionable policy recommendations. The 2021 state operating budget also funded a research collaboration between the Workforce Board and Washington STEM (WA STEM). This partnership will develop an analysis of the talent development pipeline for behavioral health workers, along with a projection for employer demand, which will inform recommendations for the BHWAC's full report in 2022.

As with previous iterations, the BHWAC is led by staff at the Workforce Board. Stakeholder membership, which includes health facility leaders, behavioral health providers, educators, organized labor, not-for-profit organizations, state and local government agencies, and many more, shaped the recommendations in this preliminary report. The items addressed in this report reflect those identified by stakeholders as "Highest Priority" for the 2022 Legislative Session. The BHWAC will release a full report and recommendations in December 2022.

Key Findings

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

Medicaid Reimbursement Rates

- Medicaid reimbursement rates, particularly those in community behavioral health, remain too low to provide the level of financial compensation needed to recruit and retain a well-qualified, well-supported workforce.

- Recent legislative funding increases to Medicaid reimbursement rates, while appreciated, are insufficient to translate to demonstrated increases in staff compensation. This report estimates an increase of at least 7 percent is needed.

Support for Community Behavioral Health

- Employers in community behavioral health struggle to recruit, but particularly to retain, well-qualified workers amidst the surging challenges brought on by the COVID-19 pandemic. Additional resources and incentives for community-based employers would help to the state gain ground in this struggle.
- As they grapple with the second year of the pandemic, workers in community behavioral health need increased financial support and incentives to address rapidly increasing rates of burnout and professional trauma, and prevent further departures from the field.

Recommendations

For specific details on each topic area, including the action required for each recommendation, please see page 20.

Topic I: Medicaid Reimbursement Rates

Recommendation: Adjust reimbursement rates to better support competitive recruitment and retention of a skilled behavioral health workforce. (*Originally issued as Recommendation 1, 2017.)*

Updated Policy Action: Implement a minimum 7 percent increase to Medicaid reimbursement for licensed and certified community behavioral health agencies contracted through managed care organizations, to be effective January 2022. Washington's Health Care Authority (HCA) shall continue mechanisms such as directed payment or other options allowable under federal Medicaid law to assure the funding is used by the managed care organizations (MCOs) and/or behavioral health administrative service organizations (BH-ASOs) for a 7 percent provider rate increase.

- The rate increase shall prioritize staff compensation in all behavioral health non-hospital inpatient, residential, and outpatient providers receiving payment for services contracted through the MCOs and/or BH-ASOs.
- HCA shall provide an annual report to the Governor and the appropriate committees of the Legislature detailing how the rate increase was used to improve employee recruitment and retention; and where data is available, information on recruitment and retention of underrepresented populations.

Topic II: Retention Incentives – Community Behavioral Health Employers

Recommendation: Increase the ability of behavioral health agencies to accept students/trainees by incentivizing and supporting clinical and registered apprenticeship training sites. *(Originally issued as Recommendation 3d, 2017.)*

Updated Policy Action: Develop and implement a readiness assessment to support behavioral health agencies providing behavioral health services to evaluate their capacity and ability to implement behavioral health training programs. This should include considerations regarding the agency's ability to recruit, support, and retain clinicians/students from underrepresented communities, with potential for sharing best practices among employers.

Reissued Policy Action: Promote increased collaboration between universities/colleges and clinics providing behavioral health services for clinical training of behavioral health professions.

Reissued Policy Action: Review opportunities to provide additional incentives, possibly loan repayment and stipends, for clinical training sites to send preceptors to become trained as supervisors and provide clinical training.

Recommendation: Develop and implement a funding mechanism that recognizes and supports community behavioral health agencies for performing a significant training function required for behavioral health workers to obtain their educational degree or completion of a registered apprenticeship and their clinical licensure. (*Originally issued as Recommendation 1.1, 2020.)*

Updated Policy Action: HCA was directed by proviso 74a from ESSB 5092 (2021) to develop a recommended teaching clinic enhancement rate for behavioral health agencies training and supervising students and those seeking their certification or license. After recommendations are issued as charged in proviso to HCA, the Washington Council for Behavioral Health (the Council) should further develop the rate via pilot site testing, as previously funded by private philanthropy. HCA must coordinate with the Council throughout the pilot site testing process and may seek supplemental funding from the Legislature if necessary.

Topic III: Retention Incentives – Community Behavioral Health Workers

Recommendation: Provide financial support and other incentives to those pursuing careers in behavioral health. *(Originally issued as Recommendation 5a, 2017.)*

Updated Policy Action: Funding should be appropriated for grants providing pandemic-specific retention bonuses to be allocated to community behavioral health workers. Funding should be allocated to licensed and certified behavioral health agencies to distribute to their workers.

Updated Policy Action: With funding previously allocated by the Legislature, local government, and private philanthropy, behavioral health apprenticeships developed for entry-level roles should be implemented throughout the state using a pilot site testing model.

Recommendation: Strengthen and fund loan repayment programs, including the established Washington Health Corps model, that incentivize direct behavioral health service provision. *(Originally issued as Recommendation 1.3, 2020.)*

Reissued Policy Action: Increase funds allocated to the Behavioral Health Program (BHP) to expand the number of behavioral health workers in Washington who receive loan support through the BHP. Additional funding sources should be explored, including private philanthropy and the private sector, and a dedicated funding source should be established.

Reissued Policy Action: The Washington Student Achievement Council (WSAC) should modify the existing BHP model to increase access for eligibility and participation in the program. This should include:

- Increasing the number of workers able to receive BHP loan repayment funds per profession type, per site, from two to at least three.
- Increasing the percentage of FTE allotted to administrative work to 30 percent to increase the ability of individuals providing clinical supervision to participate.

Additional Reissued Recommendations

Recommendation: Assess the impact of current supervision requirements on size, distribution, and availability of select occupations in the behavioral health workforce. Provide recommendations on ways to reduce or standardize the number of supervised hours required for licensure, while assuring clinical competency. *(Originally issued as Recommendation 2.2, 2020.)*

Updated Policy Action: Develop a workgroup to identify discrepancies in the number of supervised hours required for certain clinical licenses and to make recommendations regarding standardizing the number of supervision hours required for clinical licensure across these occupations. The workgroup should include behavioral health professional associations (social workers, mental health counselors, and marriage & family therapists); relevant state agencies; employers; individuals with clinical supervision experience; and individuals pursuing clinical licensure.

Recommendation: Anticipate a possible increase in behavioral health workers in emergency services/first responder roles. *(Originally issued as Recommendation 5.2, 2020.)*

Reissued Policy Action: Expand the role for certified peer counselors in Washington to address any potential increase in demand for workers, as behavioral health workers are needed to support emergency services/first responder departments.

Recommendation: Reduce paperwork requirements for established professionals. *(Originally issued at Recommendation 4.2, 2020.)*

Reissued Policy Action: Update DOH's recently adopted rule providing a behavioral health professional who has been licensed for five consecutive years in good standing (no discipline and no criminal history). This should state that a professional who has been licensed for two consecutive years in good standing is deemed to have met the required post-graduate supervised hours without providing formal documentation, regardless of the base number of supervised hours required in the other state at original licensure.

Background

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

Four years ago, the Washington State Behavioral Health Workforce Assessment highlighted the severity of the state's behavioral health workforce shortage, stating that "the demand for behavioral healthcare—mental health and substance use disorder treatment—exceeds the availability of services throughout the state."[1] This 2017 report, the product of two years of research, stakeholder dialogue, and policy development, identified many of the barriers contributing to the recruitment and retention of a well-qualified behavioral health workforce. The report also included specific policy recommendations to increase the availability of behavioral health workers to provide Washington residents with accessible, appropriate behavioral healthcare.[2]

A subsequent assessment, published in 2020, expanded upon the work conducted in the 2017 report. At the direction of the Washington State Legislature, a workgroup was formed in 2019 to address specific workforce barriers identified in the prior assessment. As with the 2017 report, this work was led by the Workforce Board, in collaboration with the University of Washington Center for Health Workforce Studies (UW CHWS).

The workgroup was charged with developing research and policy recommendations to address five specific barrier 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.

This work, which involved the participation of over 250 individual stakeholders from across Washington and the behavioral health landscape, culminated in the publication of a final report and recommendations to the Governor and the Legislature in December 2020.

[1] Gattman, McCarty, Balassa, & Skillman, 2017, p.1.
[2] Gattman et al., 2017.

Advances in the 2021 Legislative Session

Many of the policy actions recommended in the 2020 report resulted in legislative action during the 2021 session, including successful legislation and funding appropriations. The table below highlights these investments and policy changes in behavioral health workforce enacted by the state:

Recommendation & Policy Action	Legislation/Budget Item
Recommendation 1.1: Develop and implement a funding mechanism that recognizes and supports community behavioral health agencies for performing a significant training function required for behavioral health workers to obtain their educational degree and their clinical licensure. **Policy Action:** HCA shall collaborate with DOH, WTB, the Washington Council for Behavioral Health, licensed and certified BHAs, and higher education to develop a recommended teaching clinic enhancement rate for BHAs training and supervising students and those seeking their certification or license. This work should include: developing standards for classifying a BHA as a teaching clinic; a cost methodology to determine a teaching clinic enhancement rate; and a timeline for implementation.	**Budget:** Sec. 215. HCA Community Behavioral Health Program (74)(a) $150,000 of the general fund—state appropriation for FY22 is provided solely for the authority to convene a work group to develop a recommended teaching clinic enhancement rate for behavioral health agencies training and supervising students and those seeking their certification or license. This work should include: Developing standards for classifying a behavioral health agency as a teaching clinic; a cost methodology to determine a teaching clinic enhancement rate; and a timeline for implementation. The work group must include representatives from: (i) The department of health; (ii) The office of the governor; (iii) The Washington workforce training and education board; (iv) The Washington council for behavioral health; (v) Licensed and certified behavioral health agencies; (vi) Higher education institutions. (b) By October 15, 2021, the health care authority must submit a report of the work group's recommendations to the governor and the appropriate committees of the legislature. *Note: Recommendation deadline changed to January 1, 2022.* **Legislation:** HB 1504 (Rep. Chopp) *Behavioral Health Workforce Pilot Program & Training Support Grants* • HCA must establish a behavioral health workforce pilot program and training support grants for community mental health and substance use disorder treatment providers. The HCA must implement the pilot program and training support grants in partnership with and through the Accountable Communities of Health or the University of Washington Behavioral Health Institute.

	• The pilot program's purpose is to provide incentive pay for individuals service as clinical supervisors within community behavioral health agencies, state hospitals, and facilities operated by DSHS. The HCA must ensure the pilot program covers three sites serving primarily Medicaid clients in both eastern and western Washington. Of those three sites, one must specialize in the delivery of behavioral health services for Medicaid enrolled children and one must offer SUD treatment services. The HCA must report to the Legislature and OFM by September 30, 2023 on the pilot program's outcomes.
Recommendation 1.3: Strengthen and fund loan repayment programs, including the established Washington Health Corps model, that incentivize direct (clinical) behavioral health service provision. **Policy Action:** Increase funds allocated to the Washington Health Corps Behavioral Health Program (BHP) to expand the number of behavioral health workers in Washington who receive loan repayment support through BHP. Additional funding sources should be explored, including funding from private philanthropy and the private sector, and a dedicated funding source should be established.	**Budget:** Sec. 613. Student Achievement Council – Office of Student Financial Assistance (8) $1,000,000 of the general fund—state appropriation for FY22 and $1,000,000 of the general fund—state appropriation for FY23 are provided solely for behavioral health loan repayment program grants, pursuant to chapter 302, Laws of 2019 (2SHB 1668) (Washington health corps). (9) $4,125,000 of the general fund—state appropriation for FY22 and $4,125,000 of the general fund—state appropriation for FY23 are provided solely for expenditure into the health professionals loan repayment and scholarship program account. The amount provided in this subsection is provided solely to increase loans within the behavioral health program.
Recommendation 2.1: Remove barriers to effective tele-precepting for supervision in clinical education and pre-licensure settings. **Policy Action:** Support the increased use of tele-precepting for clinical supervision, including but not limited to: amending relevant laws and policies, or making permanent	**Legislation:** HB 1007 (Rep. Klippert) The limitations on the number of supervised experience hours that a person pursuing a license as an independent clinical social worker or advanced social worker may complete through distance supervision are removed. **Legislation:** HB 1063 (Rep. Harris) The Secretary of Health is authorized to grant a waiver for additional credential renewals due to barriers to testing or

provisional changes, to allow increased tele-supervision hours required for clinical education requirements, and for licensure requirements.	training resulting from a Governor-declared emergency for the following credentials: • Substance use disorder professional trainee (SUDPT) certifications; and • Social worker (LSWAIC), mental health counselor (LMHCA), and marriage and family therapist (LMFTA) associate licenses.
Recommendation 3.1: Support development of a registered apprenticeship model for behavioral health professions. **Policy Action:** Continue to work with and support the existing efforts of SEIU Healthcare 1199NW Multi-Employer Training Fund, SEIU Healthcare 1199NW, the Behavioral Health Institute, and relevant stakeholders to develop and implement behavioral health registered apprenticeship models, with state support.	**Legislation:** HB 1311 (Rep. Bronoske) As an alternative to participation in an approved education program, an applicant for a substance use disorder professional (SUDP) certification or a substance use disorder professional trainee (SUDPT) certification may participate in an approved apprenticeship program. An apprenticeship program must be registered and approved by the Department of Labor & Industries, reviewed by the Substance Use Disorder Certification Advisory Committee, and approved by the Secretary of Health (Secretary). The educational requirements for an approved apprenticeship must be defined by the Secretary. All educational requirements credited by an approved education program for participants in an apprenticeship program must meet or exceed competency requirements established by the Secretary. The Department of Health may adopt any rules necessary for implementation of SUDP apprenticeship programs. **Budget:** Sec. 220. Department of Labor & Industries (19) $1,360,000 of the accident account—state appropriation and $240,000 of the medical aid account—state appropriation are provided solely for the department of labor and industries, in coordination with the Washington state apprenticeship training council, to establish behavioral health apprenticeship programs. The behavioral health apprenticeship programs shall be administered by the Washington state apprenticeship training council. The amounts provided in this subsection must be used to compensate behavioral health providers for the incurred operating costs associated with the apprenticeship program, including apprentice compensation, staff support and supervision of apprentices, development of on-the-job training catalogs for apprentices, and provider incentives for implementing a behavioral health

	apprenticeship program. In awarding this funding, special preference must be given to small or rural behavioral health providers and those that serve higher percentages of individuals from black, indigenous, and people of color communities.
Recommendation 5.2: Anticipate a possible increase in behavioral health workers in emergency services/first responder roles. **Policy Action:** Expand the role for peer counselors in Washington to address any potential increase in demand for workers, as behavioral health workers are needed to support emergency services/first responder departments.	**Budget:** Sec. 215. HCA Community Behavioral Health Program (83) $2,000,000 of the general fund—federal appropriation is provided solely for grants to law enforcement and other first responders to include a mental health professional on the team of personnel responding to emergencies.
Recommendation 5.4: Convene leadership of state agencies with jurisdiction to reduce barriers to behavioral health employment related to criminal background checks. **Policy Action:** Create a taskforce comprised of representatives from the office of the Attorney General, DOH, DSHS, Office of the Governor, Division of Behavioral Health and Recovery within the Health Care Authority, and others (including behavioral health employers and those with lived experience), to examine impacts and changes proposed to the use of criminal background checks in employment in behavioral health settings, with the goal of reducing barriers to developing and retaining a robust behavioral health workforce, while maintaining patient safety measures.	**Budget:** Sec. 215. HCA Community Behavioral Health Program (40)(a) $100,000 of the general fund—federal appropriation is provided solely for the authority to convene a task force to examine impacts and changes proposed to the use of criminal background checks in employment in behavioral health settings, with the goal of reducing barriers to developing and retaining a robust behavioral health workforce, while maintaining patient safety measures. The task force membership must include representatives from: (i) The office of the attorney general; (ii) The department of health; (iii) The department of social and health services; (iv) The office of the governor; and (v) Others appointed by the authority, including behavioral health employers and those with lived experience. b) The task force shall consider any relevant information and recommendations made available by the work group created under Substitute House Bill No. 1411 (health care workforce). (c) By December 1, 2021, the authority must submit a report of the task force's recommendations to the governor and the appropriate committees of the legislature.

A New Legislative Charge

Despite the many investments of the 2021 Legislature, challenges to the recruitment and retention of behavioral health workers in Washington persist. During the 2021 Legislative Session, the stakeholder workgroup responsible for the previous recommendations was formalized as the BHWAC. As with previous iterations, the Workforce Board was charged with convening and staffing the group, which is charged with "*monitoring and reporting on the progress of recommendations from the board's previous behavioral health workforce assessments, and continuing to develop policy and practice recommendations on emerging issues in the behavioral health workforce.*"[3]

During the 2021-23 biennium, the BHWAC will individually review the many recommendations issued during the 2017 and 2020 reports; identify action taken (legislative or otherwise) related to those recommendations; assess the relevance of each recommendation in the post-COVID reality; and propose updates to actionable policy, as necessary.

Research Partnership with WA STEM

In tandem with the BHWAC's legislative charge, the 2021 Legislature charged the Workforce Board and WA STEM with collaborating on an employer demand projection and talent development pipeline analysis, focused on behavioral health workforce in the state. This includes "*an analysis of behavioral health workforce shortages and challenges, data to inform systems change, and relevant policy recommendations and actions*."[4]

WA STEM, with engagement from over 150 individuals, including active participation of the Workforce Board and BHWAC, identified a list of occupation groupings that are related to behavioral health. This list will be used in in the development of a behavioral health labor market projections tool that will support the 2022 BHWAC work.

A draft, but comprehensive, list of behavioral health occupations and job titles that accurately reflects the field and the contexts of the work can be found here: https://washingtonstem.app.box.com/v/BH-Job-Titles.

WA STEM released a draft Tableau dashboard in November 2021 that aims to accurately reflect the behavioral health occupation landscape and the projected job openings in that landscape, by both sub-occupation and region. This tool is a behavioral health industry-specific version of WA STEM's more general Labor Market Data Dashboard. The draft Behavioral Health Labor Market Data Dashboard can currently be found here: https://bit.ly/2Z8iNSu.

[3] ESSB 5902, 2021.
[4] ESSB 5902, 2021.

For more detailed information on this project, a preliminary report authored by WA STEM staff can be found in **Appendix A** of this report.

The Workforce Board's related efforts will concentrate on developing a ground-level picture of employer demand, including focus groups and employer interviews regarding their workforce needs. A major focus of this work is discussing with employers whether the structure of the behavioral health workforce pipeline is meeting their needs for client care, and if Washington's system is providing the appropriate mastery levels of competencies and skills to address the complex needs of the patient population.

Demand for health workforce, including behavioral health, is also evaluated by the Health Workforce Sentinel Network,[5] an initiative of the Washington Health Workforce Council,[6] in collaboration with UW CHWS and the Workforce Board. The Sentinel Network utilizes data and responses from a voluntary short survey of Washington's healthcare employers ("Sentinels"), which collects qualitative information regarding changes in health workforce demand across the state. An in-depth analysis of the Sentinel Network's 2021 findings will be available in the 2021 Health Workforce Council report.

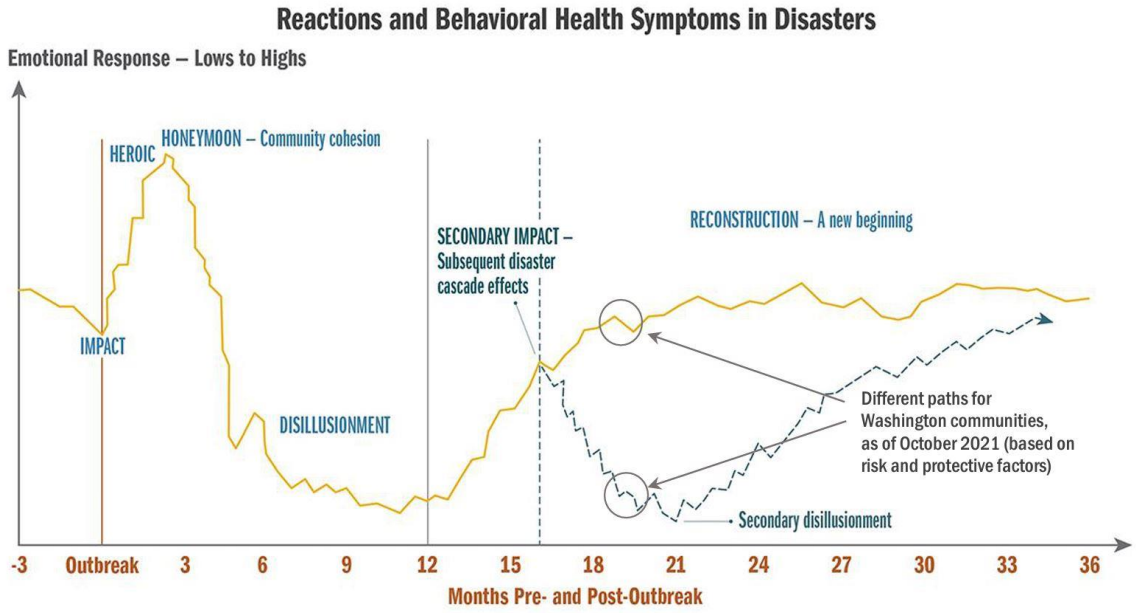
Behavioral Health During the COVID-19 Pandemic

As the second year of the COVID-19 pandemic progressed, behavioral health needs have remained exceptionally high, both nationwide and in Washington. Likewise, the economic and social hardships exacerbated by the continued pandemic have placed additional behavioral health burdens on the population, particularly with the onset of new waves of the pandemic. Figure 1 demonstrates the phases of behavioral health symptoms presenting before, during, and after a pandemic (or other disaster), illustrating the significant emotional and behavioral toll the ongoing pandemic has taken. Distribution of, and access to, various COVID-19 vaccines has shifted cultural norms in the direction of "before times," with restaurants, gyms, and schools re-opening, even as the mask mandate continues. However, there have also been setbacks, including the Delta and Omicron variants, that have led to higher infection rates that keep people uneasy and fearful, heightening the gradual and fluctuating nature of reopening and a return to social participation has also contributed to heightened prevalence of behavioral health symptoms.

[5] http://wa.sentinelnetwork.org/

[6] https://www.wtb.wa.gov/planning-programs/health-workforce-council/

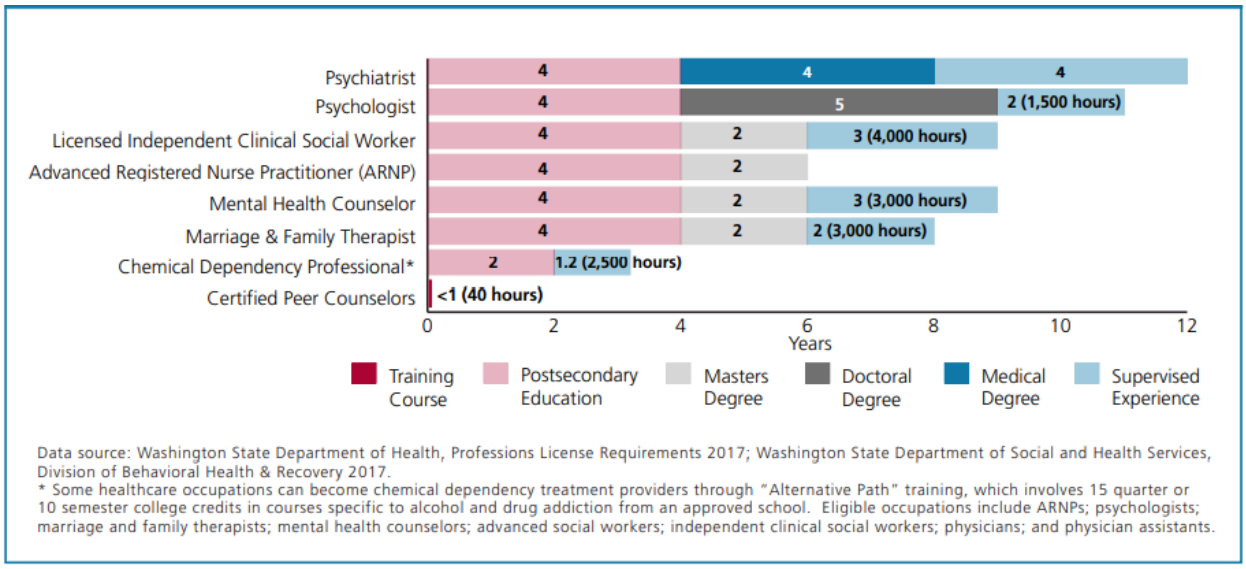
Figure 1. Reactions and Behavioral Symptoms in Disasters



Source: WA DOH; adapted from Substance Abuse and Mental Health Services (SAMHSA)

As behavioral health workers have navigated the stress and strain of the pandemic in their personal lives, they've also contended with an ongoing surge of clients battling symptoms of anxiety, depression, and other behavioral health diagnoses. Staff burnout is at an all-time high, stakeholders report, adding further stress to the already enormous retention challenge facing the industry. This substantial professional fatigue makes it difficult for behavioral health workers to continue pressing ahead to obtain the necessary years of training needed to advance their careers, or to enter the profession (Figure 2). Add to this the ongoing challenge of low pay earned even by those clinicians with a post-graduate degree.

Figure 2. Minimum Years of Typical Education and Supervised Experience Required for Select Behavioral Health Occupations in Washington State



Data source: Washington State Department of Health, Professions License Requirements 2017; Washington State Department of Social and Health Services, Division of Behavioral Health & Recovery 2017.
* Some healthcare occupations can become chemical dependency treatment providers through "Alternative Path" training, which involves 15 quarter or 10 semester college credits in courses specific to alcohol and drug addiction from an approved school. Eligible occupations include ARNPs; psychologists; marriage and family therapists; mental health counselors; advanced social workers; independent clinical social workers; physicians; and physician assistants.

Community-based settings are particularly impacted by professional churn, as experienced behavioral health professionals depart for private practice or other settings with higher compensation packages and lighter caseloads, while others permanently exit the field. New clinicians, carrying significant student loan burdens, often begin working in community-based settings, but large caseloads and increasing demand for services add further stress to an already-strapped workload. These retention and recruitment challenges are further complicated by significant variation in the geographic distribution of providers. This creates significant challenges, and disparities, in access to care for those living in the state's rural and other underserved regions.

Project Approach

Stakeholder engagement for the 2021-23 biennium began in August 2021, when stakeholders, led by the Workforce Board, gathered via virtual meeting for an in-depth review of each previously issued recommendation. Workforce Board staff provided historical context for the development of each recommendation, reviewed language, and solicited stakeholder feedback regarding legislative and other policy action taken in the years since those recommendations were issued.

The August meeting was followed by distribution of a stakeholder prioritization survey, in which stakeholders were asked to rank each recommendation on a scale of zero to five (five being "Highest Priority," zero being "Not a Priority") and to further identify information regarding progress or action related to the recommendation. Workforce Board staff subsequently reviewed a qualitative assessment of the prioritization and grouped each recommendation within five categories:

1. Highest Priority
2. High Priority
3. Mid-Level Priority
4. Low Priority
5. Lowest Priority

Given the limited timeframe in which this preliminary report was developed, Workforce Board staff elected to move forward with those items identified as "Highest Priority" in the stakeholder survey: Medicaid reimbursement rate increase for community behavioral health and increased financial support/incentives for both workers and employers in community behavioral health. During the second year of the current charge, the BHWAC will review individual recommendations, with each meeting focused on a different priority tier.

A second stakeholder meeting was held in October 2021. Stakeholders had an opportunity to review the findings of the prioritization survey and to engage in discussion regarding the recommendations identified as "Highest Priority." Certain recommendations were identified as "reissued," with minimal changes to the original language, while others were "updated" to provide additional guidance or recommend new policy action.

Draft preliminary recommendations were shared with stakeholders at the end of October, with two weeks' time provided to share feedback with the Workforce Board staff. Stakeholder input was incorporated into the final preliminary recommendations, in subsequent sections of this report.

Topic I: Medicaid Reimbursement Rates

As highlighted in the 2017 report, low reimbursement rates for services provided in community behavioral health continue to be identified by stakeholders as a substantial barrier to workforce recruitment and retention. Such low rates are regularly described as the root cause for challenges to offering competitive compensation packages (both salary and benefits), which combine with higher caseloads, nontraditional work hours, and other barriers to drive many clinicians out of community practice and into roles in private practice, hospital settings, or state agencies.

The majority of patients served in community behavioral health settings receive Medicaid benefits, leading Medicaid to serve as the primary funder of services in this realm of the behavioral health system. As such, Medicaid capitation rates are a primary determinant of community-based providers' ability to recruit, support, sustain, and retain a qualified workforce. The low reimbursement rates in community practice mean that such agencies are not equipped to compete with larger health systems, MCOs, or government salaries.

Stakeholders have long called for an increase to Medicaid reimbursement rates and legislative action has been taken. The 2020 legislative appropriations included a 2 percent increase to such rates, though the increase was ultimately cut as part of Governor Inslee's pandemic-related budgetary veto. The Legislature subsequently passed and enacted the 2 percent Medicaid rate increase in the 2021 session, with the increase going into effect in July 2021.

Despite this, stakeholders repeatedly described such an increase as insufficient and reported a lack of impact on their ability to translate a 2 percent rate increase into sufficient staff compensation change. In discussion, stakeholders identified a 7 percent increase to Medicaid reimbursement rates as the minimum desired amount; additional increases would and should be considered. To concentrate the dollars resulting from such an increase, a focus on increasing rates specifically at licensed and certified community behavioral health agencies was identified, as was a prioritization of staff compensation.

The recommendation below is directly reflective of stakeholder sentiment and was developed and finalized with extensive stakeholder feedback over the course of this project. It is also in line with a similar priority issued by the Children & Youth Behavioral Health Workgroup, demonstrating broad stakeholder support for this crucial issue.

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

Originally Issued: Recommendation 1, 2017.

Updated Policy Action: Implement a minimum 7 percent increase to Medicaid reimbursement for licensed and certified community behavioral health agencies contracted through managed care organizations, to be effective January 2022. HCA shall continue mechanisms such as directed payment or other options allowable under federal Medicaid law to assure the funding is used by the MCOs for a 7 percent provider rate increase.

- The rate increase shall prioritize staff compensation in all behavioral health non-hospital inpatient, residential, and outpatient providers receiving payment for services contracted through the MCOs.
- HCA shall provide an annual report to the Governor and the appropriate committees of the Legislature detailing how the rate increase was used to improve employee recruitment and retention; and where data is available, information on recruitment and retention of underrepresented populations.

Topic II: Retention Incentives – Community Behavioral Health Employers

Stakeholders repeatedly emphasized the role of the community behavioral health system not only as a source of service provision, but as the primary training ground for both students and early-career clinical professionals.[7] These entities serve as training sites for professionals seeking the supervised practice hours necessary to meet clinical licensure requirements, but the fiscal reality of providing such supervision and training is neither fully reimbursable nor adequately recouped by the host agency.

Moreover, these community-based agencies frequently serve the highest acuity and chronically ill behavioral health patients, which can pose challenges for new entrants to the field. Providers routinely depart community-based practice for more lucrative opportunities with lower acuity clients once they have completed their required supervision hours and exhausted the training offered by such agencies – a retention burden further complicated by the severe burnout experienced amidst the pandemic. One stark example of such a challenge is the over-20 percent vacancy rate shared by a stakeholder, the CEO of an Eastern Washington community-based agency. Another stakeholder, an executive at an agency serving multiple counties throughout the state, cited the loss of over 100 staff in the past year.

Insufficient – or completely lacking – compensation for services as a training site have long negatively impacted the ability of community behavioral health facilities to meet the needs of their client populations. The ongoing pandemic has compounded this, with several now struggling to maintain operations. Support for these agencies as the vital training ground of our behavioral health workforce is now more necessary than ever.

The recommendations below are directly reflective of stakeholder sentiment and were developed and finalized with extensive stakeholder feedback over the course of this project.

[7] While we acknowledge that medicine includes specific definitions for interns and trainees, for the purposes of this report, we define interns as students completing field work for academic credit, and trainees as graduated professionals seeking hours of supervised clinical practice required for independent clinical licensure.

Recommendation: Increase the ability of behavioral health agencies to accept students/trainees by incentivizing and supporting clinical and registered apprenticeship training sites.

Originally Issued: Recommendation 3d, 2017.

Updated Policy Action: Develop and implement a readiness assessment to support clinics providing behavioral health services to evaluate their capacity and ability to implement behavioral health training programs. This should include considerations regarding the agency's ability to recruit, support, and retain clinicians/students from underrepresented communities, with potential for sharing best practices among employers.

> As community-based agencies continue to serve as training sites for both students and early-career clinicians, assessment of their ability to provide adequate supervision (both clinical and interpersonal), evidence-based practice training, and other workplace supports to students/trainees is necessary. Developing a readiness assessment could help agencies identify areas for improvement and/or additional investment, as well as strengths, in operating as a training facility. Particular attention should be given to an agency's ability to support clinicians from underrepresented populations, such as persons of color and the LGBTQIA+ community.

Reissued Policy Action: Promote increased collaboration between universities/colleges and clinics providing behavioral health services for clinical training of behavioral health professions.

> Stakeholders often mention a gap between clinical and evidence-based preparation when students/trainees transition from the classroom into field work. Employing strategies to support and encourage additional collaboration between educational and employment partners in behavioral health could help to close this gap, while ensuring students receive the preparation necessary to provide meaningful, well-qualified services to patient populations.

Reissued Policy Action: Review opportunities to provide additional incentives, possibly loan repayment and stipends, for clinical training sites to send preceptors to become trained as supervisors and provide clinical training.

> Clinical supervisors provide the supervision of students/trainees that is fundamental to their development as behavioral health professionals. Many stakeholders expressed concern that too few clinical training sites have sufficient numbers of appropriately trained supervisors/preceptors available, and that incentives are needed to better develop the supervisor population.

Recommendation: Develop and implement a funding mechanism that recognizes and supports community behavioral health agencies for performing a significant training function required for behavioral health workers to obtain their educational degree or completion of a registered apprenticeship and their clinical licensure.

Originally Issued: Recommendation 1.1, 2020.

Updated Policy Action: HCA was directed by proviso 74a from ESSB 5092 (2021) to develop a recommended teaching clinic enhancement rate for behavioral health agencies training and supervising students and those seeking their certification or license. as After recommendations are issued as charged in proviso to HCA, the Washington Council for Behavioral Health (the Council) should further develop the rate via pilot site testing, as previously funded by private philanthropy. HCA must coordinate with the Council throughout the pilot site testing process and may seek supplemental funding from the Legislature if necessary.

> The Council has been a crucial leader in advocating for, and developing, a teaching clinic enhancement rate to better support community behavioral health agencies as clinical training sites. In addition to their significant participation in the workgroup, led by HCA, charged with developing the foundation of the rate, WCBH has already received funding from the Ballmer Group to conduct a multi-year process of pilot site testing; the organization has already developed a thorough work plan for conducting such testing.
>
> The long-term goal of this effort is to demonstrate feasibility and proof of concept via pilot site testing, with a subsequent request to the Legislature for permanent implementation and funding, if this model proves effective at improving recruitment and retention at community sites.

Topic III: Retention Incentives – Community Behavioral Health Workers

Nearly two years into the pandemic, the frontline behavioral health workforce has been devastated. Clinicians, particularly those serving the state's most vulnerable populations in community behavioral health settings, have been forced to mitigate the trauma of the pandemic with their clients, while also navigating their own trauma and pandemic experiences. Stakeholders reported staff retention losses at record levels, with many workers departing the field altogether. These losses have been most severe in the community behavioral health realm, where pre-COVID challenges like substantial caseloads, burdensome documentation requirements, low salaries, and extended (non-traditional) work hours were further exacerbated.

While long-term efforts to shore up the behavioral health workforce should concentrate on both recruitment and retention, the BHWAC identified this preliminary report as an opportunity to focus on strategies for immediate impact on retention, particularly as behavioral health workers continue to navigate the challenges of treating and supporting patients through a historic period of trauma. The Workforce Board staff and stakeholders sought to recommend policy concepts for quick action in the upcoming legislative session, with both one-time implementation (retention bonuses) and increased support of existing programs (loan repayment).

While the full report (due in December 2022) may build upon these ideas, it is the intention of the stakeholder workgroup to recommend the following concepts as stopgaps to address the substantial – and unique – challenges facing behavioral health workforce retention at present.

The recommendations below are directly reflective of stakeholder sentiment and were developed and finalized with extensive stakeholder feedback over the course of this project.

Recommendation: Provide financial support and other incentives to those pursuing careers in behavioral health.

Originally Issued: Recommendation 5a, 2017.

Updated Policy Action: Funding should be appropriated for grants providing pandemic-specific retention bonuses to be allocated to community behavioral health workers. Funding should be allocated to licensed and certified behavioral health agencies to distribute to their workers.

> While compensation alone is not sufficient to bolster the behavioral health workforce as it grapples with the trauma of the pandemic, stakeholders agreed it is the fundamental starting point. Particularly in community-based settings,

employers expressed a wish to provide further financial incentives and recognition of their workforce, but realistically lack funds to do so, or must divert resources from other programming – hardly an ideal scenario. As the BHWAC works to develop its full report in 2022, the group developed a short-term concept of pandemic-specific retention bonuses, funded via grants to licensed and certified community behavioral health agencies. Distribution via agencies will allow employers to identify the most effective compensation strategies for their workers, while a focus on licensed and certified community behavioral health providers will ensure the funds are allocated to those workers serving the most vulnerable, high acuity populations.

Updated Policy Action: With funding previously allocated by the Legislature, local government, and private philanthropy, behavioral health apprenticeships developed for entry-level roles should be implemented throughout the state using a pilot site testing model.

Registered apprenticeships promote an "earn-while-you-learn" model, which reduces direct costs and student loan debt risk to workers and may reduce cost barriers to education required for a career in behavioral health. These features promote access to behavioral health professional training for marginalized and underrepresented groups, help promote diversity of the workforce, and potentially increase availability of patient-provider background-concordant care. Registered apprenticeships for certain roles in behavioral health are under development, an effort led by the SEIU 1199NW Multi-Employer Training Fund and the Behavioral Health Institute at Harborview Medical Center. As part of this work, in 2021, the Legislature passed HB 1311, which allows substance use disorder provider trainees (SUDPTs) to participate in a registered apprenticeship.

Recommendation: Strengthen and fund loan repayment programs, including the established Washington Health Corps model, that incentivize direct (clinical) behavioral health service provision.

Originally Issued: Recommendation 1.3, 2020.

Reissued Policy Action: Increase funds allocated to the BHP to expand the number of behavioral health workers in Washington who receive loan support through the BHP. Additional funding sources should be explored, including private philanthropy and the private sector, and a dedicated funding source should be established.[8]

[8] RCW 28B.115.030 currently permits the Washington Student Achievement Council to "solicit and accept grants and donations from public and private sources for the programs."

When asked to identify specific retention incentives for workers, stakeholders repeatedly mentioned loan repayment. Access to, and participation in, such programs presents an opportunity to alleviate the barriers to long-term retention in community practice stemming from lower annual compensation found in direct service (clinical) roles, as compared with administrative roles at state agencies/managed care organizations. Increased funding, a priority of many behavioral health workforce advocates, would expand the number of individuals able to participate in loan repayment programming and could lessen the substantial burden of debt often required to pursue education and career opportunities in behavioral health.

Reissued Policy Action: WSAC should modify the existing BHP model to increase access for eligibility and participation in the program. This should include:

- Increasing the number of workers able to receive BHP loan repayment funds per profession type, per site, from two to at least three;
- Increasing the percentage of FTE allotted to administrative work to 30 percent to increase the ability of individuals providing clinical supervision to participate in program.[9]

While increased funding could broaden participation in loan repayment, so could making changes to the eligibility requirements. Expanding the number of workers per profession type, per site, could reduce competition within individual agencies and allow more workers at each agency to participate. Similarly, consideration of the unique circumstances of rural behavioral health settings – where direct care providers are more likely to have additional administrative duties – could help to expand participation statewide.

WSAC, which administers the BHP, can make such adjustments without legislation or formal rulemaking. It is worth noting that the original language of this recommendation included "permitting the participation of individuals licensed at the associate level." Following that recommendation, WSAC has amended the eligibility requirements to permit individuals with associate clinical licenses (i.e., those post-graduate workers accumulating supervised practice hours) to participate effective January 2022.

[9] It should be noted that making such adjustments, without adequate financial support for the programs, could have the unintended consequence of limiting the number of awards of fully licensed professionals unless some prioritization of profession types is considered.

Additional Reissued Recommendations

As part of the prioritization survey, stakeholders were asked to identify additional recommendations from the 2017 and 2020 reports that were particularly relevant to the current legislative environment and ready to be reissued with minimal change. Three such recommendations were identified:

Recommendation: Assess the impact of current supervision requirements on size, distribution, and availability of select occupations in the behavioral health workforce. Provide recommendations on ways to reduce or standardize the number of supervised hours required for licensure, while assuring clinical competency.

Originally Issued: Recommendation 2.2, 2020.

Updated Policy Action: Develop a workgroup to identify discrepancies in the number of supervised hours required for certain clinical licenses and to make recommendations regarding standardizing the number of supervision hours required for clinical licensure across these occupations. The workgroup should include behavioral health professional associations (social workers, mental health counselors, and marriage & family therapists); relevant state agencies; employers; individuals with clinical supervision experience; and individuals pursuing clinical licensure.

> Stakeholders remain very invested in addressing both the volume of, and discrepancies between, requirements for post-graduate supervised practice hours required for clinical licensure, particularly after some clinicians faced challenges in meeting these requirements during the first year of the pandemic. The topic remains a complex one, requiring the inclusion and input of behavioral health, legal, quality assurance, and credentialing experts to identify the origins of such discrepancies, explore any necessity of those discrepancies, and to develop consensus regarding recommendations for potentially streamlining supervised hour requirements across occupations employed in similar/overlapping clinical positions.
>
> *As with the Medicaid rate increase, this topic has also been prioritized by the Children & Youth Behavioral Health Workgroup, demonstrating additional support from stakeholders in the field.*

Recommendation: Anticipate a possible increase in behavioral health workers in emergency services/first responder roles.

Originally Issued: Recommendation 5.2, 2020.

Reissued Policy Action: Expand the role for certified peer counselors in Washington to address any potential increase in demand for workers, as behavioral health workers are needed to support emergency services/first responder departments.

> Stakeholders remain enthusiastic about addressing the need for more positions for qualified peers through an expansion and professionalization of the certified peer counselor role, particularly as behavioral health workers are increasingly incorporated into the staffing of first response/emergency services roles. The lived experience of peers, their foundational qualification, could serve as particularly meaningful in a first responder role, given the percentage of emergency services calls to address mental health and/or substance use concerns. While the 2021 Legislature appropriated funds for a grant program for law enforcement to employ mental health professionals in first response, stakeholders previously identified concepts like a state-endorsed training certificate for peer crisis responders, which could simultaneously advance professionalization of the valuable peer counselor role and address demand for increased behavioral health workers in emergency services.

Recommendation: Reduce paperwork requirements for established professionals.

Originally Issued: Recommendation 4.2, 2020.

Reissued Policy Action: Update DOH's recently-adopted rule providing a behavioral health professional who has been licensed for five consecutive years in good standing (no discipline and no criminal history). This should state that a professional who has been licensed for two consecutive years in good standing is deemed to have met the required post-graduate supervised hours without providing formal documentation, regardless of the base number of supervised hours required in the other state at original licensure.

> Individuals relocating to Washington, who have a demonstrated record of providing high-quality behavioral healthcare, should be encouraged to provide those services to residents of the state. Stakeholders previously reported difficulty transferring clinical licenses and/or hiring employees who require licensure reciprocity due to challenges in documenting initial supervision hours and/or academic requirements; this has only worsened with the administrative delays caused by the pandemic. While DOH has undertaken significant work to alleviate this, one potential improvement would be waiving the paperwork requirement for professionals with at least two consecutive years of good standing licensure, a lesser burden than requiring five consecutive years of good standing licensed practice.

Appendix A: Behavioral Health Workforce – Building & Sustaining Career Pathways

Project Authors: Bish Paul, Policy Director; Jenee Myers-Twitchell, Chief Impact Officer; Mikel Poppe, Impact Data Manager

Washington STEM is pleased to submit this summary report on the status of the work that we have completed to date on the Behavioral Health Pathways Data Project in partnership with the Workforce Education and Training Coordinating Board (Workforce Board). This report reflects the agreed-upon goals and milestones for the project, approved by the Workforce Board, the activities accomplished for each milestone to date, as well as the continuing and planned activities for the milestones for the rest of the project this year.

Project goals:

- **Provide regional supply data and partnership** to drive an expansion of high-quality behavioral health workforce in Washington.
- **Provide Data & Measurement** for current career pathways or degree programs providing credentials for each behavioral health and related occupations.
- **Develop a Credential Opportunities by Region and Industry tool** to highlight what credentialing opportunities exist (or do not exist) in every region of the state in order to help with targeted expansion of both programs in postsecondary and career exploration experiences in K-12.
- **Identify gaps and barriers to participation and completion of programs** that lead to high demand behavioral health occupations.
- **Develop an interactive dashboard and series of regionalized reports** for current supply and demand of behavioral health and related occupations. This may enable advocacy and education efforts to expand access to behavioral health.

Project milestones and details to date:

Stakeholder input and project planning meetings: Workforce Board staff have helped coordinate WA STEM meetings with many stakeholders who are integral to helping us understand the Behavioral Health occupations landscape and to building out a BH job projections tool. Meetings and feedback sessions held to date:

8/12/21	BH Health Data Discussion	WA STEM, Workforce Board
8/20/21	WA STEM proviso BH planning meeting #2	WA STEM, Workforce Board
8/27/21	Health Workforce Council Meeting	WA STEM, Workforce Board
9/9/21	Connect: Behavioral Health workforce data	WA STEM, Workforce Board, UW
11/2/21	Statewide BH Occupations list feedback | Building & Sustaining Career Pathways	Over 150 unique participants across two meetings, see below (table in #3)
11/8/21	Data on Statewide BH Occupations list feedback session #2 | Building & Sustaining Career Pathways	Over 150 unique participants across two meetings, see below (table in #3)
11/15/21	Behavioral Health Proviso Check-in	WA STEM, Workforce Board

Data collection: WA STEM has gathered data from the Washington State Employment Security Department (ESD), the federal Bureau of Labor & Statistics, Washington State Labor and Industries, individual apprenticeship programs, the Workforce Board, and key stakeholders (listed above) and identified a list of initial occupation groupings that are related to behavioral health.

In order to figure out what we need to do to increase the supply of BH professionals, we need to know where the biggest gaps are in job openings and in credentials available in the BH sector.

The Behavioral Health Workforce has many occupations that have specific credential and training requirements. Traditional job projection data (demand) and higher ed/training data (supply) mask the hiring crisis within many occupations in the BH sector. In order to identify behavioral health demand we determined which jobs exist within the traditional occupation groups and used this to generate job projections.

The initial data source we used was the ESD Occupations-industry matrices, used to identify the occupations typically found in the behavioral health and related industries.

The resulting list of occupations is broken down into two categories.

- Occupations exclusively found in behavioral health industries, examples include Psychiatrist, Social Worker, and Psychologist.
- Occupations found in multiple industries including behavioral health, examples include Registered Nurse and Physician.
    - Occupations are defined by the U.S. Bureau of Labor Statistics (BLS) Standard Occupation Classification (SOC) system.

- Typical credentials and work experience required to enter an occupation are provided by U.S. Bureau of Labor Statistics (BLS) Occupational Characteristics.

The list of occupations available for consideration is then matched to occupational projections provided by ESD.

The list of occupations included in the Washington State occupational projections are limited to the 6 digit "detailed occupation level" and do not include all occupations included in the SOC system, as a result some occupations are combined. An example of combined occupation projections would be "21-1014 Mental Health Counselors" which do not have an occupational projection and are instead included in "21-1019 Counselors, All Other".

The list of occupations was then expanded to include job titles specific to behavioral health. This was initially accomplished using a list of behavioral health professions provided by stakeholders and sources such:

- Washington State Department of Health Behavioral Health Professions, Facilities, and Agencies.
- O*Net OnLine was then used to match these job titles with occupations. O*Net OnLine provides a searchable list of reported job titles associated with occupations found in the SOC system.
    - Unique job titles also represent the variation in credentials and work setting experience required for each.

The below snapshot is a portion of the occupations first identified as being related to behavioral health; the full list includes 60 total occupational groupings.

SOC code	Occupational title	Projected Job Openings
31-1120	Home Health and Personal Care Aides	8,181
21-1093	Social and Human Service Assistants	1,353
21-1019	Counselors, All Other	1,083
21-1021	Child, Family, and School Social Workers	996
31-1131	Nursing Assistants	957
11-9151	Social and Community Service Managers	589
21-1094	Community Health Workers	486
21-1015	Rehabilitation Counselors	352
29-1141	Registered Nurses	315
21-1023	Mental Health and Substance Abuse Social Workers	302
31-9092	Medical Assistants	279
21-1022	Healthcare Social Workers	248
19-3039	Psychologists, All Other	206
29-1125	Recreational Therapists	166
11-1021	General and Operations Managers	161
29-2053	Psychiatric Technicians	149
21-1099	Community and Social Service Specialists, All Other	148
21-1091	Health Education Specialists	130

Stakeholder feedback & shaping of the data: WA STEM worked with representatives across a large group of stakeholders to review the occupations list, refine it, and make naming and other decisions about the jobs on the list. We have engaged with over 150 stakeholders to obtain feedback in crafting the list and the tools, including the following, to date:

Workforce Training & Education Coordinating Board (Workforce Board) staff	Children and Youth Behavioral Health Work Group (CYBHWG)
Behavioral Health Workforce Advisory Committee (BHWAC)	Health Workforce Council
Healthcare Authority (HCA)	Washington State Hospital Association
Washington Association of community health centers	Sentinel Network, UW
Behavioral Health Institute, UW	SEIU Healthcare 1199NW Multi-Employer Training and Education Fund
Kaiser Permanente	Behavioral Health Northwest
Sound Mental Health	Catholic Community services
Downtown Emergency Services	Skagit Behavioral Health group (led by Rep Paul)
Behavioral Health Workforce Task Force (convened by Rep Frank Chopp)	Association of Advanced Practice Psychiatric Nurses
Comprehensive Life Resources	Cascade Community Healthcare

Lake Washington Institute of Technology	Molina Healthcare
Washington State Department of Health (DOH)	School of Nursing, UW
Greater Columbia ACH	Lifeline Connections
DSHS	Kitsap Mental Health Services
Lummi Indian Business Council	Frontier Behavioral Health
Telecare Corp	Dept. of Veterans Affairs
Discovery Behavioral Healthcare	Evergreen Recovery Centers
National Association of Social Workers - Washington Chapter	Amerigroup
Valley Cities	Sunrise Services, Inc.
Greater Lakes Mental Healthcare	Coordinated Care
Yakima Valley Farm Workers Clinic/Behavioral Health	Eastern Washington University
Swedish Edmonds Behavioral Health Inpatient Unit	Coalition Ending Gender Based Violence
Council of Presidents	Association of Alcoholism and Addiction Programs of Washington State
Washington State Employment Security Department	South Central Workforce Council
Sea Mar Community Health Centers	State Board for Community & Technical Colleges
WA State Psychological Association	Children's Home Society of Washington
Washington Association for Community Health	Elevate Health Pierce County ACH
Elevate Health Pierce County ACH	School of Social Work, UW
Washington State Nurses Association	Workforce Development Council Seattle -King County
North Sound Behavioral Health Administrative Services	Washington State Labor & Industries
Nursing Care Quality Assurance Commission	Washington State Office of Financial Management
Health Care Apprenticeship Consortium	

Data cleaning and shaping: WA STEM, with engagement from over 150 individuals representing the stakeholder list above, has produced a much more accurate and relevant list of BH jobs that reflects the field, and prepared the list for use in a behavioral health labor market projections tool. The following is a draft, but

comprehensive, list of behavioral health occupations and job titles that accurately reflects the field and the contexts of the work; followed by screenshots as examples of the job titles that more accurately reflect the BH industry in Washington: [https://washingtonstem.box.com/v/BH-Job-Titles.](https://washingtonstem.box.com/v/BH-Job-Titles)

Occupation Titles are defined by the Bureau of Labor Statistics (BLS) Standard Occupational Classification (SOC) System. Occupations are limited to those included in the Washington State Employment Security Departments occupational projections. (https://esd.wa.gov/labormarketinfo/projections)

Job Titles are those jobs found within the same occupation but require different credentials and/or work experience.

Exclusively Behavioral Health Occupations

Occupation Title	Job Titles
Child, Family, and School Social Workers	Child Life Specialist
Child, Family, and School Social Workers	Child, Family, and School Social Workers
Community and Social Service Specialists, All Other	Community and Social Service Specialists, All Other
Community Health Workers	Community Health Workers
Counselors, All Other	Agency Affiliated Counselor
Counselors, All Other	Behavior Analyst
Counselors, All Other	Case Manager
Counselors, All Other	Certified Adviser
Counselors, All Other	Certified peer counselor/Peer counselors/Peer support counselors/Peer support specialists
Counselors, All Other	Educational, Guidance, and Career Counselors and Advisors
Counselors, All Other	Licensed Mental Health Counselor (LMHC)
Counselors, All Other	Licensed Mental Health Counselor Associate (LMHCA)
Counselors, All Other	Licensed Professional Counselor (LPC)
Counselors, All Other	Mental Health Counselor
Counselors, All Other	Recovery coach

Occcupations Found in Multiple Industries, Including Behavioral Health	
Occupation Title	**Job Titles**
Adult Basic and Secondary Education and Literacy Teachers and Instructors	Adult Basic Education Teacher (ABE Teacher)
Clergy	Clergy
Clinical Laboratory Technologists and Technicians	Lab Technician
Clinical Laboratory Technologists and Technicians	Medical and Clinical Laboratory Technicians
Clinical Laboratory Technologists and Technicians	Medical and Clinical Laboratory Technologists
Computer Systems Analysts	Health Informatics Specialists
Data Scientists	Clinical Data Managers
Dietetic Technicians	Dietetic Technicians
Dietitians and Nutritionists	RN/Registered Dietician
Dietitians and Nutritionists	Dietitians and Nutritionists
Directors, Religious Activities and Education	Directors, Religious Activities and Education
Emergency Medical Technicians and Paramedics	Crisis Responder
Emergency Medical Technicians and Paramedics	First Responder

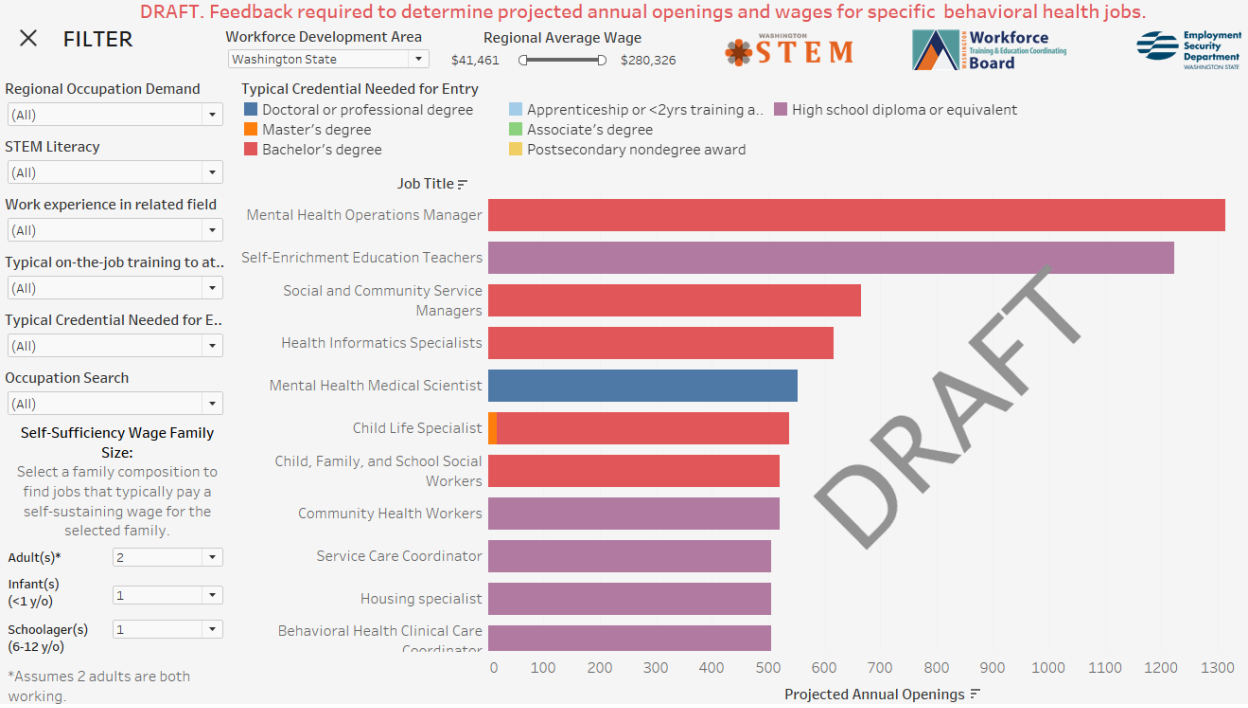
Projection weighting/assignment (continuing): WA STEM has begun to work with representatives from a small group of key stakeholders to assign percentages of sub occupations to job projections groups. This includes a meeting with the Workforce Board and Melody McKee, Behavioral Health Training, Workforce and Policy Innovation Center, Harborview Medical Center - Behavioral Health Institute. We are also planning out future meetings with a slightly larger group of stakeholders. The following is an example of how the assignment of percentages of sub occupations to a job projections groups works:

- For occupations found primarily in the behavioral health industry we will assume 100 percent of projected job openings are distributed among the job titles we have identified. While the weighting of job projections has not yet occurred, here is an example of how it will be done:
    - We have identified 5 unique job titles that fall under the occupation of "Social Worker, All Other". The occupation is projected to have 100 job openings statewide. With input from key stakeholders, we would estimate projected job openings. A *draft example* of how these may be distributed is follows:

Job Title	Weighting	Projected Openings
Certified Affiliate Sex Offender Treatment Provider	5%	5
CORF Social Worker/Psychologist	10%	10
Licensed Advanced Social Worker (LASW)	30%	30
Licensed Independent Clinical Social Worker (LICSW)	25%	25
All Other Social Workers	30%	30
Total Projected Job Openings		**100**

For occupations found in multiple industries, such as Registered Nurse, we will first seek to determine what share of projected job openings are specific to behavioral health. We will then distribute those behavioral health industry openings across the 10 unique job titles for a Registered Nurse in behavioral health.

Tool drafting (Behavioral Health Labor Market data dashboard): On November 12, WA STEM released a draft Tableau dashboard that aims to accurately reflect the behavioral health occupation landscape and the projected job openings in that landscape, by sub occupation and by region. This tool is a BH industry-specific version of WA STEM's more general Labor Market Data Dashboard (https://washingtonstem.org/labor-market/). The draft Behavioral Health Labor Market Data Dashboard can currently be found here: https://bit.ly/2Z8iNSu.



Planned efforts and project goals:

1. Health Workforce Council report: While this report acts as a draft, WA STEM will provide an updated summary of our efforts, research, tools, and work to date as part of the report to be submitted in December 2021 to the Health Workforce Council.

2. Projection weighting/assignment (continuing): As mentioned in item #5 above, WA STEM has begun to work with representatives from a small group of key stakeholders to assign percentages of sub occupations to job projections groups.

3. Stakeholder feedback and iterating:

    - WA STEM has already presented the draft Behavioral Health Labor Market data dashboard to key stakeholders (listed above), and over the next two to three months, we will engage stakeholders in rounds of updates, feedback, user testing, and iterations. We will be adjusting projected weighting/assignment of percent of openings by job title, ensuring that average regional wage is accurately reflected for each job, and ensuring that projected openings by region are accurately reflective of the field.

4. Training, licensure, and credentials required:
    - WA STEM will draft out and apply the required trainings, licensures, certificates, degrees, etc., for each listed job title generated in the Behavioral Health Labor Market Data Dashboard.
    - We will then engage stakeholders, in multiple rounds, to ensure that these accurately reflect the field's requirements in those jobs.
5. BH Credential Opportunity by Region Index (BH CORI):
    - In 2022, WA STEM will combine the Behavioral Health Labor Market Data Dashboard and the draft trainings, licensures, and credentials required for each BH job, along with the estimated capacity in each training, licensure, and credential program in the state, to inform and create a tool that can display the relative supply-demand index for each credential/licensure. In other words, it will display whether there is relatively enough capacity in various training and credential programs to meet the demands of the workforce projections in our state, by region. It will help prioritize the need for expansion or program creation and/or provide reasoning for changing credentialing requirements, for each BH job in the state.