If

HEALTH SYSTEMS DIVISION
Behavioral Health Workforce Initiative, House Bill 2235 Workgroup

Tina Kotek, Governor

Oregon Health Authority

500 Summer Street NE
Salem, OR 97301
https://www.oregon.gov/oha/HSD/AMH/Pages/HB-2235-Workgroup.aspx

House Bill 2235 Workgroup MINUTES
Wednesday, April 3, 2024 1:00 – 3:00 pm
Location: https://www.zoomgov.com/j/1618065772?pwd=M0pDZFRIcXVURGc2dFgzRFl0ZkNtQT09

Members in Attendance:		OHA Staff in Attendance:
☐ Diane J Bocking	☒ Jose Luis Garcia	☒ Christa Jones
☒ Belindy Bonser	☒ David Geels	☒ Vitalis Ogbeama
☐ Kelli Bosak	☒ Qurynn Hale	☒ Tim Nesbitt
☒ Chris Bouneff	☒ Clark J Hazel	☐ Jen Eisele
☒ Cheryl Cohen	☒ Jenn Inman	☒ Daniel Page
☐ Sarah Conyers	☒ Tony Lai	☒ Kelli Taylor
☐ Deanna Cor	☒ Lucia Mendoza-Meraz	☒ Mireya Williams
☒ Anthony R. Cordaro, Jr.	☒ Shyra Merila	
☒ Lorie DeCarvalho	☐ Michael Spencer	
☒ Melinda Del Rio	☒ Diane Benavides Wille	

Resources:
HB 2235 Draft Charter

START	TIME	END	TOPIC	OUTCOME	LEAD(S)
1:00	10 min	1:10	Welcome Roll Call	 Establish quorum	Tim Nesbitt Kelli Taylor
1:10	10 min	1:20	Public Comment	Public testimony	Vitalis Ogbeama
1:20	5 min	1:25	Matters from previous meeting	Group consensus	Vitalis Ogbeama
1:25	10 min	1:35	Core Priorities/Topic Roadmap	Organize work	Tim Nesbitt
1:35	10 min	1:45	Licensing presentation	Information	Clark Hazel
1:45	10 min	1:55	Discussion	Group consensus	Vitalis Ogbeama
1:55	10 min	2:05	Break		
2:05	45 min	2:50	Retention: Reflections on experiences and reading	Recommendation input	Vitalis Ogbeama
2:50	10 min	3:00	Wrap up/Next steps	Group consensus	Tim Nesbitt
			Next meeting:	**Wednesday, April 17, 1:00 – 3:00 pm**	

MEETING MINUTES:
Tim Nesbitt: Welcome
Kelli Taylor: Roll call and minutes approval: roll call completed, quorum established, and 3.20.24 minutes approved.
Public Comment: None
Vitalis Ogbeama: Matters from previous meeting: none.
Tim Nesbitt: Charter update, peek at current priority ratings based on survey results.
Jenn Inman: Definitions of the terms such as “workforce workload”, “administrative burden”, with a one sentence statement of purpose to narrow the focus of discussion.
Christa Jones: We will need to connect internally with Government Relations on definitions to ensure the intent of the legislation is reflected within definitions.
Clark Hazel’s Licensing presentation: potential examples/changes for restructuring licensure process and delineation of roles in Oregon. Clark was able to consult with Professor Ericka Kimball, school social work professor that works on policy. Licensure process is very tedious, time consuming and many barriers are in place to get licensed currently. Comparison to licensure processes and different roles different levels can fill in other states. Have BSW/MSW getting into the field, and a typical route is CWSA to start with LCSW as the end goal. LMSWs are a different licensure and underutilized. Clinical licenses can create debt and creates more barriers for a diverse workforce. Creating a new structure that eliminates the pitfalls of the current CSWA process could alleviate ongoing issues with staffing, as well as redefining/eliminating requirements that are unneeded. Clinical social work in Minnesota includes diagnosis, providing therapy services, clinical based settings such as hospitals, prisons, etc., with a minimum requirement of an MSW. Minnesota has four levels of licensure, LSW: Licensed Social Work (allows practice of social work with initial two years of practice under supervision, however not permitted to practice clinical social work; requires a BSW degree, ASWB Bachelors Exam, 4000 hours supervised practice upon licensing, and 40 CE hours at biennial renewal), LGSW: Licensed Graduate Social Worker (allows practice of social work with initial two years of practice under supervision, and engaging in clinical practice under supervision; requires MSW or DSW degree, ASWB Masters Exam, 4000 hours supervised practice upon licensing – one time requirement if non-clinical, ongoing requirement if clinical not to exceed 8000 hours and must test for LICSW, and 40 CE hours at biennial renewal), LISW: Licensed Independent Social Worker (LISW exam pass, 100 hours documented supervision, 4000 hours practice), and LICSW: Licensed Independent Clinical Social Worker (allows practice of social work and clinical social work independently without supervision; requires ASWB Clinical Exam, 360 clinical knowledge clock hours, 4000 hours post-LGSW supervised clinical practice, and 40 CE hours at biennial renewal). Next step proposal is to review other states’ license structures and glean what we can from their processes, such as Washington, Massachusetts, Illinois, Idaho, and Minnesota. Inviting Professor Ericka Kimball (PSU SSW) to address the workgroup as has in-depth knowledge and lived experience of both Oregon and Minnesota’s systems. Dr. Kimball’s recommendations include the need to expand our thinking of social work practice beyond mental health. The focus on mental health is partly why we’re doing the issues outlined, to be covered in depth later. We have to distinguish social work beyond just mental health behavioral professionals, distinguish the jobs between LMSW and CSWA/LCSW. The hierarchy of making the LCSW seem like the terminal license is part of the issue, as there are many social work jobs that do not require the CSW/LCSW. Another recommendation is Oregon is missing out on opportunities to quickly infuse our workforce with licensed practitioners at the Bachelors’ and Masters’ level as we are under utilizing the LMSW license. Change for Registered Bachelor Social Worker to LBSW, develop Bachelors’ professional degree to be licensed. Most states already have LBSW/LSW in place and in the workforce, due to Oregon’s lack of education and support for the practice we are underutilizing this group and keeping them from accessing salary gains and professional trajectories beyond entry level positions. Utilizing the LMSWs in a greater degree where clinical work is done within a

practice under the regular supervision of an LCSW, whether public or private setting, as most states utilize LCSW and LICSW.
Cheryl Cohen: Agree with Clark on next steps, talked about these same issues in the Mid-Valley Behavioral Health Consortium and Michelle Martinez Thompson sits on that Consortium, she would be happy to come and meet with this group as well. Would like to see what other states do that could benefit Oregon.
Melinda Del Rio: Bachelor and Master level is being underutilized. Cost of licensure, as QMHA and QMHP, comparing costs to other states and the difference in cost. Wondering what the differences are in Minnesota's and other states licensure, cost of being registered through the board versus being registered through MHACBO which is a bit cheaper.
Diane Benavides Wille: If you have somebody that has a Bachelors in social work, they would qualify to be a QMHA. MHACBO certification is currently waived, where the state is still charging hundreds of dollars for both LCSW and LPC registration license renewal. Less hoops and less money for MHACBO certification.
Shyra Merila: Point of clarification that unlicensed QMHPs can bill Medicaid, as it's an open network. Challenge in community mental health programs as it means that we're missing an opportunity to hire folks if they're going straight into private practice with the ability to bill Medicaid.
David Geels: Think it would be helpful to make the process for folks on a social work track more accessible to everyone, but not sure if it's going to help the public health system, as currently in public health they have the option to become a QMHA, QHMP and they can bill for services under a COA organization like a community mental health program. So by establishing these under the licensing board it could broaden for the folks there and actually might have an opposite effect that it opens up people to other opportunities outside of the public health system more than they are now. Right now a lot of these folks, especially at the Bachelors' level, their options are to go work for a certification of approval (COA) organization and if the had options to go somewhere else then that would divert more of the workforce to other areas, potentially. LPC and LMFT boards reduced the hours requirements which gets folks licensed quicker but also contributes to a less experienced workforce as well. Think we need to look into opening up the pathways like this and we have used what is LMSWs in Oregon, in my organization we use them the same way as any other QMHP.
Shyra Merila: Was trying to figure out what roles in a community mental health program could be filled by these professionals if they were to acquire these credentials that would somehow be different than the workforce that we currently have access to. Don't know if decreasing hours for license certification solves problems because we're using Masters' level providers and I still think that people benefit from having the clinical experience and field work before they get an elevated license. Supervision hours are really critical to development, but licensed or not, we're looking at Masters' degrees.
Anthony Cordaro: Thank you for the presentation, very eye opening to me. Wondering about the data on states that have adopted these practices, has it led to providers getting more clinical training and going on to the highest level of clinical social work. Is there any data that shows this does not decrease the higher end of people who have more training and ability. Support outside expert coming in to help with this.
Jenn Inman: May be helpful for this group to have an overview of what all the credentials are, what the acronyms are and what services they are currently providing in the BH space in Oregon. That might help level set and give some folks some resources about where they can learn about all those different elements. We're experiencing a huge lag time with the Oregon Social Work Board right now. Can't get folks certified by the board to be able to do clinical supervision to licensure. We've been waiting for five months just to get an unlicensed social worker for them to just process the paperwork, certify for licensure for clinical supervision, and it seems like that should be an easy policy fix. If not, then what? Why is that happening? That's a big barrier. We're using unlicensed folks in a number of different ways to do everything that we possibly can, but that doesn't mean we don't value licensure and what folks get from that experience. But it's also investment in time and providing meaningful internships for folks and having those internships count in the nature of the work that they're providing, which is also a challenge for us to be able to use interns, whether they're counseling or social work interns, particularly in the crisis mental

health space, to actually have those hours count for them in a meaningful way, and that's not what is happening. Folks who are trying to move toward licensure are not getting the clinical hours that they need in the publicly funded behavioral health space because of the nature of the work and the way things are being defined. So in this conversation, if we can include those elements about the responsiveness of the boards that are available to us and what those internships really need to really look like and if they're serving us well in the broad range.
Clark Hazel: Good questions. I also want to echo what has been said about using folks that are unlicensed for everything under the sun, including clinical work.
Tim Nesbitt: I'm hearing there is a desire to invite an expert, at least one, to answer some of these questions and some definitions for some of these roles.
10 Minute Break
Tim Nesbitt: Opens the floor to culturally and linguistically specific providers and non-management for discussion on assigned reading retention article.
Melinda Del Rio: Working with clients, especially the cultural/linguistically specific services, it comes down to time. Whether it's resources, documentation, translation, etc. There's so much that happens in care that are non-billable services, what stands out is that people are not going to be reimbursed or see a return on specific services.
Jose Luis Garcia: Burnout comes on the culturally/linguistically specific perspective, as we're being asked to do more than what someone who isn't culturally specific to do. We can be peers, nurses, therapists, but we're asked to translate, we're asked to get materials in different languages, we're being asked to do more things than just what the job is about. We're talking about equitable pay, the rate could be the same, making the same as the other person, but doing ten times as much work to be culturally/linguistically specific. In my community I've seen people who don't read and write so we have to read for them, write for them, and that becomes more of a burden for us now we have to do more and more administrative pieces to support our community. Some culturally specific organizations are starting to do four days on three days off for recovery time. People in acute care should be doing three on four off as they are dealing with so much trauma. Conversation with a sheriff about the police force not having the time to process the work-related trauma, same principle. When it comes to specialized skill sets and how much we are asking our staff to do it is important to retention that they get enough rest.
Tim Nesbitt: Open the floor to everyone for discussion.
Jenn Inman: Would like to reflect the comments Jose made have been happening in our organization as well, the layered impact and that expectation that adds another depth to burnout. SAMSHA's study from last fall on burnout and the behavioral health workforce has policy level organizational strategies, things that have and have not worked. Surgeon general is putting out whole model and framework for thinking about well-being in the workforce and it captures all of these elements as well with worker voice and equity in the middle. Protection from harm, connection and community work, life, harmony, mattering at work and opportunities for growth and focusing on all of those as both recruitment and retention needs. Thinking about what the daily working conditions and what it's like now compared to a year ago, or what people thought it was going to be when they took the positions.
Shyra Merila: Wanted to thank Jose for his comments, and having conversations that are reflective of that in our organization. Provide a 10% pay differential for people who are Spanish speaking, automatic 10% increase but that doesn't mean they are expected to provide translation services. It is an equity differential, and leadership team forgets that just because they speak Spanish doesn't mean they are paid for translation. Gotten feedback from our team that some SUD providers are struggling with chronic negativity and holding hope for people and struggling with staying strength based. So I can come in and say here's your trauma informed resiliency training, blah blah blah. And that feels tone deaf to the fact that the climate that they're working in is completely different than anything we've ever seen before. And I don't think we've trained our providers for it and I certainly don't think we're paying them appropriately for it. I think that folks that are community based, especially in the SUD teams, should be getting hazard pay. Would really like to highlight the working conditions piece. Poverty level, the despair, the hopelessness, the houselessness, and fentanyl and the post pandemic fallout, it's all unprecedented, we haven't been here before. Supporting a team as leaders, who haven't supported a team in this way before also needs

to be central to the conversations.
Diane Benavides Wille: Yes, our work environment is very different today than 20 years ago. Lost a client to accidental overdose, another client assault one of our clinicians. Article didn't feel relevant/timely/regional. Oregon's healthcare workforce needs assessment in 2023 was done by Oregon State University. First recommendation is to look at what has already been done in the state in terms of data, assessment, and what recommendations we can take further given the nature of how things have changed in the behavioral health workforce.
Jose Luis Garcia: We need to understand how to supervise people who are in recovery. We tend to focus on the administrative side of things when we do clinical supervision and forget the fact that we're dealing with people that are in recovery themselves and we need to be checking on what are they doing to support their recovery. What are they doing/going to their AA meeting? What are they doing for their support? If somebody is in recovery from a mental health or substance use disorder, they may see themselves in their clients and their clients may see themselves more than other providers that are not in recovery. It's important to look at when it comes to our clinical supervision and understanding how we train our supervisors or how do we have supervisors with lived experience in these positions too so they can support the workforce, and checking in on their recovery because that's really important too. It's another way that we lose people, by committing ethical violations, because they're just burnout and they relapse. We're getting more people in recovery in the workforce because that is what the people want, and we need to keep the recovery component important for those that identify as in recovery. We need to look at our clinical supervision in a different way, also supporting their recovery within the organization they work in.
Tim Nesbitt: What kind of investments, state funding, etc., would you like to see based on what's being said about burnout for culturally/linguistically specific service provider, the supervision that's needed, the working environment, worker safety, are there any thoughts around about what the state could do?
Jenn Inman: Looking over investments over two different sessions and two different biennium. It takes time to realize those investments and the allocations have been rushed and abbreviated in time. Tuition reimbursement has to include the time it takes to go to school, then get reimbursed which is not an 18 month turn around time while folks also figure out how to do life and keep working while they're going to school, etc. Longer term investments, which is hard in biennial budget framework. How could that be structured into other investments if it's around schooling, as the investments that have been made don't allow us to do longer term supports. Addressing the backlogs at the licensing boards. What internships look like for Masters level counselors and social workers and how to acknowledge and respect the importance of their time doing work on the crisis side, policy piece to explore for state schools. Redefine this workforce from one that is routine, scheduled, primarily office based, to 24/7 in the field, different kinds of client population, whether residential or mobile or field based, etc. How scheduling is set up reflects the routine/appointment based, and is how the unions think about represented folks in these positions. I would like to see some more thought and analysis on what has been tried and didn't produce what we thought it was going to do.
Qurynn Hale: I work for CareOregon as the CCO and I'm contracted with Columbia Pacific's Coordinated Care Organization, I mostly serve Tillamook/Clatsop in Columbia County, but CareOregon does provide continuing education component called Medicaid Essentials. It's CEUs that are available for any new or ongoing clinicians. Been helpful for new clinicians that are coming into some of our CMHPs that are super green and need that basic training on case management or safety planning; how to incorporate feedback informed treatment, how to build an assessment, discharge planning. This is something that a CCO can offer to their providers. Specific trainings, free CEUs, tips and tricks and how to build out robust assessments, these are things that CCOs can do for providers.
Tim Nesbitt: When we talk about safety in the workplace for clinicians and clients, what investments/policy changes can we make or look at?
Diane Benavides Wille: Safety has been one of our big challenges in our workforce. One component we hear consistently through exit interviews, surveys, safety is always ranked number one. The Tri-county Behavioral Health Association is just forming its safety committee, we got some funding from CareOregon to bring in trainers to teach all staff members in the association Post Traumatic Stress Management as

well as a full day training on post traumatic stress management. Breakdown of Syntegix on badges that are given to staff and related processes for staff support. Debriefing incidents and using external partners to affirm staff involvement and processing the situation.
Tim Nesbitt: Something that popped up for me from that was an ongoing application that the state could provide for organizations to apply for funds for safety devices, etc.
Cheryl Cohen: I've heard in this groups and throughout the state is that the biggest need is around the Masters level workforce. I would really like to see OHA collaborate more with Higher Education and look at expanding the Oregon Healthcare Provider Inventive Program. Loan repayment program with OHA and the Office of Rural Health, and there are existing payment programs whether that's loan repayment or forgiveness in exchange for a service obligation. Expanding, replicating, scaling, anything like that would be huge. Attracting Masters level to public health, as Associates go straight into private practice and bypass community behavioral health. While well intended, I'm part of two consortiums that are funded by the HOWTO grants, which does amazing work around workforce development, and all of those have been supported by regional workforce boards and none of them have sustainable funding. I would love to have three workforce boards stepping into this place, they're good at this work, blending and braiding funding and they know workforce systems better than the education system or OHA. Exploring sustainable funding for communities across Oregon to develop their own programs that would specifically be around QMHP or Masters level workforce development since that is the biggest gap in creating pathways for people who have a Bachelors and Masters degree that takes many years and is very expensive.
Tony Lai: Recommendation I would like to make is the Oregon Rural Practitioner Program in the state offers a tax credit to healthcare providers, I would like to see therapist of behavioral health workforce be added as part of that program. Concrete step to retain the workforce, especially in rural areas.
Lori DeCarvalho: I had reached out about the tax credit a couple of years ago and they sent it through to be approved. As most government things the wheels turn slowly, so may already be in effect.
Tim Nesbitt: Would love to look into that and see how we could expedite it.
Wrap up/Next steps: Christa Jones to be transitioning out of the workgroup into the role of Deputy Director of Service Delivery, Tim Nesbitt promoted to manager of workforce team, workgroup to be sponsored by another executive at OHA. Next meeting April 17, 1:00 pm, presentation by Deanna Cor on Zoom, proposal form closing April 10 for priority schedule, bio reminder, gratitude.

Record of Vote
Topic: 3.20.24 Minutes approval
Outcome: 3.20.24 Minutes approved

Y	N	Abstain	Absent	
☐	☐	☐	☒	Diane J Bocking
☐	☐	☐	☒	Belindy Bonser
☐	☐	☐	☒	Kelli Bosak
☒	☐	☐	☐	Chris Bouneff
☒	☐	☐	☐	Jose Luis Garcia
☒	☐	☐	☐	David Geels
☒	☐	☐	☐	Qurynn Hale
☒	☐	☐	☐	Clark J Hazel
☒	☐	☐	☐	Jenn Inman

☒	☐	☐	☐ Cheryl Cohen	☒	☐	☐	☐ Tony Lai
☐	☐	☐	☒ Sarah Conyers	☐	☐	☐	☒ Lucia Mendoza-Meraz
☐	☐	☐	☒ Deanna Cor	☒	☐	☐	☐ Shyra Merila
☒	☐	☐	☐ Anthony R. Cordaro, Jr.	☐	☐	☐	☒ Michael Spencer
☒	☐	☐	☐ Lorie DeCarvalho	☒	☐	☐	☐ Diane Benavides Wille
☒	☐	☐	☐ Melinda Del Rio				

https://www.oregon.gov/blsw/Pages/LicenseDescriptions.aspx - Oregon social work licensure page
https://www.hhs.gov/sites/default/files/workplace-mental-health-well-being.pdf - U.S. Surgeon General's Framework for Workplace Mental Health and Well-Being
https://www.tandfonline.com/doi/full/10.1080/23761407.2017.1319775 - State Definitions of Social Work Practice: Implications for our Professional Identity (Kelli Taylor has requested the article and will send to the group once delivered)
https://store.samhsa.gov/sites/default/files/pep22-06-02-005.pdf - SAMHSA's Addressing Burnout in the Behavioral Health Workforce Through Organizational Changes
https://health.oregonstate.edu/sites/health.oregonstate.edu/files/healthcareworkforce/pdf/health-care-workforce-needs-assessment-report-2023.pdf - OSU's Oregon's Health Care Workforce Needs Assessment 2023
https://www.ruralhealthinfo.org/ - Rural Health Information Hub