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
May 1, 2024 1:00 – 3:00 pm
Location: https://www.zoomgov.com/j/1618065772?pwd=M0pDZFRIcXVURGc2dFgzRFl0ZkNtQT09

Members in Attendance:		OHA Staff in Attendance:
☒ Belindy Bonser	☐ David Geels	☒ Vitalis Ogbeama
☒ Kelli Bosak	☒ Qurynn Hale	☒ Tim Nesbitt
☒ Chris Bouneff	☒ Clark J Hazel	☒ Jen Allen
☒ 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	☒ Tara Sanderson	Guests:
☒ Melinda Del Rio	☒ Sheri Selander	☐ Dr. Ericka Kimball
☐ Jose Luis Garcia	☒ Diane Benavides Wille	

Resources:
HB 2235 Draft Charter

START	TIME	END	TOPIC	OUTCOME	LEAD(S)
1:00	5 min	1:05	Welcome Community Agreements Review	Grounding	Tim Nesbitt
1:05	5 min	1:10	Roll Call	Establish quorum	Kelli Taylor
1:10	10 min	1:20	Public Comment Period	Public testimony	Vitalis Ogbeama
1:20	5 min	1:25	Matters from Previous Meeting	Consensus	Vitalis Ogbeama
1:25	40 min	2:05	Dr. Kimball and Social Work Licensing (POSTPONED)	Inform	Dr. Ericka Kimball
2:05	10 min	2:15	Break		
2:15	35 min	2:50	Retention Discussion: Policy and Legislative Investments	Discuss	Tim Nesbitt
2:50	10 min	3:00	Wrap up/Next Steps	Inform	Tim Nesbitt
			Next meeting:	**May 15, 2024 1:00 – 3:00**	

MEETING MINUTES:
Welcome, notice of agenda change as Dr. Kimball unable to present on social work licenses. Review of community agreements established previous meeting.

Roll call completed; quorum established. Vote for approval of minutes from 4.3.24 & 4.17.24, minutes approved for 4.3.24.

Introduction of new workgroup members, Sheri Selander and Tara Sanderson.
Sheri Selander: My name is Sheri Selander, my pronouns are she/her, I'm the CEO of New Directions Northwest in Baker City, Oregon. We work quite extensively throughout the state but are very involved with Eastern Oregon activities and GOBI. Really excited and pleased to be a part of this group.
Tara Sanderson: My name is Tara Sanderson, and I am a licensed psychologist running a group practice in Tigard. I work with students all the way through associates and psych residents, and I represent a groups of group practice owners and we'll be working with them to collaborate and gather information about things that are helpful for this committee as well.

Public comment period: none.

Matters from previous meeting:
Cheryl Cohen: Wanted to share an update about legislation signed by Governor effective April 4, House Bill 4092, two-part bill that impacts the scope of the workgroup around administrative burden. Part one of the bill requires OHA to conduct a study to determine the funding required for each Community Mental Health Program (CMHP) to provide the services and perform the functions required of them by law. Part two of HB 4092 is what is relevant to the work of this group since it's around admin burden. This bill requires OHA to contract with the Oregon Council for Behavioral Health to work with a group of mental health and substance use disorder providers to study the statutory and regulatory framework for behavioral health systems and make recommendations for changes to the laws and address redundancy, redundancies, contradictions and outdated language, to define and clarify the rules and responsibilities of behavioral health system partners, and to ensure a regulatory framework that is better for providers and consumers. And the bill specifies the membership and the duties of the group and requires that group to submit reports to the legislature. It's going to be convened by the Oregon Council for Behavioral Health and we probably want to have this group have some connection to that group and we probably in our recommendations want to point to that group that is going to be working much more deeply on admin burden.
Chris Bouneff: Member of steering committee for HB 4092 workgroup, can keep the group updated as work progresses.
Tim Nesbitt: Awesome, thank you Cheryl and Chris, we will continue to collaborate fully with these groups. Internally connecting with the TAB (Tackling Administrative Burden) Workgroup to align recommendations and present to the group. And then we can we also have time for anyone else that has anything that has come up from any recent meetings or if you just have anything you'd like to share with the group.
Lindy Bonser: CADC I, II, III levels – QMHA/QMHPs I don't know if those are able to provide direct services? Could those SUD levels be applied to mental health? We also don't have a co-occurring disorder credential or license. Only four employees for the Oregon Board of Social Work and six for MHACBO.
Melinda Del Rio: CADC III is a Masters level, ICD (integrated co-occurring disorders) is new to Oregon. There are a lot of barriers billing wise, but with ICD there are trainings that have to be completed to be

considered an ICD provider. Maybe include David Corse in that discussion? Also worry of just all the fees with certifications/licensures and barriers that could cause.
Tim: I really appreciate that Lindy and I think that there's definitely a place in a conversation with this group. In Colorado where I'm also licensed, they have a licensed addiction counselor, so a LAC and that is like a master's level license that has similar supervision requirements and education requirements as a licensed professional counselor and other masters level clinicians.
Precedence for it but the LAC is also mental health involved too because the CADC has some limitations when it comes to providing mental health services. And then the whole staffing issue with the boards that you mentioned, Lindy, is certainly an issue that I think probably we're all aware of at this point in this work group and something that we've talked to the boards about, the governor's office has talked to the boards about. We were notified before the meeting that Doctor Kimball will not be able to attend because of a protest that's happening on PSU's campus. Before we get into the retention discussion I wanted to confirm that we are not leaving the topic of retention, we will be going into what affects retention that we can influence, including having guest speakers on specific topics. And I just also wanted to clarify too, based on the last meeting that when we talk about investments, we're talking about what kind of funding the legislation could approve to create grant programs for example, like the ones that we have for loan repayment, clinical supervision, grants, housing and stipend bonuses, things like that or things like tax breaks versus policy changes, which are more like how do we change the administrative rules, how do we change laws that could release some burden or lower barriers to increasing the behavioral health workforce?

Dr. Kimball will not be presenting due to protests on PSU campus.

Retention discussion:
Tony Lai: I know there is another agency doing this, as an example the lack of Spanish speaking providers, if we can identify some medical Spanish classes, to offer reimbursement for anyone that would like to partake in those classes. If that can be a policy or a recommendation, that's one idea that I have to hopefully increase the Spanish speaking workforce or any other foreign language that's needed in the area.
Lindy: I know it's not the best approach, but there are MSW programs in Texas that the majority of the graduating population are bilingual in English and Spanish. Again, that would mean telehealth. But we have people dying in the streets. I don't care how, people are not getting help and we have to get it done.
Sheri Selander: I realize another group is focusing on admin burden, but one of the critical factors we see in CMHP far exceeds private practice admin burden. That is one of the things that we're kind of seeing people wanting to leave you know CMHP programs because they can truly do much more of the work in terms of that's why they're in the business working with the clients in a private practice mode versus the requirements set forth within a behavioral health CMHP program. One of the things that makes me nervous is those higher end clientele, those safety net programs that are not typically done by your private clinicians. We don't want to get into a spot in Oregon where we don't have credentialed people that really was driven because of the frustrations of the amount of paperwork that it takes to see a client. I hope that at some point there can be a really healthy conversation about all of that because what I see is people that do stay and we have lots of licensed clinicians even within our organization here in Baker City.
Anthony Cordaro: Get a contract w/ a good electronic health record (EHR) as that reduces admin burden. EPIC costs money and is unaffordable for smaller programs. I think that that's one of the little things that really makes a huge difference in someone's time and the burdens that they experience is like being able to manage a good EHR versus a bad one and certainly having some flexibility in those.
Diane Benavides Wille: In terms of investment, it makes me think about contracts and as mental health provider contracts come through, but in none of the contracts are there built in cost-of-living increases, and Counties and CCO's pass along cost of living to their staff. But the people that are providing services as an organization, I can't give my staff raises, colas, any of those things unless those are

also passed along through the rates. Costs have increased and yet the administrative costs that are built in haven't also gone up with the same rate of inflation as sort of other things. I would like to see from the state is investment into the systems for providers. So if it is additional funding around electronic health record, we're seeing this really great movement along AI right now. And so can the state provide funding opportunity for AI, which I mean it has been shown already to be effective not only in timely documentation, good quality controls over the documents and what we are serving, but also it helps reduce staff turnover and burnout. Burden are on practices and groups when mental health is a state issue for all of its residents, investments from the state saying this is important and we want to support those providing the work to our community members.
Tim Nesbitt: Been seeing it in the contracts we've been putting out, but haven't seen it across the board. Could look into making that an OHA policy in the short term as we present to legislation.
Jenn Inman: Just a note to remind everybody that in this publicly funded behavioral health system, we're doing things that are treatment and things that are not treatment. So in the community mental health program space you have a good deal of work around care coordination that is not treatment driven, but that is not a treatment service but is getting folks in transitions from point A to point B. We do work in the in that forensic space aid and assist and when folks who are in the under the supervision of the public safety the PSRB, the security Board and psychiatric Security Board. We need to also be thinking about how flexible we have to be in these non treatment episode areas of work as well, which all still require this level of credential. So when I'm thinking about retention strategies that are promising, I won't say that anything's working right now, but that are promising investments in professional development and giving us an opportunity to have real breadth in what that means. The professional development for each employee so that they can find meaning and an opportunity to grow in their position and potentially pursue higher levels of credential while in work. Having the space to do professional development more broadly and be thinking about things beyond licensure and licensure status, but all of those other pieces, the loan repayment is fine. One of the things that would be helpful again is to have a state or other organization managed administered scholarship or tuition reimbursement process. So having an external program that people can apply to makes that a lot easier to administer. We've got a lot of public employees providing behavioral health services in the state, should we think about whether or not they too should follow the 911 dispatch operators and be identified as first responders and be able to retire earlier? I might be able to retain more people if they could retire sooner rather than retire later. So the folks who work right next to law enforcement and right next to our first responders, it feels appropriate they're being dispatched into the same spaces. My next suggestion is one of the other things that seems to be incredibly important for people to stay healthy in the jobs that they're doing is that our ability to create working conditions that don't make people more sick to do work so that folks have to be able to recover from the work. Part of that would be us able to create safe work limits to give back. Right now I'm really struggling with how to cover the required elements of community mental health service without enough staff to do it. And so but something like that in policy that solidifies, there's only so much that's reasonable without depleting ourselves and literally not practicing what we what we share with clients. The availability of child care slots as well as funding to support childcare services. And then last, just a note on what I'm seeing is not working right now is new employees are not gaining the benefits of sign on bonuses and retention bonuses. They're paying them back and leaving anyway.
Cheryl Cohen: It's about aligning financial incentives with workforce needs are where you want to retain the workforce. Community mental health programs, organizations that hold a certificate of approval or COA and integrated behavioral health and primary care, that's where the bulk of people are served in the publicly financed system. And so that's really where I think a lot of the incentives need to be prioritized and targeted. If you're wanting you know I think about what is the workforce we want to reach and that's where we target or put the incentives if we want to increase the cultural, linguistic diversity of the staff, If you want to increase the rural workforce, that's where you put money, that's where you put investment. I think there's some things this group has talked about it's really the postmasters QMHP workforce is the hardest workforce to recruit and retain and so and then licensed behavioral health providers and they're the hardest to retain in community behavioral health. I would

love to see us really expand existing programs through the Oregon Office of Rural Health, things like the Oregon Healthcare Provider Incentive loan repayment program, loan repayment, loan forgiveness for a service obligation. I would love to see if we could expand eligibility beyond rural. So that if you're a COA organization or a CMHP, you know or integrated behavioral health in primary care and you're serving priority populations. I'd love to see us really, you know is it possible to make a policy recommendation to expand an existing successful program like that to the workers where we need them? I think Tony has talked about the Oregon Rural Practitioner tax credit before and making a recommendation to see if we could expand that to behavioral health providers. So I think that's one recommendation would be around incentive programs like that, let's see another recommendation would be looking at if we can increase one time or sustainable funding for locally driven behavioral health workforce projects or programs that really have cross sector partnerships and braiding and blending of funding that also have wrap around supports for trainees. So things like housing, things like childcare for the workforce and really looking at funding, I mean it's kind of like wrap around in systems of care that we've talked about for kids. It's like funding programs with multiple partners, investing resources or funding. So you know educational institutions, healthcare providers, workforce boards, higher education coordinating Commission, health plans, the OHA, the legislature, all of those different partners coming together and doing something that's really like locally or regionally driven and having you know one time or sustainable funding to do something like that. I also just I think there are some lessons to be learned by how with Future Ready Oregon that's been implemented by the Higher Education Coordinating Commission and it's they've done a really good job. So I think that there are some lessons to be learned in how that grants program has been run and operationalized I think compared to the how to grants program and some of the ways that that the OHA has operationalized things. I think related to that the last question around kind of this last thing, how the OHA can support retention for the publicly funded BH workforce. I think some of the feedback that I've heard from providers or other recipients about implementation for House Bill 2949, the behavioral health workforce investment dollars. I think just listening to feedback from people who received that funding, some of what I heard was the implementation was difficult or could have gone better. So I think if there are future dollars to see if there are ways to, to improve on how it was done last time.

Shyra Merila: Direct service hours was a barrier with 2949 funding. Not rolling out new programs that are connected to positions with one time funding. Deflection dollars is an example and creates a burden, as we can't retain if don't have the money to support the program long term. Preparing Masters level graduates for our programs, and what the work actually looks like in the public sector. Intersections of Social Determinant of Health and seeing the mental health impact in our community, graduates come into our workforce and they're like holy shit. Mobile Crisis program in compliance with the new regulations – CMHP is expected to ensure the training list is completed within the first 90 days of training, and six months of hire. Expectation is on CMHP to do the training and provide services when the required training is a degree, CMHPs are now ad-hoc universities, instead of providers being ready to provide direct services.

Jenn Inman: One of the important things is clinical supervision and support to clinicians while they're working, and the definitions in the Behavioral Health Workforce initiative and investments are around clinical supervision to licensure, which is important. But why not broaden the definition of clinical supervision so that whatever future investments are happening, we can talk about the clinical supervision and clinical consult that's needed on an ongoing basis when we're working with folks in super short-term spaces in crisis and acute situations. The ability to consult and communicate with someone who has expertise when needed is what brings them back every day. Have brought on new employees who go through four months of training with hardly any direct client contact. Developing CMHW's in the pipeline but not having the required CMHP training be a part of the curriculum. Bring in subject matter experts to cover the subject areas during education. If you're taking a grant to prepare CMHPs the curriculum should include the things that we're actually required to train providers in.

Shyra Merila: Clinical supervision towards licensure – highlight that a perk of working in CMHP is embedded CS, don't have to pay for it which is about $180-200/hour. But if we don't have the ability to have people who are board approved supervisors working at CMHPS, then we lose that ability to offer

that perk. Oregon's board for LPCS specifically has many barriers to become a board approved supervisor, which I'm currently doing because I wanted to see how much of a pain in the ass it would be. The licensing board has vacancies, and we're waiting on licenses. Researched board application process and expectations, its unreasonable that these are volunteer positions with an expectation of 15 hours a month. Board approved supervisor list, but can supervise without being board approved which doesn't make sense for those seeking supervision.
Clark Hazel: Consultations/supervision being billable for insurance, billing code that could be used for consultation or supervision.
Cheryl Cohen: Align requirements between the OR board of SW and the OR board of Licensed Professional Counselors and Therapists.
Jenn Inman: Is there parity with the medical/nursing board? How are those staffed and what is the turn around? Should this be a benchmark to compare to? Are they operating with the same amount of effectiveness?

10 Minute Break

Tara Sanderson: From the Spanish speaking providers that I know who work in some of the group practices that have the CLSS certificate designation, one of the pieces that I hear from them often is that they get treated like interpreters or treated like transcribers to be able to translate things into the language that they speak or that they're asked to come in and support other clinicians or other services. So, they're not being treated like they are clinicians who are doing things in their in their language. As we're thinking about how do we keep them engaged in the work that they're doing, I think it would be beneficial to have policy or add some practical space where we are acknowledging the difference between a provider who speaks Spanish or speaks by sign language or does those culturally specific services and somebody who is facilitating that being something that happens at the practice. Staffing interpreters and treating CLSS providers as the direct service provider they are.
Diane: When we're talking about the issue of diversity in the behavioral health workforce I think we have to take a step back and acknowledge that all the norms and outcome tools that we use are normed on dominant culture. And without that perspective of culture coming in and having a diverse workforce, we miss the opportunity to really make meaningful and sustained change in the lives of those that we are serving because we are primed and conditioned around outcomes that don't reflect the communities in which we're serving. So I do think it's important to keep in mind that how much dominant culture even when we think about some of the work flows it feels real good, we can kind of check a box, but when you're talking about providing services to our diverse community members, I don't keep those things in my mind. What is in front of me is their experiences and the validations that that need to come. And then also knowing that my interventions may look very different because I have that cultural aspect that is so important. So I just want to make a plug that we've got to keep it in mind that the systems that we're working in really come from dominant culture, which means that we are excluding providers that bring that specific expertise to a very diverse community in which we're trying to serve.
Tim Nesbitt: White supremacy is pervasive in everything that we do and in and I think that definitely speaks to the levels when you look at the numbers of culturally and linguistically specific providers within companies or organizations that are closer to the systems rather than farther away.
Shyra Merila: I'm also thinking what Diane's talking about this distrust of this system that's rooted in white supremacy and built in dominant culture. And so I think there's a lot of distrust for historically marginalized populations that we're trying to serve and then also folks that we're trying to hire. And then the other piece is Oregon, and Oregon's long-standing history of KKK prevalence and the way that we've treated our indigenous populations and it's especially hard in rural communities that still really like hold on to very racist belief systems. And there's a lot of hate crimes that happen in rural Oregon. I feel we have to talk about both things or talk about how our current behavioral health system continues to create and perpetuates systems and processes that lead to distrust and marginalization of people. Also, what are we going to do about Oregon and what's the state's role in that and what's the

CCO's role in that and then what are the CMHPS roles and all our other community providers. Can we hold our state to a certain expectation of inclusivity and equity, what does that mean for us as participants of this state and of these processes.
Cheryl Cohen: I think how we think of mental health and Wellness, a lot of those concepts are really about whiteness. They're just not very culturally relevant for a whole lot of people, workers, consumers, just a whole lot of people, let alone the systems that people are working within. I think there's a lot of work to kind of unpack that and develop more culturally relevant ideas about what like health and Wellness might look like. The more education and training that's required, the whiter the workforce gets, the more English speaking the workforce gets. There are behavioral health workers, traditional health workers that are peer support specialists and peer Wellness specialists and certified alcohol and drug counselors that are more diverse. We do have some behavioral health workers that are more diverse and more reflective of the local demographics and more reflective of the people that they serve. When you look at the whitest, most English-speaking workforce, it is generally as people get more licensed and higher in education, so if we're wanting to diversify that workforce, we really need long term investment, right? You need to invest in people getting a master's degree, getting licensed, you need to invest in people going to medical school. If you're wanting to invest in, you know, culturally and linguistically diverse people going through an education and training pipeline that takes years and years and years, that's a year over year over year investment. And then you have to think about once people get into that system, are they going to be bought into selling whiteness, which is what a lot of what we're selling. The other piece that I'll say is when I look there is in case you want to geek out on data that Oregon Health Authority does have like their data dashboard where you can look at like all the different healthcare providers, also it has all of their demographics and ages, ethnicity and all sorts of things like that. And so when I do look at clinical social work associates and you can filter by that by that provider type, it's a pretty diverse workforce compared to even like LCS, WS or compared to LP you know licensed professional counselors. And so I do think that the clinical social work associates that are coming up, that are going to school, that are going through that pipeline, are more diverse in Oregon than other segments of the workforce. I think a pay differential for people with language proficiency that whether it's their employer giving them a pay differential or a payer having a pay differential for a service provided in a non-English language.
Shyra Merila: I would like push that even a little bit further and maybe call it reparations, call it what you want. But can we talk about a pay differential just for people of color who are living in predominantly white communities in rural Oregon where they're going to go through, you know, the experiences of racism much more prevalently than they may in a more metro area? Can we start talking about things that might sound a little bit more radical even than giving someone an additional 10 to 20% because they're either Spanish speaking or language proficient in a different way?
Jenn Inman: Some of the things that have worked better for us at times in the past have been when we can make sure that there is a workforce that has community in the workforce too. Regardless of what makes folks feel lonely in the workforce, whatever the CLSS aspect might be, when you're alone it's really a lot harder even if you're not facing all of the big barriers of living in rural Oregon, etc. once we've lose lost some of the community within our workforce, then it's easy to lose the rest of the community. So I know that we're talking about providers and providers with credential and provider with license, but it does matter what happens with all of the staff from the front door on. And is there a space and whether they're professional networks or OHA sponsored ways for folks to come together and have that community who are working in community health program, community mental health programs etcetera to have those affiliation connections and share those challenges. Big changes here happen when the leadership teams are diverse and is there a way and I'm really trying to stay in this like policy space and what can we do in terms of policy? Is there a space or a way or an option to provide connections and leadership development opportunities for folks to be together?

Wrap up and next steps

Record of Vote
Topic: Approval of 4.3.24 meeting minutes
Outcome: Minutes approved

Y	N	Abstain	Absent		Y	N	Abstain	Absent	
☒	☐	☐	☐	Belindy Bonser	☐	☐	☐	☒	David Geels
☒	☐	☐	☐	Kelli Bosak	☒	☐	☐	☐	Qurynn Hale
☒	☐	☐	☐	Chris Bouneff	☒	☐	☐	☐	Clark J Hazel
☒	☐	☐	☐	Cheryl Cohen	☒	☐	☐	☐	Jenn Inman
☐	☐	☐	☒	Sarah Conyers	☒	☐	☐	☐	Tony Lai
☐	☐	☐	☒	Deanna Cor	☐	☐	☐	☒	Lucia Mendoza-Meraz
☒	☐	☐	☐	Anthony R. Cordaro	☒	☐	☐	☐	Shyra Merila
☒	☐	☐	☐	Lorie DeCarvalho	☐	☐	☒	☐	Tara Sanderson
☒	☐	☐	☐	Melinda Del Rio	☐	☐	☒	☐	Sheri Selander
☐	☐	☐	☒	Jose Luis Garcia	☒	☐	☐	☐	Diane Benavides Wille

Record of Vote
Topic: Approval of 4.17.24 meeting minutes
Outcome: Minutes not approved

Y	N	Abstain	Absent		Y	N	Abstain	Absent	
☒	☐	☐	☐	Belindy Bonser	☐	☐	☐	☒	David Geels
☒	☐	☐	☐	Kelli Bosak	☒	☐	☐	☐	Qurynn Hale
☒	☐	☐	☐	Chris Bouneff	☒	☐	☐	☐	Clark J Hazel
☒	☐	☐	☐	Cheryl Cohen	☒	☐	☐	☐	Jenn Inman
☐	☐	☐	☒	Sarah Conyers	☒	☐	☐	☐	Tony Lai
☐	☐	☐	☒	Deanna Cor	☐	☐	☐	☒	Lucia Mendoza-Meraz
☐	☐	☒	☐	Anthony R. Cordaro	☒	☐	☐	☐	Shyra Merila
☐	☐	☒	☐	Lorie DeCarvalho	☐	☐	☒	☐	Tara Sanderson
☒	☐	☐	☐	Melinda Del Rio	☐	☐	☒	☐	Sheri Selander
☐	☐	☐	☒	Jose Luis Garcia	☐	☐	☒	☐	Diane Benavides Wille