DATE: Friday, March 16, 2018
TIME: 10:00 a.m. – 11:00 a.m.
PLACE: Via Go-to-Meeting

Fri, Mar 16, 2018 10:00 AM - 11:00 AM PDT
Please join meeting from computer, tablet or smartphone.
https://global.gotomeeting.com/join/483410717
You can also dial in using your phone - 1 (872) 240-3212
Access Code: 483-410-717

AGENDA

1. Call to Order

2. Action Items
   a. Welcome
   b. February 16, Meeting Notes (Attachment 2.b) pg.2

3. Discussion Items
   a. Topic for May 8th OWDC Meeting
   b. New Bylaws
   c. Olympic Workforce Development Area Budget

4. Updates
   a. Labor Market Data by County (Attachment 4.a) pg.6
   b. Human Trafficking Re-Entry Work
   c. Sector Partnership – Construction, Public Sector, Maritime, Healthcare (Attachment 4.c) pg.7
   d. WIOA News
   e. OWDC Roster

5. Adjourn

Next Meeting: Friday, April 27, 2018 Via Go-to-Meeting
1. **Call to Order**

2. **Action Items**
   a. Welcomes and Introductions
   b. Approval of February 16, 2018 Meeting Notes

3. **Discussion Items**
   a. Topics for the May 8th Olympic Workforce Development Council Meeting
      We will be covering the themes of “working in the gig economy” and millennials and would like guidance from the Board on what other types of related topics could be covered.
   b. New Bylaws
      The newly approved Olympic Consortium Board Bylaws have been posted on the new website.
   c. Olympic Area Budget
      We will review 2017 actuals for 19131 and 19132.

4. **Updates**
   a. Labor Market Data- Firm size and employment, by firm size, by County
      The Board had inquired for additional data regarding businesses including size of firms.
   b. Human Trafficking Re-Entry Work
      We will discuss the current efforts of County and Recovery staff regarding this project.
   c. Sector Partnerships
      - Construction – Olympic Consortium hosted booths at the Spring Builder Expos in Clallam, and Jefferson. The Kitsap event is next week.
      - Public Sector – Hiring Event March 28, 2018 - 10:00 a.m. to 2:00 p.m.
      - Maritime – Upskill Backfill Grant, Staff is currently working with the Northwest Maritime Center and staff / participants from the Olympic Consortium and Pierce County.
   d. WIOA News – Staff will share information regarding Hiring Event successes.
   e. OWDC Roster – The roster is up-to-date. The Clallam County Economic Development Council Executive Director has resigned so that spot is vacant, however the alternate will be attending the OWDC meetings.
CALL TO ORDER – Commissioner Kate Dean, Chair, called the meeting to order at 10:02 a.m.

ANNOUNCEMENTS

INTRODUCTIONS – Self introductions.

AGENDA

ACTION ITEM
a. Welcome new Chair, Commissioner Dean
b. Approval of Meeting notes January 19, 2018
   
   MOTION: Commissioner Johnson moved to approve the notes of the January 19th board meeting. Commissioner Garrido seconded. Motion carried.

   c. Human Services Budget Approval for OWDC Staff
   
   • Allen Sharrett gave the overview of line items pertaining to the 2018 budget of the Olympic Workforce Development Area. Commissioners requested review of the actuals to be placed on the next agenda.

   MOTION: Commissioner Johnson moved to adopt the previously approved budget from September 2017. Commissioner Dean seconded. Motion carried.

d. Bylaws
   
   • Revisions discussed at the last meeting were reviewed for accuracy.

   MOTION: Commissioner Johnson moved to adopt the revised Bylaws with minor changes to 4.4.1. Commissioner Garrido seconded. Motion carried.

DISCUSSION ITEMS

a. Website
   
   • Hannah Shockley introduced to new website she built for the Olympic Workforce Development.

b. Data Dashboard
   
   • The Commissioners gave feedback on additional items to add; to include an about us description, renaming the Systems Performance Dashboard to read; “How are we doing”, upload quarterly reports and updated meeting calendar with meeting locations included.

c. Performance Report
   
   • Elizabeth Court explained how the numbers for unemployment are reducing and the plan is to move 30% of the Dislocated Worker funds to Adult’s with Barriers.
This would allow incumbent workers an opportunity to increase their skill level to promote to higher wage positions. She further explained the enrollment criteria for Adults with Barriers as being less strict compared to those guidelines for the Dislocated worker.

d. **Salaries and Wage Data**
- The Commissioners reviewed the top 25 occupations and wage data of the tri-county region. The information presented was compiled through the Employment Security Department, Occupational Employment Statistics, The Conference Board and Help Wanted Online Job announcements. The data shows estimates for each area and may differ from published OES wages.

e. **Career Connected Learning**
- Sarah Oliver gave an in-depth explanation of the Apprenticeship program being launched through Career Connected Learning. This program focuses on increasing diversity and broadening the spectrum of types of employees hired by corporations including Microsoft and Google. This innovative apprenticeship program will look at hiring patterns and the evaluation process of individuals who are creative and underrepresented, with the ability to be further trained for these careers. This program has approval from Labor and Industries and will offer six career pathways. The program requires a one-year commitment from employers and employers are not required to hire at the end of the program. The wages will rise incrementally from year to year. Individuals who come from the WIOA programs will have support services available.

f. **Sector Partnerships**
- Construction Sector- Elizabeth Court announced the North Peninsula Building, Remolding and Energy Expo being held at the Sequim High School on February 17 & 18th, Sat 9-4 and Sun 9-3.
- Public Sector Hiring Event- Elizabeth discussed the March 28th event that will be held in the President’s Hall at the Kitsap County fairgrounds. Approximately 40 jurisdictions and entities will be present.
- Maritime- Elizabeth discussed the grant-supported training that is coming this spring to the Northwest Maritime Center with partnership from the Washington Workforce Training and Education Board. Special preference will be given to women, minorities, and economically disadvantaged people.

**UPDATES**

a. **Carol Padovan Visit**
- Sarah Oliver gave a recap on the visit from Carol Padovan, Federal Project Officer who presented at the Olympic Workforce Development Council on February 13th. She engaged the Council in an interactive session, where the Council analyzed the region’s strengths and weaknesses.

[11:45 a.m. -Commissioner Johnson left the meeting]
b. Human Trafficking Re-Entry Work
   • Elizabeth Court announced the pilot grant received by the Prosecutor’s office and Kitsap Recovery Center to assist individuals who have been victims of human trafficking. Worksource staff are working with Prosecutors and Court staff to be educated on the special needs and challenges faced by this population. The goal is to help these young women identify and develop skills that will enable them to integrate into the workforce.

c. OWDC Chair Updates-Julie Tappero (Call In)
   • Julie Tappero gave a recap of the Olympic Workforce Development Council meeting held on February 13th. She announced Larry Eyer’s retirement and his decades of service. She announced the new OWDC Chair, Aschlee Drescher. She gave summaries on the multiple presentations.

d. Washington DC-NAWB Conference
   • The 2018 NAWB Conference is scheduled for March 24-26th and Commissioner Dean will attend. Commissioner Garrido gave insights on what to expect and suggestions for getting the most of out the experience, including the value in breakout sessions.

e. OWDC Roster
   • New member Chuck Moe was announced. Elizabeth reiterated the need for a private sector representative from Jefferson.

f. Calendar
   • The calendar with the Olympic Consortium Board, Olympic Workforce Development Council and Olympic Executive Board meetings was reviewed.

g. WIOA News
   • Commissioner Garrido explained the progress of the Homes For All project and the momentum it is gaining with multiple builds (12 total) completed by various organizations. Current work is focused on a partnership with a local Kitsap county golf course and details of business training is being discussed.

PUBLIC COMMENT: None

NEXT MEETING: Friday, April 27, 2018 *Go-To-Meeting

ADJOURNMENT – The meeting adjourned at 12:00 p.m.
ATTENDANCE BOARD

MEMBERS

Present:
Commissioner Charlotte Garrido
Commissioner Kate Dean
Commissioner Randy Johnson

Staff
Elizabeth Court, Olympic Workforce, Director
Allen Sharrett, KC Human Services Accounting
Hannah Shockley, Recording Secretary
Sarah Oliver, EOC Officer

Guests

Excused:
Doug Washburn, KC Human Services Director

NOTE: These notes are not verbatim.
## Employment figures for establishments in size class 1-4 include employees who work more than 0.5 hours but less than 1.0 full time employee

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>King</td>
<td>87880</td>
<td>13000000</td>
<td>6507</td>
<td>18973</td>
<td>1063</td>
<td>7024</td>
<td>548</td>
<td>16351</td>
<td>212</td>
<td>14905</td>
<td>118</td>
<td>18086</td>
</tr>
<tr>
<td>Kitsap</td>
<td>6766</td>
<td>101029</td>
<td>6217</td>
<td>1020</td>
<td>681</td>
<td>890</td>
<td>443</td>
<td>11597</td>
<td>116</td>
<td>8066</td>
<td>63</td>
<td>8886</td>
</tr>
<tr>
<td>Kittitas</td>
<td>1439</td>
<td>2211</td>
<td>1422</td>
<td>148</td>
<td>1590</td>
<td>9</td>
<td>2928</td>
<td>139</td>
<td>1268</td>
<td>13</td>
<td>916</td>
<td>1114</td>
</tr>
<tr>
<td>Lewis</td>
<td>2442</td>
<td>2580</td>
<td>2316</td>
<td>329</td>
<td>1596</td>
<td>54</td>
<td>3666</td>
<td>32</td>
<td>4688</td>
<td>4</td>
<td>1357</td>
<td>*</td>
</tr>
<tr>
<td>Mason</td>
<td>2589</td>
<td>389</td>
<td>415</td>
<td>56</td>
<td>239</td>
<td>79</td>
<td>273</td>
<td>17</td>
<td>1353</td>
<td>13</td>
<td>1173</td>
<td>414</td>
</tr>
<tr>
<td>Okanogan</td>
<td>1862</td>
<td>1590</td>
<td>1285</td>
<td>291</td>
<td>1459</td>
<td>18</td>
<td>876</td>
<td>42</td>
<td>1283</td>
<td>4</td>
<td>118</td>
<td>1222</td>
</tr>
<tr>
<td>Pend Oreille</td>
<td>395</td>
<td>2945</td>
<td>314</td>
<td>430</td>
<td>42</td>
<td>260</td>
<td>23</td>
<td>304</td>
<td>7</td>
<td>224</td>
<td>*</td>
<td>462</td>
</tr>
<tr>
<td>Pierce</td>
<td>2234</td>
<td>1568</td>
<td>1997</td>
<td>3001</td>
<td>10647</td>
<td>2152</td>
<td>28818</td>
<td>1881</td>
<td>47884</td>
<td>475</td>
<td>32858</td>
<td>29886</td>
</tr>
<tr>
<td>San Juan</td>
<td>993</td>
<td>658</td>
<td>693</td>
<td>1132</td>
<td>190</td>
<td>80</td>
<td>107</td>
<td>30</td>
<td>4</td>
<td>295</td>
<td>3</td>
<td>646</td>
</tr>
<tr>
<td>Skagit</td>
<td>4074</td>
<td>4993</td>
<td>4266</td>
<td>699</td>
<td>1450</td>
<td>84</td>
<td>601</td>
<td>22</td>
<td>388</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>垣县</td>
<td>5013</td>
<td>15571</td>
<td>1950</td>
<td>3001</td>
<td>1252</td>
<td>224</td>
<td>273</td>
<td>17</td>
<td>208</td>
<td>17</td>
<td>172</td>
<td>228</td>
</tr>
<tr>
<td>Thurston</td>
<td>3373</td>
<td>15217</td>
<td>7622</td>
<td>1157</td>
<td>7619</td>
<td>887</td>
<td>11300</td>
<td>566</td>
<td>17725</td>
<td>179</td>
<td>12240</td>
<td>93</td>
</tr>
<tr>
<td>Walla Walla</td>
<td>2157</td>
<td>26332</td>
<td>1490</td>
<td>170</td>
<td>17</td>
<td>14</td>
<td>137</td>
<td>14</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Whatcom</td>
<td>7493</td>
<td>18507</td>
<td>2564</td>
<td>767</td>
<td>379</td>
<td>113</td>
<td>590</td>
<td>23</td>
<td>1467</td>
<td>12</td>
<td>1923</td>
<td>18</td>
</tr>
<tr>
<td>Yakima</td>
<td>1726</td>
<td>1207</td>
<td>1726</td>
<td>242</td>
<td>1597</td>
<td>18</td>
<td>3110</td>
<td>18</td>
<td>1346</td>
<td>18</td>
<td>12993</td>
<td>13</td>
</tr>
<tr>
<td>Washington</td>
<td>629111</td>
<td>256080</td>
<td>31156</td>
<td>28810</td>
<td>46308</td>
<td>31</td>
<td>2128</td>
<td>32</td>
<td>7278</td>
<td>229</td>
<td>1847</td>
<td>26</td>
</tr>
</tbody>
</table>

* Asterisk used for suppressed data to avoid disclosure of individual employer information.

*Employment figures for establishments in size class 1-4 include employees who work more than 0.5 hours but less than 1.0 full time employee.

Data are subject to revision.
Washington State
Behavioral Health Workforce Assessment

December 2017

Project Team
Nova E. Gattman, Workforce Training and Education Coordinating Board
Rachelle L. McCarty, University of Washington Center for Health Workforce Studies
Agnes Balassa, Agnes Balassa Solutions, LLC
Susan M. Skillman, University of Washington Center for Health Workforce Studies
available in person or by telepsychiatry (Unutzer, Harbin, Schoenbaum, & Druss, 2013; Unutzer, et al., 2008). Other models might use psychiatric ARNPs in the role of consultant, or have psychiatric specialists provide direct patient care via technology rather than serve as a consultant. A telehealth pilot in Washington uses an onsite nurse care manager and offsite physician to deliver medication-assisted treatment and buprenorphine prescriptions (Speaker, Mayfield, Yakup, & Felver, 2017). First-year outcomes were positive, and while challenges remain around billing and contracts, and added support staff and information technology infrastructure, patients were better served by the program.

Providing care from a distance through technology has been found to be efficacious but ideally requires psychiatric consultants with the skills and confidence to communicate effectively through videoconferencing. Financial incentives for telepsychiatry must be sufficient to compete with the option chosen by a significant number of psychiatric specialists to open private, cash-based practices.

In 2016, the Washington State Legislature passed Senate Bill 6519 to create the Collaborative for the Advancement of Telemedicine to enhance the understanding and use of health services provided through telemedicine and other similar models in the state. The Collaborative’s recommendations for improving reimbursement and access to services, provider-to-provider consultative models, technologies and models of care not currently reimbursed, and other issues are due to the Health Care Committees of the Legislature on December 1st of 2016 - 2018 (Washington State Legislature, “SB 6519”, 2015). The 2016 report recommended updating the telemedicine statutes to allow for access and reimbursement for any site of origin, which was enacted by SB 5436 in 2017; inventoried the telehealth programs currently in place in Washington; and discussed concerns from stakeholders (Washington State Hospital Association, 2016).

For the behavioral health workforce described above to deliver the highest quality services in Washington, attention is needed to minimize barriers that limit their practice and bolster resources that can enhance its effectiveness. The following section describes key workforce issues that can influence the state’s ability to reach its goals to improve the behavioral health of Washington’s population.

**WORKFORCE ISSUES RELATED TO WASHINGTON’S BEHAVIORAL HEALTH GOALS**

A variety of factors influence the supply, distribution of, and demand for, behavioral health occupations and occupations that can deliver integrated behavioral health and physical health services across Washington. While the number of new professionals completing education and training programs is one factor related to workforce adequacy, other key issues that affect workforce development, and can impact the speed and effectiveness of the state’s healthcare transformation, include:

- The scope and timing of shifts in payment and policy, such as implementation of Healthy Washington initiatives, revision of billing codes, and unanticipated legal concerns.
- Training and education that better connects the behavioral health and physical health care workforces, groups that previously have worked in separate spheres and must be responsive to the rapidly changing demands in the workplace.
- Workforce retention efforts, such as reducing high rates of turnover and addressing low and stagnant wages (especially in safety net settings with the highest acuity clients).
- Approaches to addressing workforce equity in healthcare, with the goal of promoting access to, and opportunities for, diverse populations.
IMPACT OF SHIFTS IN PAYMENT AND POLICY ON WORKFORCE DEMANDS

Driving Force of Healthcare Change in Washington: Healthier Washington Initiatives

The health workforce is shaped and organized in response to the payment systems and policy governing the healthcare delivery system. Arguably the most significant healthcare payment and policy change occurring in Washington at present is the state’s Healthier Washington initiatives. Healthier Washington leverages federal and state funding and resources to build healthier communities through a collaborative regional approach, integrate physical and behavioral health needs through increased focus on “whole person” care, and improve how healthcare payment rewards quality over quantity (Washington State Health Care Authority, “Healthier Washington”, 2017).

Healthier Washington employs nine regional Accountable Communities of Health (ACHs, roughly aligned with the state’s Medicaid regional service areas – see Figure 2) that contract with Healthier Washington. Each ACH brings together leaders from multiple health sectors to better align healthcare resources and activities. ACHs can receive millions of dollars to conduct specific projects each year, some required and others chosen from among a list of options. Two of the required projects are behavioral health related and ask each ACH to: (1) integrate behavioral health with physical healthcare, and (2) address the opioid use public health crisis. One of the optional projects for 2018, “Meeting the behavioral health needs of community-based care coordination”, includes behavioral health-related goals. In addition, each ACH must address three health system and community capacity-building domains, one of which involves addressing healthcare workforce issues in the region.

![Figure 2. Washington State’s Accountable Communities of Health](https://www.hca.wa.gov/assets/program/ach-map.pdf)

One of Healthier Washington’s primary strategies to achieving the triple aim of better health, better care, and lower costs is by paying for value (“value-based payment”). Moving from traditional volume-based payment for health services (e.g., fee-for-service) to linking quality and value of care to payment (Washington State Health Care Authority, 2016), may support improved access to behavioral healthcare and better outcomes by enabling healthcare providers/facilities to use their resources for non-face-to-face services that may help improve a person’s health and quality of life. Examples include connecting clients to social services.
(e.g., food banks or housing programs), providing wellness checks for behavioral health clients, and increasing access to prevention programs (e.g., smoking cessation). The shift to value-based payment may also provide more opportunities for peer counselors and community health workers, whose services may not be directly reimbursable in traditional payment systems, to be deployed in behavioral health settings. Payment rates will require demonstrated quality improvement and attainment against clinics’ quality baseline (Healthier Washington, 2017). Effective implementation of Healthier Washington’s value-based payment strategy will require staffing and workflow adjustments to measure, document, and report outcomes, as well as investment in education and training to foster the new skills required (Soper, Matulis, & Menschner, 2017).

It is too early to assess the effects of ACH implementation on the state’s health workforce because implementation of the approved plans has just begun. Nonetheless, as a result of initiatives like Healthier Washington, there is great potential for better aligning the workforce with the population’s behavioral healthcare needs.

**Updates to Billing and Coding of Behavioral Health Services**

New Medicare Physician Fee Schedule codes introduced in January 2017 by the Centers for Medicare and Medicaid Services (CMS) address a primary barrier to behavioral health integration by allowing payment to medical professionals who provide behavioral health services (Press, et al., 2017). Three of these “G-codes” specifically paid for integrated behavioral health services described in the Collaborative Care Model, which uses care management support and psychiatric consultation in the primary care setting. In January 2018, the interim “G-codes” will be replaced by standardized medical CPT® (Current Procedural Terminology) codes. At the same time, CMS will implement two new billing “G-codes” for Federally Qualified Health Centers and Rural Health Centers to bill for behavioral health integrated care, chronic care management, and the Collaborative Care Model services (University of Washington, “Financing Strategies for Collaborative Care”, 2017).

Passed in the 2017 Legislative Session, SSB 5579 requires the Washington State Health Care Authority to review payment codes related to primary care and behavioral health, and to create and publish a matrix to provide information to providers for successful reimbursement (Washington State Legislature, “SB 5579”, 2017). Developed with stakeholder participation, the matrix is intended to help providers in Washington navigate complex billing codes in order to more effectively implement “bidirectional” or integrated healthcare that is also financially sustainable. The matrix will describe the current requirements for selected billing codes as well as eliminate potential barriers to use of these codes. The proposed implementation plan is scheduled to be developed by the end of 2017 (Washington State Health Care Authority, “Behavioral Health”, 2017).

**Volk Court Ruling**

At the same time Washington policymakers are supporting integration of primary and behavioral health care, an unanticipated concern may serve as a barrier to increasing the participation of medical care providers in delivering behavioral health services. The Washington Supreme Court ruling in Volk v DeMeerleer expanded the scope of liability for providers specific to the treatment of patients who later harm or kill persons previously not identified as at-risk of harm by the patient (Neiman & Peters, 2016). Specifically, a psychiatrist was deemed as having a “special relationship” with his patient of nine years, and as such was “under a duty of reasonable care…to protect foreseeable victims of his or her patient” (Neiman & Peters, 2016; Volk v. DeMeerleer, 2016).
In summary, "The liability rule announced by the Volk decision concerns mental health professionals, but can easily be expanded to other healthcare providers...This decision raises many questions, including whether changes in clinical practice are needed, patients will be deterred from effective treatment, lawsuits will increase, and catastrophic events will lead to mass litigation." (Neiman & Peters, 2016).

Companion bills Senate Bill 5800/House Bill 1810 were introduced in the 2017 regular legislative session to clarify the obligation to individual healthcare provider or mental health professional, but did not advance past committee (Washington State Legislature, “SB 5800”, 2017).

**TECHNICAL SKILLS NEEDED BY THE BEHAVIORAL HEALTH WORKFORCE**

Achieving the goals of integrating behavioral and physical healthcare and eliminating barriers to accessing needed mental health and substance use disorder treatment requires significant emphasis on education and training. Technical skills are needed to provide appropriate and evidence-based services. This applies to both new entrants as well as the incumbent members of the workforce.

Lack of adequate training creates discomfort in practice, reduced morale, and likely leads to poorer patient outcomes (Olfsen, 2016; van der Leeuw, Lombarts, Arah, & Heineman, 2012). Recruitment and retention are enhanced when students and incumbent workers have education and training corresponding to their responsibilities and are trained in up-to-date and evidence-based skills for fast-changing roles in a technologically advancing environment. The training needed includes high-quality practical clinical training sites, the shortage of which creates a bottleneck to increasing the numbers of students in educational programs (e.g., psychiatric ARNPs).

Behavioral health providers who were trained to provide 1-on-1 psychotherapy may be underprepared for the fast-paced environment and brief interventions of an integrated primary care setting. Settings that are processing Medicaid documentation requirements for the first time may require their staff to gain skills in this area. Medical practitioners should understand the importance of addressing patients’ behavioral health needs in the primary care setting to reduce stigma and integrate care. Behavioral health practitioners should be aware of how common medical concerns co-exist with mental health and substance use disorder issues and how to be partners and advocates in whole-person health. Behavioral and physical healthcare
providers need coaching in how to collaborate with other healthcare professionals in integrated settings. The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) identified core competencies to create an essential foundation for preparing and further developing a workforce to deliver integrated care (see Table 3). They are designed to be used as a benchmark to educate, recruit, train, and evaluate providers of behavioral healthcare services.

But training alone may not be enough. Physicians who wish to prescribe the drug buprenorphine for opioid dependency must complete an 8-hour online training course before applying for and receiving waivers of the special registration requirements defined in the Controlled Substances Act (SAMHSA, "Medication-Assisted Treatment (MAT)", 2016; SAMHSA, "Qualify for a Physician Waiver", 2016). Physician assistants and nurse practitioners can apply for and gain a waiver after 24 hours of training. Yet rural waivered physicians’ reported concerns about diversion or medication misuse, time constraints, and lack of available mental health or psychosocial support services prevent them from incorporating buprenorphine maintenance treatment into their practice (Andrilla, Coulthard, & Larson, 2017). Those who had received a waiver but did not currently or ever prescribe buprenorphine cited as barriers the lack of specialty backup for complex problems and lack of confidence in their ability to manage opioid use disorders. These both speak to workforce concerns surrounding healthcare system sufficiency and self-perceived competence.

### RETENTION AND TURNOVER

The ability to recruit and retain healthcare providers with needed technical skills and cultural competency is key to effective functioning of care delivery systems. Some turnover of employees at a workplace is normal, and even necessary to support professional development, accommodate work-life balance, and refresh the mix of workers in the work setting to encourage skills mix, mentoring between experienced and newly trained staff, and adjust team compositions.

High turnover, however, "reduces the availability and continuity of care, and is an obstacle to the creation of stable teams of providers, all of which has a negative impact on quality and cost of service" (Barriball, et al., 2015). High staff turnover is also expensive. Studies have reported costs ranging from $22,000 to over $85,000 to replace a single nurse (Drake, Pawlowski, & Riley, 2013; Jones & Gates, 2007). High turnover rates in behavioral health settings reduce productivity, put financial stresses on organizations, disrupt client relationships, and can hinder implementation of evidence-based practices (Clay, 2004; Institute of Medicine (IOM), 2006; Woltmann, et al., 2008).

Lack of formalized supervision opportunities is one reason for turnover, especially in community mental health centers and community substance use disorder treatment facilities. Because these settings offer formal

<table>
<thead>
<tr>
<th>Table 3. Core Competencies for Integrated Behavioral Health and Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Interpersonal Communication</td>
</tr>
<tr>
<td>II. Collaboration &amp; Teamwork</td>
</tr>
<tr>
<td>III. Screening &amp; Assessment</td>
</tr>
<tr>
<td>IV. Care Planning &amp; Care Coordination</td>
</tr>
<tr>
<td>V. Intervention</td>
</tr>
<tr>
<td>VI. Cultural Competence &amp; Adaptation</td>
</tr>
<tr>
<td>VII. Systems Oriented Practice</td>
</tr>
<tr>
<td>VIII. Practice Based Learning &amp; Quality Improvement</td>
</tr>
<tr>
<td>IX. Informatics</td>
</tr>
</tbody>
</table>

Source: SAMHSA-HRSA Center for Integrated Health Solutions (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014)
supervision to new mental health counselors and chemical dependency professionals, they may readily hire new graduates by providing them with required supervision, but lose these professionals to higher-paying practice sites after the supervision period is completed.

Wages can play a significant role in workforce retention. Stakeholders providing input for this report strongly argued that below-market Medicaid reimbursement rates in Washington resulted in low, non-competitive wages in safety net settings, seriously hindering recruitment and retention of the behavioral health workforce for those service sites. Some safety net settings can only afford part-time workers, presenting another challenge to recruitment. Data comparing wages in public and private settings in Washington are not readily available, but Figure 3 showing 2016 average wages for six behavioral health occupations in Washington illustrates the wide range of wages in behavioral health. Some examples of salaries of other occupations in and outside of healthcare are included for comparison.

Improvements in organizational culture and climate are likely to improve job satisfaction and organizational commitment, and, subsequently, reduce staff turnover. Although agencies and programs cannot always offer competitive salary and/or benefits, having a positive culture and climate can still influence staff to stay.

Preventing turnover benefits behavioral health settings because money invested in training staff will be less likely to be wasted on those who take those marketable new skills to another employer. Relationships are important in the workplace, especially in the human services. High turnover negatively impacts the development of long-term occupational relationships, reducing camaraderie and perceived peer supports. Because turnover increases during times of organizational change, organizations should consider how to bolster staff retention when implementing new technologies or service models—a particularly salient point as behavioral health and physical health are integrated in Washington. Technical assistance, training, and support are vital to the stability of the behavioral health workforce (Aarons & Sawitzky, 2006).

Health professionals respond to incentives, but financial incentives alone are not enough to improve recruitment and retention. Beyond increasing wages, there are measures which healthcare providers and facilities can take to improve staff retention (Barriball, et al., 2015). Many resources exist to improve retention in behavioral health settings, such as toolkits offering tools to collect retention data at agencies, to perform a job analysis to identify qualified candidates, and to build a retention plan (see Box on page 25).
Figure 3. Full Time Salaries of the Behavioral Health Occupations & Comparison Occupations in Washington State in 2016

* Ranges on bars indicate 10th and 90th percentiles of salaries for each occupation

LESSONS FROM EARLY ADOPTERS OF BEHAVIORAL HEALTH AND PHYSICAL HEALTH INTEGRATION

Through Healthier Washington initiatives, Medicaid service provision is being redesigned to bring together payment and delivery of physical and behavioral health services through managed care. The strategy of integrating the financial systems of behavioral health and physical health as a catalyst to integrate the delivery of those services was launched in the Southwest Washington Accountable Community of Health (SW ACH) region in April 2016. Clinically, the biggest shift in the early adoption of integrated behavioral health and physical health care was on how payers and providers coordinated and communicated. SW ACH has observed changes in the behavioral health workforce needs through their integration efforts. Recommendations from SW ACH on best practices can be found in the box on page 26.
Lessons from the Early-Adopter Region: Integration in Southwest Washington

A foundational goal of the Healthier Washington initiatives is integration of physical and behavioral health care in the state. In April 2016, the Southwest Washington Accountable Community of Health was the first region to integrate the financial systems of behavioral health and physical health to support integration of services. Key workforce-related recommendations reported from their experience are:

1. Focus on bringing stakeholders together to create a more regional approach to clinical service delivery.
2. Break down silos between primary care and behavioral healthcare cultures.
3. Prepare for an increased demand for dual credentialed (mental health and substance use disorder) professionals.
4. Prepare for new training and onboarding in Medicaid documentation for chemical dependency professionals.
5. Prepare for an increased need for experienced, well-trained back office personnel who can navigate claims and explanations of benefits in a multi-payer environment.
6. Build fully integrated managed care systems on well-trained paraprofessionals and care coordination rather than advanced degree holding, difficult-to-recruit specialists.
7. Explore leveraging resources from multiple sources, such as shared practitioner models and consulting with psychiatric nursing programs, to address the shortage of psychiatrists.
8. The optimal employee for the integrated environment would be comfortable in different evidence-based, brief treatments, have a good overview of common elements of primary care as well as behavioral health, have excellent people skills, use advanced motivational interviewing, and think critically about whole-person care (“connect the dots”).

(Source: Daniel Smith, Vice President for Clinical Integration, personal communication, November 20, 2017)

FINDINGS SUMMARY

Ensuring adequate access to behavioral healthcare is complex; while workforce shortages exist in a variety of occupations at all levels of delivery, simply “turning on the spigot” to increase output from education programs will not resolve all of the challenges. A number of underlying systemic, structural, and perceptual problems affect the ability to recruit, educate, train, credential, and retain a sufficiently large and adequately skilled and diverse workforce to provide access to behavioral health services for those who need them most.

KEY FINDINGS FROM OCCUPATIONAL PROFILES

Several interesting issues were revealed while studying the behavioral health occupations included in the profiles (Attachment B):

- For professions who may practice independently (licensed independent clinical social workers, psychiatric ARNPs, psychologists, psychiatrists), literature and stakeholder reporting suggests that self-employment in cash-only practices is a threat to behavioral healthcare access.
- In psychiatric nursing and social work, securing adequate numbers of clinical placements sites for students is the largest barrier to increasing enrollments in these programs.
- Employment of peer counselors and community health workers may help eliminate health disparities, but their successful deployment in healthcare settings relies on strong support in the workplace and clarity around their value and roles.
Highlights for specific occupations include:

- **Psychiatric ARNPs** programs show the largest proportional growth of the behavioral health educational programs studied here, and while the profession currently represents a small part of the behavioral health workforce, their ability to prescribe psychiatric medication is greatly valued by employers. The Washington State Hospital Association specifically called out the need for more psychiatric ARNPs in their 2017 legislative agenda (Whiteaker, 2017).

- To combat the opioid epidemic, in 2016 the Comprehensive Addiction and Recovery Act extended the privilege of prescribing buprenorphine in office-based settings to qualifying **ARNPs** until October 1, 2021. It is too early to measure the impact of this expansion.

- New requirements for **psychologists’** internships expected to be enacted by 2020 may affect the solvency of currently non-accredited internships, thereby further limiting access to this critical training.

- The facility types in which **chemical dependency professionals** may work was expanded in 2017 by SB 5779, but it is too early to measure the impact on the workforce (Washington State Legislature, “SB 5779”, 2017).

- ESHB 1713 (passed in 2017) calls for the creation of a new residency position for a child and adolescent **psychiatrist** at Washington State University, which would help to grow this high-demand workforce (Washington State Legislature, “HB 1713”, 2017).

- **Social workers** and medical family therapists (a specialty within marriage and family therapy), as behavioral health professionals who already work in medical settings, are a resource for further integrating behavioral and physical health care.

- **Peer counselors** and **community health workers** commonly have college-level education and are already employed in agencies when they pursue their training.

- The sustainability of **peer counselor** and **community health worker** training programs is of concern because they are largely grant-funded. The Washington Health Workforce Sentinel Network reports high demand for these professionals, but lack of funding and salary constraints are barriers to their employment.

**BARRIERS IDENTIFIED BY STAKEHOLDERS**

Barriers identified by stakeholders and key informants fall into four categories:

- **Recruitment and retention:** Recognizing that the integration of behavioral health with physical health will fundamentally change how and where many patients will access behavioral health services, there will likely be an ongoing need to provide services for some patients in behavioral health settings. The behavioral health work environment, especially in settings serving low-income populations, is characterized by heavy caseloads, patients with high acuity of behavioral health and other healthcare needs, time-consuming documentation requirements, and relatively low pay. Cultural stigma related to behavioral health was identified by stakeholders and informants as an additional challenge to workforce supply for this field. As a result, recruiting and retaining a skilled and diverse workforce across the range of occupations required to deliver appropriate behavioral health services is difficult.

- **Skills and training:** The changing behavioral healthcare environment, including moving toward the goal of integration of behavioral health and physical healthcare, increases the need for the behavioral health and physical health workforce to work effectively in inter-professional teams, be up-to-date with new models of practice and evidence-based skills, have access to and demonstrate proficiency using current health information technology systems, and efficiently meet documentation requirements. The opportunities and resources to meet these training needs are not adequate to meet demand, both in initial education...
programs as well as for incumbent workers. Stakeholders and key informants identified concerns not only with the availability of "real world" training opportunities, such as preceptorships and supervised practice sites in integrated settings, but also with the ability of new and incumbent workers to keep up with the competencies needed to deliver evidence-based and integrated behavioral healthcare.

- **Credentialing, licensing and related policy issues:** Numerous policies and regulations influence the number, distribution, and scope of practice of the occupations that comprise the behavioral health workforce. These include what were described by stakeholders as overly burdensome requirements for credentialing some occupations, limited opportunities for dual credentialing or the addition of endorsements to those with credentials, lack of supervisors for mental health associates, and long timelines to receive some types of credentials.

- **Paperwork and documentation burdens:** The healthcare system, including behavioral health, must respond to requirements of multiple payers/insurers and oversight organizations. Responding to these reporting requirements takes considerable workforce commitment to keep up with the paperwork and to respond to documentation and audit requirements. These processes can be duplicative and inconsistent. In addition, compliance with these requirements demands considerable resources to train clinicians and staff to use the different systems for reimbursement and compliance. Stakeholders identified these administrative burdens as contributing to low morale and high turnover in the field.

**POLICY RECOMMENDATIONS**

**WHAT'S NEW IN THIS REPORT?**

Many of the issues and recommendations for actions from the *Washington's Behavioral Health Workforce Assessment: Project Phase I* report have been updated and refined in this Phase II report. The delivery of healthcare in Washington is beginning to change as providers move from planning to implementation of integrated behavioral and physical health services. In Phase II, providers were able to offer more detailed and nuanced descriptions of the challenges facing them and the potential solutions.

Additionally, since the Phase I report was completed in November 2016, a number of policy actions have been taken by the Governor and Legislature to address behavioral health needs. For example, ESHB 1713, which was passed into law, includes a provision requiring behavioral health organizations to reimburse providers for the use of telemedicine to deliver medically necessary services to Medicaid clients. SB 5436 expands the definition of "origination site" for telehealth to any site of the patient's choosing, removing an additional barrier to the use of telehealth for patients in underserved areas. Implementing recommendations from the Children's Mental Health Workgroup, ESHB 1713 requires Washington State University to establish one additional 24-month residency position specializing in child and adolescent psychiatry, and requires the Office of the Superintendent of Public Instruction (OSPI) to fund pilot programs in two Educational Service Districts to employ a lead staff person for mental health, which could expand mental health education programs over time. HB 1819 requires the Department of Social and Health Services (DSHS) to review documentation policies by April 1, 2018 in order to reduce paperwork, also addressing issues identified in the Phase I report. The legislatively-adopted 2017 budget increased behavioral health Medicaid rates effective October 2017, although a number of factors have limited the impact of that effort. In March 2017, the Bree Collaborative adopted its report and recommendations for promoting Behavioral Health Integration in the state (Bree Collaborative, 2017).
Most recently, on November 3, 2017, Governor Inslee issued a Directive to establish a cabinet-level leadership structure to develop a strategic plan, advance behavioral health integration, respond to opioid use and form an interlocal leadership structure (Inslee, 2017). This sub-cabinet convenes health oversight agencies as well as the Department of Commerce, Corrections, Insurance, and others as needed to consider and coordinate key interrelated issues. The issuance of this Directive demonstrates both the commitment of the state to improve the delivery of behavioral health in Washington, and an understanding of the complexity to do so.

In light of the ongoing evolution of Washington efforts to support greater healthcare integration, this final report focuses more narrowly on actionable recommendations, and includes fewer suggestions for future research, than the Phase I report.

RECOMMENDATIONS

1. ADJUST REIMBURSEMENT RATES TO BETTER SUPPORT COMPETITIVE RECRUITMENT AND RETENTION OF A SKILLED BEHAVIORAL HEALTH WORKFORCE. (UPDATED FROM PHASE I)

Workforce-related barrier: In Phase I of this project, low reimbursement rates for behavioral health services were identified as a major barrier to healthcare integration. Stakeholders consistently identified low reimbursement rates for behavioral health services as the root cause for challenges to paying competitive salaries, and for recruiting, educating, training, and retaining a skilled behavioral healthcare workforce, especially in settings with large numbers of Medicaid-insured patients, such as Community Behavioral Health Centers. The primary recommendation in the Phase I report was to “adjust reimbursement rates to better support competitive salaries, and recruitment and retention of a skilled behavioral health workforce.”

Stakeholder input for this Phase II report once again identified the continued need to address the issue of low Medicaid reimbursement rates for behavioral health providers. Medicaid expansion, increased emphasis on physical care and behavioral health integration, and growing awareness of behavioral health needs among the public and the medical profession increase the need for skilled behavioral health workers throughout the healthcare system. The national opioid epidemic has hit Washington hard, ramping up pressure on the behavioral healthcare system. Low reimbursement rates exacerbate these issues.

Because Medicaid is the primary funder of community mental health1 services, Medicaid capitation rates are a primary determinant of community-based Medicaid providers’ ability to recruit and retain a qualified workforce. Stakeholders and key informants emphasized that low reimbursement rates mean that community-based agencies cannot compete effectively with hospitals, including the state hospitals, larger health systems, managed care organizations (MCO), or government salaries.

Actuarial studies used to set Medicaid rates reflect current system capacity based on historical use, not accounting for increased need or interest in prevention and early intervention work. Low rates perpetuate the problem. If rates remain low, capacity continues to fall, producing fewer encounters and even lower rates (and therefore capacity) in successive actuarial cycles.

Additionally, state-determined low Medicaid reimbursement rates – which are passed on to providers – results

---

1Note that while Washington is working toward an integrated behavioral and physical health system, in this section we are specifically talking about the impact of reimbursement rates for behavioral health services. To that end, we have been specific in referring to mental health in this section.
in fewer providers willing to accept Medicaid patients. Many psychiatric care and counseling providers who are allowed to practice independently are now working in cash-only private practice. This in turn burdens the public behavioral health system, which is already stretched to meet high demand from acute patients with co-occurring disorders and health challenges. Low reimbursement rates translate directly into reduced capacity for outpatient treatment, which overloads the crisis, inpatient, and criminal justice components of the healthcare system.

In 2016, the legislature’s Children’s Mental Health Work Group mirrored these findings, reporting: “Medicaid rates reflect current system capacity (i.e., historical use), not service need or demand, or the desire to actively engage people in treatment further upstream. This is even more apparent in rural areas. Qualified providers choose to opt out of serving Medicaid clients, and many are taking private pay only. Medicaid rates are only about two-thirds of Medicare rates for the same units of service, highlighting care inequities between children and adults within our system.” (Washington State Legislature, “Children’s Mental Health Group”, 2016).

While the long-term effort to reform healthcare in Washington may address some of these challenges by creating new care models and funding arrangements, in the short term, reduced system capacity negatively impacts patient care. Additionally, the move to integrate behavioral health services in physical health settings will not eliminate the need for community-based behavioral health care providers. Patients with severe mental health and/or substance use disorder (SUD) issues can display disruptive behavior, posing management problems in physical health settings. In addition, primary care providers are not always confident in the management of patients with severe mental illness, and tend to refer these patients to specialists.

The opioid epidemic means a growing number of patients need mental health and SUD treatment; many delay seeking treatment for these issues, as well as physical health issues, until they are very sick. Community-based behavioral health providers incorporate proactive outreach and intervention functions to identify these patients earlier, potentially reducing the need for more expensive treatments later. These outreach services, however, are not reimbursable under the current state Medicaid plan. In addition to raising rates, stakeholders recommended amending the state plan with the goal of incorporating additional medically necessary services, including outreach and patient navigation. Adding services to the state plan would accomplish two goals: (1) expanding the number of services that could be documented and billed or reported as encounters (and thus captured in the utilization data for the actuarial study); and (2) capturing federal match, bringing new resources into our state system.

Any effort to increase reimbursement rates needs to be sufficiently high to achieve the desired effect of increasing pay and capacity. For example, during the 2017 session, the Legislature provided a 2.5 percent rate increase to Behavioral Health Organizations (BHOs) and the fully integrated managed care region, which became effective on October 1, 2017. The budget proviso required DSHS to work with the actuaries responsible for certifying behavioral health capitation rates to adjust average salary assumptions in order to implement the increase. However, the rate increase was not large enough to balance out the millions of dollars in cuts that the community behavioral health system has sustained over a number of years or to raise salaries to a currently competitive level.

Lack of action to remedy low behavioral health reimbursement rates puts transformation to behavioral and physical health integration at risk. In order for integration to work, the portion of the healthcare system that
provides behavioral health services in community-based settings needs to be strong and robust.

**Action required:** In order to better support the competitive recruitment and retention of a skilled behavioral health workforce at the community-based level that is necessary for both healthcare integration and the treatment of a growing mental health and substance use disorder crisis, policymakers, Department of Social and Health Services, and/or the Health Care Authority should act on the following recommendations:

- Prioritize funding levels that keep Medicaid capitation rates high enough to positively influence wages.
- Examine the way capitation rates are set and address the underlying assumptions in the actuarial study to set a rate that better reflects the true cost of care and regional impacts. This would allow providers to hire more staff to meet the growing demand for community-based behavioral health treatment. The Legislature would need to be more directive with the actuary developing the rates.
- Open up the Medicaid state plan to make more services reimbursable. Community behavioral health agencies providing CMS-eligible services are not reimbursed for them because they are not currently included in Washington’s state plan amendment. Community behavioral health agencies specifically called out the need to reimburse outreach, patient navigation/management, travel, and similar care coordination activities, and should be consulted in this process.
- Provide additional technical assistance and regional salaries data to facilitate transition to Value-Based Payments, particularly to assist community-based facilities who are investing time in identifying their needs and resources. This can be accomplished using the existing Healthier Washington Practice Transformation Hub (HUB) or other mechanisms. Smaller community-based facilities stated that they are already disadvantaged based on their inability to provide competitive salaries. As they transition to new Value-Based Payment systems, they need to know if their pay rates are competitive within their regions. Greater transparency regarding the costs of doing business would help these organizations make reasonable assumptions about costs.

**2. PROMOTE TEAM-BASED AND INTEGRATED (BEHAVIORAL AND PHYSICAL HEALTH) CARE.**

**Workforce-related barrier:** The Phase I report identified the following barrier to integration: “too little education and training in team-based and integrated (behavioral and physical health) care is available for the incumbent workforce and for students entering clinical occupations.” Providing more team-based integrated training could be one of the most effective solutions for ensuring healthcare integration has the desired impact. Stakeholders identified the need for more cross-training, development of common language/approaches, and training to communicate with and work in cross-disciplinary teams. A report resulting from a taskforce convened under ESHB 1713 (2017) supported these observations, recommending the delivery of substance use disorder and mental health services in a less fragmented way, and noting the complexity of integrating primary and behavioral healthcare beyond funding challenges.

Stakeholders also identified structural challenges to integrating teams and called out two opportunities to address them: (1) adjusting the way that payers credential professionals and sites to reduce administrative burdens and create an opportunity to expand integrated team-based care, and (2) expanding the occupations that can bill as mental health providers.
2-a. Strongly encourage payers (Managed Care Organizations (MCOs)/health plans and BHOs) to contract with and credential licensed community behavioral health agencies, as well as individual licensed clinicians. Work with payers to standardize the credentialing process. (Revised and expanded from Phase I) Many of the recommendations in this report refer to the credentialing of individual practitioners via licensing or certification by the DOH. However, the term credentialing, as used in this recommendation, refers to the process whereby a health plan or carrier (MCO) approves a practitioner, facility, or organization for inclusion in the health plan's provider network. Most payers' credentialing processes and payments are directed to a specific licensed clinician. While there will likely be an ongoing need to contract with individual licensed clinicians, credentialing licensed behavioral health agencies at the organizational level is allowable and more in line with healthcare transformation. Strongly encouraging payers to contract with, and credential, licensed community behavioral health agencies could encourage a systemic shift toward value-based, integrated delivery of care models by providing the financial flexibility for community behavioral health agencies, as well as private practices, hospitals, etc., to employ and adequately compensate “care-teams” as opposed to individual provider “fee for service” visits. By supporting the use of licensed positions working “at the top of their credential” to oversee the work of non-licensed individuals, this recommendation expands the overall behavioral health workforce pool and provides opportunities to expand workforce diversity by employing non-licensed individuals who work within an organizational and supervisory structure that ensures appropriate standards and protections. However, it should be noted that broad supervision/oversight of unregulated/unlicensed practitioners may add to the concerns related to scope of practice and ethics associated with such individuals as expressed by licensees in counseling professions, and could shift quality assurance responsibilities to agencies and organizations.

Additionally, each MCO uses its own standards, forms and approaches for credentialing. Stakeholders report that the process is time-consuming, repetitive and needlessly complex for provider agencies that are already licensed by the state and may employ hundreds of clinicians. 25HB 2335 was passed in the 2016 session to streamline credentialing by requiring providers and carriers to use the credentialing database created by OneHealthPort for this purpose, eliminating redundancy. 25HB 2335 applied the requirement to private insurers, but the requirement could apply to MCOs in their capacities as licensed carriers. The final 2017-19 Operating Budget, SSB 5883 included a directive (Sec.204(1)(x) (2017)) to implement a standardized provider credentialing system via a single credentialing platform.

It should be noted that this approach does not necessarily address the potential that requests for credentialing could be denied due to network adequacy. Once payers determine that they have an adequate network, they have no incentive to consider additional applications.

Action Required: The Department of Social and Health Services and the Health Care Authority should move quickly to identify and implement a single-platform provider credentialing system as directed by SSB 5883, and encourage credentialing licensed behavioral health agencies at the organizational level.

2-b. Continue to support the use of/expansion of the Healthier Washington Practice Transformation HUB efforts to promote adoption and training of team-based integrated behavioral health and primary care. (Updated from Phase I) The Healthier Washington Practice Transformation Hub (Hub) is actively providing resources to support healthcare practice transformation and achieve the reform goals of better healthcare quality, greater patient satisfaction, more efficiency, and more satisfied practitioners. Practice coaches are now in place,
or just getting into place throughout the state. The Hub's web-based Resource Portal provides an extensive suite of curated resources related to behavioral health integration as well as practice transformation resources related to readiness for value-based payment, population health, and improving community-clinical linkages. A workgroup of about 30 providers, administrators, and others from every Accountable Community of Health (ACH) in the state meet monthly to provide feedback on Hub activities.

Stakeholders report that they are starting to use the Hub as an important resource to support their transformation efforts, as they move from planning to implementation, and gain new knowledge of both the opportunities and challenges that come with transformation. During Phase II, stakeholders specifically called out the need for increased technical assistance, their need for health care transformation support to transition to value-based payment and clinical integration is anticipated to continue several years past 2020, but financial support for the Hub will end in December 2019.

**Action Required:** A sustainability plan should be developed to support the Practice Transformation Hub after the conclusion of the Healthier Washington initiative and funding period in 2019.

**2-c. Expand the list of professions eligible to bill as mental health providers.** (Updated from Phase I) In Phase I, stakeholders identified expanding the list of professions able to perform and bill for behavioral health functions as a way to support greater team-based and integrated care. In Phase I, based on an approach used by Oregon, Pennsylvania, Minnesota, Tennessee, Massachusetts, Maine, and Illinois, the majority of stakeholders and key informants (see stakeholder concerns below) recommended adding Occupational Therapists (OTs) to the list of professions allowed to provide and bill for behavioral health services. Currently, OTs may be able to perform limited behavioral health services, such as Applied Behavior Analysis for autism, but they are not defined as mental health professionals. During Phase II, stakeholders also suggested expanding the list beyond OTs to include other professions, including speech-language pathologists. The definition of mental health professional found in the mental health-related Revised Code of Washington (RCW) and Washington Administrative Code (WAC) would need to be addressed in order to expand the list of healthcare professions who may provide and bill for mental health services in Washington. Research and stakeholder input would help determine which professions should be added to yield the greatest expansion to needed services at the lowest risk to patient safety.

**Stakeholder Concerns:** In Phase I, the Washington State Society for Clinical Social Work objected to including OTs in the definition of mental health professionals. The Society noted that OTs cannot bill as mental health providers under Medicare and are not "trained specifically to create differential diagnoses in mental health or the counseling and psychotherapy to alleviate these conditions." Some stakeholders suggested that additional research should be conducted to determine whether there is sufficient capacity within the OT workforce to add behavioral health work, as some parts of the state, especially rural areas, report difficulty recruiting OTs, and questioned whether OT mental health billing would significantly increase access for clients.

**Action Required:** Policymakers should request that the Department of Health conduct a Sunrise Review of the professions recommended for an expanded scope of practice to include a greater range of behavioral health services, and the Health Care Authority/DSHS to review billing limitations for approved services.
Items for further study to promote team-based and integrated (behavioral and physical health) care.

- **Provide the incumbent medical and behavioral health workforce with additional training in effective practices in integration.** Skills training for team-based care provision exists for providing behavioral healthcare in the community (Wraparound with Intensive Services (WISE) and Program of Assertive Community Treatment (PACT)), in primary care settings and behavioral health settings (SAMSHA-HRSA Center for Integrated Health Solutions (CIHS), see example models), and by occupation (see Attachment B for occupational profiles). Further research could review options to incentivize additional training on best practices in integration, and encourage staff who participate in care coordination, screening, etc. to take training to identify potential behavioral health issues earlier. Due to the national interest in integrating healthcare, trainings and models exist, but adoption must be incentivized and championed. Disseminating best practices in use at CIHS Level 5 and 6 fully integrated clinics in Washington could be beneficial. State programs are also in development and dissemination, such as the University of Washington AIMS Center resource library, University of Washington Psychiatry and Addictions Case and Conference (PACC) telepsychiatry case review podcasts, and the Washington Association of Community Migrant Health Center topical online and in-person trainings. The work of ACHs may introduce some new opportunities.

- **Review workforce and staffing-related recommendations promoted by the Bree Collaborative in March 2017’s “Behavioral Health Integration Report and Recommendations.”**

- **Support psychology internship/fellowships and psychiatric fellowships for team-based, fully integrated programs.** The state could consider incentives to community health centers to support an increase in integrated programs.

- **Reduce the cost of maintaining dual credentials.** Maintaining dual credentials is expensive to the individual, and without incentives to continue one or both credentials, some providers let their credentials lapse. Providing a “bundled rate,” dual credential discounts, or reimbursement might address this issue, although the Department of Health has noted that current fees are set at the minimum level required to regulate the profession. Implementation would require subsidies to address the cost of credentialing.

### 3. INCREASE ACCESS TO CLINICAL TRAINING AND SUPERVISED PRACTICE FOR THOSE ENTERING BEHAVIORAL HEALTH OCCUPATIONS.

**Workforce-related barrier:** Current capacity to provide students and new graduates with real world, hands-on, clinical training and supervised practice for behavioral health occupations is inadequate, which negatively impacts both trainees and behavioral health institutions. Stakeholders in Phase I identified too few internships, residencies, clinical training placements/practicums, supervised practice sites, and other “real-world” learning opportunities for behavioral health workforce development as a significant challenge to expanding the behavioral health workforce. In addition, they identified too few incentives to overcome the added burden on preceptors and administrative staff responsible for clinical training as a challenge. In Phase II, stakeholders confirmed these challenges remain, but focused in on issues related to supervision and dual credentialing as additional issues.

**3-a. Improve availability and quality of supervision for behavioral health associate-level providers. (New Recommendation)** To obtain their independent credential, mental health professionals (mental health counselor, marriage and family therapist, and social workers) and chemical dependency professionals must first...
supervisors to complete their required supervised hours. While there are many overlaps in the competencies needed for various occupations, the statutory requirements regarding the number of supervised trainee hours necessary for certification/licensure, and which occupations may supervise which percentage of those hours, create challenges for training sites as well those entering the field. DOH staff report receiving frequent requests from mental health associates seeking for supervisors with the appropriate licenses to supervise practice hours. Community-based agencies more frequently offer supervised practice opportunities than other settings, and so many new graduates work in community-based settings for this purpose, leaving those with the least experience working with the highest-acuity clients in the most under-resourced environments. Others pay private supervisors out-of-pocket. Stakeholders reported practitioners leaving the field before completing licenses, due to challenges finding supervisors and completing hours. A lack of supervisor training was also identified as a barrier, as many supervisors are practitioners who have risen through the ranks. Without training and support, supervisors may lack effective teaching and management skills, leading to frustration on all sides.

**Action Required:** DOH should, with additional resources allocated for this purpose, convene a workgroup to develop policy and practice recommendations to standardize behavioral health supervision, to the extent possible, and streamline supervisory requirements. The workgroup should:

- Review best practices in other states, and identify potential new models or support expansion of existing best practice models for supervision that will promote healthcare transformation to improve and integrate behavioral health.
- Determine the feasibility of creating a generalized behavioral health supervisor qualification to oversee training of a variety of behavioral health occupations (possibly an agency affiliated supervisor to support community mental health centers in their training role).
- Expand the access to supervisor training opportunities.

3-b. Review the incentives for Licensed Mental Health Professionals (LMHPs) to become certified as Chemical Dependency Professionals (CDPs). (New recommendation) While behavioral health education programs are adjusting to provide more students with dual credentials, facilities working to better serve patients with co-occurring mental health and substance use disorders reported a number of challenges to dually credential incumbent mental health practitioners as chemical dependency professionals (CDPs). In response to feedback from these agencies, the Department of Health adopted new rules in July 2016 to facilitate the expansion of dual credentialed professionals. The new WACs, which reduced requirements for supervised practice hours, were the culmination of a rulemaking process to create an alternative CDP track. However, in Phase II, behavioral health providers reported challenges with this new alternative track: coursework that duplicates what licensed mental health professionals already receive and the requirement for the first 50 hours of supervised practice to be face to face. As noted in Recommendation 3.a., it can also be challenging to recruit CDP supervisors.

Additionally, there are few incentives for mental health practitioners to earn the dual credentials. For example, psychologists eligible for the alternative track to obtain a CDP credential can provide and bill Medicaid for

---

2Practitioners with one or more of the following Washington State active and “in good standing” credentials – licensed advanced registered nurse practitioners, licensed marriage and family therapists, licensed mental health counselors, licensed advanced social workers, licensed independent clinical social workers, psychologists, osteopathic physicians, osteopathic physician assistants, physicians, and physician assistants – may be certified as CDPs by completing 15 quarter or 10 semester hours of education in specific topics from an approved school, as well as 1000 hours of experience while under the supervision of a CDP. Practitioners with specified national certifications (e.g., American Society of Addiction Medicine or American Board of Addiction Medicine) can meet the CDP educational or experience requirements. (Washington State Department of Health, 2017)
treatment delivered to clients with addiction without being certified as a CDP. Physical health settings are not required to become substance abuse disorder (SUD) agencies in order to offer and bill for SUD treatment. These sites may draw away mental health practitioners, who do not want to become dually credentialed, from settings requiring dual credentials, exacerbating recruitment and retention challenges at community-based sites. One community-based site reported losing the majority of its master’s level therapists as a direct result of requiring dual credentialing for these practitioners, despite a commitment to pay for training and raise pay for completers.

Stakeholders reported that discussions about dual credentialing tend to break down with LMHPs on one side and CDPs on the other, limiting progress on this issue, and suggested engaging someone from outside the state to take a fresh look at this issue.

**Action Required:** Department of Health should consider the following actions to address these issues:

- Continue with its plan to monitor the use of the new CDP alternative training pathway, working with the CDP Advisory Committee at quarterly meetings, periodically reviewing Department credentialing data, and inviting stakeholders to provide feedback to determine the extent that licensed healthcare practitioners use the alternative training pathway.

- Consider requesting funding to bring on a third-party expert from outside the state to identify new ways of approaching this challenge and models that might work in the short-term to incentivize becoming a dual credentialed provider.

3-c. **Recognize and compensate the function that community-based settings play in training new behavioral health professionals and paraprofessionals in their first year of practice. (Carried forward from Phase I)** Community mental health agencies, SUD treatment agencies, and federally qualified health centers (FQHCs) often serve the most complex and chronically ill behavioral health clients, which can be a challenging population for new entrants to the workforce. At times, due to the reimbursement issue covered in recommendation 1, providers leave for better-paid opportunities after only one year of employment at community-based sites, and often after completing their facility-sponsored supervision requirements. As a result, these sites serve as de facto training sites, a role which is not compensated and has a disproportionate impact on the ability of these sites to meet their primary mission: to provide behavioral healthcare services. Recognizing and compensating these sites for this function may help community-based settings better retain workers. Additionally, providing such compensation would, at least partially, address reductions in standard clinical productivity as a result of time spent supervising new workers, enabling better absorption of the costs of high turnover, and/or allowing for these settings to staff appropriately to support a training function.

**Action Required:** The Washington Association of Community and Migrant Health Centers (WACMHC) and the Washington Council of Behavioral Health (WCBH), in coordination with the Washington Association of Alcoholism and Addiction Programs (AAP) should:

- Charter/convene a work group of community mental health agencies, federally qualified health centers, and similar organizations that are Medicaid funded for mental health services to determine which incentives would be useful, and identify the level of funding needed if financial incentives were recommended.

- Work with policymakers to establish and obtain funding for incentives for community mental health agencies, substance use disorder programs and federally qualified health centers with existing training programs.
3-d. **Increase the ability of behavioral health agencies to accept students/trainees by incentivizing and supporting clinical training sites.** *(Updated from Phase I)* Stakeholders emphasized that trainees gravitate to where they had positive clinical training experiences and role models, and that competence gained in challenging settings/populations increases job satisfaction. Appropriate clinical training prior to credentialing is necessary not only to effectively teach real-world practice, but also to ensure that skills that were introduced in school programs are mastered. Staff at behavioral health sites take on additional responsibilities when serving as preceptors. Backfill arrangements must be made to adequately manage caseloads for those also serving as preceptors. Informants have expressed concern that too few clinical training sites with appropriately trained preceptors are available to adequately support existing behavioral health education programs and future expansion, and that the costs of precepting need to be covered. They have requested incentives for training sites and preceptors.

**Action Required:** WACMHC, universities and colleges with behavioral health programs, and clinical training sites (such as FQHCs) will need to work together on the following tasks:

- Develop and implement a readiness assessment to support clinics to evaluate their capacity and ability to implement long-term residency and training programs.
- Promote increased collaboration between universities/colleges and clinics for clinical training of behavioral health professions. Examine the approach used by Clinical Placements Northwest[^3] as a potential model for expanding coordination across the state.
- Consider legislative and funding support that provides financial incentives for current and potential clinical training sites to make up for the time and money lost while training new healthcare workers.
- Review opportunities to provide additional incentives, possibly to include loan repayment or stipends, for clinical training sites to send preceptors to become trained as supervisors and provide clinical training.

**Items for further study to increase access to clinical training and supervised practice for those entering behavioral health occupations.**

- **Work toward a standardized core curriculum for entry-level workers across behavioral health professions.** Development and implementation of a common curriculum could encourage and expedite behavioral health training across a range of entry-level occupations. Consider convening a work group composed of education/training program and employer stakeholders to review existing efforts to standardize or develop a curriculum for this purpose. Once developed, the core curriculum could be used by community-based health clinics to provide as the basis for a more robust on-boarding of new employees.

- **Increase the number of psychiatric residencies, especially in rural and other underserved communities.** There are not enough psychiatric residencies to support the workforce needs of the state. Research shows, and key informants have observed, that physicians and other doctoral-level providers are more likely to stay with an organization or in sites similar to where they complete residency training (such as rural locations) when they enter practice. In 2016, 41.4 percent of psychiatrists practicing in Washington had completed a residency in the state (Skillman & Dahal, 2017). To encourage more psychiatrists to practice in Washington, the state should support expansion of the number of psychiatric residencies. ESHB 1713 requires Washington State University to establish one additional 24-month residency position.

[^3]: Clinical Placements Northwest (CPNW) is the umbrella of three clinical placements consortia (East, North & South) representing 34 healthcare organizations and 35 nursing education programs working to consolidate into a single organization. CPNW negotiates nursing student clinical placements between healthcare partners and education programs and identifies additional placements when there is a shortfall. CPNW is working to provide “one-stop shopping” and automated placement grid to allow a clinical placement coordinator to work on placements for all healthcare students.

---

Washington State
Behavioral Health Workforce Assessment
December 2017

37
specializing in child and adolescent psychiatry, per the recommendation of the Children's Mental Health Workgroup, but additional residencies are needed.

4. EXPAND THE WORKFORCE AVAILABLE TO DELIVER MEDICATION-ASSISTED BEHAVIORAL HEALTH TREATMENTS.

Workforce-related barrier: Too few providers have the prescribing authority needed to deliver medication-assisted treatment for substance use disorder and manage psychotropic medications. Currently, physicians (including physical care physicians and psychiatrists), advanced registered nurse practitioners (ARNPs), including psychiatric-mental health nurse practitioners (PMHNP), physician assistants (PAs), and pharmacists working under a physician's prescriptive authority may prescribe medications for behavioral health conditions. Only licensed physicians, PAs, and ARNPs who have received a waiver from the Drug Enforcement Agency can currently prescribe drugs such as buprenorphine to treat opioid addiction. There are too few of these professionals available to efficiently serve the needs of all behavioral health service sites in the state. This is a both supply shortage issue and a recruitment/retention issue. Low Medicaid rates, discussed in recommendation 1, further reduce the number of buprenorphine prescribers in behavioral health settings.

4-a. Increase primary care providers' (physicians, ARNPs, PAs, pharmacists) confidence to use their full prescriptive authority for psychiatric medications. (Updated from Phase I) In Phase I, stakeholders and key informants cited a lack of comfort or confidence managing serious behavioral health conditions as a challenge to current prescribers' willingness to practice to the full scope of their licenses, including prescribing psychiatric medications and those used to treat opioid addiction. Providing training and support within integrative collaborative systems is ideal, but challenging, due to the shortage of psychiatrically trained providers. The University of Washington's (UW) AIMS Center is working to expand the reach and availability for consultation of Washington's psychiatric prescribing workforce by offering educational modules, coaching, and evaluation for sites implementing the collaborative care model. The UW Integrated Care Training Program provides an integrated care fellowship program to provide up to five psychiatric providers annually an opportunity to learn how to provide integrated care through consultation to non-mental health settings (such as primary care) and telepsychiatry, as well as enhancing leadership to improve systems of care. Additionally, Columbia Health is testing a model of partnering with a managed care organization to fund a nurse care manager to allow for the monitoring that is critical to prescribing.

A 2016 report by the Children's Mental Health Work Group recommended providing psychiatric care consultations via telemedicine. (Washington State Legislature, “Children's Mental Health Group”, 2016). Stakeholders in Phase I suggested gathering information on the effectiveness of the Children’s Hospital Partnership Access Line (PAL) telephone consultative service as a potential best practice. PAL provides reimbursable, interactive consultations with psychiatrists within or outside of Washington via telehealth. The lack of reimbursement for consultative services was identified as a challenge to expanding its use; providers are not paid for the time they spend using the line. There are no billing codes for staff members who manage care, outreach, etc. to be able to bill as part of telehealth-delivery team.

Action Required: In order to increase capacity to support the comfort of primary providers prescribing psychiatric medications, several actions should be considered:

- Adjust the Medicare, Medicaid, PEBB, commercial insurance, and other relevant payment models to provide greater support for and sustainability of telepsychiatry to support primary care providers via tele-consulting services with a psychiatrist. Two bills passed in the 2017 legislative session have begun
to address this challenge: SB 5436 expands the definition of origination site to any site of the patient's choosing and ESHB 1713 includes a provision requiring Behavioral Health Organizations to reimburse providers for the use of telemedicine to deliver medically necessary services to Medicaid clients.

- Provide resources and billing codes for those who manage care, outreach, etc. to be able to bill as part of a telehealth delivery team.
- Expand MCOs/BHOs providing telepsychiatry networks for contracted provider networks.
- Continue support for psychiatrist training through the UW Integrated Care Training Program and consider expansion of this program to support all psychiatric prescribing providers (e.g., ARNPs, PAs), with a plan for ongoing investment in such training beyond 2018.
- Review and consider implementation of the recommendations made by the Collaborative for the Advancement of Telemedicine, a workgroup created by SSB 6519 (2016).

4.b. Graduate more behavioral health professionals licensed as prescribers. (Updated from Phase I) The limited availability of professionals able to prescribe psychiatric medications and provide medication-assisted substance use treatment was identified as a barrier to the integration of healthcare in Phase I. Since 2016, ARNPs have been able to prescribe both psychiatric and physical health medications, but stakeholders report that many ARNPs are not comfortable providing psychiatric medication management for patients with an acute mental health diagnosis. Prescribing medication-assisted treatment (MAT) for opioid disuse treatment requires a special training and waiver process beyond the necessary ARNP education and credentialing. It is too soon to measure the impact of extending ARNPs’ prescriptive rights.

In Phase II, CEOs reported a need for both types of practitioners and stated that it had become increasingly challenging to recruit for ARNPs in general and PMHNPs in particular. One CEO reported relying on consultation with a professional located in Kentucky, another worked with a provider from Texas. At least one stakeholder cautioned that as ARNP programs are moving from the master’s level toward doctoral level training, fewer ARNPs may enter the workforce over the next several years. However, schools report an anticipated increase in PMHNP outputs in the next few years.

In Phase I, the Washington State Hospital Association (WSHA) identified that universities offering PMHNP programs could accept more qualified candidates if they had more funding to recruit faculty to teach the courses and to increase the number of clinical preceptorship placements. A preceptor’s productivity is reduced while educating students, meaning the clinician’s billable hours decline without compensation. Stakeholders also suggested finding ways to support both costs and time for registered nurses to become trained as ARNPs and PMHNPs. However, increasing the numbers of PMHNPs produced by schools will not provide employers with a greater applicant pool if these practitioners choose to work in private practice, where they may earn better salaries with less paperwork burdens. An occupational profile for PMHNPs is included in Attachment B of this report.

Action Required: The Phase I recommendation that policymakers create a grant program to increase capacity in PMHNP training programs is carried forward here. If the grant program was created, universities could apply for single or multiple $400,000 grants for a 2-3 year cycle to educate and train additional PMHNPs and support preceptorships, resulting in approximately 80 additional PMHNPs over the next 2-3 years. Efforts to help RNs move along career ladders to become ARNPs and PMHNPs should also be explored.
Items for further study to expand the workforce available to prescribe behavioral health treatment medications:

- Provide prescriptive training/examination/credentialing to a broader range of behavioral practitioners. While some states address this issue by allowing clinical psychologists with additional training to become prescribers for psychiatric medication, some stakeholders cautioned against providing prescriptive training/examination/credentialing to a broader range of behavioral healthcare practitioners without careful consideration. As one stakeholder stated: "...because medical complications can arise from the administration of medications, and medical training currently consists of four years, please keep in mind any adverse outcomes that might arise if the approaches are not thoughtful." In order to implement such an approach, a Sunrise Review and legislative action would be required, and research into what other states are doing is strongly recommended.

- Increase the number of psychiatric prescribers by: (1) Increasing the number of residencies and encouraging medical school graduates in Washington to enter psychiatric residencies in Washington; and (2) Consider developing a PMHNP residency program and expanding the behavioral health training slots in the current ARNP training programs. Washington is facing a major shortage of psychiatrists, as those currently in the field are aging out and demand for these services is increasing. Encouraging psychiatrists to complete their residencies in Washington could help to address this shortage while increasing the pool of prescribers, but is an expensive proposition. Another, less costly option, might be to develop a PMHNP residency and increase the behavioral health training slots in current ARNP and PA programs.

- Identify and resolve barriers to community-based facilities to host psychiatry residents for rotations. For example, a stakeholder noted that community-based sites must cover the costs associated with to hosting a psychiatry resident, creating a disincentive to training psychiatrists in underserved settings.

- Consider facilitating expansion of PA internships in psychiatry.

5. IMPROVE WORKFORCE SUPPLY, DISTRIBUTION AND DIVERSITY.

Workforce-related barrier: While stakeholders report shortages in various behavioral health occupations, simply expanding the workforce pipeline will not sufficiently resolve the issues in the field. The behavioral health workforce, in general, inadequately reflects the diversity of the population wanting to access services. Additionally, the workforce is not distributed based on the needs of specific communities, particularly in rural areas. As a result, it is difficult to provide culturally appropriate care early and in a proactive way that reduces the need for addressing behavioral and physical healthcare issues when they become more acute. Access to services is uneven. For the purposes of this report, the term diversity is used to focus on the broad category of underserved populations, including but not limited to providers representing various genders, class, sexual orientation, countries of origin, disabilities, race/ethnicities, and history of substance use disorders. For example, one key informant was concerned with the ability to replace a provider for deaf clients, were that provider to leave the facility.

5-a. Provide financial support and other incentives to those pursuing careers in behavioral health. (New recommendation, combining and updating several recommendations in Phase I) Stakeholders identified a variety of financial supports and other incentives that could help increase the quantity, diversity and distribution

---

4Behavioral health occupations' rate per 100,000 population by Accountable Communities of Health are available in the occupational profiles, see Attachment B.
of the behavioral health workforce, including loan repayment, work study, apprenticeship (especially for non-credentialed or entry-level occupations), as well as direct incentives.

**Loan repayment programs.** In Phase I, stakeholders encouraged expanding both the funds appropriated and occupations approved for existing state loan repayment programs, recognizing that these programs are limited to those who financed their education and training using loans. Four licensed behavioral health occupations – Clinical Psychologist, Licensed Independent Clinical Social Worker, Marriage and Family Therapist, and Mental Health Counselor – have recently been added to the state Health Professional Loan Repayment Program, allowing providers in these occupations with a minimum of a Master or Doctoral Degree level education working in an integrated setting/system of care to apply for loan repayment.

In Phase II, stakeholders again voiced a desire to increase the program appropriation and the settings and professions eligible for loan repayment programs. Because the number of loan repayment awards directly results from the size of the state appropriation, making more sites and occupations eligible does not equate to more loan repayment awards, unless the appropriation also grows.

In both Phases of this project, stakeholders expressed confusion regarding various program aspects, such as eligibility, and the difference between the state programs and federal National Health Service Corps. They encouraged more outreach to facilities and practitioners. Stakeholders noted challenges with the state application process and the financial penalties, set in the RCW 28B.115.110, for those who do not fulfill their service commitment, as possible disincentives for those who might otherwise benefit from the program. In an effort to streamline the process, the Washington Student Achievement Council (WSAC) reports that beginning in 2017 sites only need to fill out one application per physical location, whereas in prior years sites had to fill out an application for each discipline and location. This improvement cuts the workload down significantly, as a majority of sites may now complete just one application instead of three. There remain other issues with the application process that WSAC continues to work to improve.

**Direct Incentive.** Stakeholders suggested that the DOH consider convening a workgroup or task force to explore a new direct incentive program, since the current loan repayment program doesn’t help those providers without educational debt who might be incented to practice in underserved behavioral health settings. A direct incentive could be less restrictive and require a less complicated application process. For example, a direct incentive could be created for practitioners who work at a community based behavioral health facility for a set period of time, perhaps 3-5 years. This would reduce turnover at these sites and support greater continuity of care.

The Alaska SHARP program was identified as a potential model (Alaska Department of Health and Social Services, 2017). The program provides support for service to practitioners in the form of either repayment of qualifying education loans and/or payment of direct incentive for practicing in underserved sites.

**Work Study.** The state work study program is the only state funded student financial aid program that includes support for graduate and professional students as well as undergraduates. Work Study is an approach to make higher education more affordable for students, while also providing them with work experience. Student participants are placed with employers that meet their career interests. There are work study sites at behavioral health service providers across the state, largely in community health centers, which increase exposure to behavioral health career paths serving a diverse clientele. At one time, Washington had the largest state Work Study program in the country; however, the program has been cut by two-thirds since the Great Recession. WSAC has requested an additional $10 million for the program in the 2018 legislative session to serve an additional 3,000 students.
Apprenticeship. As an “earn and learn” model, apprenticeship provides a vehicle for trainees to earn an income while they become proficient in their occupation. Apprenticeship could be especially useful to train non-credentialed or entry-level behavioral health occupations by providing the supervised, hands-on, real world experiences these trainees need, without requiring them to reduce their incomes to attend traditional education programs and/or accumulate educational debt. The Washington Association of Community and Migrant Health Centers (WACMHC) is conducting a needs assessment within the FQHCs and rural and tribal clinics to develop a behavioral health apprenticeship program for integrated care implementation. The behavioral health apprenticeship program would train incoming and current support staff using didactic and clinical training at participating FQHCs and rural clinics to triage, do brief interventions, screening, motivational interviewing, and support care coordinators, allowing more time for providers in higher demand (e.g., psychiatrists, child psychologists, physician assistants, and psychiatric advanced registered nurse practitioners) to carry out work at the top of their scope of practice and training. A similar model of apprenticeship could be developed and implemented for Community Behavioral Health Centers.

Action Required: Actions to provide financial support and other incentives to those pursuing careers in behavioral health include:

- DOH, WSAC and the Washington State Behavioral Health Council should convene a workgroup to develop a list of options to incent and retain the behavioral health workforce, including loan repayment, simple direct incentives, expanding the state Work Study program, and exploring apprenticeships in behavioral health settings in order to create a flexible package of financial supports to increase the distribution and diversity of the behavioral health workforce.

- The state should fund additional resources for the Department of Labor & Industries Apprenticeship Division to support development of apprenticeship programs, in consultation with behavioral health leaders and healthcare union leaders, for entry-level roles in the behavioral health field.

5-b. Convene education programs with behavioral health care providers to identify mismatches between the skills of graduates/completers and expectations of employers. (Updated from Phase I)

Stakeholders identified mismatches between the skills of trainees completing programs and the skills necessary for success in behavioral health settings as being among their challenges to providing high quality care. Encouraging frequent connections between employers from a specific industry sector and the educational system is a best practice to align training programs with the needs of employers. Convening regional or statewide conversations among behavioral health employers, professional associations, postsecondary education institutions, and other training providers would allow for better understanding of employer needs for these occupations, and encourage partnerships between industry and education to meet future workforce demands. A team would need to identify the specific outcomes to be achieved, identify a lead organization(s), and otherwise organize the meetings.

Action Required: The State Workforce Board, with support from DOH, WSAC and the Allied Health Center of Excellence, should be resources to convene education programs, healthcare union representatives and behavioral health care employers to identify mismatches between the skills of graduates/completers and expectations of employers.

5-c. Improve behavioral health literacy as a foundation for healthcare careers. (Carried forward from Phase I with minimal changes) Stakeholders identified the stigma associated with behavioral health as a barrier that reduces the number of individuals considering behavioral health careers, and the diversity of that
workforce. Earlier exposure to behavioral health concepts, literacy, and career paths, particularly those leading to targeted postsecondary education and credentialing, may reduce this stigma. In Phase II, behavioral health CEOs advocated for getting young people interested in healthcare, and especially behavioral health occupations, at the earliest age possible. Existing approaches in Washington and elsewhere could be implemented locally or expanded for this purpose:

- Washington State University has a program in partnership with tribal groups focused on nursing, which could be adapted to include behavioral health as well.
- OSPI is implementing Project AWARE (Advancing Wellness and Resilience in Education) to increase awareness of mental health issues among school-aged youth, including training in mental health for school personnel, families and community members, and collaboration to bring mental health literacy curriculum into high school health classes.
- UW Psychiatry and Psychology departments are collaborating to offer a new course and minor in behavioral medicine to UW undergraduate students in pre-health professional training programs (e.g., pre-medicine, pre-nursing, pre-physical therapy, pre-pharmacy).
- Lake Washington Institute of Technology will begin offering a Baccalaureate of Applied Science degree in Behavioral Healthcare, beginning September 2018. The BAS in Behavioral Healthcare prepares students for work in the integrated treatment of mental illnesses, substance use disorders, physical illness, poverty, and homelessness.
- Eastern Washington University is poised to offer a new major in Health Sciences and has a relatively new course offered through their Psychology department, Introduction to the Helping Professions.
- Nebraska is offering a high school pre-vocational behavioral health course through an introduction to behavioral health careers curriculum.
- The Alaska Area Health Education Centers (AHECs) are offering behavioral health career camps.

**Action Required:** Actions that could expand behavioral health literacy in Washington include:

- Policymakers could enhance funding for behavioral health literacy education; using models such as the programs listed above, and emphasize support for programs which include training and resources for educators.
- The Professional Educator Standards Board, OSPI, and selected teacher preparation programs could provide behavioral health literacy training for pre-service instructors, as well as in-service behavioral health literacy training for teachers and school staff.
- Policymakers could consider funding a program manager for behavioral health literacy efforts at OSPI.
- OSPI, Workforce Board, Educational Services Districts, and local districts, in collaboration with OSPI content specialists and program supervisors, could create and implement a Behavioral Health career pathway curriculum, based on promising practices in Washington, Nevada, Alaska, Nebraska and others, especially in areas that include rural, underserved, and diverse populations.
- Policymakers could increase emphasis in state funding for Washington AHECs to continue and expand their health career pathway programs, particularly those focused on behavioral health careers.

**5-d. Increase the use of peer counselors and other community-based workers in behavioral health settings, by continuing to expand training capacity and consistency across these occupations.** *(Updated from Phase I)* By their very nature, peer counselors and other community health workers in the behavioral health workforce reflect the diversity of their communities. Lived experience is often what causes
these individuals to become part of the community health workforce. Stakeholders noted that community behavioral health organizations are increasing their demand for peer counselors and other community health workers. In the Phase I report, stakeholders identified limited availability of training spots and oral examinations required for a certificate of completion for peer counselors as a major hurdle in Washington. Washington’s Office of Consumer Partnerships (within the Department of Social and Health Services) plans to increase the number of certifications by 15-20 percent in 2018 (from approximately 350 to 410 individuals trained annually) by increasing the number of trainings and the capacity per training. However, with over 12 different titles for community health workers, stakeholders reported a desire for clear standards and some level of consistency across this category of workers. In 2018, the DSHS Division of Behavioral Health and Recovery will be adding SUD peer counselor training for targeted SUD recovery support as part of the State Targeted Response to the Opioid Crisis Grant (“Opioid STR”) efforts, though their services will not be eligible for Medicaid reimbursement.

**Action Required:** The Community Health Worker (CHW) Task Force was created to develop policy and system change recommendations to align the CHW with the Healthier Washington initiative and recommend measures to support CHW integration into our healthcare system. The Task Force provided recommendations in 2015 concerning increasing the scope of training and education for CHWs, investigating sustainable financing options, and means of integrating CHWs into transformation initiatives. (Community Health Worker Task Force, 2016) Policymakers and stakeholders should review and consider implementation of these recommendations.

**5-e. Expand access to the I-BEST teaching model, and encourage additional programs that include behavioral health occupations.** (Carried forward from Phase I) Washington’s Integrated Basic Education and Skills Training Program (I-BEST) quickly teaches students literacy, work, and college-readiness skills so they can move through school and into living wage jobs faster. Some I-BEST programs focus on healthcare occupations, and there are a few programs in the state that include a focus on behavioral health. For example, Grays Harbor Community College has an I-BEST for their Human Services program that admits 40 students per year, and generally has a waiting list of students. The program has a generalist track, and a track that leads to the CDP certificate. Expanding I-BEST healthcare programs to include more information on behavioral health occupations could provide the state an untapped resource of diverse entry-level and paraprofessional providers, such as CDPs (one of the occupations most highly in demand, according to Key Informants and Sentinels), medical assistants with integrative skills, and peer counselors. Expanding I-BEST to include more behavioral health occupations could also help students from diverse backgrounds to progress toward degree programs and develop additional skills in areas such as psychology, human services, and community health.

**Action Required:** Increased funding support of policymakers for the I-BEST program.

**5-f. Reduce paraprofessional care worker turnover and improve diversity by creating career pathways and opportunities for certification of behavioral health and other paraprofessional roles.** (Carried forward from Phase I) Underrepresented minorities, immigrants and refugees, and others from diverse population groups often work at the entry and middle-skilled positions across the healthcare sector. Viable pathways to better-paying healthcare positions are limited, especially for those with barriers to traditional education and training programs. The development of career lattices, with wage and job progression across the full spectrum of the healthcare workforce, can support the retention and advancement of these workers, resulting in a more diverse healthcare workforce, and potentially improving patient outcomes as the workforce develops from within communities being served.
National and international efforts to stem the loss of care workers by using career pathway development and increased autonomy over the work have shown success. These efforts have generally been focused on one or a few aspects of caregiving, like long-term care, with limited position or wage growth. Even so, Pennsylvania, Massachusetts, New York, Oregon, North Carolina, Georgia, Florida, and Vermont all had successful long-term care career pathway efforts, and have been able to show significant turnover reductions. Massachusetts, the only state that looked at the effect of workforce development interventions on federal patient care quality indicators, showed a significant increase in certain quality indicators, and positive changes in revenues that were transferred to direct patient care and care worker wage increases. The five states that participated in Robert Woods Johnson Foundation’s “Better Jobs for Better [long-term] Care Initiative” were able to show reductions in worker turnover. The United Kingdom, anticipating an almost double-digit increase in the need for care workers, has begun an effort to look across the caregiving subsectors to improve front-line worker recruitment and retention. The project looks at career pathways, portable and stackable credentials, and customer-endorsed badges.

The Health Workforce Council (HWC), with adequate funding support, could be the logical body to convene a Care Worker Task Force. The Workforce Board, which staffs the HWC, could work with the Council to support a stakeholder process to create a statewide care worker career lattice framework over an 18 to 24-month period.

**Action Required:** The Workforce Board, with funding from the state budget to support project staff, could work with the HWC to establish a Care Worker Task Force and develop a care worker career lattice over an 18-24 month time period.

**Items that require further study to improve workforce supply, distribution and diversity in the behavioral health workforce.**

- **Expand the Welcome Back Center program to additional sites.** Several colleges in Washington provide this program to help foreign-trained professionals enter careers in the U.S. Further study could examine the applicability of this program to address behavioral health workforce needs.

- **Consider the recommendation of the Children’s Mental Health Work Group to increase payment for providers offering interventions in community locations.** The interventions may include primary care, education, child welfare, and juvenile justice. The Work Group also called for ensuring that payment can be made when providing services in non-traditional settings by a variety of professionals. (Washington State Legislature, “Children’s Mental Health Group”, 2016).

- **Consider addressing challenges related to obtaining and maintaining a CDP certificate.** CDPs were among the occupations in the highest demand according to stakeholders. Stakeholders noted that the cost of obtaining and maintaining a CDP certificate may be a barrier. DOH is required to monitor the recovery of impaired practitioners including CDPs through measures such as drug screening and required attendance at for-cost peer support groups, the cost of which is paid by the practitioner and cuts into earnings. For dual credentialed professionals, the cost of maintaining an additional license may be a barrier. Stakeholders suggested creating a pool, maintained by fees in low-cost years to offset certificate costs in high-cost years. Stakeholders also noted that some CDPs are lost to the system because they do not complete training and supervised practice in the five-year window, causing them to take other jobs, wasting the investment in their training. Expanding the window for completion might address this.
## Olympic Workforce Development Council Membership 2018

### BUSINESS (15 Members Required [51% of Membership] – 14 Members)

<table>
<thead>
<tr>
<th>Number</th>
<th>Member Name, Title and Address</th>
<th>Phone, Fax, E-Mail</th>
<th>Type of Association</th>
<th>Term Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Monica Blackwood, Director of Administration Rice Fergus Miller 275 5th Street Bremerton, WA 98337</td>
<td>360-362-1435, 360-792-1385, <a href="mailto:mblackwood@rfmarch.com">mblackwood@rfmarch.com</a>, 360-908-0855</td>
<td>Business</td>
<td>2/22/16 – 2/21/19</td>
</tr>
<tr>
<td>2</td>
<td>Randy Colson, Program Manager General Dynamics NASSCO 423 Pacific Ave, Suite 200 Bremerton, WA 98337</td>
<td>360-782-5623, <a href="mailto:rcolson@nassconorfolk.com">rcolson@nassconorfolk.com</a></td>
<td>Business</td>
<td>2/17/17 - 2/16/20</td>
</tr>
<tr>
<td>4</td>
<td>Kelly Fox, Chief Executive Officer Lumber Trades Inc. 3111 Highway 101 E Port Angeles, WA 98362</td>
<td>360-417-8399, 360-452-8943, <a href="mailto:kellyf@lumbertradersinc.com">kellyf@lumbertradersinc.com</a></td>
<td>Business</td>
<td>2/17/17 – 2/17/20</td>
</tr>
<tr>
<td>5</td>
<td>Kevin Gallacci, General Manager Clallam Transit Systems 830 W. Lauridsen Blvd. Port Angeles, WA. 98363</td>
<td>360-417-1357, <a href="mailto:keving@clallamtransit.com">keving@clallamtransit.com</a></td>
<td>Business</td>
<td>1/15/17-1/15/20</td>
</tr>
<tr>
<td>6</td>
<td>Julie Hatch, VP Business Development Officer, Sound Community Bank 226 Motor Ave Port Angeles, WA 98362</td>
<td>360-437-8805 x824, 844-884-7377, <a href="mailto:julie.hatch@soundcb.com">julie.hatch@soundcb.com</a></td>
<td>Business</td>
<td>8/19/16 – 8/18/19</td>
</tr>
<tr>
<td>7</td>
<td>Marilyn Hoppen, SVP Human Resources Kitsap Bank P.O. Box 9 Port Orchard, WA 98366</td>
<td>360-876-7892, 360-876-7801, <a href="mailto:mhoppen@kitsapbank.com">mhoppen@kitsapbank.com</a></td>
<td>Business</td>
<td>9/18/15 – 9/17/18</td>
</tr>
<tr>
<td>8</td>
<td>Heidi Lamprecht, Scholarship Advisor and Job Training Coordinator 1033 Old Blyn Hwy Sequim, WA. 98382</td>
<td>360-681-4635, <a href="mailto:hlamprecht@jamestowntribe.org">hlamprecht@jamestowntribe.org</a></td>
<td>Business</td>
<td>3/30/17 – 3/29/20</td>
</tr>
<tr>
<td>Council Member’s Name, Title, Business and Address</td>
<td>Phone</td>
<td>Fax</td>
<td>E-Mail</td>
<td>Type of Association</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------</td>
<td>-----</td>
<td>--------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>ECONOMIC DEVELOPMENT (1 Member Required - 3 Member)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>1</strong> John Powers, Executive Director Kitsap Economic Development Alliance 2021 NW Myhre Rd. # 100 Silverdale, WA. 98383  Alternate Kathy Cocus</td>
<td>Phone</td>
<td>Fax</td>
<td>E-Mail</td>
<td>Economic Development</td>
</tr>
<tr>
<td>Phone</td>
<td>Fax</td>
<td>E-Mail</td>
<td>Economic Development</td>
<td>11/21/17 – 11/20/20</td>
</tr>
<tr>
<td><strong>2</strong> Vacant</td>
<td>Phone</td>
<td>Fax</td>
<td>E-Mail</td>
<td>Economic Development</td>
</tr>
</tbody>
</table>
### EDUCA TION K-12 (2 Members Required - 2 Members)

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Organization</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Greg Lynch, Superintendent</td>
<td>Olympic Edu. Service Dist. #114</td>
<td>105 National Avenue N. Bremerton, WA 98312</td>
<td>360-478-6880</td>
<td>360-478-6869</td>
<td><a href="mailto:glyynch@oesd.wednet.edu">glyynch@oesd.wednet.edu</a></td>
<td>6/20/15 – 6/19/18</td>
</tr>
<tr>
<td>Alternate</td>
<td>Jeff Allen, Director</td>
<td>High Risk Youth Programs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Lisa Heaman, Principal</td>
<td>West Hills S.T.E.M. Academy</td>
<td>Bremerton School District</td>
<td>360-473-4600</td>
<td></td>
<td><a href="mailto:lisa.heaman@bremertonschools.org">lisa.heaman@bremertonschools.org</a></td>
<td>11/21/17 – 11/21/20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>520 S National Avenue</td>
<td>Bremerton, WA 98312</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### EDUCATION POSTSECONDARY (2 Members Required - 2 Members)

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Organization</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dr. Luke Robins, President</td>
<td>Peninsula College</td>
<td>1502 E. Lauridsen Blvd. Port Angeles, WA 98362</td>
<td>360-417-6200</td>
<td>360-417-6220</td>
<td><a href="mailto:lrobins@pencol.edu">lrobins@pencol.edu</a></td>
<td>11/21/17 – 11/20/20</td>
</tr>
<tr>
<td>Alternate</td>
<td>Dr. Laura Brogden</td>
<td>Associate Dean for Basic Education and Corrections</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Vacant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## LABOR (3 Members Required - 3 Members)

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>David A. McMahan, Secretary/Treasurer Olympic Labor Council</td>
<td>360-477-1901</td>
<td></td>
<td><a href="mailto:labordave@gmail.com">labordave@gmail.com</a></td>
<td>6/20/15 – 6/19/18</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Chuck Moe, Field Rep 11871 Silverdale Way NW, Ste. 111 Silverdale, WA 98383</td>
<td>360-613-4073</td>
<td>360-692-2759</td>
<td><a href="mailto:chuck@laborerslocal252.org">chuck@laborerslocal252.org</a></td>
<td>1/8/18 – 1/8/21</td>
</tr>
<tr>
<td>3</td>
<td>Bob Zindel, President Olympic Labor Council 508 South H Street Port Angeles, WA 98363</td>
<td>360-457-1435</td>
<td></td>
<td><a href="mailto:bobzindel70@gmail.com">bobzindel70@gmail.com</a></td>
<td>2/13/18 – 2/12/21</td>
</tr>
</tbody>
</table>

## PUBLIC EMPLOYMENT SERVICE (1 Member Required - 3 Members)

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Phone</th>
<th>Fax</th>
<th>Email</th>
<th>Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Jeff Cartwright, Director of Human Resources Kitsap Transit 60 Washington Ave. Suite 200 Bremerton, WA. 98337</td>
<td>360-478-6227</td>
<td>360-405-9140</td>
<td><a href="mailto:jeffc@kitsaptransit.com">jeffc@kitsaptransit.com</a></td>
<td>10/24/17-10/23/20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Robin Hake, Human Resources Director City of Port Townsend 250 Madison Street Port Townsend, WA 98368</td>
<td>360-379-5045</td>
<td></td>
<td><a href="mailto:RHake@cityofpt.us">RHake@cityofpt.us</a></td>
<td>11/21/17 – 11/20/20</td>
</tr>
<tr>
<td></td>
<td>Alternate Kelly Wheeler</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>360-302-2195</td>
<td></td>
<td><a href="mailto:kwheeler@cityofpt.us">kwheeler@cityofpt.us</a></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Margaret Hess, Kitsap Administrator Washington State Employment Security Department 1300 Sylvan Way, 2nd Floor Bremerton, WA 98310</td>
<td>360-337-4754</td>
<td>360-337-4770</td>
<td><a href="mailto:mhess@esd.wa.gov">mhess@esd.wa.gov</a></td>
<td>2/13/18 – 2/12/21</td>
</tr>
<tr>
<td></td>
<td>Alternate Matt Bench, North Sound Regional Director 3201 Smith Ave. Suite 414 Everett, WA 98201</td>
<td>425-258-6345</td>
<td></td>
<td><a href="mailto:mbench@esd.wa.gov">mbench@esd.wa.gov</a></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Office/Address</td>
<td>Phone</td>
<td>Fax</td>
<td>E-mail</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------------------------</td>
<td>-------------------------------------</td>
<td>--------</td>
<td>---------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>STATE VOCATIONAL REHABILITATION (1 Member Required – 1 Member)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>VACANT Hankinson</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alternate Diane Warwick</td>
<td></td>
<td></td>
<td></td>
<td>360-698-4369 <a href="mailto:Diane.warwick@dshs.wa.gov">Diane.warwick@dshs.wa.gov</a></td>
</tr>
<tr>
<td><strong>PUBLIC ASSISTANCE (1 Member Required – 1 Member)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Gina Lindal, Administrator</td>
<td>Bremerton Community Services Office</td>
<td></td>
<td></td>
<td>360-473-2202 <a href="mailto:gallagl@dshs.wa.gov">gallagl@dshs.wa.gov</a></td>
</tr>
<tr>
<td></td>
<td>Bremerton Community Services</td>
<td>4710 Auto Center Blvd.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office</td>
<td>Bremerton, WA 98528</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COMMUNITY BASED ORGANIZATIONS (1 Member Required – 1 Member)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>David Wunderlin, Executive</td>
<td>Kitsap Community Resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Director</td>
<td>845 – 8th Street</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kitsap Community Resources</td>
<td>Bremerton, WA 98337-1512</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>845 – 8th Street</td>
<td></td>
<td>360-478-2301 <a href="mailto:davidw@kcr.org">davidw@kcr.org</a></td>
<td>Community Based Organization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alternate</td>
<td></td>
<td>360-473-2159 <a href="mailto:ttierney@kcr.org">ttierney@kcr.org</a></td>
<td>7/1/15 – 6/30/18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trish Tierney</td>
<td></td>
<td>360-874-1493</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Olympic Workforce Development Council Membership 2018

### STAFF

<table>
<thead>
<tr>
<th></th>
<th>Name</th>
<th>Committee/Position</th>
<th>Phone</th>
<th>Fax</th>
<th>E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Elizabeth Court, Staff</td>
<td>Executive Committee, OWDC</td>
<td>360-337-4767</td>
<td>360-337-5721</td>
<td><a href="mailto:ecourt@co.kitsap.wa.us">ecourt@co.kitsap.wa.us</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Economic Development and Business Coordination Committee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Kathy Gross, Staff</td>
<td>Operations Committee</td>
<td>360-337-4805</td>
<td>360-337-4470</td>
<td><a href="mailto:kgross@co.kitsap.wa.us">kgross@co.kitsap.wa.us</a></td>
</tr>
<tr>
<td>3</td>
<td>Sarah Oliver, Staff</td>
<td>Kitsap County</td>
<td>360-337-4873</td>
<td></td>
<td><a href="mailto:soliver@co.kitsap.wa.us">soliver@co.kitsap.wa.us</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Programs Supervisor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Mike Robinson, Staff</td>
<td>OWDC</td>
<td>360-337-4727</td>
<td></td>
<td><a href="mailto:mrobinson@esd.wa.gov">mrobinson@esd.wa.gov</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>One-Stop Operator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Hannah Shockley, Staff</td>
<td>Kitsap County Human Services Department</td>
<td>360-337-7185, Ext. 3530</td>
<td>360-337-5721</td>
<td><a href="mailto:hshockley@co.kitsap.wa.us">hshockley@co.kitsap.wa.us</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supervisor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Doug Washburn, Staff</td>
<td>Kitsap County Human Services Department</td>
<td>360-337-4526</td>
<td>360-337-5721</td>
<td><a href="mailto:dwashbur@co.kitsap.wa.us">dwashbur@co.kitsap.wa.us</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Director</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Executive Committee

- Julie Tappero, Chair (Vacant), Vice Chair
- Elizabeth Court, Staff
- David Wunderlin
- Margaret Hess
- David McManan
- Allison Plute
- John Powers
- Monica Blackwood

### Economic Development and Business Coordination Committee

- Elizabeth Court, Staff
- David Wunderlin
- Robin Hake
- Matt Bench
- David Hankinson
- Amy Hatfield
- David McMahan
- Allison Plute

### Operations Committee

- Margaret Hess, Chair
- Kathy Gross, Staff
- Felix Vicino
- Lisa Heaman
- Matt Bench
- Bob Zindel
- Allison Plute
- Julie Tappero

### Youth Council Committee

- Vacant, Chair
- Sarah Oliver, Staff
- Jeff Allen (Greg Lynch)
- Lisa Heaman
<table>
<thead>
<tr>
<th>Member(s) At-Large</th>
<th>Phone</th>
<th>Fax</th>
<th>E-mail</th>
</tr>
</thead>
</table>
| **1.** Jim McKenna, Retired One-Stop Operator  
13677 Rocky Ridge NE  
Silverdale, WA 98383 | 360-697-4559 |  | Jimmck5@hotmail.com |
| **2.** Sara Hatfield, CTE  
Director, South Kitsap School District | 360-874-7000 |  | hatfields@skitsap.wednet.edu |
| **3.** Laura Ryser, Assistant Professor, Washington State University Extension  
345 6th St. Ste 550  
Bremerton, WA 98337 | 360-337-7281 |  | Laura.ryser@WSU.edu |
| **4.** Janel Mcfeat, Re-Entry Program Manager, Port Gamble S’Klallam Tribe | 360-271-0778 cell  
360-297-6305 work |  |  |
| **5.** Meilana A. Charles, Assistant Professor, Youth and Families Department  
Director, Family Development Specialist  
WSU Kitsap County Extension  
345 6th Street, Suite 550  
Bremerton, WA 98337 | 360-337-7157 x6271  
360-900-7276 |  | meilana.charles@wsu.edu |
| **6.** David Hankinson, Voc. Rehab Spvr.  
Division of Vocational Rehabilitation  
3888 NW Randall Way, Suite #201  
Silverdale, WA 98383 | 360-698-4386  
360-698-4373 |  | hankid@dshs.wa.gov |