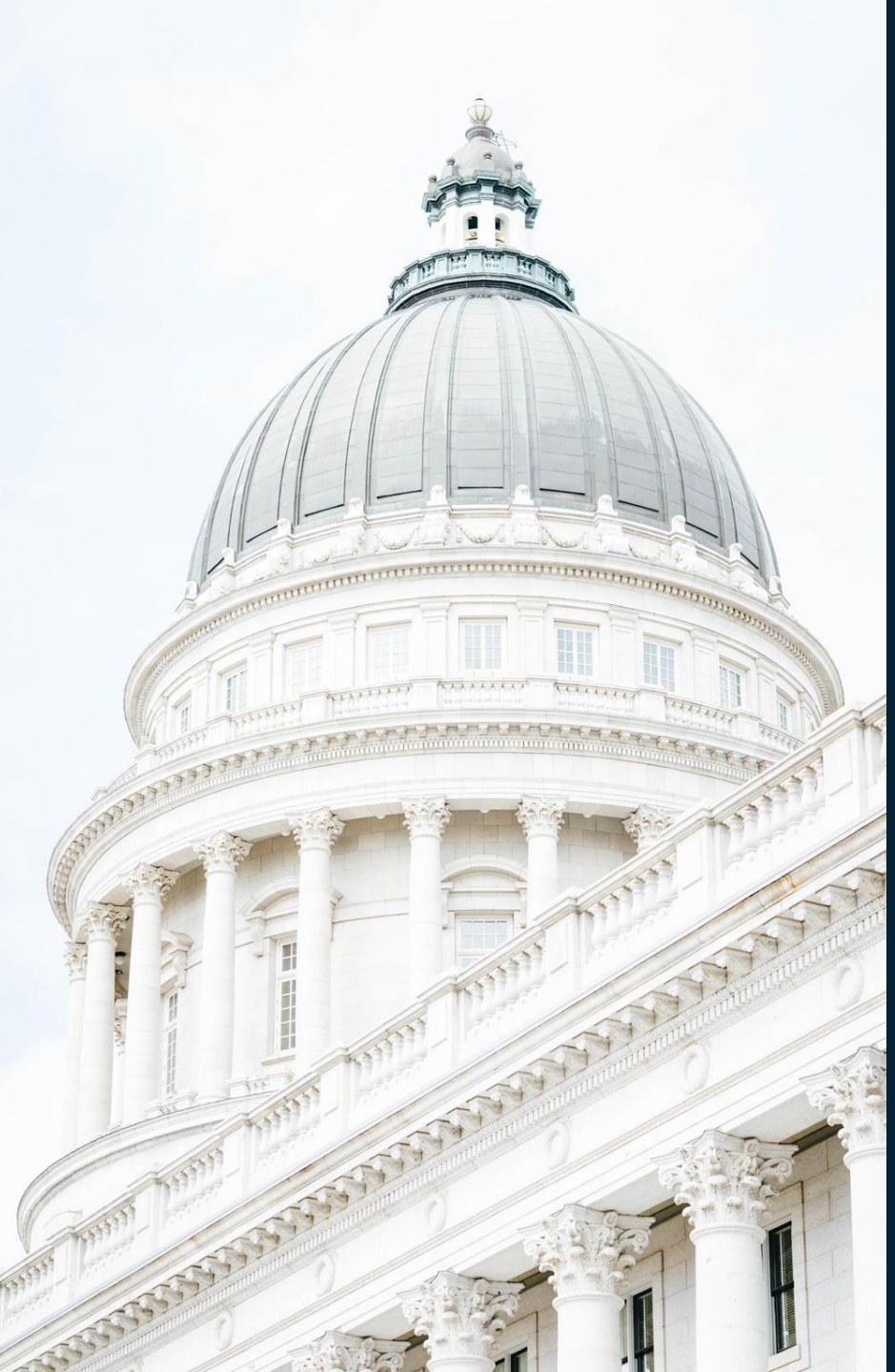


UTAH DEPARTMENT OF COMMERCE
Office of Professional Licensure Review

SB26: Behavioral Health Licensing Amendments

February 12, 2024

PRELIMINARY

Findings from OPLR's review:

Access to care

Utahns **receiving** behavioral health care

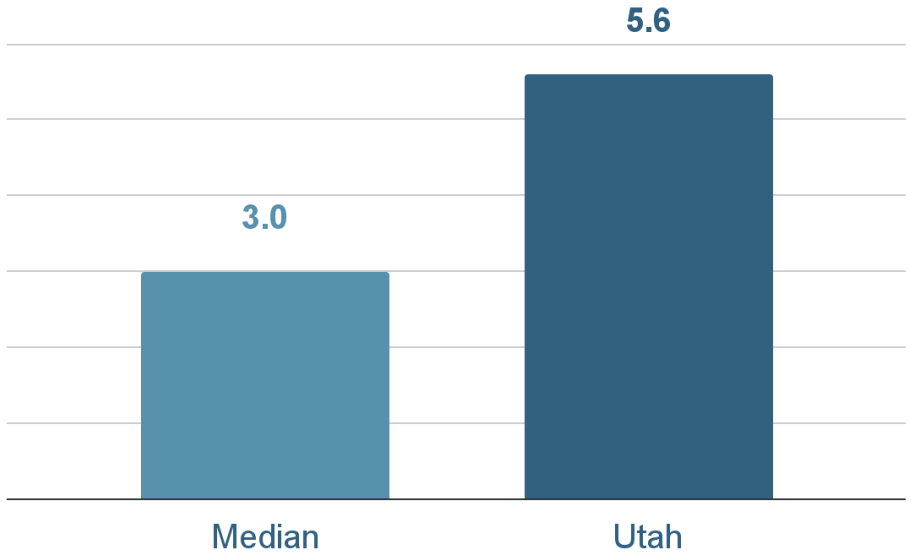
~530k

Utahns with an **unmet need** for behavioral health care

~210k-515k

Safety of care

Annual[1] NPDB Reports Per 1,000 BH Providers
(2015-2022)



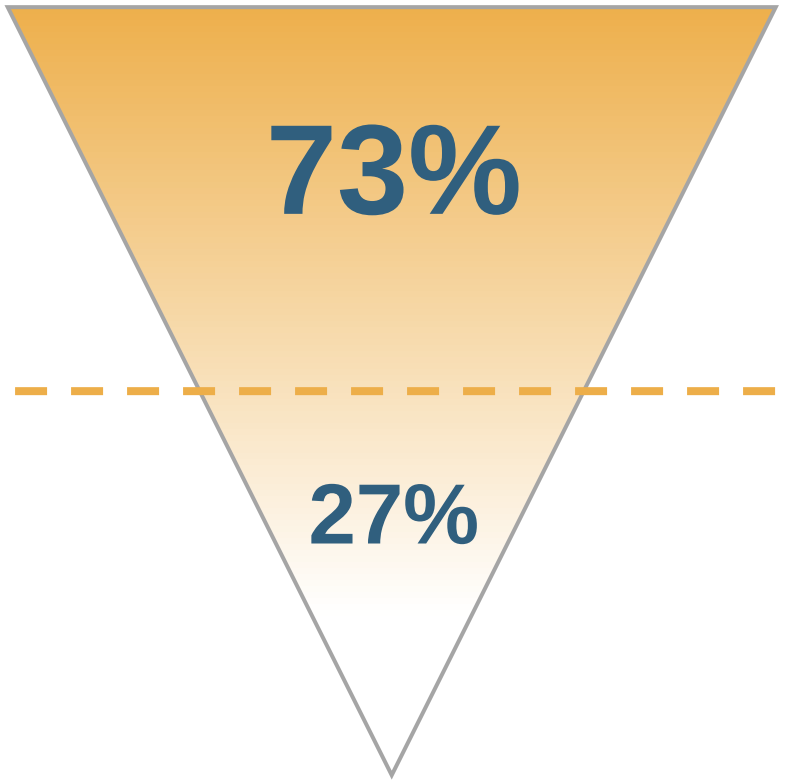
Utah ranks far above the median number of NPDB reports[3] per behavioral health licensee[4] in the US, at **12th** of 51 states.

Source: All data drawn from 1) the 2020-2021 National Survey of Children's Health and 2) the 2018-2019 National Survey on Drug Use and Health. For detailed calculations and limitations, see Appendix.

PRELIMINARY

Behavioral Health Care Lacks Extenders

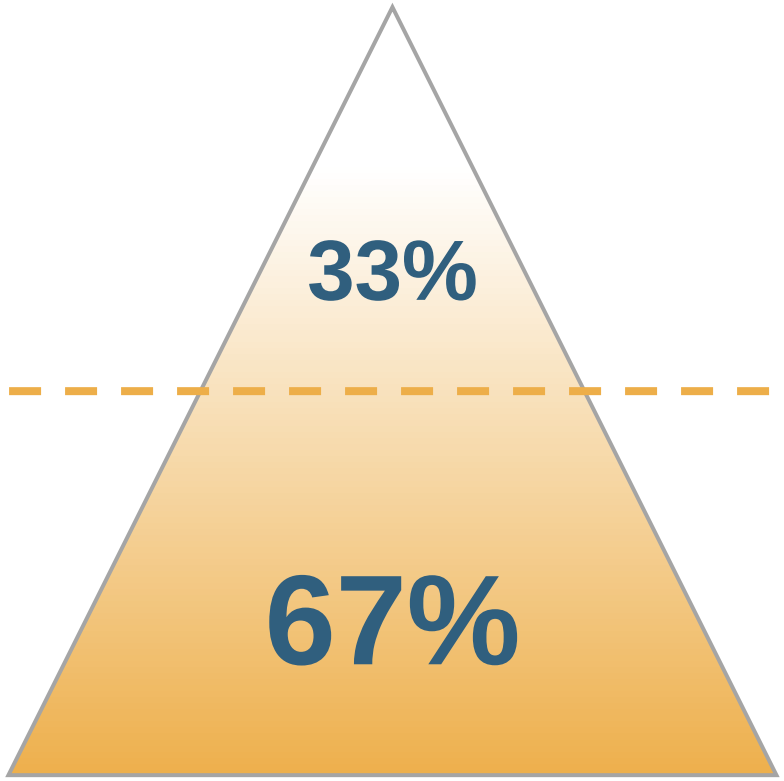
Utah Behavioral Health Workforce
(% of Active Licensees)



Requires a Master's Degree or Higher

Requires a Bachelor's Degree or Lower

Utah Medical Field Workforce
(% of Active Licensees)



Source: DOPL licensee data obtained from DOPL MLO report "Active License Count," accessed 2/28/2023; data on DHHS licensees provided to OPLR by DHHS administrators in July, 2022.
The figures presented do not reflect members of the workforce who hold a private certification (e.g., CNAs) or no certification (e.g., psych techs).

SB26: **Access**

Fill Gaps in Career Ladders & Care

- BH Technician Certification (1-year)
- BH Coach License (Bachelor's)
- Prescribing Psychologist

Expand Pathways & Portability

- Exam Alternatives for MA-level Therapists
- Master Addiction Counselor license

Train Smarter, Not Harder

- Flexible Continuing Education

Streamline Governance Structure

- Multi-Profession BH Board
- Removes Voc Rehab license

PRELIMINARY

SB26: **Safety**

Train Smarter, Not Harder

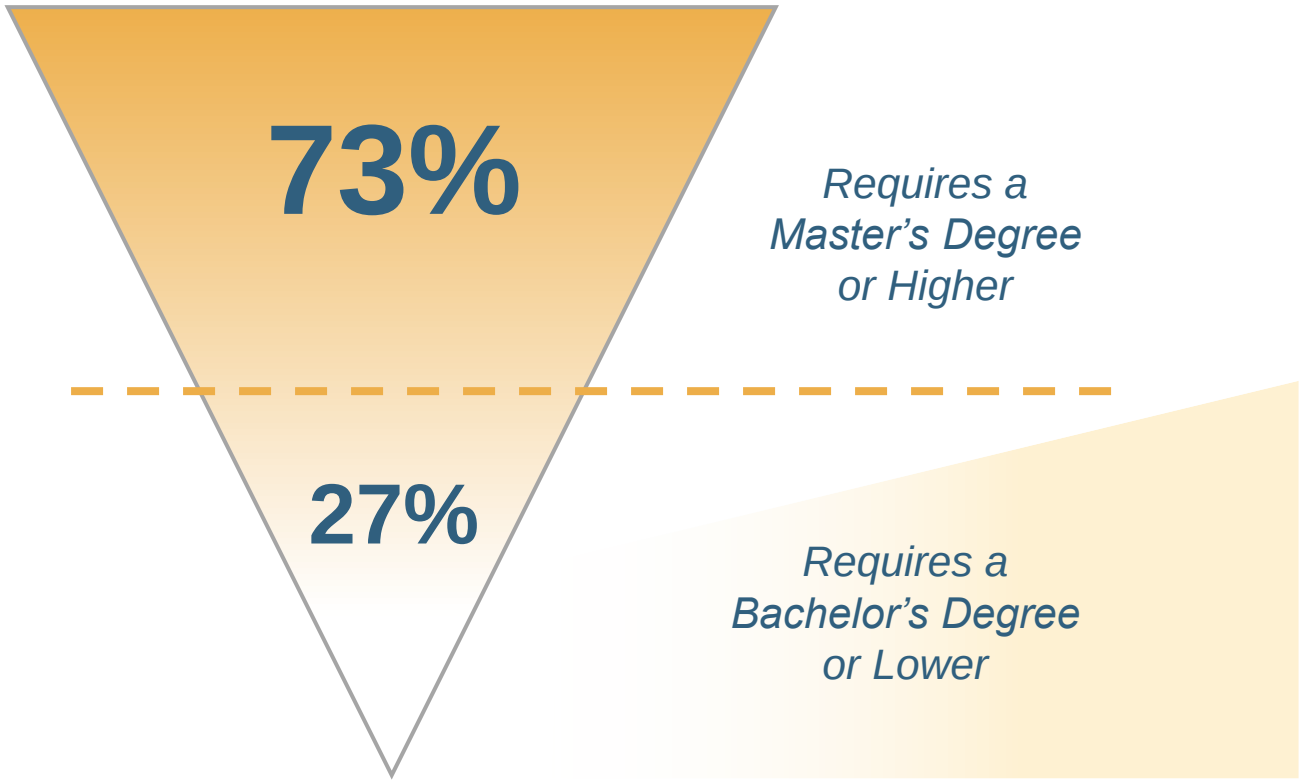
- Supervision Hours
- Supervision Quality

Strengthen Upstream Monitoring

- Background Checks for Therapists
- Consumer Disclosures
- UPHP Expansion

Fill Gaps in Careers & Care: Extender Roles

Utah Behavioral Health Workforce
(% of Active Licensees)



Proposed Solution

Behavioral Health Coach (License)

- For 4-year grads in multiple related majors
- Requires courses and experience in BH

Behavioral Health Technician (Certification)

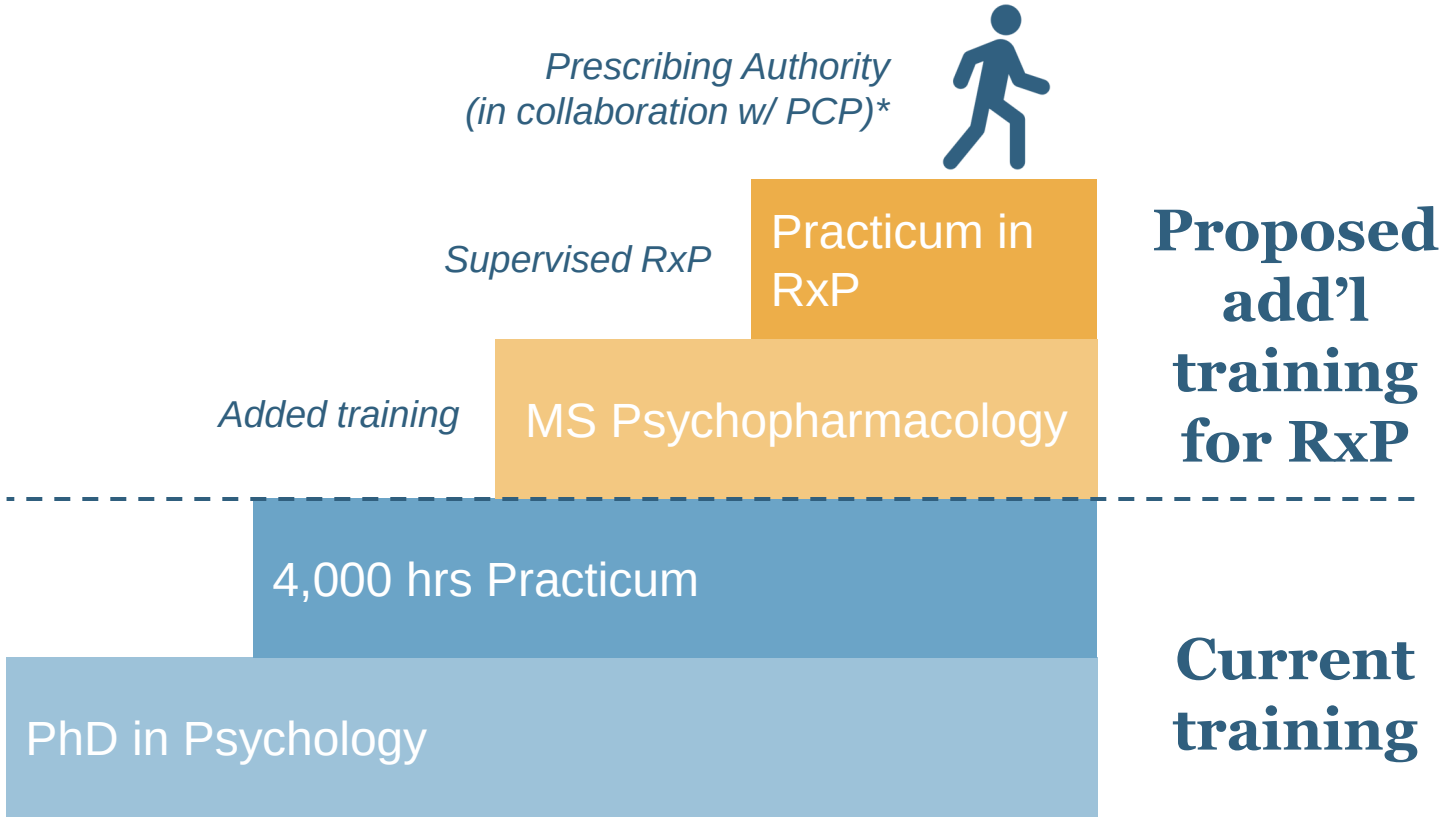
- 1-year certificate in applied BH
- Offered at 4 USHE campuses starting 2024

Source: DOPL licensee data obtained from DOPL MLO report "Active License Count," accessed 2/28/2023; data on DHHS licensees provided to OPLR by DHHS administrators in July, 2022.
The figures presented do not reflect members of the workforce who hold a private certification (e.g., CNAs) or no certification (e.g., psych techs).

PRELIMINARY

Fill Gaps in Care: Prescribing Psychologists (RxP)

'RxP' refers to authority for psychologists to prescribe drugs related to behavioral health



- OPLR finds **RxP is safe** when psychologists meet proposed requirements for licensure**
- Per UC 13-1b, OPLR considers '**present, recognizable, and significant harm**' to the public
- The **U.S. Dept. of Defense** granted prescriptive authority in 1994
- **Six additional states** (including neighboring Idaho and Colorado) now authorize RxP

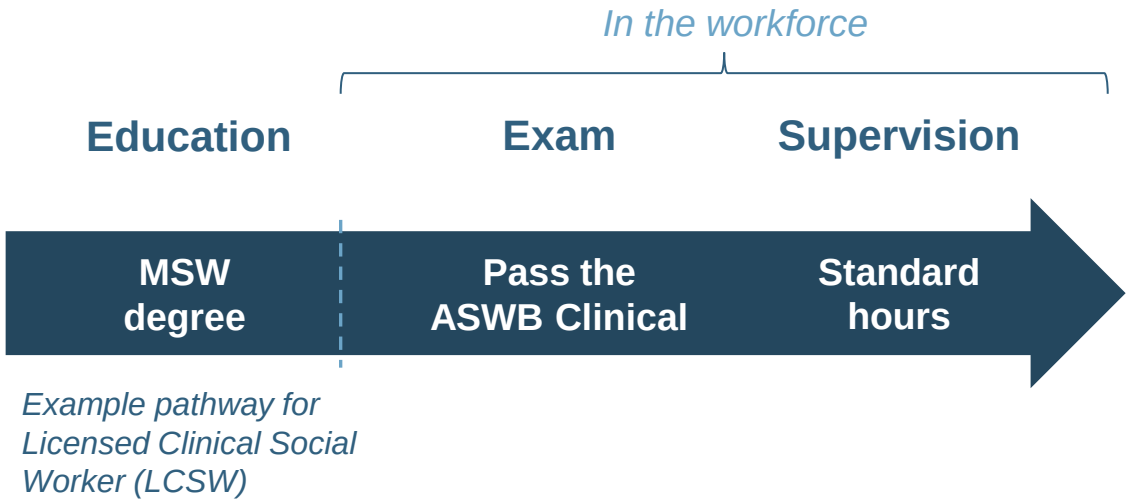
*As proposed in SB26, RxP would allow certified psychologists to prescribe a limited formulary of drugs relevant to BH disorders in collaboration with a healthcare practitioner who oversees the patient's general care.
**See pages 135-151 in OPLR's '2023 Periodic Review: Behavioral Health' for detail.

PRELIMINARY

Expand Paths & Portability: National Exams

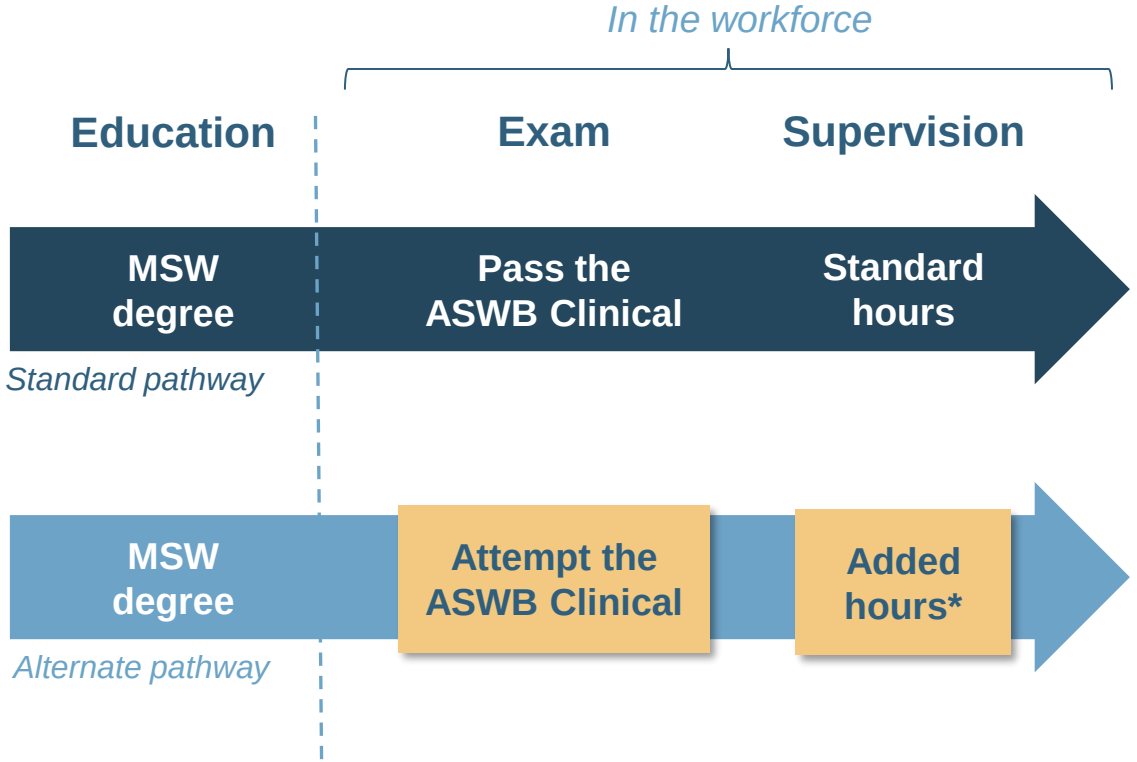
For master's-level clinical therapists:

Current



Example pathway for Licensed Clinical Social Worker (LCSW)

Proposed



*Added hours are 500 additional direct client care hours, 25 additional direct supervision hours, and 5 additional direct observation hours. See OPLR's '2023 Periodic Review: Behavioral Health' for detail.

PRELIMINARY

Streamline Governance: Multi-Profession Board

Current

DOPL (Commerce)

Licensing Boards (advisory)

Social Work | MFT | SUDC | CMHC | Psych./ Behavior Analysis | …

Licensed Practitioners

Social Work | Marriage & Family Therapy | SUDC | CMHC | Psych./ Behavior Analysis | …

Occupation-specific structure **limits cross-occupation & systems thinking** in policy matters

Proposed

DOPL (Commerce)

Licensing Board (advisory)

Policy functions: Behavioral Health Board[1]

Licensing functions[2]: Committee: Qualifications | Committee: Investigations | Committee: Probation

Licensed Practitioners

Social Work | **MFT** | **SUDC** | **CMHC** | **Psychology** | **Behavior Analysis**

Multi-profession structure encourages **collaborative, system level approaches** to policy matters

1 The BHB would include 6 licensed professionals representing each of the main occupations here, plus 2 associate licensees (e.g., CSW), and 4 public members with specific expertise to give a broad view of the behavioral health system (medical, research, DHHS); 2 Sub committees would execute licensing functions (like enforcement) with ad hoc groups set up as needed to address occupation-specific issues.

PRELIMINARY

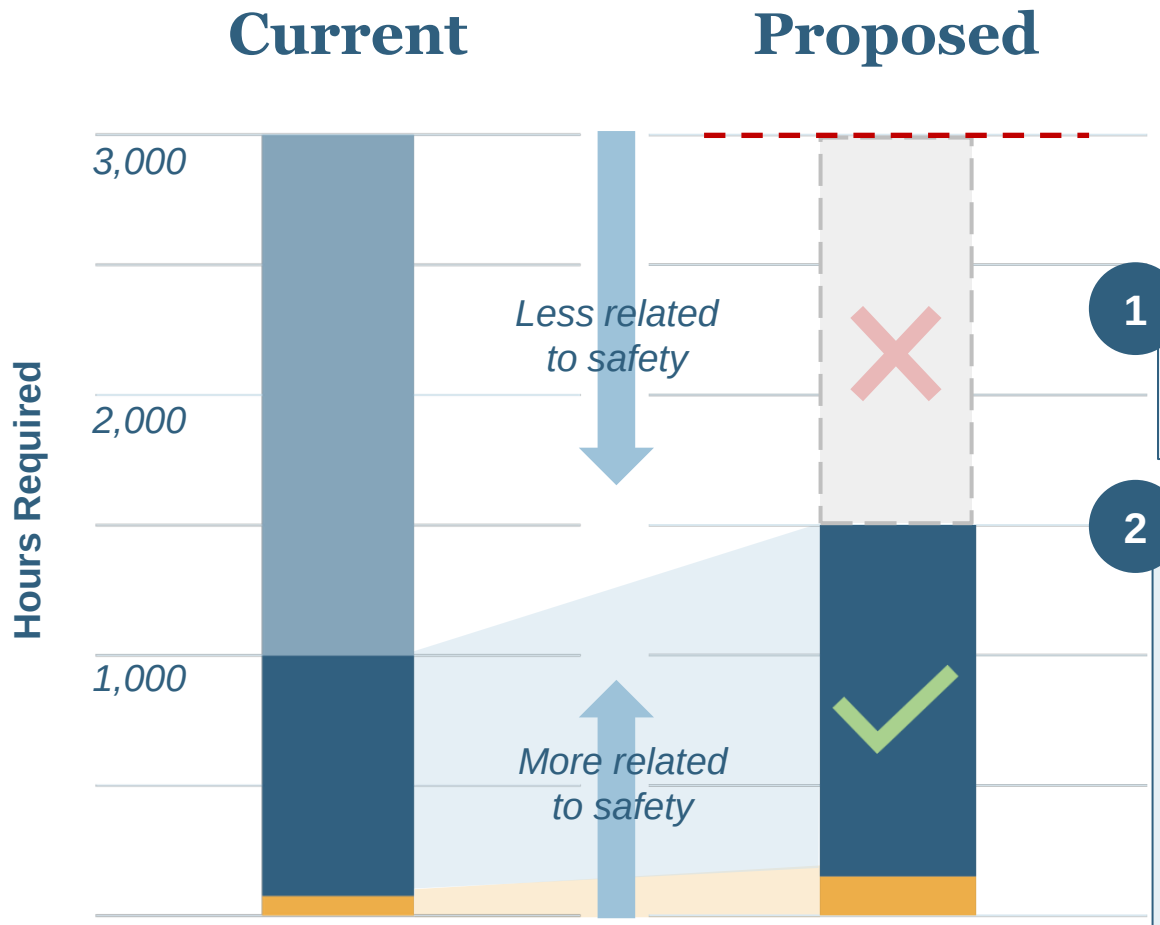
Train Smarter, Not Harder – Supervision Hours*

For master's-level clinical therapists:

General Clinical Supervision
All supervised hours including study & research, administrative tasks as well as client care

Direct Client Care
Direct contact with patients; performing mental health therapy and clinical tasks

Direct Clinical Supervision
Direct contact between supervisor and supervisee; may include case consultation or observation of actual practice



CMS Medicare requires 2 years or 3,000 general hours for reimbursement**

1

a. Eliminate general experience hours

2

a. Increase direct client contact hours

b. Increase direct clinical supervision hours

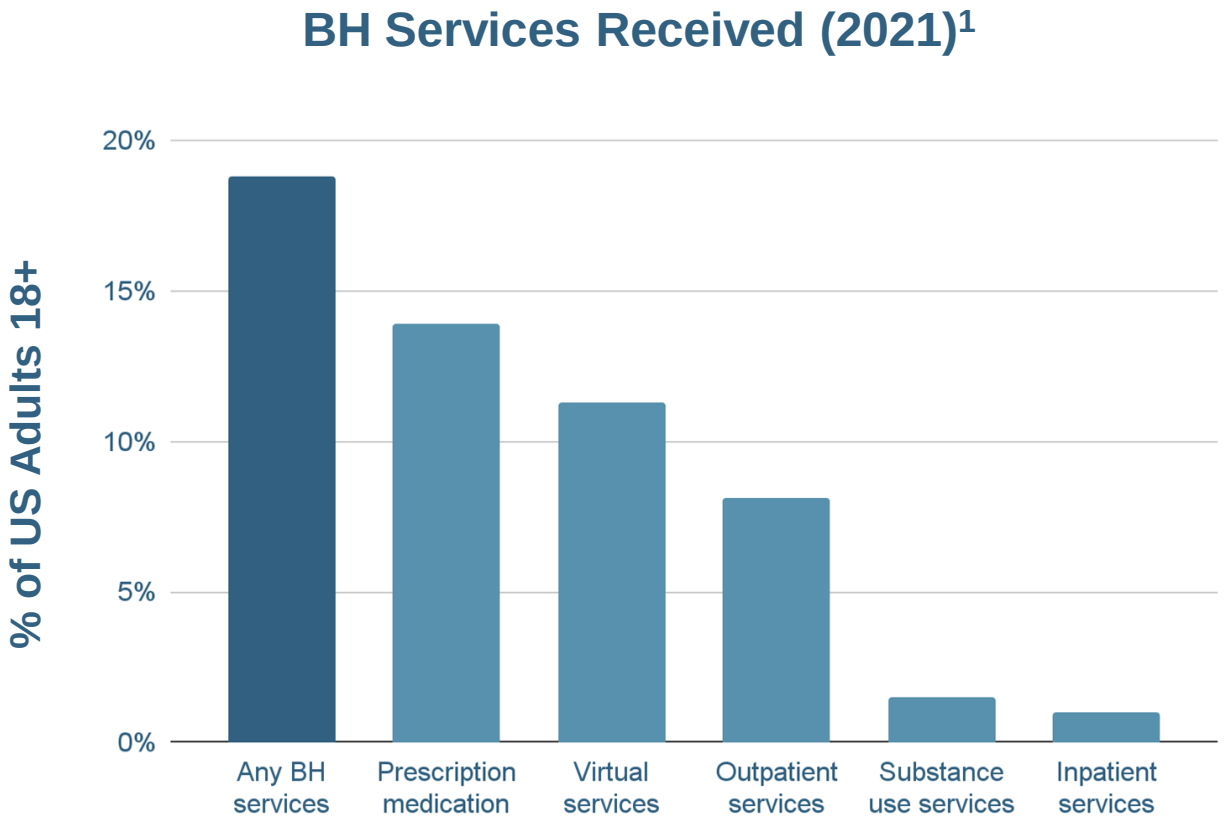
c. Require direct observation hours

* This recommendation is only in reference to MA-level clinical therapists, meaning LCSW, CMHC, MFT licenses. **Recent CMS Medicare rule (Section 4121 of CAA 2023) defines MA-level clinical therapists as having 2 years or 3,000 hours of supervised clinical training, separate from state licensure requirements.

Agenda

1. **Background & Methodology**
2. Findings
3. Recommendations
4. Discussion

Behavioral Health: Overview

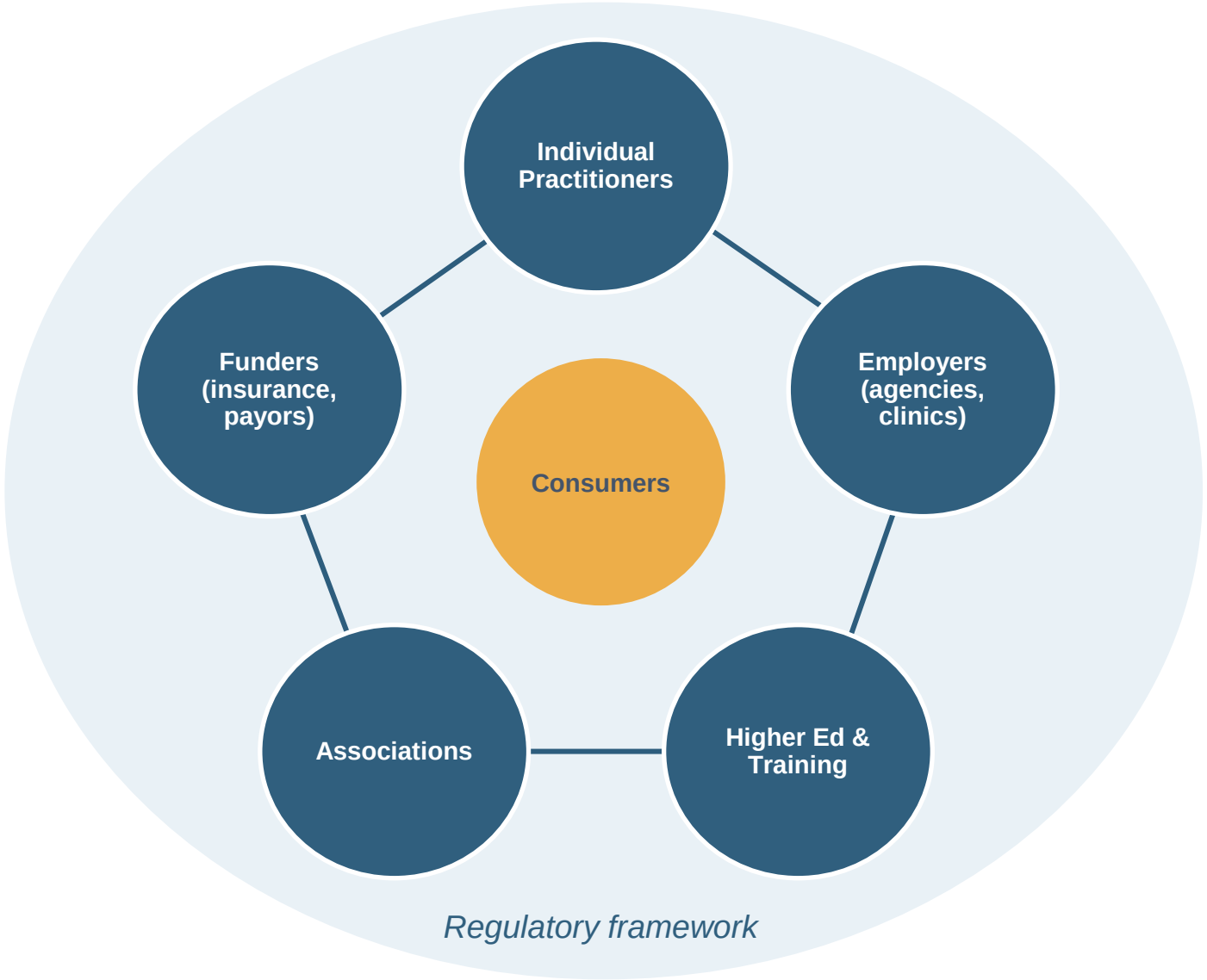


- **Behavioral Health (BH)**[2]
  Encompasses mental health & substance use disorders
- **Common Disorders**[3]
  Anxiety, depression, bipolar, post-traumatic stress, schizophrenia, eating disorders, disruptive behaviors & dissocial disorders, neurodevelopmental disorders, & substance use disorders (e.g., alcohol, opioid)
- **Common Treatments**[4]
  Psychotherapy, psychotropic medication, psychosocial support services – e.g., therapy, case management
- **Treatment Settings**[5]
  Outpatient, inpatient, and informal – e.g., clinics, hospitals, residential programs, support groups

In the U.S., the most commonly used form of treatment for BH is prescription medication.
These medications are most often prescribed by a primary care provider without specialized training in BH.[6-9]

1. Center for Behavioral Health Statistics and Quality, 2022. 2. BHI Collaborative, 2021 3. World Health Organization, 2022 4. National Alliance on Mental Illness, 2020 5. Center for Behavioral Health Statistics and Quality, 2022 6. Jetty, Petterson, Westfall, & Jabbarpour, 2021 7. Mark, Levit, & Buck, 2009 8. DeLeon & Wiggins, 1996 9. Beardsley, 1988

Behavioral Health: System Overview



- The behavioral health (BH) system has **multiple actors** working in coordination
- The BH system operates within a regulatory framework which includes **professional licensure**
- OPLR's objective is the '**health, safety, [and] financial welfare of the public**'[1]
- OPLR balances input from all actors in the system…but we **preference the needs of the Utah public**

[1] Utah Code 13-1b

PRELIMINARY

Behavioral Health: Licenses Under Review

Department of Commerce

- Social Worker *(~9,800 active licensees)*
- Clinical Mental Health Counselor (*2,900)*
- Psychologist *(1,300)*
- Marriage & Family Therapist *(1,500)*
- Recreational Therapist *(500)*
- Behavior Analyst *(800)*
- Substance Use Disorder Counselor (*500)*
- Vocational Rehabilitation Counselor *(200)*
- State Certified Music Therapist *(80)*

Department of Health & Human Services

- Certified Case Manager (1,000)
- Certified Peer Support Specialist (600)
- Child/Family Peer Support Specialist/ Family Resource Facilitator (25)
- Certified Crisis Worker (350)
- Behavioral Emergency Services Technician (0)
- Advanced Behavioral Emergency Services Technician (0)

Source: Department of Commerce data retrieved June 15, 2023 from Division of Professional Licensing, MLO Database. Department of Health & Human Services data shared by administrators in July, 2022.

Why Review Behavioral Health?

Utah's high rates of BH disorders[1,2] have serious consequences

3rd
Worst in Nation

- Adult Serious Mental Illness (SMI)
- Youth Severe Major Depressive Episodes

2x higher mortality risk
for individuals with SMI[3]

~75,200 years
lived with disability in Utah due to mental disorders in 2022[4]

~$5.5 billion
lost to mental disorder disability-adjusted life years (DALYs) in Utah in 2022[5]

1. 2021 National Survey on Drug Use and Health: Model-Based Prevalence Estimates 2. 2022 State of Mental Health in America 3. Chang, Hayes, Broadbent, Fernandes, Lee, Hotopf, & Stewart, 2010.
4,5. Estimates based on research and data drawn from GBD 2019 Mental Disorders Collaborators, 2022. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019; PAHO, 2021 The Burden of Mental Disorders - PAHO/WHO | Pan American Health Organization.

OPLR Statutory Mandate & Research Questions

Utah Code 13-1b review criteria…

- Supply of qualified BH practitioners
- Unnecessary barriers to entry
- Portability & alternative paths to licensure

- Need for regulation to reduce risk of harm
- Severity, probability, permanence of harm
- What policies best prevent & reduce harm

Does Utah regulation provide sufficient **access to behavioral health care?**[1]

Access refers to whether people receive the care they need, based on its availability, affordability, accessibility, acceptability, and adequacy, and their awareness of options for their care.[2-6]

Does Utah regulation provide sufficient **safety in behavioral health care?**

Safety reflects the incidence of adverse events, and refers to the extent to which receiving care exposes consumers to risks of harm to their health, safety, and/or financial welfare.[7-14]

1. Utah Code Section 13-1b; 2. Penchansky & Thomas, 1981; 3. Saurman, 2016; 4. Andersen & Aday, 1978; 5. Andersen & Davidson, 2007; 6. McLaughlin & Wyszewianski, 2002; 7. Mental Health Patient Safety: A Rapid Literature Review, 2019; 8. Averill, Vincent, Reen, Henderson, & Sevdalis, 2023; 9. Berzins, Baker, Brown, & Lawton, 2018; 10. Brickell, Nicholls, Procyshyn, McLean, Dempster, Lavoie, Sahlstrom, Tomita, & Wang, 2009; 11. Briner & Manser, 2013; 12. Cuomo, Koukouna, Macchiarini, & Fagiolini, 2021; 13. D'Lima, Crawford, Darzi, & Archer, 2017; 14. Quinlivan, Littlewood, Webb, & Kapur, 2020.

PRELIMINARY

Data & Methods

Primary Data Collection

Behavioral Health Workforce Survey[1]
- ~4,000 total respondents
- ~1,100 open-ended comments

Stakeholder Listening Tour

Industry Focus Groups (10)
- 68 total attendees
- 90 minutes avg.

Board Chair Interviews (8)
- 60 minutes avg.

Expert & Leader Interviews (150+)

Stakeholder Vetting Tour
- 35 sessions w/200+ participants
- e.g., HMHI, USH, UHIA, LMHAs, IHC, DHHS, USHE, DOI

Secondary Data Analyses

Access to Care
- National Survey of Children's Health (NSCH)
- National Survey on Drug Use & Health (NSDUH)

Safety of Care
- National Practitioner Data Bank (NPDB) adverse action & malpractice data
- Division of Professional Licensing (DOPL) data on complaints & dispositions

Academic & Policy Review

Interstate Law Review
- Policy data on 500+ BH license types across U.S. jurisdictions

Policy Landscape Review
- Legislative history, international approaches, case studies

Literature Review
- 800+ relevant resources (e.g., articles) identified
- Evidence on the impact of various regulations on consumer access & safety
- Research on behavioral health systems, workforce, & policies

1. This survey used the core questions from the Cross Profession Minimum Data Set (CPMDS), developed by Dr. Hanna Maxey, Director of the Bowen Center for Health Workforce Research and Policy in collaboration with multiple national health professions' regulatory associations. The survey was distributed to all active DOPL behavioral health licensees (16,236 individuals) and achieved a response rate of 24.8%.

Agenda

1. Background & Methodology
2. **Findings: Access**
3. Recommendations
4. Discussion

Utah Has an Access Problem

Utahns **receiving** behavioral health care	Utahns with an **unmet need** for behavioral health care
~530k	**~210k-515k**

Even among those children in Utah who do access care, **40% of parents report that it is difficult or impossible** to obtain this care for their children.

From 2020-2021, **58% of children** aged 3-17 in Utah with a clinically diagnosed mental or behavioral health condition **did not receive treatment** or counseling.

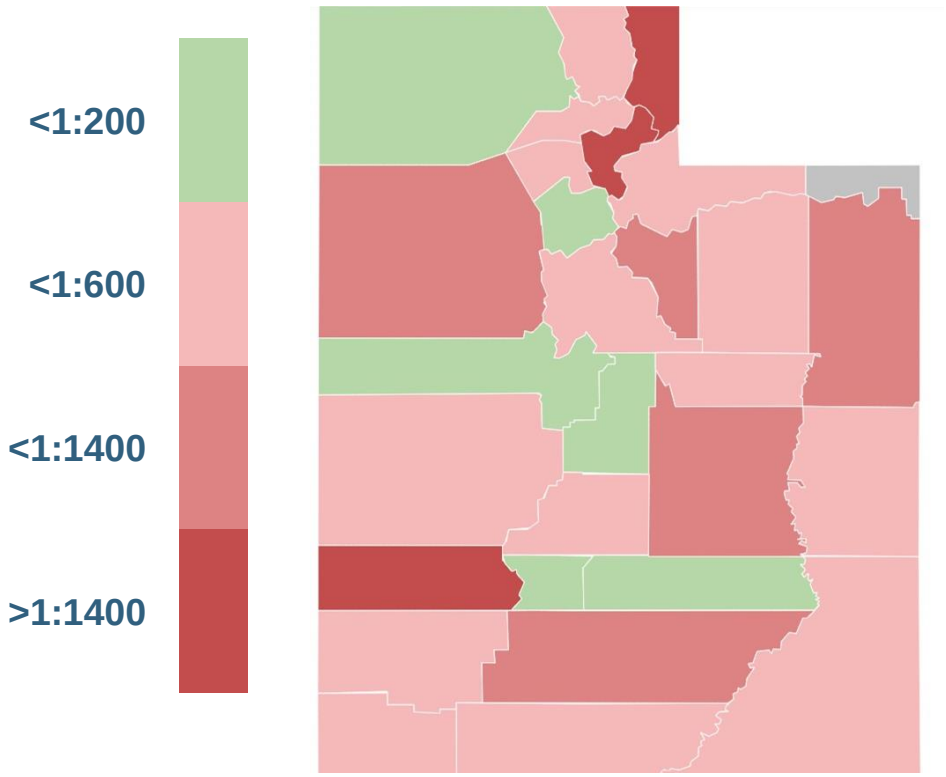
~750K-1 million Utahns need access to behavioral health care

Source: All data drawn from 1) the 2020-2021 National Survey of Children's Health and 2) the 2018-2019 National Survey on Drug Use and Health. For detailed calculations and limitations, see Appendix.

The Access Problem May Be Worse in Rural Utah

BH Provider to Population Ratios, by County[1]

All BH Provider Types

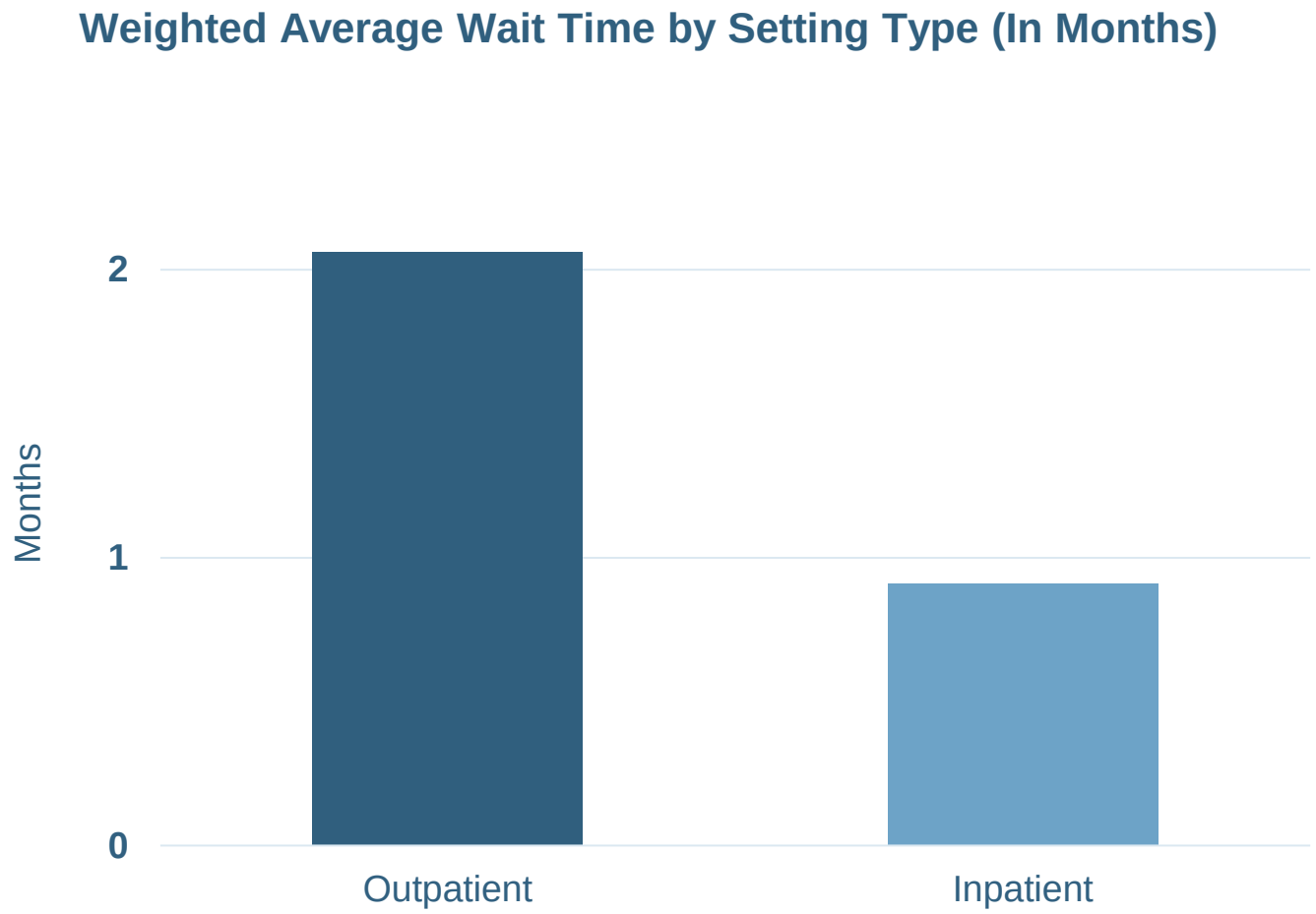


Rural counties struggle to attract & retain psychiatrists[2]

- All Utah counties with more than 600 residents per BH practitioner are rural
- Rich County and Morgan County have one provider for every 2,600 and 4,220 residents, respectively

1. County Health Rankings, University of Wisconsin Population Health Institute. Number of BH Providers drawn from NPI estimates for Psychiatrists, Psychologists, Licensed Clinical Social Workers, Counselors, Marriage & Family Therapists, Mental Health Providers that treat alcohol/drug abuse, Advanced Practice Nurses specializing in BH. 2. Behavioral Health Workforce Research Center, University of Michigan.

Access is Poor for Outpatient BH Services



Proposed federal guideline for behavioral health outpatient wait time is **10 calendar days**[1]

Based on data from the Behavioral Health Workforce Survey, distributed by OPLR from Feb 27-Mar 6, 2023.
1. 2023 Draft Letter to Issuers in the Federally-facilitated Exchanges (CMS).

Unmet Need for Care Has Serious Consequences

Impact on Human Life

- **15-23K more adults (18+) in Utah will suffer from suicidal ideation** in any given year because they have an unmet need for BH care.[1,2]
- **7-10K more youth (11-17) in Utah will suffer from suicidal ideation** in any given year because they have an unmet need for BH care. [1,3]

Societal & Economic Consequences

- Unaddressed BH issues lead to **2-10x increase in burdens of healthcare & criminal justice spending** and decreased economic productivity.[4]
- **Utahns will earn $2.8 billion less** in any given year because they have an unmet need for BH care.[5]

1. Ali, Lackey, Mutter, & McKeon, 2018 2. 2021 National Survey on Drug Use & Health 3. DHHS Student Health & Risk Prevention (SHARP), Prevention Needs Assessment Survey, 2021 4. McDaid, Park, & Wahlbeck, 2019 5. Kessler, Heeringa, Lakoma, Petukhova, Rupp, Schoenbaum, Wang, & Zaslavsky, 2008.

The access problem may be worsened by:

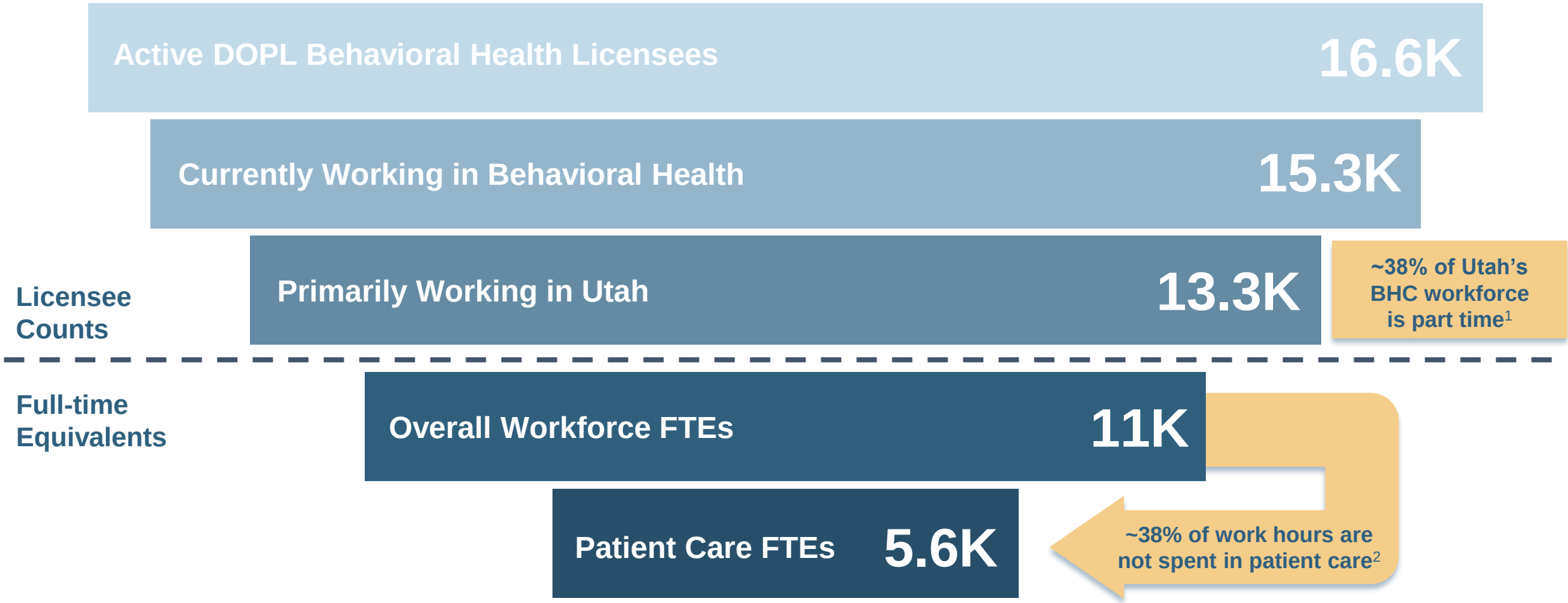
Workforce Capacity Constraints

Shortage of BH Care Extenders

Misaligned Education & Career Paths

PRELIMINARY

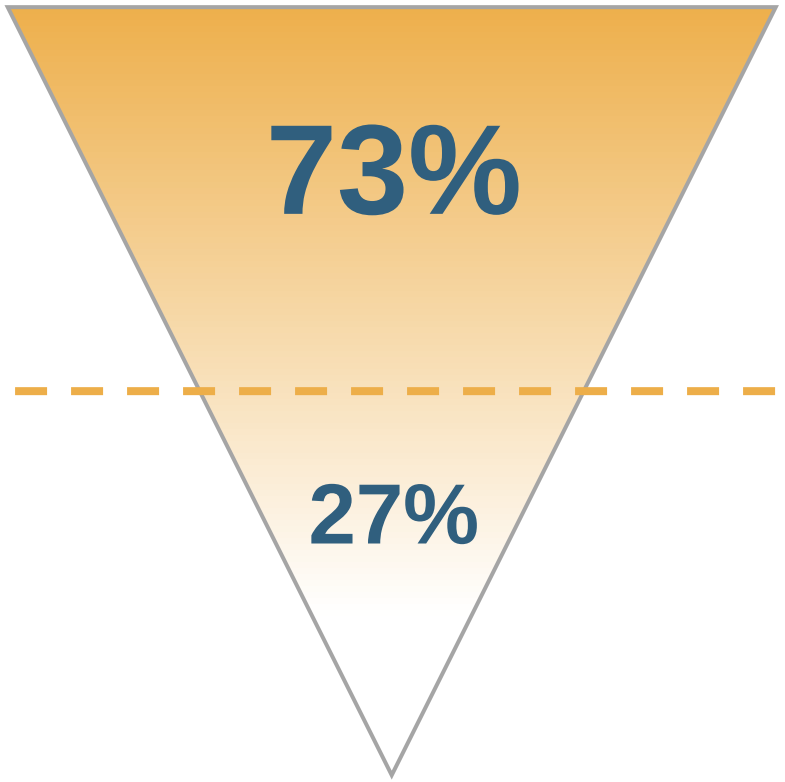
Part-Time Work & Admin Tasks Limit Capacity



Source: Data drawn from OPLR's 2023 Behavioral Health Care Workforce Survey; OPLR Analysis. UMEC's Utah's Mental Health Workforce 2021 report estimates: 10.3K total licensees, 9K actively providing services in Utah, and 7.4K total hour FTEs. Differences in estimates are due to differences in the population sampled; OPLR includes licensees below master's level. Proportion of active licensees to overall workforce FTEs is consistent across both analyses, at 65.7% (OPLR) and 71.9% (UMEC). 1. 38% part time reflects those workforce working part time at their primary practice location. An additional 14% of respondents report working at a secondary practice location. 2. 38% patient care hours subtracts time of those in non-patient facing roles (e.g., administrators), as well as admin burden for those in direct patient care roles.

Behavioral Health Care Lacks Extenders

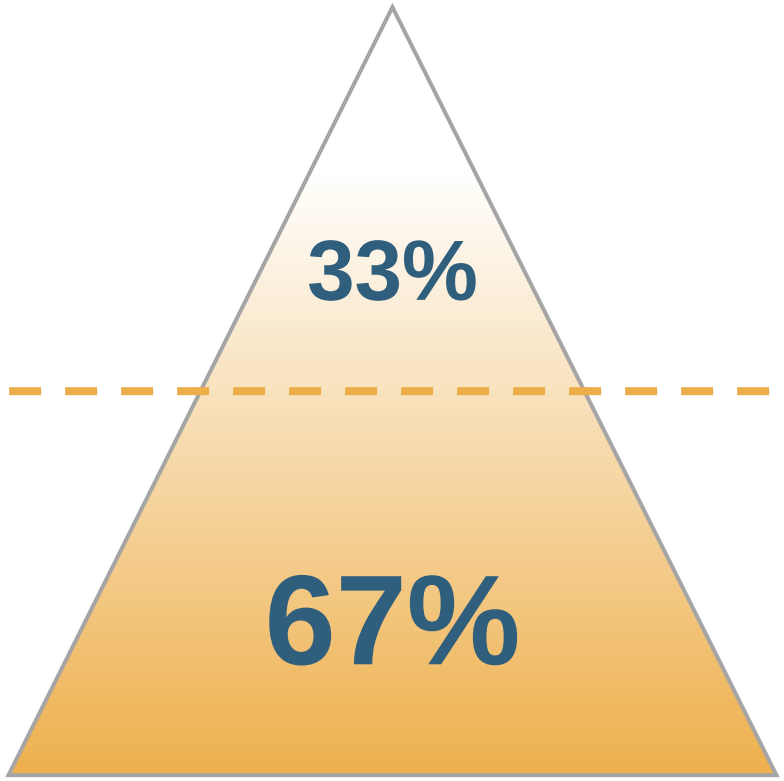
Utah Behavioral Health Workforce
(% of Active Licensees)



Requires a Master's Degree or Higher

Requires a Bachelor's Degree or Lower

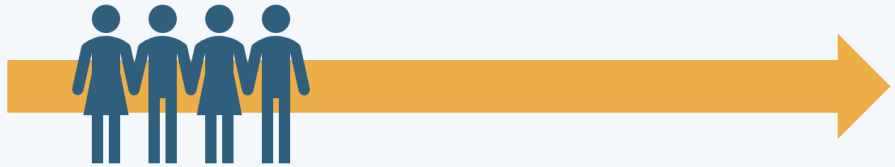
Utah Medical Field Workforce
(% of Active Licensees)



Source: DOPL licensee data obtained from DOPL MLO report "Active License Count," accessed 2/28/2023; data on DHHS licensees provided to OPLR by DHHS administrators in July, 2022.
The figures presented do not reflect members of the workforce who hold a private certification (e.g., CNAs) or no certification (e.g., psych techs).

PRELIMINARY

Education & Career Paths Are Misaligned

USHE Institutions	Total # of Graduates (2018 - 2022)	License Available?	BH Employers
Bachelor's Degree in **Psychology[1]**	 ~5,700 graduates	No	 *Workforce shortage at all levels*
Bachelor's Degree in **Social Work[2]**	 ~1,500 graduates	Yes	

Source: USHE IPEDS Completions Survey; Graduates from 5 year span of 2017-2018 to 2021-2022 academic years. 1. Psychology undergraduates can work under an Assistant Behavior Analyst, Music Therapist, Therapeutic Recreation Specialist, Certified Advanced Substance Use Disorder Counselor, or Social Service Worker license, but only with additional coursework (like any other undergraduate). In other words, a psychology undergraduate major provides students with no advantage in terms of licensure for any BH license in Utah. 2. Bachelors in Social Work corresponds to the Social Service Worker license.

PRELIMINARY

Utah Needs More Specialists & More Extenders

	Current	Target	Gap
Total BH Workforce	20K	28K	+8K (40%)
Advanced BH Specialists *Diagnose & treat severe, recurrent, & complex BH conditions,* e.g., psychologists, psychiatrists, psych nurse practitioners, psych physician assistants	2K	3K	+1K (60%)
Clinical BH Therapists *Diagnose & treat mild to severe BH conditions* e.g., clinical social workers, marriage & family therapists, clinical mental health counselors	12K	16.5K	+4.5K (35%)
BH Support Workforce *Treat or assist in treating mild to severe BH conditions* e.g., substance use disorder counselors, social service workers, crisis workers, peer supports	6K	8.5K	+2.5K (40%)

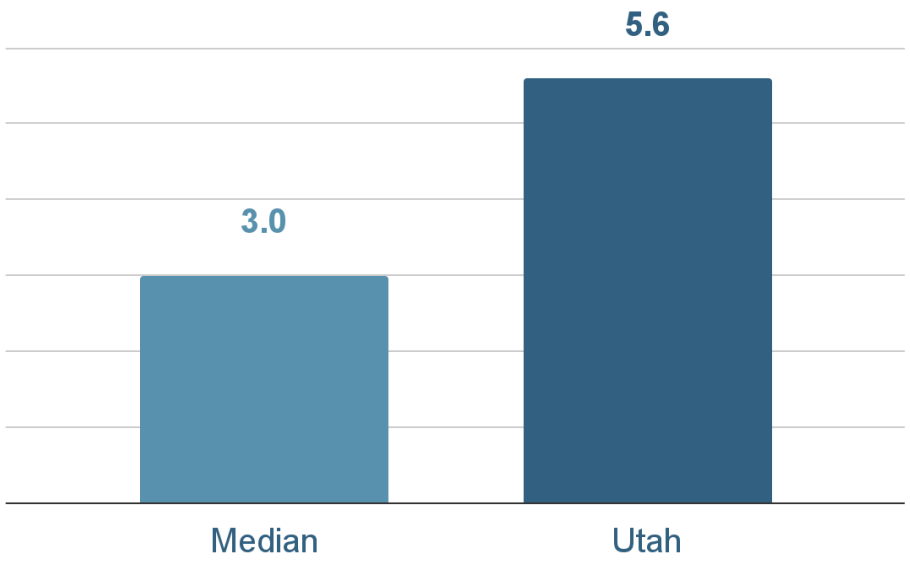
Values rounded to nearest 5% or to nearest 500. Target uses IAPT guideline of 10% advanced, 60% clinical, & 30% support. Workforce figures based on DOPL MLO report "Active License Count," accessed 2/28/2023; data on DHHS licensees provided to OPLR by DHHS administrators in July, 2022; data on advanced BH specialists from University of Michigan, Behavioral Health Workforce Research Center, 2018 – Mapping Supply of the U.S. Psychiatric Workforce; Unmet need figures based on 2020-2021 National Survey of Children's Health; 2018-2019 National Survey on Drug Use and Health.

Agenda

1. Background & Methodology
2. **Findings: Safety**
3. Recommendations
4. Discussion

Utah Has a Safety Problem

Annual[1] NPDB Reports Per 1,000 BH Providers
(2015-2022)



Utah ranks far above the median number of NPDB reports[3] per behavioral health licensee[4] in the US, at **12th** of 51 states.

Utah has a high rate of repeat offenders

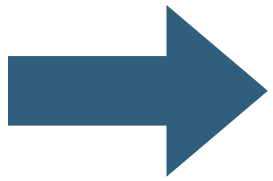
- The National Practitioner Data Bank (NPDB) tracks **adverse actions**[2] (e.g., loss of license) and **medical malpractice payments** for BH
- **44.4%** of Utah BH practitioners with an NPDB report will offend again, which is very high relative to the US median (25%).
- **Utah ranks #4** among US states for highest proportion of repeat offenders among BH practitioners with at least one NPDB report.

1. Annual refers to the yearly average number of reports across the given time period. 2. Adverse actions reduce, restrict, suspend, or deny clinical privileges or membership in a healthcare organization or program. This includes actions related to: State Licensure/Certification, Clinical Privileges/Panel Membership, Drug Enforcement Administration, HHS OIG Exclusion, and Professional Society Membership. 3. Analysis includes all 50 states and D.C. and the following NPDB licenses: Clinical Social Worker, Psychologist, Mental Health Counselor, Professional Counselor, Addictions Counselor, Marriage and Family Therapist, Prof. Cnslrs. of Family/Marriage and Alcohol. 4. Number of BH practitioners from County Health Rankings number of Mental Health Providers, drawn from NPI estimates. Includes: Psychiatrists, Psychologists, Licensed Clinical Social Workers, Counselors, Marriage and Family Therapists, Mental Health Providers that treat alcohol and other drug abuse, and Advanced Practice Nurses specializing in mental health.

Unsafe Care Has Serious Consequences

Common **Substantiated Complaints** Against BH Practitioners

1. **Boundary Violations**
   (e.g., sexual relationships, harassment, or assault)
2. **Billing Fraud**
   (e.g., billing for sessions that did not occur)
3. **Confidentiality & Other Violations**
   (e.g., failure to keep confidentiality; inappropriate involvement in custody proceedings)



Worsening of symptoms[1]

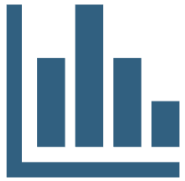
Additional harms to health, safety, & welfare[2,3]

Reduced willingness to access care in the future[4-6]

1. Martin & Beaulieu, 2023 2. Reamer, 2003 3. Frueh, Dalton, Johnson, Hiers, Gold, Magruder, & Santos, 2000 4. Martin & Beaulieu, 2023 5. Feldman-Summers & Jones, 1984 6. Robins, Sauvageot, Cusack, Suffoletta-Maierle, & Frueh, 2005

The safety problem may be worsened by:

Inconsistent supervision & support for clinicians

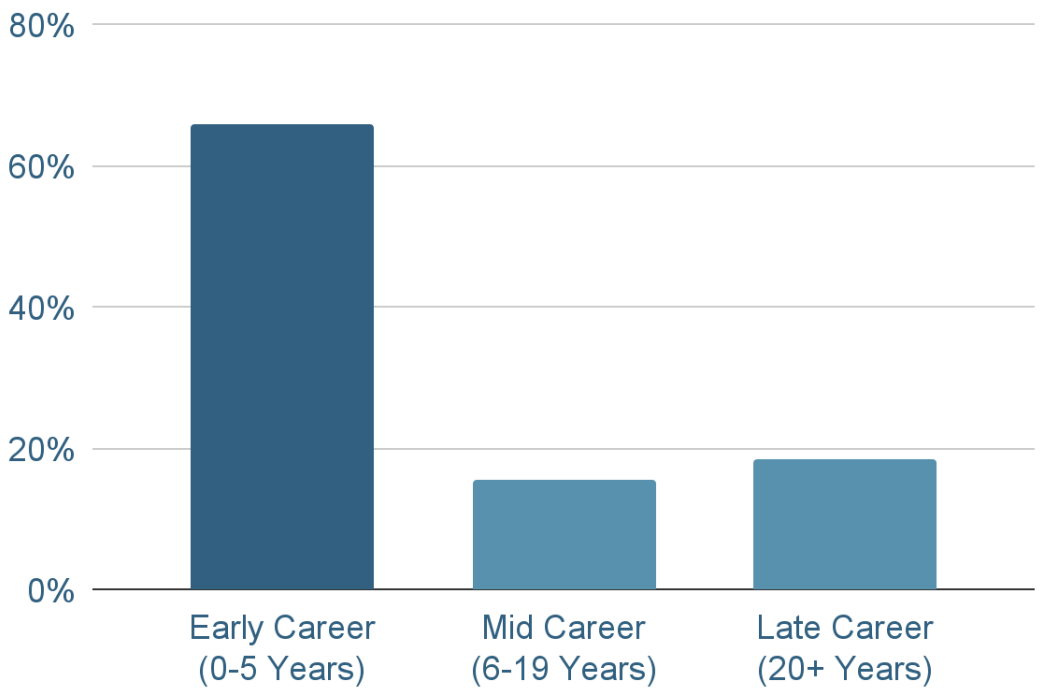


Siloed data on safety/quality of care

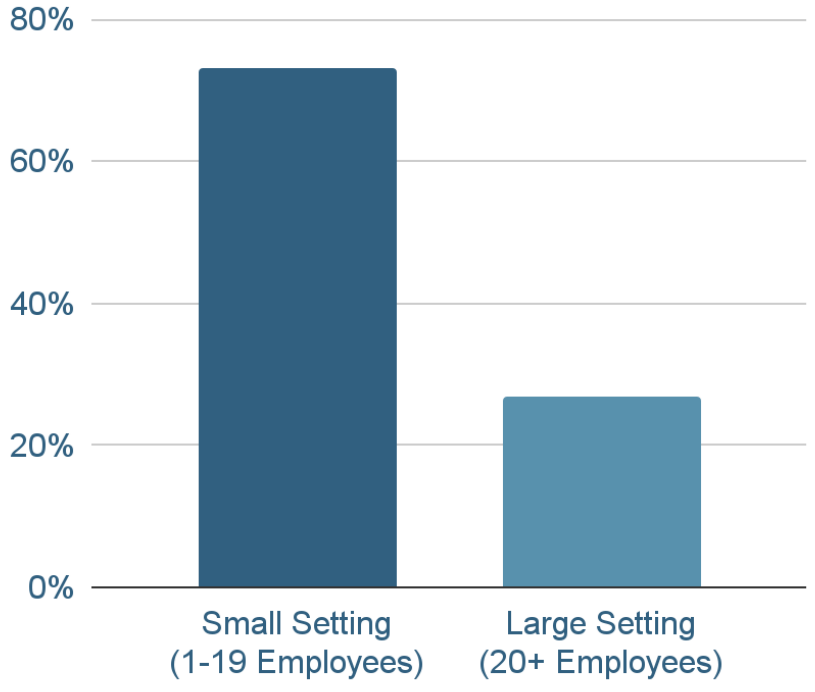
Reactive rather than proactive monitoring

Career Stage & Setting Are Linked to Safety Issues

DOPL Substantiated Complaints by Career Stage



DOPL Substantiated Complaints by Setting Size



Utah BH providers report that **supervised training** for early career providers **lacks consistency** and that many providers have **insufficient access to ongoing support** (e.g., via case consultation)

Based on a random sampling of 2018-2022 data from the Division of Professional Licensing, Utah Department of Commerce

Agenda

1. Background & Methodology
2. Findings
3. **Recommendations**
4. Discussion

Recommendations Address Both Access & Safety

Increase Access to BH Care

- **Grow the Workforce**
  More providers overall
- **Optimize Providers' Time**
  More time at highest and best use
- **Meet High-Need Consumer Demand**
  More specialists & extenders

Increase Safety of BH Care

- **Prevent Harm to Consumers**
  More effective safeguards
- **Detect Harm to Consumers**
  More proactive monitoring methods
- **Course Correct When Harm Occurs**
  More coordinated oversight efforts

Recommendation Summary

Train Smarter, Not Harder

- Supervision Hours
- Supervision Quality
- Continuing Education

Expand Pathways & Portability

- Exam Alternatives
- Interstate Compacts
- Addiction Counseling

Strengthen Upstream Monitoring

- Proactive Measures
- UPHP Expansion

Streamline Governance Structure

- Scopes & Authorization
- Multi-Profession Board

Fill Gaps in Career Ladders & Care

- Extender Roles
- Psychology Rx

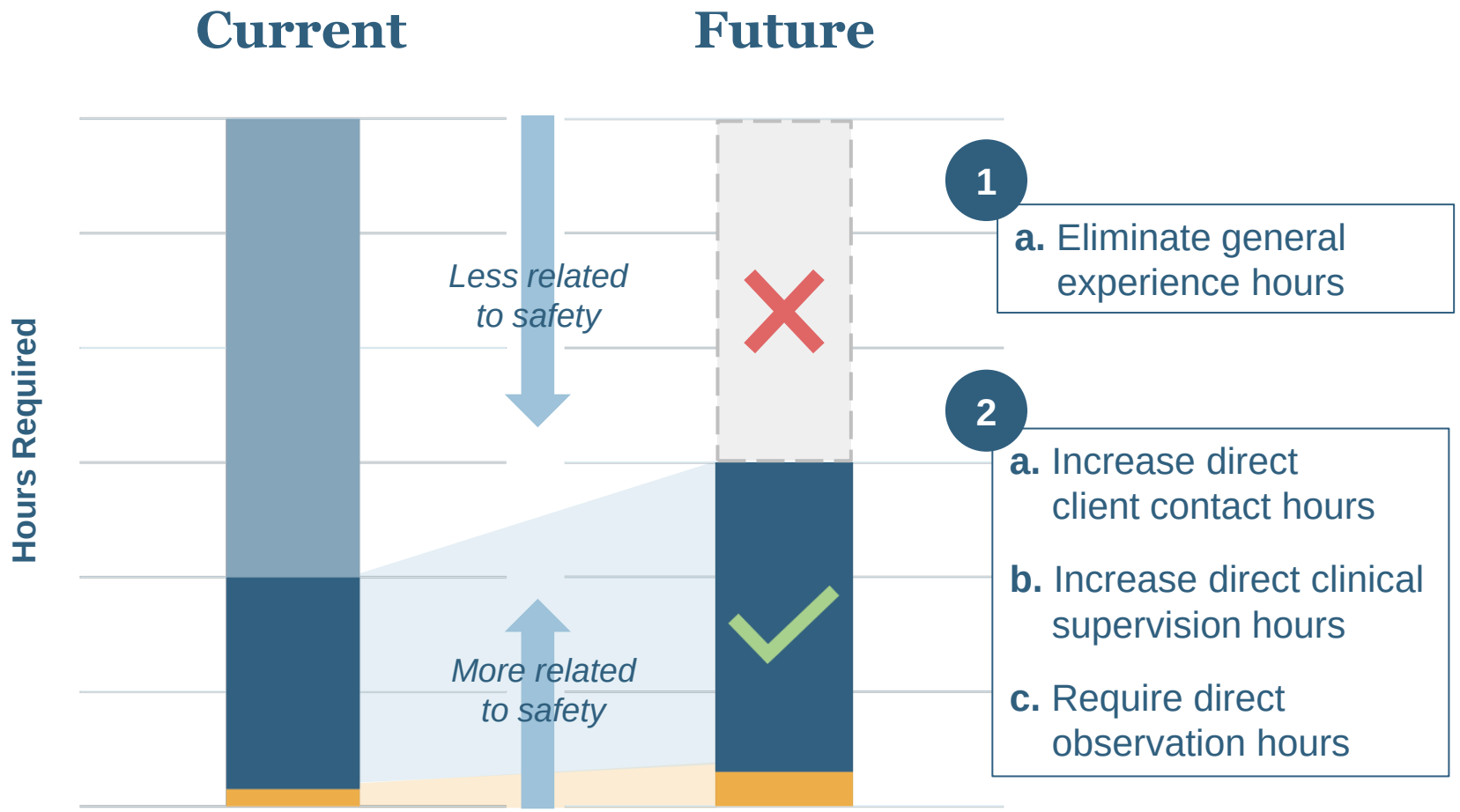
Train Smarter, Not Harder – Supervision Hours*

For master's-level clinical therapists:

General Experience
Non-clinical experiential hours (e.g., study & research, administrative tasks)

Direct Client Contact
Direct contact with patients; performing mental health therapy and clinical tasks

Direct Clinical Supervision
Direct contact between supervisor and supervisee; may include case consultation or observation of actual practice



* This recommendation is only in reference to MA-level clinical therapists, meaning LCSW, CMHC, MFT licenses

Train Smarter, Not Harder – Supervisor Reqs*

For master's-level clinical therapists:

Current

1. Unclear Definition of Supervision

2. No Training Required

3. Max Limit of 6 Supervisees

Future

1. Clear Definition of Supervision

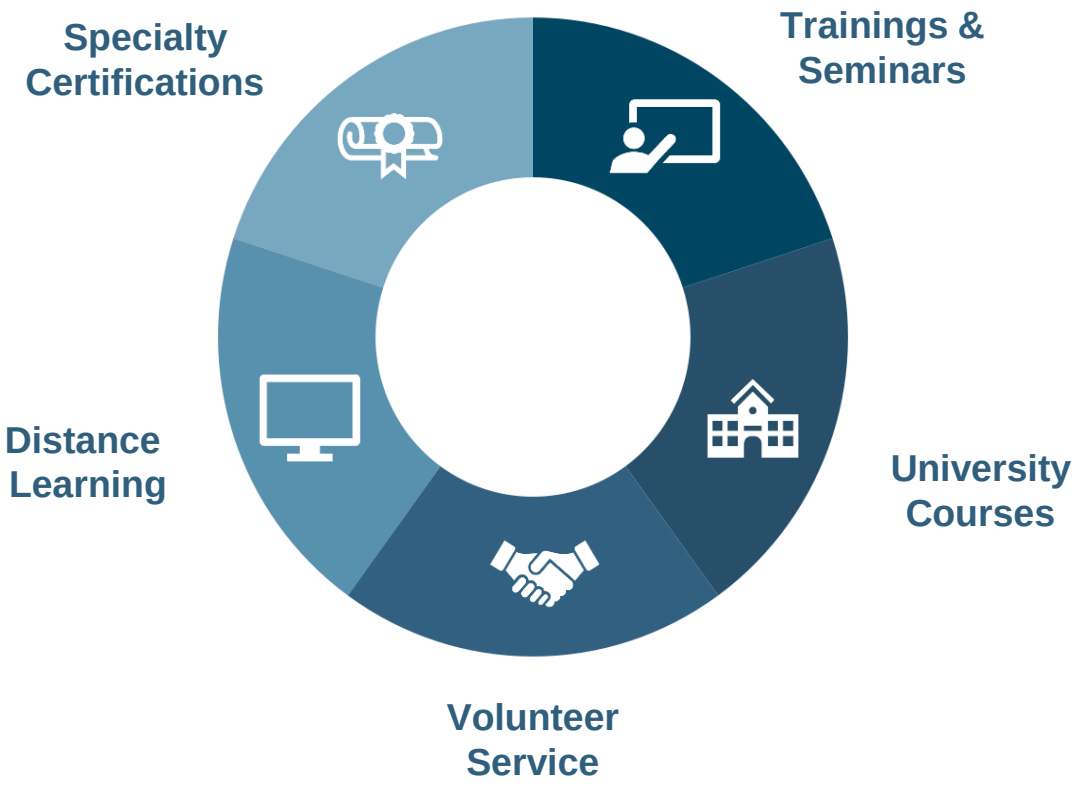
2. Training Required

3. No Limit on Supervisees

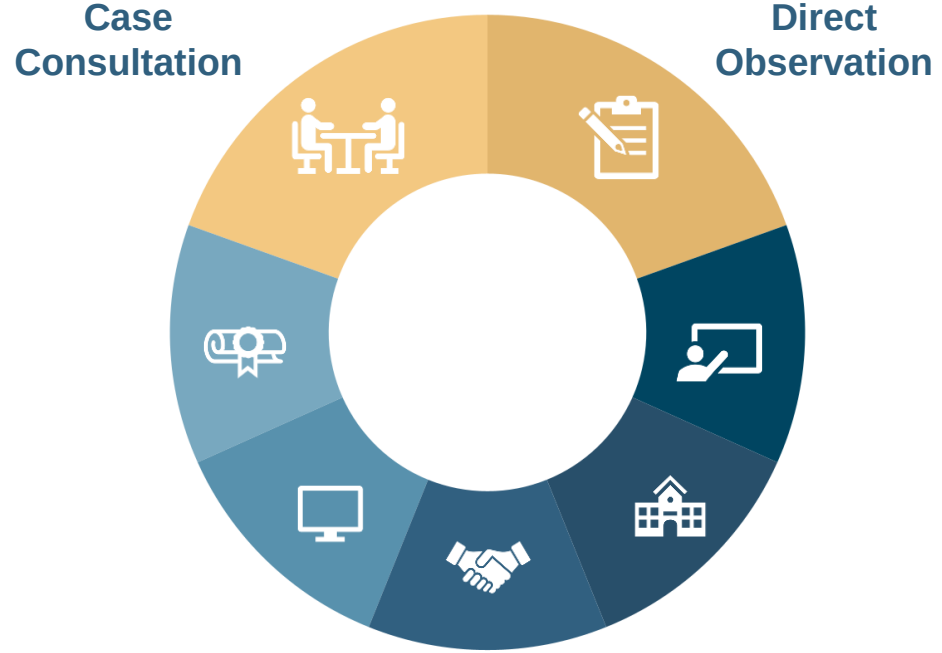
* This recommendation is only in reference to MA-level clinical therapists, meaning LCSW, CMHC, MFT licenses

Train Smarter, Not Harder – Continuing Ed

Current



Future

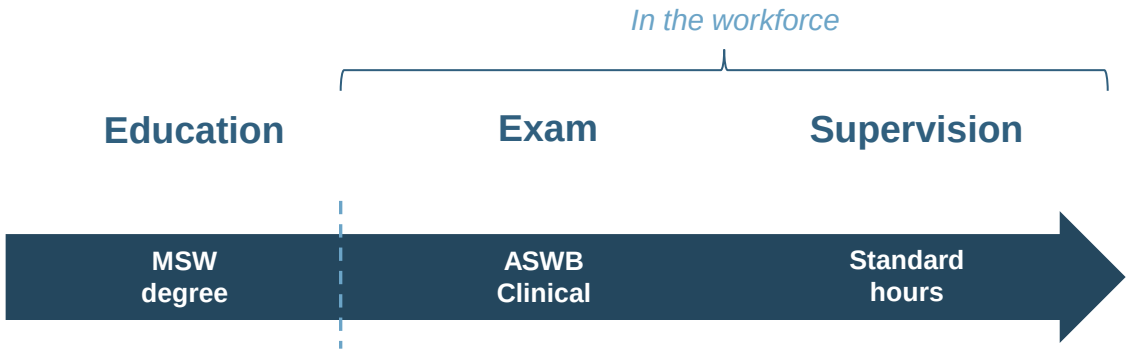


PRELIMINARY

Expand Paths & Portability – Clinical Exams

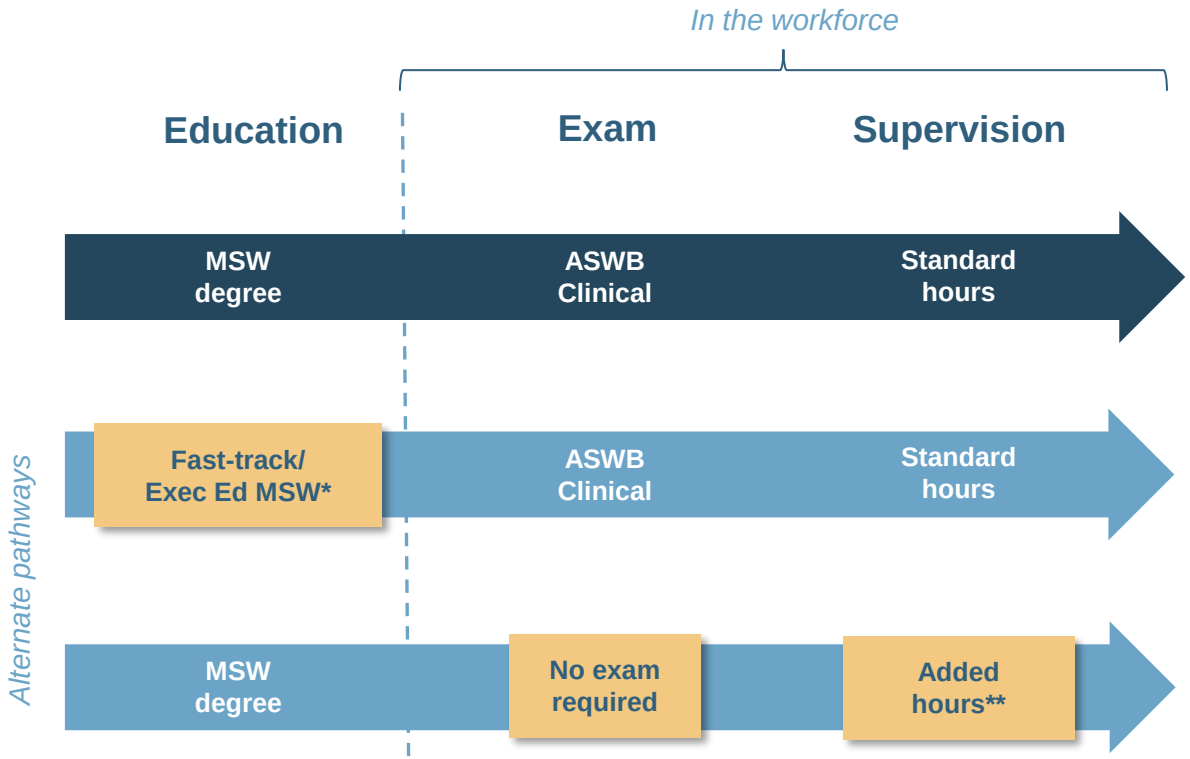
For master's-level clinical therapists:

Current



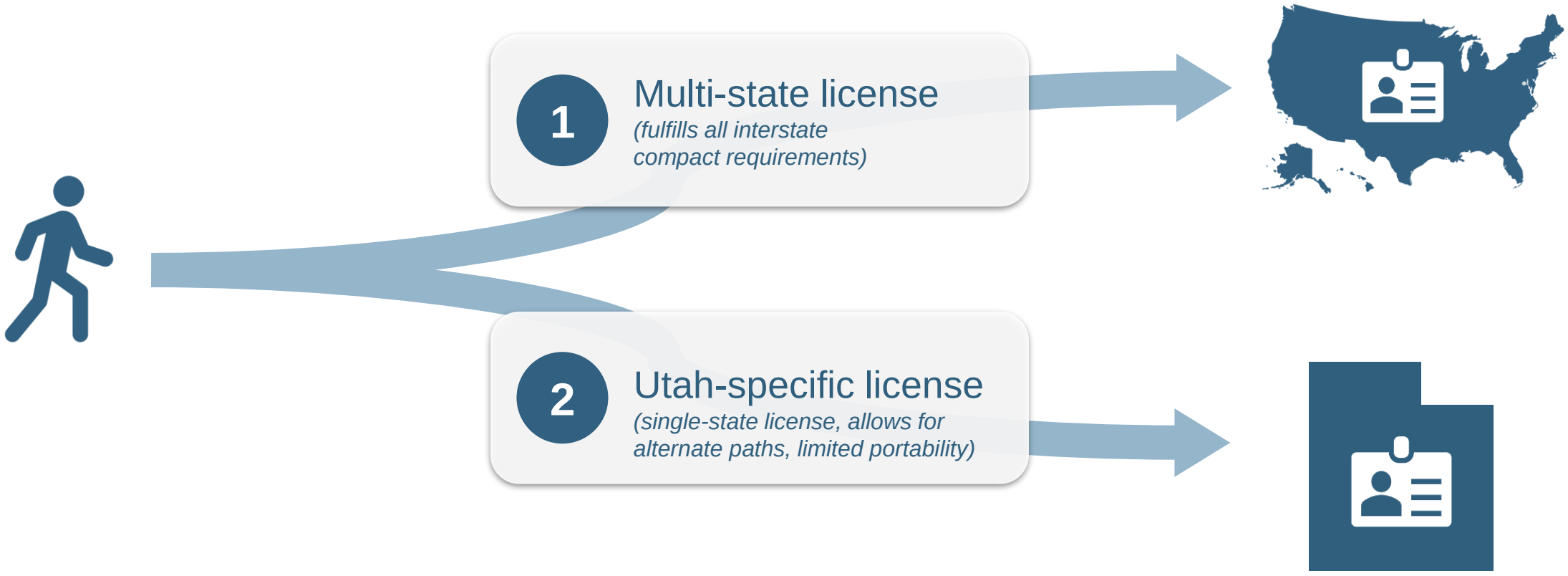
Example pathway for Licensed Clinical Social Worker (LCSW)

Future



*Exploring in conjunction with USHE/Talent Ready Utah **See previous slides for other changes to supervision/clinical training requirements

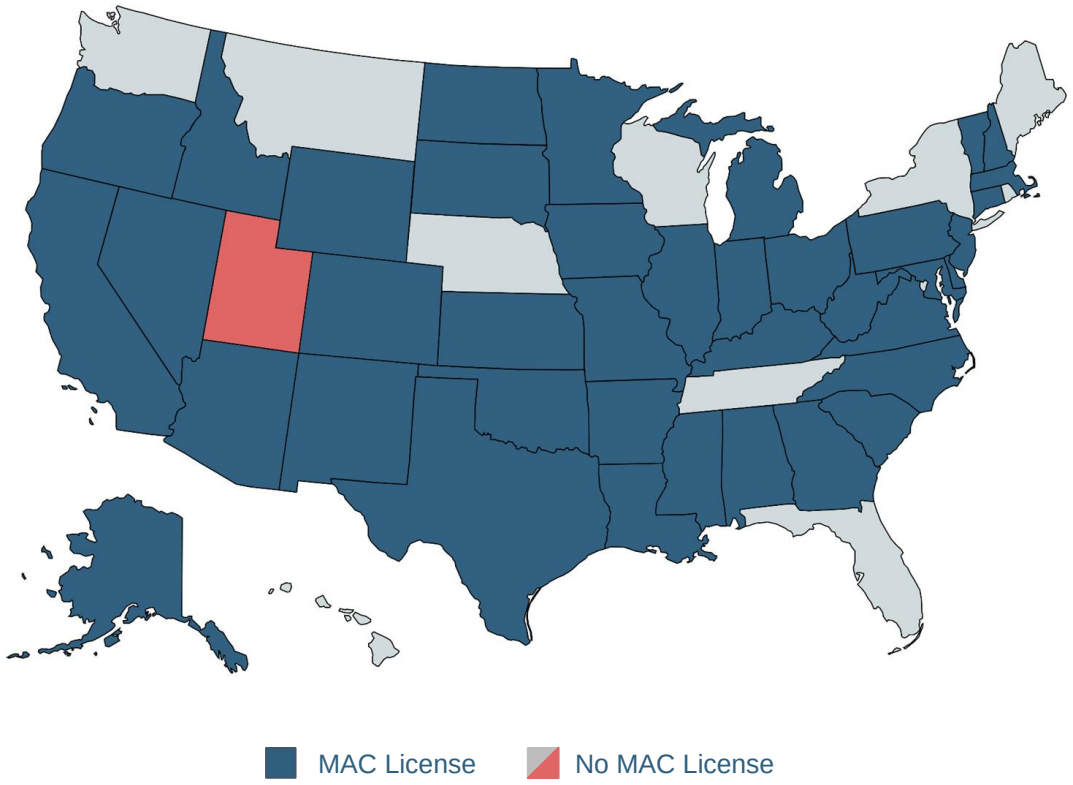
Expand Paths & Portability – Compacts



PRELIMINARY

Expand Paths & Portability – Addiction Specialty

Current



Future

Master Addiction Counselor

Source: According to the Knee Center for the Study of Occupational Regulation, csorwvu.com/find-occupations/, 38 other states have a Master Addiction Counselor (MAC) license or certification.

Strengthen Monitoring – Proactive Measures

Current

No Safety Checks at Initial Licensure / Renewal

Consumers Not Provided Safety Information

→ Higher Risk of Harm to Consumers ↑

→ Lower Rates of Reporting Harm ↓

Future

Safety Check(s) at Initial Licensure / Renewal

(e.g., criminal background, National Practitioner Data Bank)

Consumers Provided Safety Information

(e.g., what is never appropriate, how to file a complaint)

→ Reduced Risk of Harm to Consumers ↓

→ Higher Rates of Reporting Harm ↑

PRELIMINARY

Strengthen Monitoring – UPHP Expansion

The Utah Professionals Health Program (UPHP) is an alternative to public disciplinary action for licensed professionals who have substance use disorders. It enables individuals to confidentially seek & receive help.

Current

Professionals Served

- Medical Professionals (80.5K)
- Dental Professional (7.5K)
- Veterinary Professionals (1.3K)

Not Served

- BH Professionals (18.6K active licensees)

~89K professionals
~90 participants (current)

Future

Professionals Served

- Medical Professionals (80.5K)
- Dental Professional (7.5K)
- Veterinary Professionals (1.3K)

+

- Behavioral Health Professionals (18.6K)

~108K professionals
~110 participants (estimate)

Source: DOPL licensee data obtained from Department of Commerce annual reports and DOPL MLO report "Active License Count," accessed 6/15/2023

The Duties of DOPL Boards

Utah Code 58-1-201: "…the duties, functions, and responsibilities of each board include…" [selected]

Policy functions

- Recommending **rules and statutory changes**
- Recommending **policy and budgetary matters**
- …may **recommend to the appropriate legislative committee** re: changes to a licensing act
- Assisting in establishing **standards of supervision** for students in training

Licensing functions

- **Screening applicants & recommending licensing**, renewal, reinstatement, & re-licensure actions
- …acting as **presiding officer** in conducting hearings associated with **adjudicative proceedings** when so designated by the director.

The ideal board composition differs for **policy functions** versus **licensing administrative functions**

PRELIMINARY

Streamline Governance – Multi-Profession Board

Current

DOPL (Commerce)

Licensing Boards (advisory)

Social Work | MFT | Rec Therapy | SUDC | Psychology/ Behavior Analysis | …

Licensed Practitioners

Social Work | Marriage & Family Therapy | Rec Therapy | Substance Use Disorder Counseling | Psychology/ Behavior Analysis | …

Future

DOPL (Commerce)

Licensing Board (advisory)

Policy functions: Behavioral Health Board[1]

Licensing functions[2]: Sub-Cmte #1 | Sub-Cmte #2 | Sub-Cmte #3

Licensed Practitioners

Social Work | MFT | Rec Therapy | SUDC | Psych. | Behavior Analysis

Structure **limits cross-occupation & systems thinking** in policy matters

→

Structure encourages **collaborative, system level approaches** to policy matters

1 We also recommend expanding the expertise of the boards to include DHHS officials, population health experts, payors, employers, medical professionals, consumer advocates, and others to give a broad view of the behavioral health system; 2 Sub committees would execute licensing functions (like enforcement) with separate sub committees by scope of practice (e.g., clinical therapists, sub-clinical, etc…); committee composition TBD, but would be made up of primarily those licensed to perform the relevant scope of practice.

Streamline Governance – Scopes of Practice

Current

Profession-Specific Degree/Credential

1. Profession-Specific Title Protection
+
2. Profession-Exclusive Scope of Practice

Future

Profession-Specific Degrees/Credentials

1. Profession-Specific Title Protection
+
2. Level-Exclusive Scope of Practice

Profession-exclusive scopes create "**barriers to interprofessional collaboration**, practice, and respect."[1]

1. See pg. 325, Safriet, 2002; see also Trebilcock, 2022.

Streamline Governance – Authorization Types

1	2	3	4
Assessment & Monitoring	**Care Planning & Authorization**	**Intervention & Treatment Services**	**Administration & Coordination**

Higher Risk Activities

- Rigorous Testing
- Diagnosis
- Treatment planning (goals + services)
- Psychotherapy
- Medication Mgmt
- Billing
- Referrals

→ **Mandatory Licensure**

(e.g., Psychologists, Clinicians, BH Support Professionals)

Lower Risk Activities

- Intake & screening
- Progress tracking
- Info gathering
- Wellness planning
- Skills Training
- Case Mgmt
- Record keeping
- Care navigation

→ **Voluntary Certification + Negative Licensure**

(e.g., BH Support Assistants, BH Technicians)

Higher-risk activities create **more opportunities for more serious harm**, and so should require a license. Lower-risk activities **still pose some risk of harm**, and so may be regulated via negative licensure.

PRELIMINARY

Fill Gaps in Careers & Care – Extender Roles

Current

Education	Psychology	Social Work	Counseling & Therapy	Substance Counseling
Doctorate + Supervision	Psychologist			
Masters + Supervision		LCSW	CMHC/ MFT	
Bachelors		SSW		Advanced SUDC
Associates		GAP		SUDC*
Stand-alone Academic Certificate (1yr)				
DHHS Certificate (1 week)	Case Manager, Crisis Worker			Peer Support

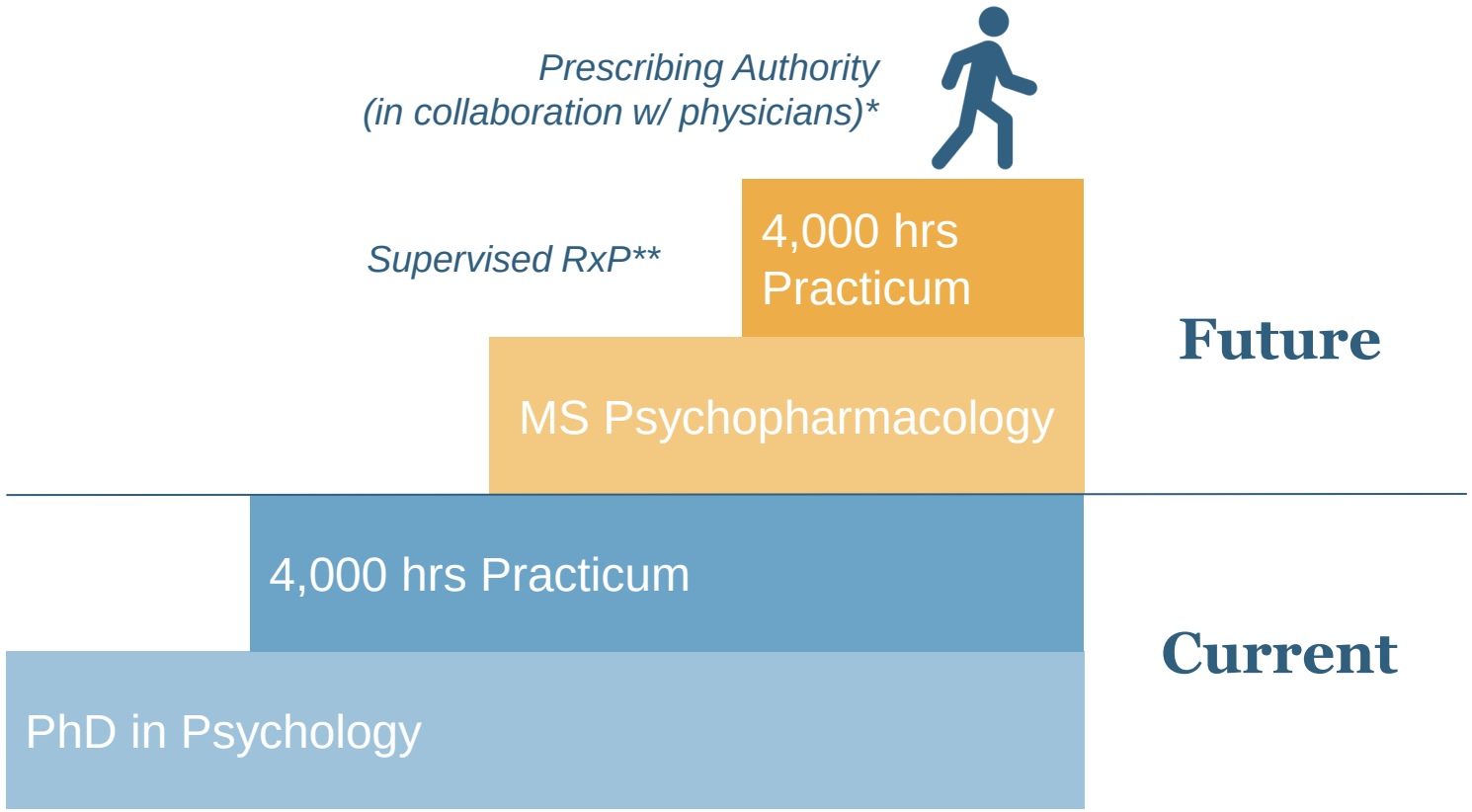
Future

Education	Psychology	Social Work	Counseling & Therapy	Substance Counseling
Doctorate + Supervision	Psychologist			
Masters + Supervision		LCSW	CMHC/ MFT	
Bachelors	**[Generalist Behavioral Health License]**			
Associates	**Behavioral Health Technician**			
Stand-alone Academic Certificate (1yr)				
DHHS Certificate (1 week)	Case Manager, Crisis Worker			Peer Support

Clinical licenses Existing sub-clinical licenses NEW sub-clinical licenses

*There are ~280 Associate's-level SUDCs licensed in the state, as opposed to 7,000 clinical social workers, or 2,700 Clinical Mental Health Counselors;

Fill Gaps in Careers & Care – RxP Specialty



RxP refers to prescriptive authority for psychologists

- Prescribing psychologists receive **4x-6x more pharmacology training** than physicians & psych APRNs[1]
- RxP legislation **increases access** to care, especially **in rural areas**[2,3]
- RxP legislation is associated with **decreased suicide rates** & deaths attributable to mental illness[3,4]
- RxP may be a **cost-effective** strategy for reducing suicide rates[5]
- From 2005-2021, prescribing psychologists had a slightly **lower malpractice claim rate than psychiatrists**—at 2.1% vs. 2.6%[6]

*RxP allows a limited formulary of medications relevant to BH disorders **Under supervision of a physician (in most states). 1. Muse & McGrath, 2009 2. Shoulders & Plemmons, 2022 3. Nebraska Psychology Prescribing Technical Review Committee, 2017 3. Hughes, McGrath, & Thomas, 2023 4. Choudhury & Plemmons, 2023 5. Hughes, Phillips, McGrath, & Thomas, 2023 6. Curtis, Hoffman, & O'Leary Sloan, 2022

Recommendation Summary

Train Smarter, Not Harder

- Supervision Hours
- Supervision Quality
- Continuing Education

Expand Pathways & Portability

- Exam Alternatives
- Interstate Compacts
- Addiction Counseling

Strengthen Upstream Monitoring

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- Scopes & Authorization
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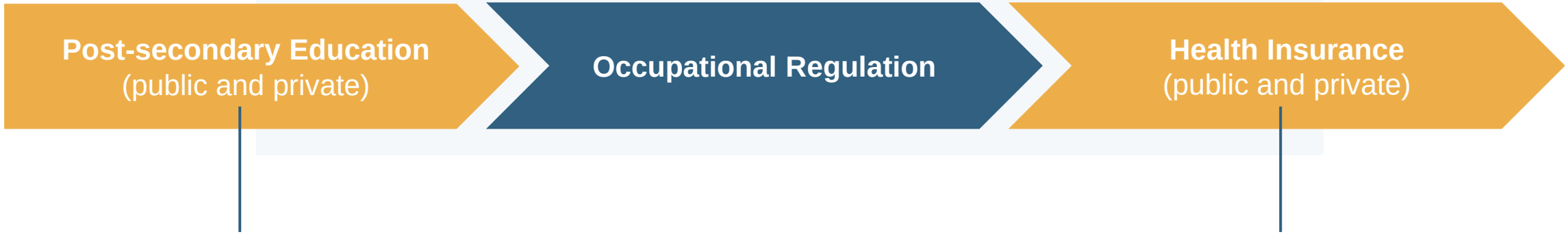
Fill Gaps in Career Ladders & Care

- Extender Roles
- Psychology Rx

Licensure is Only One Part of the Solution

Occupational regulation policy interacts with two other systems:



- Behavioral health (BH) **educational pathways are underdeveloped** at all levels
- Workforce shortages also relate to the **expense** of post-secondary training/education relative to compensation

- The market for BH services (most often covered by insurance) is **highly regulated and constrained**
- BH providers feel **reimbursement rates are low** and stagnant, and insurance may not reimburse **team-based approaches**

Agenda

1. Background & Methodology
2. Findings
3. Recommendations
4. **Discussion**

Next Steps

1. Integrate feedback from Business & Labor
2. Circulate field-level report for stakeholder comment
3. Submit field-level report to Business & Labor
4. Circulate occupation-level reports for stakeholder comment
5. Submit occupation-level reports to Business & Labor

PRELIMINARY

Agencies Coordinating On System-Wide Solutions

Commerce

- Fill gaps in **entry-level licensing / certifications**
- Expand **alternative pathways** and portability
- Strengthen & **streamline supervision** hour requirements
- **Merge** DOPL licensing boards

USHE & TRU

- Create **statewide 1- and 2- year** BH educational programs
- Create **clinical psychology** track for undergrads
- Consider policies and targeted funds **for growth of programs** and to encourage **BH workforce participation** (programmatic growth and scholarships)

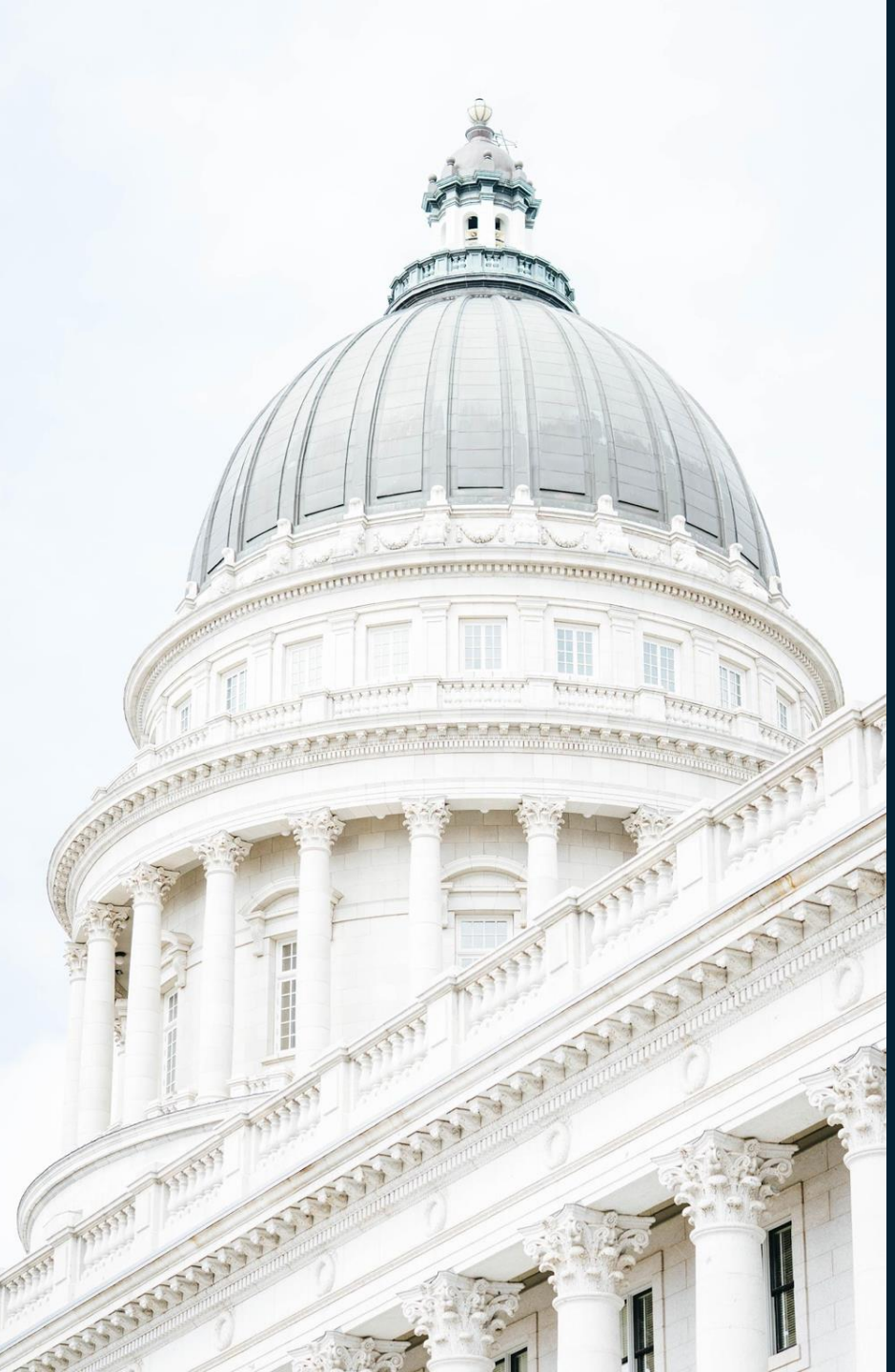
DHHS

- Evaluate whether **new Medicaid services** are needed to match new proposed paraprofessional certifications
- Emphasize subclinical practitioners in **public agency staffing** (DCFS, LMHAs)
- Create **inter-agency communication** around facility licensing & DOPL licensing
- Seek ways to reduce practitioners' **reporting and administrative burdens**

Insurance

- **Convene private insurers, public payors, and other key stakeholders** to identify & address root causes of access issues (e.g., paneling, credentialing, & reimbursement)
- Investigate and identify **network adequacy requirements** for behavioral health

GOAL: Aligned, inter-agency reform package



UTAH DEPARTMENT OF COMMERCE
Office of Professional Licensure Review

Thank You

Appendix

PRELIMINARY

Relevant Statutes and Rules

26B-5 Health Care - Substance Use and Mental Health
58-1 Division of Professional Licensing Act
58-4 Utah Professionals Health Program
58-60-40 Recreational Therapy Practice Act
58-60 Mental Health Professional Practice Act
- 58-60-1 General Provisions
- 58-60-2 Social Worker Licensing Act
- 58-60-3 Marriage and Family Therapist Licensing Act
- 58-60-4 Clinical Mental Health Counselor Licensing Act
- 58-60-5 Substance Use Disorder Counselor Licensing Act

58-60a Counseling Compact
58-61 Psychologist Licensing Act
58-60-78 Vocational Rehabilitation Counselors Licensing Act
58-60-84 State Certification of Music Therapists Act

R156-1 General Rule of the Division of Occupational and Professional Licensing
R156-4 Utah Professionals Health Program Rule
R156-40 Recreational Therapy Practice Act Rule
R156-60 Mental Health Professional Practice Act Rule
R156-61 Psychologist Licensing Act Rule
R156-61a Behavior Analyst Licensing Act Rule
R156-78 Vocational Rehabilitation Counselors Licensing Act Rule
R156-84 State Certification of Music Therapists Act Rule
R523 Human Services, Substance Abuse and Mental Health

PRELIMINARY

Methods Notes: Utah Has An Access Problem

- All data drawn from 1) the 2020-2021 National Survey of Children's Health and 2) the 2018-2019 National Survey on Drug Use and Health.
- **Utahns Currently Receiving Care** = Children Receiving Mental Health Treatment (78,949) + Children Receiving Substance Use Disorder Treatment at a Specialty Facility (1,000) + Adults Receiving Mental Health Treatment (436,000) + Adults Receiving Substance Use Disorder Treatment at a Specialty Facility (11,000) = 526,949
- **Utahns With an Unmet Need for Care (Upper Bound)** = Children with a Clinical Unmet Need for Mental Health Treatment (68,028) + Children with a Substance Use Disorder Not Receiving Treatment at a Specialty Facility (11,000) + Adults with a Clinical Unmet Need for Mental Health Treatment (300,698) + Adults with a Substance Use Disorder Not Receiving Treatment at a Specialty Facility (135,000) = 514,726
- **Alternative Unmet Need Calculation (Lower Bound).** An alternative way of calculating unmet need involves substituting perceived unmet need measures for clinical unmet need measures. Children with a Perceived Unmet Need for Mental Health Treatment (27,267) + Children with a Perceived Unmet Need for Substance Use Disorder Treatment (473) + Adults with a Perceived Unmet Need for Mental Health Treatment (172,000) + Adults with a Perceived Unmet Need for Substance Use Disorder Treatment (5,805) = 205,545
- **Limitations.** Because the available data is from 2020-2021 for children and from 2018-2019 for adults, because Utah has experienced substantial population growth during this period, and because the COVID-19 pandemic has increased the prevalence of behavioral health disorders, the figures presented likely represent an underestimate of the number of individuals who might benefit from access to behavioral health care services in the state of Utah. The original figures also do not attempt to control for the double counting of individuals with both substance use disorder and mental health treatment needs, and so may be an overestimate of the total number of individuals needing care.
  - Adjusting for population growth alone gives an estimate of 552K individuals currently receiving care, 540K with a clinical unmet need, and 216K with a perceived unmet need (or a total of ~768K to 1 million individuals needing care).
  - Using national comorbidity rates to reduce double counting produces estimates of 456K individuals currently receiving behavioral health care services, 446K with a clinical unmet need, and 178K with a perceived unmet need (or a total of ~634K to 902K individuals needing care).
  - Adjusting for both population growth and comorbidity of mental health disorders and substance use disorders gives an estimated 478K individuals currently receiving care, 467K with a clinical unmet need, and 187K with a perceived unmet need (or a total of ~665K to 945K individuals needing care).

Methods Notes: Utah Has A Safety Problem

- All data drawn from 1) National Practitioner Data Bank (NPDB) Public Use Data File, which extends from 1990-2023, and 2) the County Health Rankings number of Mental Health Providers, which reliably extends from 2015-2022.
- The NPDB data dictionary, found here: https://www.npdb.hrsa.gov/resources/publicData.jsp, provided the information necessary to properly code and label data by variables of interest, e.g. license type and license state.
- State estimates were aggregated by the license state NPDB variable, and missing license state data was imputed, where possible, with work state. In only 1% of reports does license state differ from work state, implying interchangeability between the two.
- To calculate the number of MHP across the 7-year time-span, year level data from the page linked below were appended. In years where a state aggregate was not reported, providers were summed across all counties in each state. https://www.countyhealthrankings.org/explore-health-rankings/rankings-data-documentation
- To calculate Annual NPDB Reports per 1,000 BH Practitioners, the number of reports per license (as specified in footnote 3) were summed up by state and year and divided by the number of MHP in the corresponding state and year. These figures were multiplied by 1,000 and then averaged across the 7 year time span.
- To calculate the rate of repeat offenders, the number of practitioners with 2+ reports was divided by the total number of unique practitioners, per state, with reports between 2010-2022. To ensure that practitioners were not counted twice for the same offense, reports of differing types with the same practitioner in the same year were counted as one event. This inherently assumes that if a practitioner had 2 reports of different types filed against him in one year, they originated from the same incident.
- **Limitations.** The County Health Rankings estimate for MHP includes professionals, such as psychiatrists and psychiatric nurses, that were not included in the summation of NPDB reports. Therefore, the two do not cover the exact same population of MHP, which may slightly underestimate the true number of reports per BH professional. Additionally, the filtering method applied to the repeat offenders analysis is not a perfect control for practitioners being double counted. The final figure may double count some reports while removing others that were legitimately unique incidents. Despite this, the analysis was robust to the inclusion of the filter.

PRELIMINARY

Methods Notes: OPLR BH Workforce Survey

- Cross-Profession Minimum Data Set (CPMDS) survey instrument developed by Dr. Hanna Maxey, Director of the Bowen Center for Health Workforce Research & Policy
- Distributed via Qualtrics to all active DOPL licensees in behavioral health professions (16,250 unique individuals) on Feb 27, 2023
- Unique email links prevented duplicate responses

Distribution Summary	
Bounce rate	1%
Open Rate	70%
Completion Rate	91%
Total Response Rate	25%
Avg Completion Time	5-9 minutes