OREGON HEALTH AUTHORITY

Behavioral Health Division

HB 2235 Behavioral Health Workforce Workgroup

Recommendations for

Stabilizing Oregon's Public Behavioral Health System

HB 2235 Workgroup Final Report | December 2025

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Prepared for:
The interim committees of the Legislative Assembly related to health care and to the interim subcommittee of the Joint Committee on Ways and Means related to human services

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An urgent note on changed circumstances

Dear Legislators, Policymakers and Community Partners:

The recommendations in this and the previous report represent two years of careful work by providers, administrators, community members and partners who understand the complexity of workforce challenges. This work has value. These recommendations matter. But they cannot be presented without acknowledging the magnitude of what has changed since this work began.

The landscape has shifted beneath us in ways none of us anticipated. We have made progress in recent years on workforce supply, although we still face access issues especially in rural communities. The compounding effect on the stabilization of the workforce cannot be overstated. When we lose workforce, we lose connections, and we lose trust with our clients and community members. The most recent economic forecast projects significant budget shortfalls for Oregon. Federal changes to Medicaid, after House Resolution 1 was signed into law in July 2025, are fundamentally reshaping how care is delivered.

This report's workgroup has highlighted the challenges of providing adequate and timely care for clients within an already severe behavioral health workforce crisis. Providers operate in deep uncertainty, watching as critical services disappear. Lives have already been deeply affected when people are no longer able to access mental health and addiction services. Without immediate stabilization, Oregon will lose the experienced providers these recommendations were designed to support.

Oregon needs immediate interventions to stabilize the current crisis; interventions that these recommendations alone were not designed to provide. While these recommendations were developed before these seismic changes take effect, they can still meaningfully strengthen the workforce.

We are currently in a budgetary shortfall, where funding is uncertain, and Oregon cannot wait for perfect conditions to act. With the scarce and valuable resources available, it is crucial, especially amidst the evolving behavioral health crisis, to center the experiences of clients and providers. The recommendations in this report provide a framework for strategic actions, whether through state investments, federal opportunities or innovative local solutions.

Strategic pathways forward:

- **Apply these recommendations as guidance to any emerging funding opportunities**, ensuring that new resources, whether federal, state or local, address our most urgent behavioral health workforce needs. For example, the Oregon Health Authority has applied for the Rural Health Transformation Program (RHTP), which makes funding available to states for health-related activities supporting rural communities and rural health system transformation. If granted, Oregon will begin releasing Requests for Proposals to support approved RHTP initiatives in February 2026.
- **Prioritize the recommendations that keep behavioral health workers in Oregon**, recognizing that we risk losing the providers we have if they cannot sustain their practices under current conditions.
- **Commit to reconvening community partners once the full consequences of recent policy and budget changes become clear**, using this report as a foundation for response rather than starting from scratch.

The 21 recommendations that follow, along with a prioritized implementation framework, represent the diligent efforts of the House Bill 2235 Workgroup over the course of nearly two years. They were created with hope for system transformation. That hope remains, but it must now be paired with urgent action to address the crisis at hand.

Disclaimer: This report reflects the views and recommendations of the HB 2235 Workgroup. The views expressed do not necessarily represent the official positions of the Oregon Health Authority.

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Executive summary

House Bill 2235 (HB 2235) passed in 2023 with an emergency declaration and established a workgroup to address Oregon's behavioral health workforce crisis. According to Mental Health America's 2024 State of Mental Health report, Oregon ranks 42 out of 51 when comparing both prevalence of mental illness and access to care between all states and the District of Columbia.

Oregon's publicly financed behavioral health system faces severe workforce shortages that threaten access to care for vulnerable populations. High education costs, complex licensing requirements, administrative burdens, inadequate pay and lack of support systems drive qualified professionals out of community mental health programs, community-based organizations, federally qualified health centers and private practices serving Medicaid clients.

HB 2235 directed the Oregon Health Authority to convene a workgroup to study the major barriers to workforce recruitment and retention in the publicly financed behavioral health system. Membership included frontline practitioners such as peer mentors, licensed clinical social workers, certified alcohol and drug counselors, qualified mental health associates and qualified mental health professionals. The workgroup also included supervisors carrying caseloads, directors from community mental health programs and behavioral health provider organizations. Additional members represented employee and provider associations, mental health and substance use disorder consumer organizations and coordinated care organizations. The legislation required geographic, racial, ethnic and gender diversity, including representatives from at least four culturally specific service providers. The workgroup developed recommendations across seven mandated areas: workforce recruitment, workforce retention, administrative burden reduction, reimbursement and pay increases, workload reduction, burnout reduction and workforce diversification.

Part of a two-year process, this second report fulfills the December 15, 2025 deadline including recommendations for legislative actions, building upon recommendations submitted in the January 2025 report that informed the state budget process.

An urgent note on changed circumstances. This report is published at a moment of profound disruption in Oregon's mental health and addiction treatment system. The landscape has shifted in ways none of us anticipated: budget shortfalls, delays in finalizing contracts between the state and Coordinated Care Organizations and federal changes to Medicaid have resulted in workforce

destabilization. While these recommendations provide a critical framework for strategic action, they were developed before these seismic changes and Oregon now needs immediate crisis interventions beyond what they alone can deliver. With scarce resources available, strategic pathways forward include applying these recommendations to emerging funding opportunities, prioritizing recommendations that keep behavioral health workers in Oregon and reconvening community partners once the full effects of recent changes become clear.

Key recommendations

Chapter 1: Licensing and credentialing reform

1. Expand licensure pathways for out-of-state, military and non-traditional applicants.
2. Clarify and enhance roles for non-licensed professionals.
3. Conduct gap analysis and eliminate licensing delays with transparent standardization.
4. Adopt competency-based licensure standards with added supervisor resources.
5. Strengthen clinical supervision through standardized training and guidelines.
6. Reduce financial barriers with subsidized licensing, credentialing and education.

Chapter 2: Workforce relief — burnout, administrative burden and balance

1. Strengthen clinical supervision infrastructure through comprehensive support.
2. Raise reimbursement rates and salary standards for high-demand settings.
3. Reduce provider burnout through caseload limits and enhanced support systems.
4. Develop specialized training for providers working with acute care populations.
5. Recruit individuals with lived experience, including formerly incarcerated people.
6. Create flexible regulations without compromising quality of care.

Chapter 3: Reforming reimbursement and pay

1. Streamline Certificate of Approval processes and accept equivalent accreditations.
2. Centralize Community Care Organization credentialing to eliminate redundancies.
3. Address reimbursement disparities across certification levels.
4. Reduce documentation through medical field parity and standardized templates.
5. Expand Medicaid billing options beyond current constraints.
6. Evaluate value-based payment models to address implementation challenges.

Chapter 4: Investing in proven workforce incentives

1. Fund educational programs while reducing loan forgiveness requirements.
2. Approve multi-year funding extensions for successful incentive programs.

Chapter 5: Recruitment and retention of Latine/x/a/o providers

1. Address systemic barriers through a pathway of education, recruitment, licensure reform, retention support and advancement opportunities.

Recommendations with legislative actions include:

- ✓ Statutory changes to licensing, credentialing and scope of practice.
- ✓ Multi-year funding for workforce incentives, supervision support and training programs.
- ✓ Creation of a task force to address value-based payment barriers.
- ✓ Reimbursement rate increases and salary standards for high-demand settings.
- ✓ Subsidized licensing costs, free continuing education and reduced barriers.
- ✓ Career pathways for Latine/x/a/o providers and documentation burden reduction.

Conclusion

Behind every recommendation lies the story of Oregonians who have been unable to access care when they needed it most. If implemented, these solutions will result in shorter wait times for families in crisis, culturally responsive care for underserved communities and hope for those who have been unable to find or receive care. The true measure of success will be happier and healthier Oregonians.

Introduction

Overview of HB 2235 and its mandate

House Bill 2235 (HB 2235) passed in 2023 with an emergency declaration and created a workgroup to study and address the major barriers to workforce recruitment and retention in Oregon's publicly financed behavioral health system. The emergency declaration recognized Oregon's serious behavioral health crisis. Oregon ranks 42nd out of 50 states (1) based on an index of 17 emotional and behavioral health indicators that measure prevalence, access, insurance coverage, substance use and wellness factors.

Focus on public behavioral health system

The workgroup focused on Oregon's public behavioral health system — the network of organizations and providers that deliver care primarily funded by public sources like Medicaid, state funds and federal grants. This includes community mental health programs, community-based organizations, federally qualified health centers and private practices serving mainly Medicaid clients. These providers often face unique challenges serving high-need populations with complex care requirements.

What the workgroup was asked to do

The legislature's findings recognized that low pay, administrative burden and the volume and high acuity needs of clients are major factors driving providers from community-based behavioral health practices. This often leads providers into private practice where they serve clients with lower acuity needs, receive higher pay and can better control their caseloads. HB 2235 required the workgroup to develop recommendations in seven areas:

1. Improve recruitment of the behavioral health workforce.
2. Improve retention of the behavioral health workforce.
3. Reduce administrative burdens on the behavioral health workforce.
4. Increase reimbursement paid to behavioral health providers and increase pay for the behavioral health workforce.
5. Reduce workload of the behavioral health workforce, including caseload guidelines or ratios, considering national and local studies of existing program staffing.
6. Reduce burnout within the behavioral health workforce.
7. Diversify the behavioral health workforce.

The legislation also directed the workgroup to consider the following: the number and types of workers needed to meet community demand for behavioral health treatment and services; the effect of recommendations on consumers' access to services, providers' administrative burdens, the delivery of team-based care and the ability to transition to value-based payment methodologies and the resources needed to implement the recommendations.

Who is on the workgroup

The law required specific representation to ensure diverse voices and perspectives:

1. Seven direct service providers: One peer mentor, clinical social worker, alcohol and drug counselor, qualified mental health associate and qualified mental health professional, plus two supervisors who manage caseloads while training staff toward certification or licensure.
2. Eight organizational leaders: Directors or designees from four community mental health programs and four other behavioral health providers.
3. Six community representatives: One association of behavioral health provider employees, one association of behavioral health provider organizations, one mental health consumer organization, one substance use disorder consumer organization and two coordinated care organizations.
4. Cultural diversity: At least four culturally-specific providers (integrated above) and to the extent practical, reflecting Oregon's geographic, racial, ethnic and gender diversity.

Two reports, one strategy

HB 2235 established two reporting deadlines to address Oregon's behavioral health crisis strategically.

Report 1 (January 2025) informed OHA’s budget for the biennium starting July 1, 2025, and provided 17 recommendations that could be implemented through budget allocations and administrative action such as tuition assistance, supervision expansion, safety improvements and focused support for culturally specific providers.

Report 2 (this final report) presents 21 recommendations, including recommendations for legislative action. These recommendations address causes that drive providers from the field and provide a roadmap to a more sustainable behavioral health workforce. The workgroup’s recommendations presented in this report are based on ten months of workgroup deliberations,

analysis of meeting recordings and evidence-informed research on effective workforce strategies.

Recommendation prioritization framework

To ensure legislative efforts and resources focus on the most effective and achievable reforms, all recommendations underwent a prioritization process through a survey of workgroup and steering committee members.

Workgroup and OHA team members were surveyed on each recommendation across two dimensions:

1. Feasibility and resources: Considering both financial and resource requirements and implementation complexity; specifically, how realistically each recommendation could be accomplished given current resources and existing systems?
2. Equitable benefit: Assessing potential to improve workforce stability and advance equity, does this recommendation create meaningful change, particularly for underserved communities and culturally specific providers?

How to use the priority rankings:

While all 21 recommendations are important for comprehensive reform, the priority rankings acknowledge that implementation must be a strategic and phased approach.

Recommendations are prioritized in three ways in this report:

1. The top 7 recommendations have a badge and are represented in all five strategic areas. These recommendations scored high on the survey for both feasibility and equitable benefit.
2. Within each chapter, top priority recommendations come first in the chapter, while the remaining recommendations in the chapter are not ordered by priority.
3. All 21 recommendations appear in a single prioritized list in the appendix.

Identifying legislative requirements

Throughout this report, recommendations are marked to indicate whether they require legislative action for implementation. This visual system helps legislators and policymakers quickly identify which reforms need statutory changes versus those achievable through administrative or regulatory action.

Recommendations with the above indicator may require one or more of the following:

- ✓ Statutory changes — Amendments to Oregon Revised Statutes
- ✓ Task force creation — A legislatively mandated workgroup
- ✓ Funding Allocation — Appropriation and distribution of public funds
- ✓ New authority — Expanded agency powers or mandates

A complete list of recommendations requiring legislative action and ranked by workgroup priority is included in the appendix.

Chapter 1: Licensing and credentialing reform

Oregon's licensing and credentialing systems need systemic changes. Complex behavioral health licensing and credentialing systems, unclear role definitions for peer workers and inconsistent training and guidance for clinical supervisors all contribute to the behavioral health workforce crisis.

This chapter presents six recommendations to:

- ✓ Update licensing and credentialling systems.
- ✓ Create more pathways into the profession.
- ✓ Provide role clarity for peer workers.
- ✓ Support clinical supervisors through training and guidelines.

Recommendation

1.1 Expand licensure pathways for out-of-state and military affiliated applicants; recognize non-traditional qualifications and lived experience

The problem

Licensure requirements currently prioritize traditional, western academic credentials, creating barriers for out-of-state applicants, providers of Color and military-affiliated practitioners. These standards often overlook lived experience, international training and non-traditional qualifications, limiting workforce diversity and access. While OHA already has processes like the variance process (Oregon Administrative Rules [OAR] 309-008-1600) and Certificate of Approval (COA) licensing that can recognize different qualifications, these options are not being used enough.

We recommend to	This will lead to
Make it easier for out-of-state workers, providers of Color and military people (active duty, veterans, family and spouses of those serving and those trained in military culture) to get licensed by changing reciprocation and education equivalency policies. **Give credit for different types of experience,** for example, lived experience, international training and non-college learning when deciding who gets a license. **Use existing programs better** like OHA's COA licensing and variance process (OAR 309-008-1600) to recognize valuable experience that does not come from traditional college programs.	✓ More qualified people can enter the behavioral health field. ✓ More diverse workforce with different backgrounds and experiences. ✓ Shorter wait times for license approval. ✓ Faster licensing for out-of-state and military applicants. ✓ Better use of existing licensing options.

Supporting evidence and practice

Harmonizing licensing rules across Oregon's behavioral health boards would expand pathways for military families and internationally trained professionals to join the workforce and provide culturally responsive care. The Oregon Administrative Rules for the Oregon Board of Licensed Social Workers (BLSW) and Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT) do not align on how active military, military family members (for example, spouses) and internationally trained individuals can become licensed and practice in Oregon. Further, they may be prohibiting otherwise qualified individuals from practicing in the state as licensed providers. This causes some to pursue new careers, reducing the opportunity to build capacity of providers with lived experience who could offer culturally or linguistically specific services.

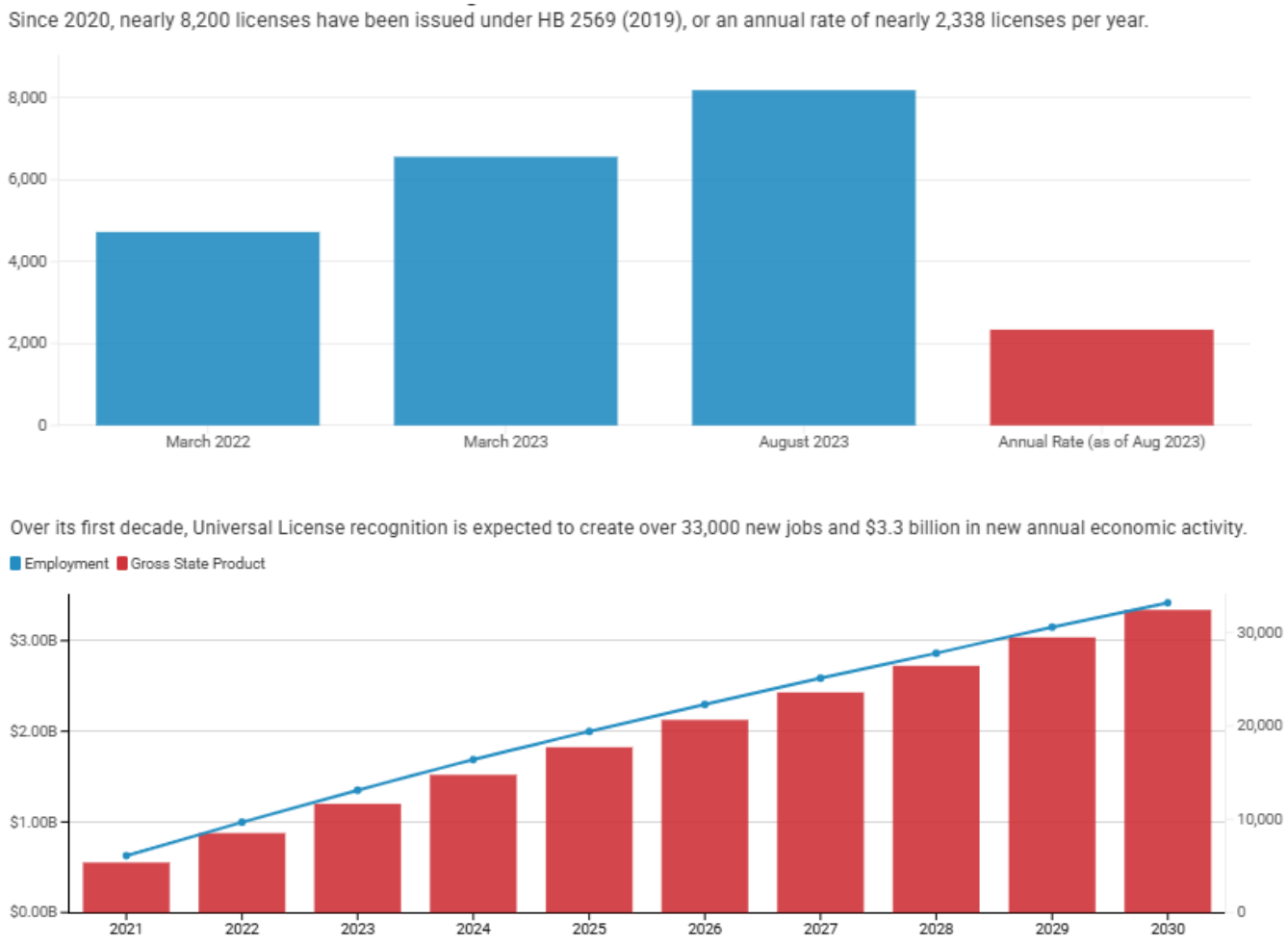
Oregon's licensing boards use conflicting credential evaluation processes that create unnecessary barriers for internationally trained behavioral health professionals. The OBLPCT only recognizes “foreign programs” that have been evaluated by “a credentialing body recognized by the Board” (OAR 833-030-011; 4) (2) while the BLSW only accepts “determinations of equivalency of foreign degrees by the Council on Social Work Education’s International Social Work Degree Recognition and Evaluation Service” (OAR 877-020-0021;1; b) (3). According to a presentation to the HB 2235 Workgroup on May 21, 2025, these two processes may be pushing internationally trained practitioners away from being able to provide highly needed culturally and linguistically specific services (4). A new more equitable process that replaces or works adjacently with current processes to more closely review the education and training of these individuals would increase the number of providers with international education and experience.

The OBLPCT also currently has a rule dedicated to supporting spouses of active military members with becoming licensed (OAR 833-020-0200) (5), while the BLSW does not appear to have any rules associated with this.

Arizona House Bill 2569 altered Section 32-4302 to make Arizona the first state in the country to broadly recognize all out-of-state occupational and professional licenses and certifications. According to Farley (6) after three and-a-half years of the recognizing all out-of-state licenses, service quality has not decreased. Additionally, at the time of that report, the increase in workers was substantial. Continuing at that same rate, the next ten

years could generate more than $3 billion in new annual economic activity for Arizona (see Figure 1).

Figure 1. Arizona's universal licensure statistics, Common Sense Institute Arizona



Washington expands license reciprocity for behavioral health professions. In 2019, Washington enacted Senate Bill 5054, which directs the Department of Health to establish a reciprocity program for behavioral health professionals licensed in other states, including psychologists, substance use disorder professionals, mental health counselors, social workers and marriage and family therapists. Governor Inslee partially vetoed the bill, though the core reciprocity provisions remained intact. The law took effect July 28, 2019, with the reciprocity program becoming operational July 1, 2020 (7).

Recommendation

1.2 Expand and clarify roles for non-licensed behavioral health professionals

The problem

The roles of Qualified Mental Health Associates (QMHA), Peer Wellness Specialists, Peer Support Specialists and other certified professionals are unclear and underutilized, limiting their ability to support Qualified Mental Health Professionals (QMHP) effectively. Oregon lacks clear protocols defining which clinical responsibilities can be appropriately assigned to non-licensed professionals while ensuring patient safety and regulatory compliance. This also restricts workforce capacity and service delivery.

We recommend to

Clearly define and expand the roles of QMHAs, Peer Wellness Specialists, Peer Support Specialists and other certified professionals through the following actions:

1. **Develop standardized tools and protocols** to support the safe delegation of appropriate tasks to non-licensed staff while still ensuring regulatory compliance and clinical quality.
2. **Align job duties within each role's scope of practice** to reduce confusion and burnout, particularly among peer staff and clarifying their expected contributions within treatment planning, which will further support licensed clinicians in practicing at the top of their licensure.

This will lead to

- ✓ Reduced workload of QMHPs, allowing clients to be served more quickly and expanded opportunities and job roles for QMHAs, Peer Wellness Specialists, Peer Support Specialists and other professionals.
- ✓ Clinical QMHP supervisors will have more time to devote to skill development of QMHP interns.
- ✓ More time for licensed supervisors to focus on clinical supervision.
- ✓ Expanded roles for QMHA IIs.

Workgroup implementation guidance

The Oregon Governor's Behavioral Health Talent Council subcommittee on Licensing and Credentialing may be able to further study and create a detailed plan, with authority, to effectively implement this strategy. This subcommittee was convened in June 2025 to create plans to reduce barriers for the behavioral health workforce (8).

The OHA Workgroup suggests possible examples of tasks non-certified behavioral health professionals could be delegated to do while ensuring regulatory compliance and clinical quality:

1. Authorize QMHA-IIs to supervise QMHAs, Mental Health Peers and support staff in COA programs.
2. Train peers to conduct select portions of intakes, that are subsequently reviewed and signed off by QMHPs.

Supporting evidence and practice

The expansion of peer workers in the behavioral health field demonstrates the unique value that they bring to the workforce because of their lived experience and shared struggle with clients. This allows them to work with clients using a non-clinical and more relationally and experientially focused approach. Peer support services are critical to person-centered care delivery (9). As the HB 2235 Workgroup points out, a lack of clarity and consistency around roles and responsibilities is a barrier toward implementation of peer services. To address confusion around the roles of different Peer Support Specialists, it will be critical to clearly define the scope of work for the different Peer Support Specialists. In their 2023 study, Adams and colleagues (10) echo the same sentiment identifying how the lack of clarity for peer support services roles continues to be a significant and concerning challenge for leveraging that role in the behavioral health field.

National interest in a paraprofessional workforce is driven by the need to fill staffing gaps and reduce the behavioral health system's dependence on master's-level or higher professionals (11). According to the National Governors Association, clarity and consistency of the roles and responsibilities for these newly developing roles (for

example, QMHA, Peer Wellness Specialists and Mental Health Peers) is essential to realize the potential of this subset of the workforce.

Arizona offers an example of how states can clearly define and expand the role of behavioral health peers. Arizona's Behavioral Health Paraprofessional and Behavioral Health Technician roles are like Oregon's QMHA position. They offer a roadmap for these employees by defining the roles in Arizona regulations A.A.C. R9-10-101(34) (12) and Arizona regulations A.A.C. R9- 10-101(39) (13) as well as providing guidance for employers through the Arizona Department of Health Services.

Recommendation

1.3 Support licensing boards through gap analysis and enhanced transparency to eliminate processing delays

The problem

While Oregon's Board of Licensed Professional Counselors and Therapists and Board of Licensed Clinical Social Workers have made significant progress in reducing processing delays, ongoing challenges with staffing, technology systems and resource allocation may continue to create barriers for applicants as the workforce increases in capacity. A comprehensive gap analysis and enhanced transparency measures can help identify where boards may need additional support to meet growing demand and ensure timely, consistent processes.

We recommend to	This will lead to
Conduct a comprehensive gap analysis of current staffing, technology infrastructure and procedural resources to: 1. **Identify existing or future systemic causes** of licensure processing delays. 2. **Guide development of standardized timelines and transparent application processes** across all boards. 3. **Recommend necessary resources and support** to address identified gaps in staffing, technology or procedure.	✓ Decreased licensing wait times and bottlenecks. ✓ Improved transparency and accountability with clear, posted timelines for application processing. ✓ Enhanced consistency and fairness through standardized application procedures across all boards. ✓ Improved responsiveness to applicant inquiries, leading to increased applicant satisfaction.

Workgroup implementation guidance

Oregon’s Mental Health Regulatory Agency and Board of Licensed Clinical Social Workers will need Legislatively approved funding to complete the recommended gap analysis and implement any interventions resulting from the analysis. These Boards should own this process and consult

with OHA as necessary. Considerations for staff or contractors supporting implementation should also be included in any associated legislative action.

Supporting evidence and practice

Utah enacted Senate Bill 26 (2024) requiring the creation of a new multi-professional behavioral health board (14). This board replaces occupation-specific boards and provides consistent and comprehensive oversight. The new board will include researchers, employers, payors, educators, consumers and licensed practitioners.

A New Arizona law allows graduates to start working while applying for licenses. Arizona House Bill 2001creates a temporary exemption for graduates seeking licensure in behavioral health to work for 90 days while applying for an associate-level license to work under qualified supervision. Direct client contact work experience performed during this period may be applied toward the licensure requirements for independent practice (15).

To better understand and address workforce gaps, Oklahoma enacted House Bill 3330 (16), which integrates comprehensive data collection into the behavioral health licensing process. The legislation requires additional questions on initial license applications covering applicants' race, languages spoken, whether they hold multiple behavioral health licenses and how many hours they provide direct services. The resulting information enables policymakers and stakeholders to identify where the behavioral health workforce does not reflect the state's population demographics and provides an accurate picture of workforce capacity and characteristics for strategic planning purposes.

Recommendation

1.4 Examine current associate licensure wait times and adopt a competency-based licensure with added supervisor resources

The problem

Current licensure requirements for associates may depend on fixed wait times rather than demonstrated competency, potentially delaying entry into the workforce. Also, supervisors often lack adequate support and guidance, which affects the quality and consistency of supervision. There is a need to reassess readiness standards and potentially incorporate a more competency-based framework within the licensure process.

We recommend to	This will lead to
Reduce barriers and wait times to licensure for Associate-level behavioral health professionals through joint efforts by the Mental Health Regulatory Agency (MHRA) and the Board of Licensed Social Workers (BLSW) and in consultation with OHA. **Examine both the feasibility and implications of adopting a competency-based licensure framework,** outlining standards for associate readiness to practice. **Implement a "pre-application" process**, whereby associates can apply with their respective licensing boards before graduation and be placed on "pending" status until degree conferral. **Increase general technical and board support** for supervisors overseeing associates.	✓ Decreased barriers to associate licensure. ✓ Increased number of licensed behavioral health providers. ✓ Improved logistical support for both associates and supervisors. ✓ Alignment of licensure requirements with workforce and workplace roles and responsibilities.

Workgroup implementation guidance

The HB 2235 Workgroup recommends that this initiative receive legislatively approved funding and be jointly overseen by the Oregon Mental Health Regulatory Agency and the Board of Licensed Clinical Social Workers. The approved actions and implementation strategies should be developed collaboratively, with input from representatives of the Oregon Health Authority

(OHA), provider organizations, clinical supervisors, graduate programs and associates. These strategies should be grounded in practical, field-based experience to ensure their effectiveness and relevance.

Supporting evidence and practice

Washington Substitute Senate Bill 5189 – 2023-24 (17) identified the Behavioral Health Support Specialist as a new member of their behavioral health workforce and University of Washington developed a competency framework for this position (18). The behavioral health support specialist clinical training program is characterized by brief, evidence-based interventions delivered to the intensity and expected duration of the behavioral health problem. The approach features routine outcome monitoring and regular, outcome-focused supervision (19).

Arizona House Bill 2001 (20) allows for intern clinicians to continue seeing clients for up to 90 days while they are in the process of applying for licensure at their practicum site. During this process interns continue being supervised by the person who provided direct supervision to them during their practicum (21).

Recommendation

1.5 Strengthen clinical supervision through standardized training and clear guidelines

The problem

Supervision requirements and standards are complex, and supervisors may often lack clear competency expectations, training and resources. Paperwork processes may be burdensome and unstandardized, limiting supervisors' ability to provide effective guidance.

We recommend to	This will lead to
Streamline supervision requirements, provide supervisor competencies and offer further training and resources for supervisors. **Streamline and standardize supervision requirements and paperwork processes.** **Enhance available supervisor trainings and supports** and develop resource and guidance documents outlining legal and regulatory expectations for clinical supervisors, improving their capacity to provide high-quality supervision. **For those previously licensed in another state, require only one year of prior supervisory experience** (assuming prior equivalent supervisory experience acquired from an outside state) to be eligible to provide clinical supervision in Oregon.	✓ Eased administrative and practice barriers for supervisors. ✓ Increased supervisor retention and satisfaction by providing the necessary resources and supports to perform their roles effectively. ✓ More uniform standards across organizations and regions, facilitating smoother transitions for supervisees and consistency in workforce development.

Workgroup implementation guidance

The OHA Workgoup suggests the state legislature mandate behavioral health boards to streamline supervision requirements. The Oregon Health Authority should provide:

1. Supervisor competencies (for example, effectively managing the administrative aspects of supervision, attending to cultural dynamics and remediating issues in supervision).

2. Offer training for supervisors (for example, working with culturally and linguistically specific service (CLSS) populations, providing effective trauma-informed care, conducting risk assessments with specialty populations and working with rural populations).

3. Provide consultative services (for example, professional networks like the Oregon Psychological Association, which offers confidential peer consultation and support services to its members).

Supporting evidence and practice

Kraemer and associates (22) examine an approach for training clinical social workers in competencies essential to providing clinical supervision and consultation. The training provided supervisory competencies that complement the more skills-based and intervention-specific supervisor competencies essential to a variety of evidence-based treatments. Their study shows promise for training clinical social workers in supervision. Last and colleagues (23) emphasize that states should invest in collaborative learning infrastructure so that providers can consult with peers, ultimately boosting their independence and professional growth.

Recommendation

1.6 Reduce financial barriers with subsidized initial licensing and certification and free continuing education

The problem

Continuing Education Unit (CEU) costs for licensed professionals can be prohibitive, placing financial strain on the supervisory workforce. Initiatives easing the financial burden associated with CEU costs can lead to higher retention within the public workforce.

We recommend to	This will lead to
Subsidize initial licensing and certification fees for all Behavioral Health providers through their respective regulatory boards. **Fund CCOs to provide free and relevant CEU trainings** to providers within their respective regions, as well as free and relevant CEU trainings for providers in other practice settings. **Amend rules or statutes to expand who can provide CEUs,** what training is authorized as CEUs or both, so that organizations can authorize their own staff to provide trainings.	✓ Increased provider retention. ✓ Enhanced workforce competency. ✓ Decreased financial burden on supervisors working in high-priority and high-demand positions.

Workgroup implementation guidance

The HB 2235 Workgroup suggests two possible subsidy strategies:

1. Need-based subsidies.
2. Lower fees for the initial years of licensure, when professionals are in direct service rather than supervisory or managerial positions.

Supporting evidence and practice

Colorado eliminated or reduced licensing fees for behavioral health professionals in 2022 when House Bill 22-1299 directed state funds to cover the operational expenses of licensing boards (24). Mental health professionals were expected to save $3.7 million when renewing their licenses.

Chapter 2: Workforce relief — burnout, administrative burden and balance

Oregon's behavioral health workforce faces significant challenges that threaten both provider wellbeing and quality of care. Low pay, inadequate training, heavy workloads and insufficient support systems drive professionals out of the field, particularly in high-need settings.

This chapter presents seven recommendations to:

- ✓ Strengthen workforce development.
- ✓ Improve working conditions.
- ✓ Build sustainable support systems.

Recommendation

2.1 Strengthen clinical supervision infrastructure through comprehensive supervisor support

Workgroup Priority

The problem

Supervisors face challenges from limited support, training and financial barriers, hindering guidance of masters-level associates. Strengthening supervisor support, especially for Medicaid and CLSS providers, is essential to enhance supervision capacity and workforce development.

We recommend to

Develop an online learning hub for supervisors providing:

1. Ongoing supervision support and resources.
2. Support for CLSS supervision.
3. Support for acute care supervision.
4. Resources for supporting diverse staff in those environments.

Support a supervisor career pathway through:

1. Continuing education offerings for supervisors.
2. Initial training to support new supervisors.
3. Readily available and accessible supervisor training throughout the state.
4. Training offered in flexible formats.

Develop scholarships to:

1. Subsidize the 30-hour required clinical supervision training.
2. Support all supervisors of masters-level associates.

Continue supporting the Clinical Supervision Expansion Grant, prioritizing:

1. Organizations holding a Certificate of Approval.
2. Any therapist, independent practice, group practice or organization (private or public) that:
    - Offers most of their services to clients with Medicaid.
    - Operates within rural areas.
    - Serves CLSS clients.

Fund loan forgiveness and repayment opportunities that:

1. Support clinical supervisors.
2. Count supervision hours as direct service hours.

This will lead to

- ✓ Strengthened clinical supervision infrastructure in Oregon, increased supervisor capacity, improved quality of care for clients and supported workforce retention, especially in high-need environments.
- ✓ Enhanced cultural responsiveness in supervision and in direct services provided to clients. Increased equity in access to supervisory roles and increase the number of trained, licensed supervisors overall, particularly CLSS supervisors.

Workgroup implementation guidance

Legislators should pass legislation that includes provisions for upfront costs for a temporary team to develop a supervisor learning hub and a dedicated state staff member to maintain the hub. State agencies suited to maintain the hub and Continuing Education offerings with proper staffing support can include a joint effort between state licensing authorities or through OHA.

OHA's Behavioral Health Workforce Incentives team can rapidly implement legislative action to support the Clinical Supervision Expansion Grant (25), support supervisor career pathways, administer scholarships for supervisor trainings, advocate for state loan repayment and MHRA and BLSW programs to be more supervisor-friendly to increase retention potential.

Supporting evidence and practice

Across the United States, several programs show that improving clinical supervision is an effective way to keep behavioral health workers in the field. States like New Mexico have created practical supervision guides with tools and templates that could be shared through a learning hub (26). National organizations such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and the American Psychological Association have also published supervision standards and strategies that help supervisors support staff in high-stress environments (27). In addition, federal workforce programs, such as the Behavioral Health Workforce Education and Training program, provide funding to expand the

behavioral health workforce, including support for supervision and training infrastructure, demonstrating the feasibility of creating sustainable training pipelines (28).

Scholarships and grants are used in many states to make required training for supervisors more affordable. For example, Oregon and California have programs that fund training and expand the number of available supervisors (29) (30). Evidence shows that high-quality supervision lowers staff burnout, improves job satisfaction and makes workers more likely to stay in their jobs (31). Loan forgiveness and repayment programs are another best practice. Federal and state programs already offer loan repayment to behavioral health providers, and these could be adjusted to reward clinicians who also serve as supervisors (32).

Recent policy changes by the Centers for Medicare & Medicaid Services (CMS) now allow some behavioral health services to be supervised under a "general supervision" model instead of requiring direct supervision. This makes it easier to count supervisory work as part of service delivery, which supports the idea that supervision hours should be recognized as valuable and billable (33).

Comparable costs

At least two other states have developed online learning centers or training platforms to support the behavioral health workforce. New York University's Community Technical Assistance Center (CTAC) and Managed Care Technical Assistance Center (MCTAC) provide one of the most noteworthy examples, supporting both behavioral health agencies and direct service providers. This program was funded at approximately $5.5 million for the 2017–2019 biennium and served about 71,200 licensed behavioral health professionals across disciplines. These models demonstrate the scale and investment required to create robust training infrastructure for a statewide behavioral health workforce. Of note, Oregon's licensed behavioral health workforce is approximately 20 percent of this size (at approximately 14,500 licensed providers), indicating that any comparable efforts undertaken in Oregon should be scaled accordingly.

Other national examples, such as the SAMHSA-funded Mental Health Technology Transfer Center Network (34), offered cost benchmarks for developing learning hubs to provide training, resources and professional development for supervisors and other behavioral health professionals. In 2018, grants between $500,000 and $745,000 were awarded to organizations to

develop and maintain training, technical assistance, resource development and dissemination and workforce development. Supervisor training efforts, such as developing and delivering 30-hour training and continuing education programs, offering technical assistance and delivering consultation, would carry additional costs; additionally, administrative and evaluation activities would be necessary to maintain program quality and to assess outcomes. Collectively, these examples illustrate both the scale of investment required and feasibility of building comprehensive training and support systems that strengthen clinical supervision capacity statewide.

Recommendation

2.2 Raise reimbursement rates and salary standards for high-demand settings

The problem

Low provider salaries can lead to high workforce turnover, especially within acute care and high-demand settings.

We recommend to	This will lead to
Support Community Mental Health Programs (CMHP), safety net services and specialty programs that provide higher levels of care and team-based approaches by: 1. **Increasing payment rates for services.** 2. **Increasing provider salaries** for those delivering these specialty services. 3. **Raising administrative overhead caps above 10 percent** to support additional requirements for optimal program delivery. Programs such as: Assertive Community Treatment (ACT) Intensive Case Management (ICM) Enhanced Adult Mental Health Service (EAMHS) programs Intensive In-Home Behavioral Health Treatment (IIBHT) Transition Age Youth/Transition Age Youth Intensive Services (TAY/TAYIS) Early Assessment and Support Alliance (EASA) Day Treatment Programs Residential Treatment Homes (RTHs)	✓ Increased workforce retention, especially in high-need, specialty (for example, acute care) settings. ✓ Decreased administrative burden due to allocating more cost toward administrative support.

Supporting evidence and practice

To ensure that resources are directed to areas of greatest need, Oregon Health Authority has revised its Qualified Directed Payments (QDPs), originally introduced in 2023. Before these changes, QDPs operated under a two-tier system:

Tier 2: Primarily Medicaid — organizations with at least 50 percent of total patient service revenue derived from Medicaid services in the prior calendar year.

Tier 1: Primarily non-Medicaid — organizations with less than 50 percent of revenue from Medicaid services in the prior calendar year.

Effective January 1, 2025, OHA eliminated Tier 1 and restricted QDPs to behavioral health services, specifically Assertive Community Treatment and Supported Employment (ACT/SE), Mental Health (MH) Non-Inpatient and Substance Use Disorder (SUD) categories (35).

Looking ahead, OHA has proposed a new rate adjustment for 2026 in response to rising costs faced by Care Coordination Organizations, which administer most Medicaid reimbursements. A significant driver of these costs has been QDPs, prompting OHA to narrow eligibility to providers offering team-based care. This proposal remains under federal review and, if approved, will take effect January 1, 2026, (36).

Kemble and Kahn (37) underscore the importance of restructuring reimbursement through hybrid models that blend fee-for-service, capitation and salary-based approaches. Their analysis shows that such models can ensure payments more accurately reflect provider effort while reducing administrative complexity. By incorporating salary-based elements, payment reforms also create more predictable and equitable compensation, indirectly strengthening workforce retention and making specialty roles, including those in behavioral health, more sustainable.

Washington State expanded its behavioral health workforce through the creation of a new bachelor's-level role, the Behavioral Health Support Specialist (38). While not directly tied to payment reform, this evidence demonstrates how innovative workforce models can reinforce capacity and sustainability when paired with fairer compensation structures. Stolarchuk and associates (39) emphasize that effective workforce retention in high-need settings requires a multi-strategy approach, combining financial incentives with improved working conditions, career pathways and infrastructure supports.

Recommendation

2.3 Strengthening provider well-being and support in high-acuity care settings

The problem

High-acuity care providers face significant job stress leading to burnout and compassion fatigue. Addressing these issues requires developing support resources and enhancing workforce wellness through team support, inspiring passion for community care and providing flexible work schedules and environments.

We recommend to

Explore and mitigate job stressors in high-acuity settings, by doing the following:

1. **Develop resources for providers to support them in working with acute clients with high service needs**, including community-based practice and consultation networks for various client populations.
2. **Mitigate general workforce challenges and burnout by building upon workforce wellness and prioritizing** passion for helping community, team support, safety and workplace flexibility, while also including wellness stipends and funds for organization-wide wellness programs and initiatives.

This will lead to

- ✓ Strengthened community-based practice networks, fostering collaboration, knowledge-sharing and peer support among providers serving diverse client populations.
- ✓ Greater provider engagement and job satisfaction resulting from feeling supported and connected within a network of peers and experts.

Supporting evidence and practice

Wisconsin's Healing the Healers initiative invests $5.6 million into programs aimed at preventing burnout and building resilience for health care professionals, including behavioral health providers, to improve job satisfaction (40).

Several states operate needed psychiatric consultation access programs that provide same-day psychiatric advice and ongoing consultation to primary care and behavioral health providers managing high-acuity clients. An example includes Washington State's Perinatal Psychiatry Consultation Line for Providers (Perinatal PCL) and the Massachusetts Child Psychiatry Access Program (MCPAP). Evaluations of MCPAP demonstrate improved provider confidence and access to care, particularly for youth with complex needs. Project ECHO models (a tele mentoring model that connects specialist teams with primary care and other providers through virtual clinics offers case-based learning and mentorship for providers in high-need areas. Evidence shows ECHO improves provider self-efficacy and workforce capacity in managing acute behavioral health conditions (41) (42).

Colorado's CO-CARES initiative offers organizational-level resources and resilience-building interventions (43).

SAMHSA's Assertive Community Treatment model, adopted across multiple states, is widely recognized as the gold standard for delivering high-acuity, team-based behavioral health care. The model specifies small, shared caseloads, typically one staff member per 10 clients, to ensure intensive, coordinated service delivery (44). In alignment with this standard, Oregon Administrative Rules (309-019-0242) (45) require that individual to clinical staff ratios within ACT programs may not exceed 10:1. Research consistently shows that maintaining fidelity to ACT caseload and staffing standards is linked to improved outcomes, reduced hospitalization rates and lower provider stress (46). Similarly, the National Wraparound Initiative provides implementation standards and caseload guidelines for facilitators working with youth and families who have complex coordination needs. Studies demonstrate that smaller wraparound caseloads are associated with greater fidelity, higher provider satisfaction and improved family engagement (47) (48). Together, these findings support maintaining manageable caseloads and investing in high-fidelity implementation to enhance both workforce well-being and client outcomes.

At the federal level, HRSA's Health and Public Safety Workforce Resiliency programs provide funding for organizational interventions to reduce burnout. In addition, the National Academy of Medicine's National Plan for Health Workforce Well-Being (49) provides a systems roadmap that includes reducing administrative burden, improving team culture and embedding flexibility in the workplace. Evidence consistently shows that wellness stipends, team supports and system-level investments in staff well-being reduce burnout and improve workforce retention (50).

Recommendation

2.4 Create specialized training tracks for crisis, suicide prevention and substance use treatment

The problem

Current training programs lack specialized tracks and placements that adequately prepare providers with critical workplace skills needed to effectively support acute client populations, such as crisis management, suicide risk assessment and intervention and substance use treatment. Development and refinement of specific education and training opportunities to better equip providers for these high-demand roles are needed.

We recommend to

Develop and refine specialized tracks and training placements in training programs that prioritize important workplace skills for working with and supporting acute client service populations (for example, crisis management, suicide risk assessment and substance use).

Expand the identification of specific job, clinical and practice skills required for working with increasingly acute service populations and integrate these skills early on in educational and workforce training (for example, beginning in Career Technical Education [CTE] programs and extending throughout licensure).

Bolster crisis management, suicide assessment and substance use detection and intervention training for all providers, at low or subsidized cost.

This will lead to

- ✓ Improved clinical competence in areas such as crisis management, suicide risk assessment and substance use, leading to higher quality care.
- ✓ Increased confidence among trainees and new clinicians to handle complex cases, reducing the likelihood of errors or burnout.
- ✓ Better alignment of training with real-world job demands, making graduates more job-ready and decreasing onboarding time.

Supporting evidence and practice

Specialized training tracks that foreground crisis stabilization, suicide risk assessment and substance use interventions are supported by federal guidance and empirical training literature. For example, SAMHSA's National Guidelines for Behavioral Health Crisis Care (51) identify workforce training in crisis response as a core system requirement and lay out implementation elements for mobile crisis and related services, offering a ready roadmap that programs can adapt (competencies, team roles and operational standards). Evidence syntheses show that structured training in suicide risk assessment and intervention, including simulation and standardized-patient methods, significantly improves provider knowledge, confidence and skills across disciplines. These approaches are scalable within graduate programs and clinical placements (52). For substance use, training clinicians in Screening, Brief Intervention and Referral to Treatment (SBIRT) increases screening uptake, clinician confidence and brief-intervention delivery outcomes that can be embedded in specialty tracks and practice (53).

Defining the competency set for high-acuity work and introducing it early, improves readiness and equity in the career pathway. State and district Career and Technical Education (CTE) pathways are already piloting mental and behavioral health courses that teach crisis response basics, care coordination and helping-skills in high school; all of which are stackable into post-secondary credentials (54). SAMHSA's (55) crisis guidance can anchor the competency framework (for example, de-escalation, suicide risk formulation, care transitions and collaboration with 988 or mobile crisis). Recent reviews in primary care suicide-risk management emphasize tailoring assessment and management strategies to setting and population, useful for specifying level-appropriate skills across the training continuum (56).

Embedding these competencies in syllabi, simulation labs and supervised placements, from CTE labs to graduate clerkships, supports consistent skill acquisition before licensure.

Evidence supports scalable, low-cost modalities (web-based, hybrid, simulation) that can reach large provider cohorts. A multi-study literature shows that simulation-based suicide prevention training improves knowledge, self-efficacy and observable skills among health care professionals and gatekeepers. These programs can be delivered virtually or via standardized patients to reduce cost while maintaining effectiveness (52). Systematic and implementation studies demonstrate improved screening frequency and confidence after concise online modules, indicating that brief, subsidized courses can shift practice patterns without extensive residency-style curricular reforms (53). Finally, federal crisis-care toolkits and CMS and SAMHSA policy memoranda provide free, public training assets and frameworks (for example, competencies, workflows and documentation examples) that states and institutions can adapt for Continuing Education credit and workforce onboarding (51).

Recommendation

2.5 Expand workforce through second-chance employment and lived experience recruitment

The problem

The workforce lacks effective strategies to recruit individuals with lived experience, such as formerly incarcerated people who possess valuable insights and skills.

We recommend to	This will lead to
Expand strategies to recruit the untapped workforce of those individuals with lived prior experience (for example, those with histories of incarceration being released from prison that have valuable experience to offer) directly into the workforce. **Develop additional strategies specific to recruiting Peer Support Specialists** within the substance use disorder (SUD), veteran and Indigenous communities.	✓ Development of innovative peer support roles and services that leverage lived experience for more effective interventions. ✓ Strengthened community ties and collaboration between behavioral health systems and justice-involved populations. ✓ Reduced stigma within organizations and the broader community by demonstrating the value and contributions of formerly incarcerated individuals.

Supporting evidence and practice

Oregon operates several reentry initiatives that could be strengthened and expanded. The Oregon Workforce Partnership (57) provides workforce preparation and support to adults exiting incarceration, beginning up to 90 days before release. This program is funded through the U.S. Department of Labor's Pathways Home 4 Grant (58) and the Future Ready Oregon Workforce Ready Round 2 Grant (also known as Senate Bill 1545 (59). It

is primarily administered by the Oregon's Higher Education Coordinating Commission (HECC). Additionally, the Oregon Health Plan (OHP) Reentry Program allows individuals within 90 days of release to activate OHP coverage and receive services such as skills training and other core supports that promote a stable transition back into the community. Oregon's Substance Use Disorder 1115 Demonstration Waiver further expands the continuum of addiction treatment by allowing federal Medicaid funding for residential substance use disorder services in facilities with more than 16 beds (60). Collectively, these programs bolster Oregon's ability to support individuals returning from incarceration by expanding access to treatment, services, employment skills and other stability-focused supports.

Evidence shows that Peer Support Specialists with lived experience bring unique credibility and are effective in supporting engagement and recovery (61). SAMHSA's Core Competencies for Peer Workers provide national standards to guide hiring, training and supervision of peers (62). A recent 50-state survey by the National Research Institute (NRI) found that twenty-nine states explicitly permit peers with arrest or incarceration histories to be hired and reimbursed through Medicaid, offering a strong model for fair-chance hiring (63). Apprenticeships and "earn-while-you-learn" pathways, such as Registered Apprenticeship programs for Peer Recovery Specialists and Community Health Workers, are recognized by the U.S. Department of Labor as effective tools to recruit justice-involved individuals into the behavioral health workforce (64).

Research confirms that peer-delivered recovery supports improve engagement, recovery capital and satisfaction for people with substance use disorders (65). New York's Certified Recovery Peer Advocate credential is a strong state model for building SUD peer pathways with specialized training, including medication-supported recovery (66). In Veterans Affairs health systems, randomized and hybrid trials demonstrate that integrating Veteran Peer Specialists improves patient activation and engagement, while facilitation strategies accelerate uptake and program fidelity (67). For Indigenous communities culturally grounded peer recovery programs support belonging and spiritual connection, particularly when co-designed with tribal leadership and culturally informed training (68). SAMHSA's Tribal Training and Technical Assistance Center further provides national resources for developing culturally responsive peer programs (69).

Recommendation

2.6 Implement regional variances to balance regulatory requirements with local needs

The problem

Regulations may often prioritize rule compliance over effective service delivery and client care, limiting flexibility and responsiveness across diverse settings. There is a need to balance specificity and adaptability in policies to apply more broadly across service settings.

We recommend to	This will lead to
Design rules for more specificity in some cases (for example, cap in outpatient settings) and more flexibility in other cases (for example, maintaining program components in rural areas). **These capitations would require collaboration with providers and organizations working within these settings**, so as not to limit funding sustainability and to additionally provide optimal flexibility for serving those populations intended by the specific programs. **Implement a variance** for various geographic regions (including rural and frontier settings) and for specific populations. Increase behavioral health provider pay.	✓ Enhanced collaboration and teamwork between peers and licensed providers through clear, consistent expectations. ✓ Improved efficiency and utilization of staff, allowing master's-level clinicians to focus on tasks aligned with their advanced training and licensure. ✓ More efficient engagement of the existing workforce, maximizing the skills and experience of seasoned QMHPs. ✓ Faster turnaround times for assessments and treatment plan reviews, improving client care timeliness.

Supporting evidence and practice

Evidence supports that behavioral health regulations function best when they combine specific operational standards to ensure quality and accountability with flexibility in local implementation (70). SAMHSA recommends that states adopt "context-sensitive fidelity" that tailors fidelity requirements to local needs. To promote sustainability and equitable service delivery, essential program elements are preserved (71). Research in implementation science confirms that policies developed with provider participation achieve higher rates of adoption and compliance (72) (73). SAMHSA's State Technical Assistance and Capacity Building Initiative similarly emphasizes that co-design with local agencies and community-based providers fosters regulatory clarity and shared accountability (71).

States that have modernized their regulatory frameworks, such as Colorado and New Mexico, emphasize adaptive rulemaking and performance-based contracting. Colorado's Behavioral Health Administration (BHA) reform (2022–2023) unified more than 70 contracts and regulatory standards, reducing duplication and allowing regional BHA Service Organizations to modify certain program requirements to fit community contexts (74). This approach preserved high-level standards (for example, staff qualifications and outcome measures) while granting flexibility in documentation, staffing ratios and service delivery formats in rural areas.

Oregon Health Authority has piloted collaborative regulatory reform in the Certified Community Behavioral Health Clinic (CCBHC) rollout (2017-2019) where stakeholder engagement and iterative feedback informed rate setting, staffing standards and performance metrics (75). This model can be expanded to include rulemaking for outpatient capitation, fidelity variance and staffing ratio flexibility.

Significant evidence supports adopting regional variance and pay adjustment policies to address disparities in access and sustainability across Oregon's rural and frontier regions. The Health Resources and Services Administration (HRSA) designates most rural Oregon counties as Behavioral Health Professional Shortage Areas (HPSAs), citing low provider density, high administrative burden and low reimbursement as key drivers of workforce scarcity (76).

The National Association of State Mental Health Program Directors (NASMHPD) (77), recommends participatory review boards composed of providers, clients and state administrators to ensure that rule changes balance service fidelity with operational feasibility.

States like Montana, Alaska and Colorado have implemented geographically adjusted payment models, such as rural differential rates or hardship stipends, to incentivize workforce retention in underserved areas (78) (79) (43). For example, Alaska's Rural Differential Pay Program provides up to 25 percent higher reimbursement for behavioral health services in frontier regions, directly improving provider retention and program sustainability.

The National Academies of Sciences, Engineering and Medicine (80) found that addressing compensation disparities and administrative overload is critical to reducing burnout and turnover among behavioral health professionals. Moreover, the Bipartisan Policy Center (81) recommends integrating cost-of-living adjustments and regional incentives within Medicaid reimbursement structures to sustain service delivery in high-need, low-resource areas.

Chapter 3: Reforming reimbursement and pay

Oregon's behavioral health rate increases, including CLSS differentials and enhanced high-acuity payments, provide a foundation for improvement. Strategic reforms that streamline administrative processes and align payment structures with the full costs of quality care will maximize these investments, strengthening workforce stability and improving outcomes.

This chapter presents six recommendations to:

- ✓ Reform payment systems.
- ✓ Reduce administrative burden.
- ✓ Create sustainable compensation models.

Recommendation

Workgroup Priority

3.1 Streamline COA processes and accept equivalent accreditations

The problem

Administrative rules for credentialing and audits can be burdensome. Audits from regulatory bodies can be redundant and time-consuming for administrative and clinical staff. For example, one agency can be audited by several regulatory bodies (for example, OHA, Commission on Accreditation of Rehabilitation Facilities [CARF], The Joint Commission, Department of Human Services [DHS], Department of Corrections [DOC], CCOs, Drug Enforcement Administration [DEA], SAMHSA, CMS) on a regular basis. As a result, credentialing and auditing processes limit access to health care and contribute to workforce burnout.

We recommend to	This will lead to
Revise and streamline the COA process, eliminating redundancies and overlap where possible. **Allow for accreditation with equivalent regulatory bodies** to suffice for OHA audits (COA, [Oregon Health Plan] OHP, CCOs, and other). **Bolster support and resources around audit processes**, particularly for fidelity audits and specialty programs.	✓ Reduced administrative burden and duplication of efforts for behavioral health organizations by eliminating redundancies in the COA process. ✓ Greater efficiency and timeliness in obtaining and maintaining certification and approvals. ✓ Increased alignment and recognition of equivalent accreditations, thus simplifying regulatory compliance. ✓ More supportive and collaborative audit processes, shifting from punitive compliance checks to improvement-focused fidelity reviews.

Supporting evidence and practice

Streamlining licensure and audit requirements would reduce administrative burden, increase efficiency and redirect resources toward direct care. Aligning OHA's COA with equivalent accreditation standards (for example, CARF, and The Joint

Commission) and implementing assistance-oriented fidelity audits can improve quality and provider satisfaction while maintaining accountability. Cross-system alignment in licensing and accreditation enhances efficiency, reduces redundancy and increases access to care by allowing providers to spend more time on service delivery (73).

In 2018, Washington integrated its mental health and substance use disorder certification systems under a single Behavioral Health Agency (BHA) license, replacing multiple overlapping reviews. The new model also allows accredited organizations (for example, CARF and The Joint Commission) to satisfy portions of state audit requirements. Evaluation results showed a reduction in audit time and staff burden while maintaining compliance and safety standards (7).

Colorado's BHA consolidated more than 70 behavioral health contracts and audits across multiple agencies into a unified oversight system, introducing a streamlined licensing and fidelity review process. The system now emphasizes technical assistance and quality improvement over punitive compliance (43). Early evaluations indicate better provider collaboration, less duplication and improved trust in the oversight process.

Minnesota's Department of Human Services launched a consolidated licensing framework that allows providers with multiple service types (for example, MH, SUD and housing) to undergo one unified audit instead of several separate ones. The program's cost-benefit analysis found that reducing overlapping audits saved both state agencies and providers significant time and administrative costs (82). This mirrors Oregon's opportunity to align COA with Medicaid, OHP and CCO audit cycles.

At the federal level, CMS has encouraged states to align Medicaid quality and compliance monitoring with national accreditation standards and move toward outcome-based auditing (33). The federal guidance promotes "streamlined oversight structures" that minimize burden while ensuring accountability through data-driven performance metrics (83).

Recommendation

3.2 Establish centralized credentialing through OHA vendor partnership and pilot testing approach

The problem

The credentialing process can be burdensome and duplicative, lacking standardization across CCOs and other systems. The current administrative burdens pull resources away from direct client care. There exists ongoing debate about whether a centralized or collective agreement approach would best serve Oregon's credentialing needs.

We recommend to

Centralize the credentialing process at the state level or through coordinated efforts among CCOs, to reduce administrative burden and duplication for behavioral health providers and health plans. For example, this process could be managed by OHA through a contracted vendor (or existing vendor), with blended funding from OHA and health plans.

Standardize credentialing procedures across the system, including forms, primary source verification and information sharing.

Revisit and build upon lessons learned from the Oregon Common Credentialing Program to guide implementation and avoid past pitfalls.

Review and update current OHA credentialing policies and systems to simplify the process and further reduce administrative burden.

This will lead to

- ✓ Clearer role definitions and credentialing process transparency.
- ✓ Elimination of redundant steps (for example, duplicate credentialing by CCOs).
- ✓ Reduced administrative burden and increased efficiency.
- ✓ Streamlined credentialing process through a single, centralized system.

- ✓ Faster onboarding and credentialing timelines for behavioral health workforce.
- ✓ Improved data consistency and integrity.
- ✓ Reliable, centralized data storage with secure access and sharing protocols.
- ✓ Cost savings and resource optimization.

Work group implementation guidance

The Oregon Common Credentialing Program was intended by legislators to simplify credentialing processes, reduce burden on practitioners and eliminate duplication. Unfortunately, significant challenges interfered with the development of a program, which ultimately ended the efforts in 2020 (84). The HB 2235 Workgroup recommends revisiting the program and including the following actions:

1. Start with a focused pilot (for example, consider beta testing this system with the behavioral health workforce before broader implementation).
2. Maintain neutrality on how the process is operationalized (for example, not tied to one model or vendor).
3. Clarify and streamline roles and processes, removing unnecessary duplication (for example, if OHA already credentials a provider, CCOs should not repeat the process).
4. Clearly define what credentialing, enrollment and contracting each involve and how they interrelate.
5. Ensure inclusive scope, including both licensed providers (for example, Licensed Clinical Social Workers [LCSW], Licensed Psychologists, Licensed Professional Counselors [LPC], Licensed Marriage and Family Therapists [LMFT] and certified providers (for example, via the Mental Health & Addiction Certification Board of Oregon).
6. Avoid limiting the solution to just CCOs; include other payors and state entities where applicable.
7. Acknowledge funding, cost, governance and administrative challenges, especially those affecting the original Oregon Common Credentialing Program mandate.
8. Consider past examples where CCOs pooled resources for a shared platform.

Supporting evidence and practice

Ohio centralizes provider credentialing. In 2022, the Ohio Department of Medicaid began centralized provider credentialing as part of their Next Generation of Ohio Managed Care (85).

Mississippi eliminates multiple credentialing requirements. In 2021, Mississippi HB 2799 required all providers seeking Medicaid participation to complete enrollment, credentialing and screening through the Division of Medicaid, rather than having to undergo separate credentialing processes with multiple entities (86).

Nevada centralized Medicaid provider credentialing. in February 2025, Nevada put into action 2023 legislation (SB 494) that requires a contracted Credentialing Verification Organization to facilitate provider credentialing for all Managed Care Entities (87).

Comparable costs

Initial cost projections provided by the Oregon Common Credentialing Program detailed a $10 million startup investment, as well as $6.5 million in annual operating costs. The OCCP program was originally intended to be solely fee-funded and was eventually discontinued in part due to budgetary shortfalls.

For the 2023-2025 biennium, Nevada state appropriated $1.6 million toward centralized credentialing through SB 494. This investment established a statewide Medicaid provider credentialing program, although specific budgetary documents were not readily available to obtain line-item costs related to this program.

Recommendation

3.3 Investigate reimbursement rate disparities across behavioral health certification levels

The problem

Pay rates are similar across certain certification levels, such as between QMHA I and QMHA II, potentially creating little incentive for advanced certification. Enhanced reimbursement for the QMHA-II could motivate more individuals to progress in credentialing and enhance workforce retention for the most trained, educated and experienced QMHAs within behavioral health.

We recommend to	This will lead to
Explore and establish a reimbursement differential or modifier for the QMHA-II as supervisory assessments clearly show QMHA-IIs to have greater competency across the 24 established QMHA competencies. This may likely affect other behavioral health credentials than QMHAs.	✓ Identification of potential barriers to career advancement caused by pay differentials, informing focused policy or compensation adjustments. ✓ Data-driven recommendations for more equitable pay structures, helping reduce turnover through achieving advanced certification levels. ✓ Increased transparency around compensation practices, fostering trust and fairness within the behavioral health workforce. ✓ Positive effect on workforce retention and quality of care.

Supporting evidence and practice

MHACBO findings highlight that strengthening QMHA advancement and pay differentials can boost satisfaction and reduce turnover. Evidence from the Annual Mental Health and Addiction Certification Board of Oregon (MHACBO) Report (88) supports the recommendation to establish a payment differential or modifier for different QMHA

levels. According to the report, QMHA II's have the highest retention rates of all QMHAs at 80.15 percent (n=3,111). Specifically, the report shows a decline in individual's intention to leave the behavioral health workforce with higher levels of certification: 23.17 percent of QMHA I's intend to leave vs. 19.85 percent of QMHA II's intend to leave (n=3,111). MHACBO's analysis also illustrates the importance of supporting QMHA I's advancement in certification around years 3-4 of employment because the desire to leave QMHA work peaks at that time. This report makes clear that an increase in pay for QMHA II's has the potential to increase job satisfaction and retention for QMHA's.

Research calls upon policy makers to invest in funding and coordination for the behavioral health workforce, including nonspecialized providers (NSP, such as Peers), to sustainably increase the behavioral health workforce. Last et al. (89), argue that using low wages as the justification for promoting non-specialized professionals is economically exploitative and short-sighted because it risks exacerbating the current workforce shortages (for example, NSPs state that they intend to leave their current roles in behavioral health within three years). Additionally, the authors state that because NSPs are limited to only a few Medicaid billing codes, their full range of services are not billable. Last and colleagues (23) synthesize evidence that suggests increasing NSPs compensation is the solution to increasing the behavioral workforce. They conclude that policy solutions are needed to address the low wages and inadequate billing codes for NSPs.

Recommendation

3.4 Address documentation burdens by pursuing parity with medical provider documentation and providing standardized forms and templates

The problem

Documentation requirements within the behavioral health system are intensive and often exceed what is required by medical providers (which are highly standardized). Treatment plans, goals and objectives in the behavioral health system seem geared toward compliance and outcomes rather than quality of care. Behavioral health providers must complete entire intake forms, even when sections don't apply to the client. Insurers and auditors often look for documentation showing coordinated care or other specific activities with clients that require extensive rather than efficient documentation practices.

We recommend to

Increase parity and alignment with the medical field for documentation standards, reducing paperwork and administrative burdens across all provider service settings.

Embrace Artificial Intelligence (AI) technologies in publicly funded behavioral health services to improve documentation efficiency by providing funding for programs to purchase effective technology platforms and to receive technical assistance with documentation and audit operating procedures (for example, templates and documentation samples).

Assertively reduce the administrative burden on Certificate of Approval and publicly funded behavioral health services with an ambitious goal such as a reduction of paperwork by 45 percent per clinician, administrator or both.

This will lead to

- ✓ Enhanced provider capacity and time to focus on direct client care rather than paperwork, boosting overall productivity.
- ✓ Reduced administrative burden, with ambitious targets resulting in less burnout and higher job satisfaction among clinicians and administrators.
- ✓ Cost savings over time through decreased paperwork processing and improved operational workflows.
- ✓ Better compliance and audit readiness supported by AI tools and improved documentation practices.
- ✓ Greater consistency and standardization in documentation across publicly funded behavioral health services.

Supporting evidence and practice

Governor's mandate reduces regulations for Virginia behavioral health providers. To reduce burden on providers, Viginia's governor mandated Executive Order #19, which requires all state agencies to reduce regulations, particularly those that are obsolete, duplicative or unnecessarily prescriptive, by at least 25 percent. As a result, in June 2025, a series of "noncontroversial regulatory reductions" took effect, including 11 regulations being repealed and 32 reduced for the Virginia Department of Behavioral Health and Developmental Services. The Governor announced that he approved regulatory changes across all state agencies that streamline more than 27 percent of the regulatory requirements in Virginia Code, saving $1.2 billion a year (90) (91).

Recent developments in AI for the behavioral health field have the potential to optimize service delivery, significantly reduce therapist burnout and turnover and ultimately lower the cost of therapy by addressing the excessive burden of clinical documentation. AI tools can automate some cumbersome tasks, including charting and documentation. According to Sadeh-Sharvit and Hollon (92), studies have demonstrated that AI-based progress notes in behavioral health can lead to up to a 42 percent reduction in time spent on administrative tasks and providers utilizing ambient AI have been found to submit their progress notes an average of 55 hours earlier than therapists providing manual documentation in the same setting. In another study, Bracken and associates (93) found that AI technologies exhibit significant promise for making clinical documentation processes more efficient.

However, the quality of the AI-generated notes must always be carefully considered alongside any time savings as these are emerging technologies.

Oregon has demonstrated successful strategies for reducing administrative burden in behavioral health services through focused reforms. Angella James' presentation (94) to the OHA workgroup provides a concrete example of how Oregon is advancing the goal of reducing administrative burden across publicly funded behavioral health services, particularly those requiring a Certificate of Approval Her findings from the Adult Mental Health Fidelity Review Reform Initiative show that OHA successfully cut data reporting requirements for ACT programs by nearly 88 percent and reduced IPS (Individual Placement and Supports) indicators by 2 percent, illustrating measurable progress toward the recommendation's proposed 45 percent paperwork reduction goal. By eliminating redundant reporting forms, clarifying submission timelines and aligning data systems across agencies, OHA's approach demonstrates how fidelity oversight can shift from compliance-driven to assistance-oriented, a core intent of the recommendation.

Recommendation

3.5 Expand Medicaid billing options for certain providers beyond a COA and provide technical assistance to ensure accessible and stable funding

The problem

Constraints and inflexibility inherent in the COA process preclude some critical behavioral health providers, settings and services from billing Medicaid.

We recommend to	This will lead to
Expand Medicaid billing eligibility beyond COA requirements to include additional qualifying organizations such as rural integrated care settings, Federally Qualified Health Centers (FQHC) and certain Tribal Behavioral Health programs. Through mechanisms like waiver programs, enable behavioral health providers, including QMHAs, Registered Bachelor of Social Work (RBSW) practitioners, graduate interns and registered associates, to serve Medicaid clients at these non-COA facilities. **Examine revenue-generating opportunities** outside of grant funding to make permanent funding streams and billing opportunities for QMHA, RBSW, interns and other associates. **Once the COA process is updated, develop and provide technical assistance for implementation,** including webinars and coaching on key operational areas (for example, hiring qualified staff, maintaining program fidelity and monitoring outcomes). The Collaborative Care model demonstrates how extensive technical assistance is essential for successful program implementation.	✓ Increased provider participation and accessibility. ✓ Broader range of qualified practitioners able to assist clients with Medicaid. ✓ Greater inclusion of QMHA, RBSW and associates in Medicaid service delivery. ✓ More clients receiving timely and appropriate care from a wider network of providers. ✓ Enhanced financial and program sustainability. ✓ Strengthened workforce development and retention.

Supporting evidence and practice

Evidence from the federally supported Certified Community Behavioral Health Clinic model shows that expanding the types of qualifying organizations leads to broader access, especially in underserved areas, while preserving quality through standardized criteria (95). Similarly, meta-analyses indicate that integrated care interventions produce measurable improvements in key aspects of primary care. Specifically, they strengthen access and continuity of care (96). Policy should direct Medicaid agencies to recognize additional provider categories, such as QMHA, RBSW, interns and associates, within integrated or certified care frameworks, ensuring these practitioners can bill Medicaid when supervised under approved structures.

Reliance on short-term grants undermines workforce stability, while permanent financing mechanisms, such as state plan amendments that enable Medicaid reimbursement for peer and associate-level providers, have been successfully adopted in multiple states nationwide (97). Studies show that Medicaid coverage of peer and associate services not only improves client engagement but also reduces reliance on higher-cost crisis care (98). Policy recommendations include:

1. Amending state Medicaid plans to expand billing codes for associate-level services.
2. Developing risk-adjusted reimbursement to reflect service complexity.
3. Incentivizing FQHCs and integrated clinics to incorporate these practitioners into their core workforce models.

Evidence from the Collaborative Care Model demonstrates that extensive technical assistance, including training, coaching and billing support, is essential to successful adoption and sustainability (97). Oregon's Value-Based Payment (VBP) Roadmap and technical assistance programs further illustrate how state-funded coaching, webinars and regional learning collaboratives help providers adapt to new payment and regulatory requirements (99). Policy should direct state behavioral health agencies to invest in technical assistance hubs that provide implementation coaching, billing templates, workforce management tools and fidelity monitoring supports, ensuring that expanded provider eligibility and Medicaid financing reforms are translated into practice effectively.

Recommendation

3.6 Convene task force to evaluate value-based payment design and address implementation challenges

The problem

Value-based payments (VBP) systems are among the most implemented and represent some advantages including the potential for more flexible, client-centered care and prioritization of quality care over client volume. However, challenges remain:

1. Not being universally beneficial or accessible, as small organizations may lack data analytics capacity to track measures.
2. Continued administrative burden, (for example, even under capitation, providers may face burdensome reporting requirements, such as entering care gaps into multiple web portals).
3. Delayed financial rewards straining resources if upfront investments are needed (for example, hiring care coordinators).
4. Enhanced payments for CLSS services within VBP models can be delayed, and enhanced rates can vary widely and cause confusion.

We recommend to

Convene a dedicated taskforce, comprising subject matter experts and other key partners and collaborators, to further evaluate and provide recommendations on the design, implementation and cost coverage of VBP models in behavioral health settings. The taskforce might address:

1. **How reimbursement could be expanded** to consider salary and supervision increases, as well as exploring timeliness in delivery of enhanced payments for CLSS providers.
2. **Increasing rates** for team-based care services.
3. **Increasing transparency and technical support** around billing of multiple services for a single client within a day.
4. **Examining rules that place billing restrictions** on medically necessary or clinically indicated services.

This will lead to

- ✓ Improved depth of evaluation of VBP models, informed recommendations on VBP design and implementation and improved financial sustainability for behavioral health providers.
- ✓ Improved equity in reimbursement and payment structures.
- ✓ Decreased wait times for enhanced payments for CLSS services.
- ✓ Improved access and quality of team-based care.

Supportive evidence and practice

The Collaborative Care Model (CCM) demonstrates that reimbursing team-based care

structures, comprising a care manager, psychiatric consultant and supervising clinician, significantly improves outcomes for depression and anxiety compared with usual care (100). High-quality supervision also plays a critical role in reducing staff burnout and improving retention, particularly when supervisory relationships emphasize support and skill development (101). Embedding these elements within Medicaid's bundled or prospective payment arrangements would not only promote clinical quality but also strengthen workforce sustainability.

The Certified Community Behavioral Health Clinic (CCBHC) model offers a proven precedent for expanding rate structures to support integrated, culturally responsive care. CCBHCs use prospective payment systems (PPS) and Quality Bonus Payments (QBP) to sustain comprehensive services for diverse populations and ensure financial stability for community providers (102). Increasing rates for culturally and linguistically specific behavioral health services (CLSS) organizations and multidisciplinary teams would align payment with the true cost of delivering equitable, community-based care. Adequate reimbursement for bilingual and bicultural providers would further address disparities in access, while incentivizing organizations to maintain diverse, team-oriented service models.

Transparent billing rules and dedicated provider support are essential for successful VBP implementation. Federal guidance now permits same-day billing for behavioral health and primary care visits, but inconsistent state Medicaid policies often lead to denied claims and administrative inefficiency (33). Oregon's VBP Roadmap and Implementation Toolkit demonstrates that structured billing education, technical assistance and clear documentation guidance can reduce errors and increase participation in alternative

payment models (103). Establishing a standardized Medicaid billing manual and continuous provider support, through webinars, coding clinics and technical consultations, would streamline billing and ensure clinicians can focus on direct service delivery rather than administrative correction.

Chapter 4: Investing in proven workforce incentive strategies

Oregon has established effective workforce incentive programs that help recruit and retain behavioral health providers, but these efforts face funding uncertainty and structural limitations. High education costs, restrictive loan repayment requirements and short-term funding cycles undermine the state's ability to build a stable workforce career pathway.

This chapter presents two recommendations to strengthen and expand proven incentive strategies, a sustainable investment in the programs that successfully bring qualified providers into high-need areas and keep them there.

Recommendation

4.1 Continue funding and expanding access to educational costs for programs while reducing loan forgiveness hour requirements

Workgroup Priority

The problem

Legislative Action Required

Behavioral health providers face financial barriers due to high education costs and limited, often restrictive, loan repayment options (particularly at the federal level). Current programs lack flexibility, can create tax burdens and do not adequately prioritize high-need areas or recognize behavioral health providers as essential workers, posing continued challenges to workforce recruitment and retention.

We recommend to

Continue funding programs supporting loan repayment and tuition assistance to offset the cost of education for students and trainees intending to provide services to underserved populations (see recommendation 4.2).

Reduce the requirements for loan forgiveness programs from 32 to 28 direct service hours for full time workers.

Prioritize retaining both certified and licensed providers working in high-need and high-acuity areas, such as rural and team-based care providers with BH certificates of approval, in educational based incentive programs (see recommendation 4.2).

Include loan repayment tax credits to offset income tax liability paid to the state incurred by loan forgiveness or loan repayment programs.

Incentivize behavioral health providers, particularly those that provide front-line crisis and high-acuity inpatient services, at a level comparable to first responders by making them eligible for tax incentives and state retirement benefits (for example, Public Employees Retirement System).

Expand the Rural Practitioner Tax credit (SB 438, 1989) to include behavioral health providers.

This will lead to

- ✓ Increased recruitment and retention of behavioral health providers.
- ✓ Greater incentive for providers to enter and remain in high-need, high-acuity areas.
- ✓ Improved workforce stability, reducing provider turnover in underserved communities.
- ✓ Financial relief for providers.
- ✓ Recognition of behavioral health providers as critical frontline responders, operating within the context of a behavioral health emergency state-wide.
- ✓ Strengthened access to care in rural and underserved areas, and enhanced availability and continuity of behavioral health services within those communities.

Workgroup implementation guidance

State programs that provide loan repayment or loan forgiveness to behavioral health providers should include a tax credit to offset these payments being counted as income at the state level. Once approved by the state legislature, OHA could provide a form to certify loan repayment and forgiveness recipients for that tax year and provide this information to the Oregon Department of Revenue to indicate that those individuals are eligible to claim the tax credit.

Legislators should continue pushing to include behavioral health providers as eligible to receive the Rural Practitioner Tax Credit. During the 2025 Legislative Session, HB 2365 was introduced to expand the types of providers eligible to receive the tax credit. The bill did not pass, but passing a similar bill would reduce tax burden for rural behavioral health providers and work to incentivize rural providers to continue practicing.

Supporting evidence and practice

Maryland's investment in behavioral health. The Investing in Maryland's Behavioral Health Talent report, prepared for the Maryland Health Care Commission, provides a blueprint for the Behavioral Health Workforce Investment Fund. It recommends approximately $149 million in public and private investment over five years, including funding for paid internships, tuition assistance, higher wages and other workforce supports (104).

Connecticut leverages university partnerships to provide tuition support. Connecticut's Child Health and Development Institute Workforce Strategic Plan report highlights how loan repayment programs can be a powerful tool for recruiting, retaining and diversifying the workforce. As a result, Connecticut launched a public-private partnership between Connecticut colleges and universities and the Office of Workforce Strategy to provide tuition support for social work students. This program, involving more than 30 public and private universities and colleges, is the first of its kind and is a model for utilizing public-private partnerships to address the behavioral health workforce crisis (105).

Washington has expanded its behavioral health loan forgiveness program through House Bill 1946 (2024), which adds a new scholarship pathway to incentivize behavioral health professionals to practice in shortage areas. Scholarship recipients commit to service obligations in high-need settings. This expansion aligns with findings from the U.S. Government Accountability Office, which concluded that scholarship programs may be more effective than loan repayment initiatives for recruiting and retaining behavioral health providers, particularly by reducing upfront tuition barriers and drawing a more racially and ethnically diverse workforce (106) (107). Scholarships reduce the burden of the upfront costs of tuition and the long-term commitment to loan repayment, which has the potential to increase of provider recruitment as well as being more likely to recruit racially and ethnically diverse providers (89).

Recommendation

4.2 Approve multi-year funding extensions for OHA incentive programs and create paid internships

The problem

Crucial incentive programs that support the behavioral health workforce, such as loan repayment, stipends and tuition assistance, lack long-term, stable funding. Without multi-year extensions and a focus on highly effective, flexible programs (including paid internships, "Grow Your Own" initiatives and support for high-demand areas), the state risks losing momentum in recruiting, training and retaining a diverse and effective workforce.

We recommend to	This will lead to
Approve multi-year funding extensions for all current OHA-based workforce incentive programs (for example, loan repayment, stipends and tuition assistance). **Prioritize grants and programs with the greatest effect and return on investment**, including tuition assistance and reimbursement and those programs assisting providers in high-need areas. **Create more paid internships and undergraduate practicum** (for example, Grow Your Own and long-term investments). **Make funding opportunities flexible**, to allow many ways to deploy incentives.	✓ Enhanced effectiveness of funding. ✓ Increased effectiveness by focusing on grant programs with proven success. ✓ More efficient use of resources by prioritizing initiatives with the highest Return on Investment. ✓ Strengthened workforce pipeline. ✓ Development of and investment in "Grow Your Own" programs that cultivate local talent for sustained workforce growth.

Workgroup implementation guidance

OHA's Behavioral Health Workforce Incentives (BHWI) team is well-positioned to rapidly and effectively implement incentive programs when approved through legislation, as they currently maintain the majority of state workforce incentive programs specific to behavioral health.

Supporting evidence and practice

OHA's BHWI team has made direct contributed to building capacity and increasing retention for Oregon's behavioral health workforce. The HB 2235 Workgroup recommends focusing on funding the most effective incentive programs and the BHWI team identifies those as behavioral education and training program scholarships, clinical supervision expansion, loan repayment and flexible grants for CMHPs. These incentives effectively influence each domain of the career pathway from education and training to supervisory and career advancement. Following are examples of how some of these programs have affected the behavioral health workforce and cost estimates along with predictions for future outputs.

The BHWI Scholarships Program, authorized by HB 2949 (2021), (108) launched in 2023 with an initial investment of just over $2 million from the American Rescue Plan Act. In its first two years, the program awarded scholarships to 286 students, of whom 166 successfully completed their training. Completion rates will continue to be monitored and are projected to rise, as many awards were granted mid-period. The program awarded applied associate-level degrees and peer training pathways designed to ensure graduates are workforce-ready and prepared to deliver direct services and transition immediately into relevant employment, which overwhelmingly includes serving Oregon's Medicaid Population (109). The cost of these education and training programs can be significant; for example, in-state tuition for applied associate programs in Oregon generally range between $6,000 and $8,000 for a full-time academic year. Further, students at community colleges are generally older, more culturally diverse, working and less reliant on their parent's income than students at 4-year colleges (110) (111) (112) (113). Training pathways like those supported by the scholarships program can provide low-barrier entries into the behavioral health field especially for students from underserved and underrepresented communities. Upon completing these programs, students will be prepared to sit for certification exams and earn credentials such as Peer Support Specialist, Certified Alcohol and Drug Counselor (CADC) I and Qualified Mental Health Associate (QMHA) I. Training pathways like those supported by the scholarships program can provide low-

barrier entries into the behavioral health field especially for students from underserved and underrepresented communities. Upon completing these programs, students will be prepared to sit for certification exams and earn credentials such as Peer Support Specialist, Certified Alcohol and Drug Counselor (CADC) I and Qualified Mental Health Associate (QMHA) I.

Scholarships were also awarded to Pacific University's Doctor of Psychology program at the School of Graduate Psychology and various graduate level counseling tracks at the Lewis and Clark Graduate School of Education and Counseling (114). These programs are costly for students, and they can expect to spend $44k per year for a Doctor of Psychology and over $68K for Master of Counseling degrees in tuition alone (115). Upon graduation from these programs, students are eligible to be Qualified Mental Health Professionals (QMHP) and board registered associates. Students earning these credentials play a vital role in addressing the 93 percent service gap identified in a 2023 report by the Oregon Alcohol and Drug Policy Commission, which represents the highest shortage among all direct service provider categories in the study (116).

The initiative includes a regular biennial investment of $1 million along with updated eligibility requirements for graduate and undergraduate education, training, and apprenticeship programs that lead directly to workforce-ready outcomes. In the first biennium, the program is projected to support at least 80 behavioral health students in completing their education or training. This approach is also expected to help reduce students' overall loan burden. Additionally, another 140 students are expected to receive support within that same biennium while progressing through their programs, further strengthening the behavioral health workforce career pathway. Service commitments required after graduation vary across academic programs, but students awarded will attest to practicing in an Oregon community upon completion of certificate or licensure to assist in retention (117).

The Clinical Supervision Expansion Grant has invested more than $13 million in ARPA funds to strengthen Oregon's behavioral health workforce (118). The grant provides funding for employers to supervise and train registered associates pursuing licensure, as well as other behavioral health provider registrants working toward certification as mental health or substance use providers. In addition, the program trains licensed behavioral health professionals to become clinical supervisors and equips all supervisors with the resources and training needed to deliver high-quality supervision. Since its launch in July 2022, the program has produced significant outcomes:

1. Nearly 900 supervisees hired and receiving supervision.

2. 348 licenses and certifications earned to date (program ongoing).
3. 136 new clinical supervisors trained.

The program prioritizes support for rural providers, culturally and linguistically specific providers and those delivering culturally responsive care. Looking ahead, the program could be further strengthened by:

1. Extending eligibility to graduate interns.
2. Increasing focus on high-need providers, including:
    - Culturally and linguistically specific providers.
    - Rural and remote providers.
    - Providers with a Certificate of Approval.
    - Team-based care providers.

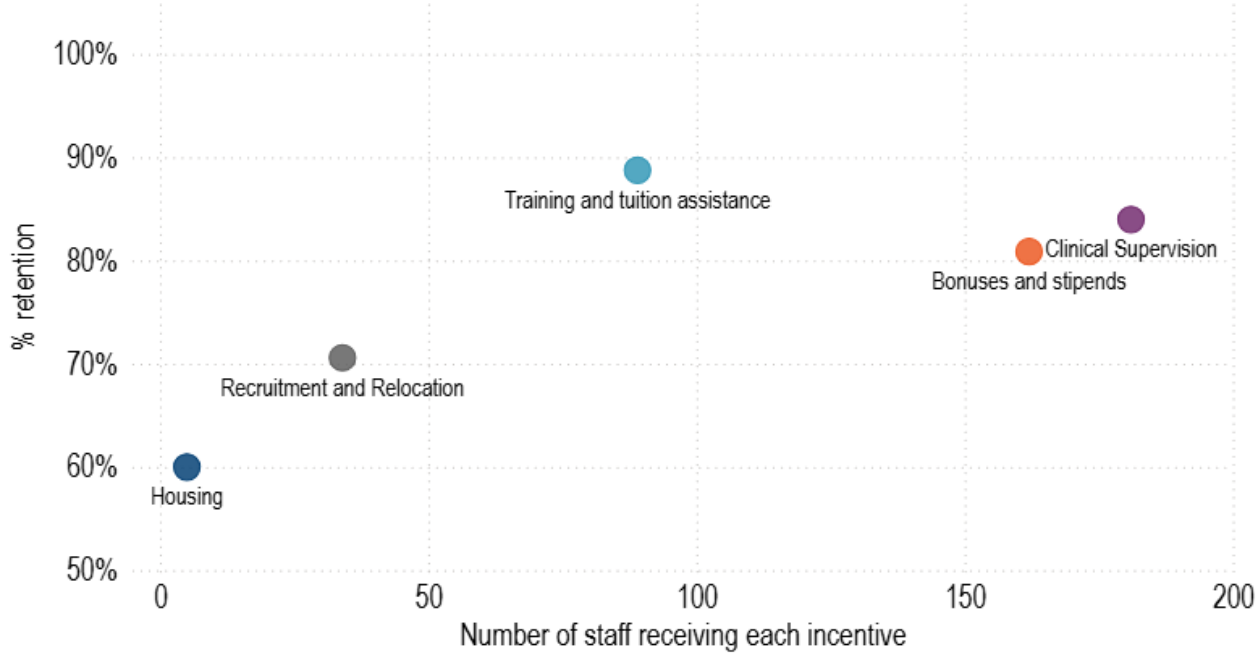
With a consistent biennial investment of $3 million, the current program's model utilizing a max award of $225,000 per organization would expect to generate at least 75 new licenses and certifications across 13 organizations operating in high-need settings, ensuring that resources are directed where they will be most effective.

The BHWI Loan Repayment program is a powerful retention tool. According to recent grant tracking, a strong majority of grant recipients who have completed their service commitment so far indicated that the program allowed them to "provide a higher quality of care" and "alleviate the financial burden of student loans" (see Figure 2). Furthermore, the 2025 evaluation on Oregon health care provider incentive programs, the BHWI loan repayments program maintained 94 percent retention within the reporting period.

This report also identified that all other loan repayment programs have been tracking a combined retention rate of 89 percent in Oregon's behavioral health system for up to 5 years (117). Continuing to invest in loan repayment like that of the Oregon Behavioral Health Loan Repayment Program or the State Loan Repayment Program (SLRP) from the OHA's Health Care Provider Incentive Program (117) can be maintained as a powerful retention tool. With a biennial investment of $3.5M set-aside for psychologists and master's level or below behavioral health providers, at least 70 providers can be awarded a max of $50,000 for loan repayment. This incentive comes with a goal of retaining providers in Oregon's high-needs behavioral health settings for a minimum of 2 years.

The Community Mental Health Program Grants (2025) (119) provide evidence for which recruitment and retention incentives are most effective for publicly financed behavioral health providers. In Spring of 2023, BHWI awarded $16M to CMHPs in ARPA funds to institute their own recruitment and retention incentives for their direct provider staff supporting a custom "Grow Your Own" approach. Preliminary reporting from the CMHP grant program indicates that out of all incentive types offered for all 34 Oregon counties that applied and were awarded that clinical supervision, training and tuition assistance and bonuses and stipends are the most successful at retaining providers in CMHPs. This data points to what incentives are most effective for retaining providers in publicly financed behavioral health provider organizations and can serve as a model for upcoming investments to these providers (see Figure 2) (120).

Figure 2. CMHP grants program participation and provider retention rates, BHWI Dashboard, OHA (Unpublished Data from the BWHI Dashboard)



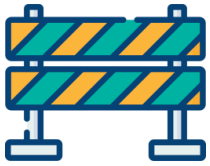
A similar approach (121) has been carried forward for the grant program, which allocates $4.9M in state funds for behavioral health incentives grants. The program expands eligibility to other outpatient and residential team-based care behavioral health providers. It narrows the incentive types to undergraduate and graduate scholarships, tuition assistance, loan forgiveness, loan repayment and stipends for behavioral health graduate students. Awards will only be for employers to recruit and retain behavioral health staff. The HB 2024 grant program expects to award at least 21 BH organizations and incentivize 145 individual providers at minimum with a goal of retaining a minimum 80 percent of providers awarded for 2 years. A continual biennial

investment of $4M in this style of grant program is expected to lead to similar outcomes and will be crucial for these organizations serving Oregon's underserved communities (122).

New Mexico prioritizes broad and adaptable support. New Mexico did just that in Senate Bill 1 (2025) that created the Behavioral Health Trust Fund and the Behavioral Health Program Fund to provide ongoing fiscal support for behavioral health in the state, including workforce development. The bill is short and open-ended stating that one of the designated services and programs to receive the funds is for the foundational infrastructure, technology and staffing supports required to ensure effective behavioral health service delivery (123). This allows the funds to be directed to areas that rise to the top as the highest need and using the highest leverage funding (for example, scholarships and loan repayments).

Paid pathways expand Maryland's behavioral health training. Maryland's SB 283/418 Investment Fund Report prioritizes expanding opportunities to reduce the financial burdens of education through apprenticeships, stipends, paid internships and residency programs (124). These "Earn and Learn," programs are like the "Grow Your Own" program recommended by the Oregon HB 2235 Workgroup. These programs allow individuals to be compensated while they are completing their education or receiving specialized training.

Chapter 5: Recruitment and retention of Latine/x/a/o providers



Oregon's Latine/x/a/o behavioral health professionals face persistent systemic barriers that limit their participation and advancement in the workforce. Current systems fail to recognize international credentials, provide inadequate language support and offer limited pathways for career advancement, resulting in underrepresentation and high attrition among qualified providers.

This chapter presents one comprehensive recommendation to:

- ✓ Increase recruitment of Latine/x/a/o providers through improved training and education pathways
- ✓ Strengthen retention through culturally responsive supervision and workplace support
- ✓ Advance equitable career progression through coordinated, cross-sector leadership initiatives

Recommendation

5.1 Create comprehensive career pathways for Latine/x/a/o providers from education through leadership

The problem

Latine/x/a/o and Spanish-speaking providers are significantly underrepresented in the Oregon behavioral health system proportional to the populations they serve. Twenty-two percent of Medicaid recipients in Oregon are Latine/x/a/o, with approximately 11 percent of these recipients being monolingual Spanish-speakers. Fewer than 9 percent of Oregon's behavioral health workforce identifies as Latine/x/a/o, and even fewer proportionally can deliver services in Spanish. Overall, Latine/x/a/o providers are the most underrepresented in Oregon's behavioral health workforce, especially within licensed behavioral health providers (109). Latine/x/a/o professionals face persistent systemic barriers throughout their behavioral health careers.

While the recommendations and examples presented within this section speak to the specific experiences of the Latine/x/a/o behavioral health workforce, the underlying challenges addressed (for example, credentialing barriers, lack of support for bilingual supervisors, uncompensated and unacknowledged cultural labor and limited advancement pathways) are shared by other underrepresented provider groups (including but not limited to the Black, Indigenous, immigrant, refugee, gender identity and sexual minority, rural, neurodivergent and bilingual workforces). Therefore, the framework presented here includes both focused strategies to bolster the Latine/x/a/o workforce and a transferable model that can be adapted to support the recruitment, retention and advancement of other Culturally and Linguistically Specific providers across Oregon.

Entry barriers:

1. Non-recognition of international degrees
2. Limited Spanish-language training and certification options
3. Rigid English-only workplace requirements excluding monolingual Spanish speakers

Workplace challenges:

1. Lack of culturally specific supervision and support

2. Uncompensated cultural and linguistic labor for bilingual staff
3. Non-inclusive workplace cultures
4. Limited Spanish-language resources and professional development

Advancement barriers:

1. Underrepresentation in leadership positions
2. Absence of structured career pathways
3. Minimal investment in Latine/x/a/o-specific recruitment and retention

Without intentional reforms, including adopting a holistic approach that considers solutions spanning educational opportunities, training, certification and licensure, workplace retention and career advancement, the field will continue to fall short in building an equitable, linguistically and culturally responsive workforce.

We recommend to

Increase, improve and sustain the recruitment, retention and advancement of Oregon's Latine/x/a/o behavioral health workforce through a comprehensive five-part pathway. Addresses systemic barriers from early education through leadership advancement. Each component below is essential and interconnected.

Comprehensive Pathway

1. Training and education
   - **Develop and invest in early career pathway programs** (for example, dual-language education from K-12 through licensure, Grow Your Own Programs for culturally and linguistically specific organizations and Career Technical Education in Behavioral Health).

Fund initiatives that:

- **Provide structured early mentorship and career exploration opportunities** in behavioral health for students from rural and marginalized communities.
- **Expand Spanish-language training tracks** in behavioral health educational and training programs (QMHA, Master of Social Work [MSW], Certified Alcohol and Drug Counselor [CADC], and other).
- **Offer loan forgiveness and repayment** specifically for Latine/x/a/o providers.

Comprehensive Pathway

2. Recruitment

- **Expand eligibility for who qualifies for enhanced payments** for delivering bilingual and CLSS services and provide greater clarity on how providers can be approved for this designation.
- **Systemically recognize and encourage employers to accept lived experience** as a valuable, compensated skill set.
- **Provide financial incentives** (for example, tax breaks) to employers for hiring and retaining providers who are Latine/x/a/o or from other marginalized communities so that provider demographics match local or regional populations.

3. Initial certification and licensure

- **Recognize Latin American (and internationally acquired) 5-year psychology degrees** as equivalent for QMHP applicants.
- **Develop pathways to integrate internationally trained providers** through policy or licensure reform.
- **Provide Spanish-language exam options** across the various licensing boards.

4. Retention

- **Support clinical supervision in Spanish.**
- **Allow providers to document in Spanish using culturally relevant frameworks and terminology** with adaptive translation support that preserves clinical meaning across languages, as well as EHR systems that accommodate cultural and linguistic differences in documentation styles.
- **Support peer supervision and reverse-mentorship** (for example, staff mentoring leadership).
- **Create and run Spanish-language support spaces** during paid work hours for community and retention.

5. Advancement

- **Establish a legislatively mandated cross-sector council to promote equitable advancement of Latine/x/a/o behavioral health providers**, with representatives spanning from frontline workers to administrators, plus partners from community

Comprehensive Pathway

organizations, advocacy groups, educational institutions and state agencies. Key functions should include:

- **Identify barriers to Latine/x/a/o advancement** and create inclusive advancement tracks and equitable promotion standards.
- **Coordinate and leverage resources** (for example, small grants, mentorship programs, workforce training and shared data systems) to support collaborative solutions.

- **Design and oversee policy and programmatic initiatives** that expand Latine/x/a/o leadership and participation (for example, paid opportunities for culturally and linguistically specific providers to lead continuing education trainings, adoption of diversity metrics tied to legislative funding).
- **Align with and collaborate alongside other statewide efforts and programs** (for example, Oregon Council for Behavioral Health, Oregon Advocacy Commission and Behavioral Health Equity and Community Partnership) to ensure cohesive, community-rooted strategies.

Supporting evidence and practice

Research underscores that workforce diversification begins with early exposure and sustained mentorship. A national pilot program introducing high school students to behavioral health careers significantly increased awareness and interest among underserved youth (125). Reviews of Latine/x/a/o community health worker and training models show that bilingual instruction, mentorship and structured curricula improve cultural competence and workforce entry (126). States such as California and New Mexico have implemented “Grow Your Own” and Career Technical Education pathways to connect bilingual high school and community college students to behavioral health degrees (127).

Recruitment of Latine/x/a/o behavioral health professionals requires inclusive hiring incentives and recognition of bilingual and lived experience as professional assets. State strategies compiled by the National Academy of State Health Policy (NASHP) (127) describe effective policies that expand bilingual pay differentials, reward cultural competence and reduce barriers to employment for underrepresented providers. Similarly, the National Hispanic Health Foundation (2024) emphasizes workforce initiatives that

pair internships, fellowships and leadership development to attract and retain Hispanic health professionals. Research in nursing and behavioral health shows that structured mentorship and culturally responsive recruitment improve retention and career satisfaction among minority professionals (128).

Systemic reform of licensure and certification processes is critical to integrating internationally trained Latine/x/a/o professionals into Oregon's behavioral health workforce. Many Latin American countries confer five-year psychology and social work degrees equivalent to U.S. master's programs, yet current Oregon licensure pathways do not recognize these credentials. To exacerbate barriers to licensure for Latine/x/a/o professionals, the Association of Social Work Boards (ASWB) exam is offered only in English. According to the 2022 ASWB Exam Pass Rate Analysis, between 2018 and 2021, first-time pass rates showed that Latine/x/a/o exam takers passed at 77 percent, while White exam takers passed at 91 percent (94).

Retention of Latine/x/a/o providers depends on culturally congruent supervision, workload support and community belonging. The Hispanic/Latino Behavioral Health Equity Playbook (129) stresses that supervision in Spanish, peer mentoring and supportive work environments is essential to sustaining bilingual and bicultural staff. Studies from University of California, San Francisco's Healthforce Center indicate that workforce retention improves when professionals have access to affinity groups, culturally aligned supervision and institutional flexibility that affirms identity (130). They also highlighted that translation and interpreter services are unevenly supported, and clinicians described inconsistencies in translated documentation across units, contributing to communication friction and extra cognitive burden.

Equitable advancement requires leadership pathways and institutional accountability. Research shows that leadership representation in behavioral health remains disproportionately low for Latine/x/a/o professionals due to barriers in promotion, mentorship and institutional recognition. California's statewide leadership initiative for underrepresented health professionals integrates mentorship, small grants and diversity metrics tied to institutional funding (131). Similarly, the Milbank Memorial Fund (132) emphasizes that embedding diversity goals into workforce development, supported by transparent data reporting and cross-sector collaboration, helps achieve measurable progress.

Conclusion

Oregon's behavioral health workforce crisis demands immediate, coordinated action. This report presents 21 evidence-based recommendations addressing the systemic barriers that prevent qualified professionals from entering, remaining in and advancing within the field.

The recommendations fall into five strategic areas: 1) modernizing licensing and credentialing systems; 2) reducing workforce burnout and administrative burden; 3) reforming reimbursement structures; 4) investing in proven incentive programs and 5) creating pathways for Latine/x/a/o providers. While each recommendation stands on its own merit, their collective implementation offers the greatest potential for sustainable change.

Success requires legislative commitment beyond single biennium funding cycles. Multi-year investments, statutory reforms and cross-sector coordination are essential to building the workforce infrastructure Oregon needs and Oregonians deserve. The prioritization framework provided throughout this report enables strategic, phased implementation when full adoption is not immediately feasible.

The cost of inaction is measured in those Oregonians waiting for care, providers leaving the field due to unsustainable working conditions and communities (particularly rural and culturally specific populations) facing widening gaps in access.

These recommendations provide a roadmap. Implementation will require partnership between the Oregon Health Authority, licensing boards, behavioral health organizations, Coordinated Care Organizations, educational institutions and the Legislature. The workgroup stands ready to support this implementation and urges swift action to stabilize Oregon's behavioral health system before the crisis deepens further. With sustained commitment and collaborative action, Oregon can transform its behavioral health system into one that supports both the providers who deliver care and the communities who depend on it.

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Finally, we honor Oregon's behavioral health workforce — those who continue serving despite the challenges documented in this report. Their dedication to Oregon's most vulnerable populations inspired this work and drives these recommendations forward.

Appendix

A. List of recommendations by workgroup priority ranking

#1 1.1 Expand licensure pathways for out-of-state and military affiliated applicants, recognize non-traditional qualifications and lived experience

#2 5.1 Create comprehensive career pathways for Latine/x/a/o providers from education through leadership

#3 4.1 Continue funding and expanding access to educational costs for programs while reducing loan forgiveness hour requirements

#4 3.1 Streamline COA processes and accept equivalent accreditations

#5 4.2 Approve multi-year funding extensions for OHA incentive programs and create paid internships

#6 3.2 Establish centralized credentialing through OHA vendor partnership and pilot testing approach

#7 2.1 Strengthen clinical supervision infrastructure through comprehensive supervisor support

#8 3.5 Expand Medicaid billing options for certain providers beyond a COA and provide technical assistance to ensure accessible and stable funding

#9 2.3 Mitigate burnout in high-acuity settings through caseload caps and wellness resources

#10 1.5 Strengthen clinical supervision through standardized training and clear guidelines

#11 2.6 Implement regional variances to balance regulatory requirements with local needs

#12 2.5 Expand workforce through second-chance employment and lived experience recruitment

#13 1.3 Support licensing boards through gap analysis and enhanced transparency to eliminate processing delays

#14 2.4 Create specialized training tracks for crisis, suicide prevention and substance use treatment

#15 2.2 Raise reimbursement rates and salary standards for high-demand settings

#16 3.4 Address documentation burdens by pursuing parity with medical provider documentation and providing standardized forms and templates

#17 1.6 Reduce financial barriers with subsidized initial licensing and certification and free continuing education

#18 1.4 Examine current associate licensure wait times and adopt a competency-based licensure with added supervisor resources

#19 1.2 Expand and clarify roles for non-licensed behavioral health professionals

#20 3.3 Investigate reimbursement rate disparities across behavioral health certification levels

#21 3.6 Convene task force to evaluate value-based payment design and address implementation challenges

B. List of recommendations requiring legislative actions by priority ranking

#1 5.1 Create comprehensive career pathways for Latine/x/a/o providers from education through leadership

#2 4.1 Continue funding and expanding access to educational costs for programs while reducing loan forgiveness hour requirements

#3 4.2 Approve multi-year funding extensions for OHA incentive programs and create paid internships

#4 2.1 Strengthen clinical supervision infrastructure through comprehensive supervisor support

#5 2.6 Implement regional variances to balance regulatory requirements with local needs

#6 2.5 Expand workforce through second-chance employment and lived experience recruitment

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#10 3.4 Address documentation burdens by pursuing parity with medical provider documentation and providing standardized forms and templates

#11 1.6 Reduce financial barriers with subsidized initial licensing and certification and free continuing education

C. Glossary of acronyms

A

ACT — Assertive Community Treatment

AI — Artificial Intelligence

ASWB — Association of Social Work Boards

B

BHA — Behavioral Health Agency/Administration

BHASO/BHASOs — Behavioral Health Administrative Service Organizations

BHI — Behavioral Health Integration

BHWET — Behavioral Health Workforce Education and Training

BHWI — Behavioral Health Workforce Incentives

BLSW — Board of Licensed Social Workers

BST — Behavioral Skills Training

C

CADC — Certified Alcohol and Drug Counselor

CARF — Commission on Accreditation of Rehabilitation Facilities

CCBHC — Certified Community Behavioral Health Clinic

CCO — Coordinated Care Organization

CE — Continuing Education

CEU — Continuing Education Unit

CLSS — Culturally and Linguistically Specific Services

CMHP — Community Mental Health Programs

CMS — Centers for Medicare & Medicaid Services

COA — Certificate of Approval

CoCM — Collaborative Care Model

CRPA — Certified Recovery Peer Advocate

CTE — Career Technical Education

D

DEA — Drug Enforcement Administration

DHS — Department of Human Services

DHSS — Alaska Department of Health and Social Services

DOC — Department of Corrections

DPHHS — Montana Department of Public Health and Human Services

E

EAMHS — Enhanced Adult Mental Health Service

EASA — Early Assessment and Support Alliance

ECHO — Extension for Community Healthcare Outcomes (Project ECHO)

EHR — Electronic Health Record

FQHC — Federally Qualified Health Centers

HECC — Higher Education Coordinating Commission

HB 2235 — House Bill 2235

HPSA — Health Professional Shortage Area

HRSA — Health Resources and Services Administration

I

ICM — Intensive Case Management

IIBHT — Intensive in-Home Behavioral Health Treatment

IPS — Individual Placement and Supports

L

LCSW — Licensed Clinical Social Worker

LMHP — Licensed Mental Health Professional

M

MCPAP — Massachusetts Child Psychiatry Access Program

MCO — Managed Care Organization

MHRA — Mental Health Regulatory Agency

MSW — Master of Social Work

N

NASHP — National Academy for State Health Policy

NASMHPD — National Association of State Mental Health Program Directors

NRI — National Research Institute

NSP — Nonspecialized Providers

O

OAR — Oregon Administrative Rules

OBLPCT — Oregon Board of Licensed Professional Counselors and Therapists

OCCP — Oregon Common Credentialing Program

OHA — Oregon Health Authority

OHP — Oregon Health Plan

P

PAL — Psychiatry Consultation Line

PPS — Prospective Payment System

Q

QBP — Quality Bonus Payments

QDP — Qualified Directed Payments

QMHA — Qualified Mental Health Associate

QMHA-II — Qualified Mental Health Associate Level II

QMHP — Qualified Mental Health Professional

QMHP-C — Qualified Mental Health Professional - Child

R

RBSW — Registered Bachelor of Social Work

RHC — Rural Health Center

RTH — Residential Treatment Home

S

SAMHSA — Substance Abuse and Mental Health Services Administration

SBIRT — Screening, Brief Intervention and Referral to Treatment

SUD — Substance Use Disorder

T

TA — Technical Assistance

TAU — Treatment as Usual

TAY/TAYIS — Transition Age Youth and Transition Age Youth Intensive Services

V

VA — Veterans Affairs

VBP — Value-Based Payment

D. Glossary of key terms

Acute care or High-acuity settings — Treatment environments serving clients with severe, complex or crisis-level behavioral health needs requiring intensive intervention.

Administrative burden — Excessive paperwork, documentation and compliance requirements that take time away from direct client care.

Administrative overhead caps — Regulatory limits on the percentage of program funding that can be used for administrative costs versus direct services.

Associates — Graduate-level behavioral health professionals working under supervision to accumulate required hours for independent licensure.

Biennium — Two-year budget cycle used by Oregon's state legislature.

Billing codes — Standardized numeric codes used to identify services for insurance reimbursement.

Bridge programs — Educational pathways helping internationally trained professionals meet U.S. licensure requirements.

Capitation — Payment model where providers receive fixed per-member amounts regardless of services provided.

Career pathway — Structured progression from education through training to employment and advancement in behavioral health.

Caseload — Number of clients assigned to a single provider, affecting workload and quality of care.

Certificate of Approval (COA) — Oregon certification allowing organizations to provide behavioral health services and bill Medicaid.

Clinical supervision — Oversight and mentoring by licensed professionals for trainees and associates, required for licensure.

Community mental health programs (CMHP) — Public or nonprofit organizations providing behavioral health services primarily to Medicaid recipients and uninsured individuals.

Compassion fatigue — Emotional and physical exhaustion from prolonged exposure to client trauma and suffering.

Competency-based licensure — Evaluating readiness to practice based on demonstrated skills rather than fixed time requirements.

Continuing Education Units (CEUs) — Required ongoing training hours for maintaining professional licenses and certifications.

Coordinated Care Organizations (CCOs) — Oregon's regional managed care entities administering Medicaid benefits.

Credentialing — Process of verifying provider qualifications for insurance network participation.

Culturally and Linguistically Specific Services (CLSS) — Services tailored to unique cultural and language needs of specific populations.

Direct service hours — Face-to-face clinical service time, often required for loan forgiveness or licensure.

Emergency declaration — Legislative designation recognizing urgent need requiring immediate action.

Equity — Fair treatment and opportunity ensuring all populations can achieve optimal health outcomes.

Evidence-based practice — Treatments and interventions proven effective through scientific research.

Feasibility — Assessment of whether a recommendation can realistically be implemented given resources and systems.

Federally Qualified Health Centers (FQHCs) — Community-based health care providers serving underserved areas regardless of ability to pay.

Fee-for-service — Payment model reimbursing providers for each service delivered.

Fidelity — Degree to which programs adhere to evidence-based practice standards.

Frontier regions — Most isolated rural areas with extremely low population density and limited services.

Gap analysis — Systematic evaluation identifying differences between current state and desired outcomes.

Grow Your Own programs — Local workforce development initiatives recruiting community members into behavioral health careers.

High-demand settings — Specialty programs providing intensive, team-based care for complex populations.

Integrated care — Coordinated delivery of behavioral health and primary care services.

International credentials — Professional degrees and licenses obtained outside the United States.

Latine/x/a/o — Gender-inclusive terms for people of Latin American origin or descent.

Licensure reciprocity — Recognition of out-of-state licenses allowing practice without repeating full licensure process.

Lived experience — Personal history with mental health or substance use providing unique insight for peer roles.

Loan forgiveness — Programs canceling educational debt in exchange for service in underserved areas.

Medicaid — Federal-state health insurance program, primary funding source for public behavioral health.

Peer support — Services provided by individuals with lived experience of recovery.

Pre-application process — System allowing licensure application before graduation, pending degree completion.

Primary source verification — Confirming credentials directly from issuing institutions.

Prior authorization — Insurance requirement for pre-approval before providing certain services.

Prospective payment — Payment made in advance based on expected services rather than actual delivery.

Public behavioral health system — Network of providers funded primarily by Medicaid and government grants.

Qualified Mental Health Associate (QMHA) — Entry-level behavioral health professional providing services under supervision.

Qualified Mental Health Professional (QMHP) — Mid-level provider meeting specific education and experience requirements.

Reimbursement rate — Amount paid by insurance or government programs for specific services.

Reverse-mentorship — Junior staff sharing expertise with senior leadership, particularly around cultural competence.

Risk-adjusted reimbursement — Payment rates adjusted for client complexity and care needs.

Rural Practitioner Tax Credit — Oregon tax incentive for health care providers in rural areas.

Safety net services — Health care for uninsured and underserved populations regardless of payment ability.

Scope of practice — Legal boundaries of services professionals can provide based on license and certification.

Second-chance employment — Hiring practices for individuals with criminal justice involvement.

Suicide risk assessment — Systematic evaluation of client's potential for self-harm.

Supervision hours — Required oversight hours needed for licensure advancement.

Team-based care — Coordinated service delivery by multidisciplinary professionals.

Technical assistance — Training and support for implementing new practices or meeting requirements.

Top of license — Professionals working at full extent of training and credentials.

Underserved populations — Communities with limited access to behavioral health services.

Value-based payment — Reimbursement tied to quality outcomes rather than service volume.

Variance process — Administrative mechanism allowing exceptions when equivalent qualifications exist.

Workforce pipeline — System for recruiting, training and retaining professionals from education through advancement.

Wraparound services — Comprehensive, coordinated team approach for youth and families with complex needs.

References

1. **Reinert, M., Fritze, D. & Nguyen, T.** *The State of Mental Health in America 2025.* Alexandria, VA : Mental Health America, 2025. https://mhanational.org/wp-content/uploads/2025/09/State-of-Mental-Health-2025.pdf.

2. **Oregon Administrative Rules.** *Educational Requirements for Licensure as a Professional Counselor.* s.l. : Mental Health Regulatory Agency, 2024. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=320391.

3. —. *Board of Licensed Social Workers.* s.l. : OAR, 2022. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=292858.

4. **Oregon Health Authority.** *HB2235 Workgroup Public Meeting May 21, 2025.* s.l. : OHA, 2025. https://www.oregon.gov/oha/HSD/AMH/docs/05.21.25%20HB%202235%20Workgroup%20Public%20Meeting%20Presentation.pdf.

5. **Oregon Administrative Rules.** *Oregon Board of Licensed Professional Counselors and Therapists.* s.l. : OAR, 2014. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=305923.

6. **Farley, G.** *Economic implications of the 2019's HB 2569: A 2023 update.* s.l. : Common Sense Institute, 2023. https://www.commonsenseinstituteus.org/arizona/research/jobs-and-our-economy/economic-implications-of-2019s-hb-2569-a-2023-update.

7. **Washington State Legislature.** *Senate Bill 5054: Increasing the behavioral health workforce by establishing a reciprocity program for behavioral health licenses and certifications.* 2019. https://app.leg.wa.gov/billsummary?BillNumber=5054&Year=2019.

8. **Office of Oregon Governor.** *Behavioral Health Talent Council.* n.d. https://www.oregon.gov/gov/policies/Pages/Behavioral-Health-Talent-Council.aspx.

9. **Matthews, E., Rahman, R., Schiefelbein, F., Galis, D., Clark, C. & Patel, R.** *Identifying key roles and responsibilities of peer workers in behavioral health services: A scoping review.* s.l. : Patient Education and Counseling, 2023. DOI: 10.1016/j.pec.2023.107858.

10. **Adams, W., Duquette, R, de Wet, A. & Rogers, E.** *Competing allegiance in an unclear role: Peer and non-peer understanding of peer support in Massachusetts, United States.* s.l. : SSM - Mental Health, 2023. DOI: 10.1016/j.ssmmh.2023.100245.

11. **National Governors Association.** *The Emerging Field of Behavioral Health Paraprofessionals.* s.l. : National Governors Association, 2024. https://www.nga.org/publications/the-emerging-field-of-behavioral-health-paraprofessionals/.

12. **Arizona Administrative Code.** *Health Services.* 2025. https://apps.azsos.gov/public_services/Title_09/9-10.pdf.

13. **Arizoa Administrative Code.** *Health Services.* 2025. https://apps.azsos.gov/public_services/Title_09/9-10.pdf.

14. **Brumble, C.** *Behavioral Health Licensing Amendments: SB 26.* s.l. : Utah Legislature, 2024. https://custom.statenet.com/public/resources.cgi?id=ID:bill:UT2024000S26&ciq=urn:user:PA194530463&client_md=8694e0c09af2245163b7cc04fd22b9cf&mode=current_text.

15. **Arizona Board of Behavioral Health Examiners.** *Additional Information on HB2001: How to Continue Providing Behavioral Health Services at Your Practicum.* 2025. https://bbhe.az.gov/sites/default/files/2025-09/HB2001Correspondence.pdf.

16. **Oklahoma Legislature.** *Mental health; definitions; application information; behavioral health professionals; renewal information; promulgation of rules; annual reports; Legislature; effective date.* 2024. https://www.oklegislature.gov/BillInfo.aspx?Bill=hb3330&Session=2400.

17. **Washington State Legislature.** *Establishing behavioral health support specialists.* 2024 : s.n. https://app.leg.wa.gov/billsummary?BillNumber=5189&Year=2023.

18. **Washington State Department of Health.** *Education Information.* n.d. https://doh.wa.gov/licenses-permits-and-certificates/professions-new-renew-or-update/behavioral-health-support-specialist/education-information.

19. **O'Connell, W., Renn, B., Arean, P. & Ratzliff, A.** *Behavioral Health Workforce Development in Washington State: Addition of a Behavioral Health Support Sepcialist.* s.l. : Psychiatric Services, 75(10), 1042-1044, 2024. https://psychiatryonline.org/doi/full/10.1176/appi.ps.20230312#:~:text=The%20University%20of%20Washington%20(UW,in%20the%20behavioral%20health%20workforce.

20. **Arizona Legislature Assemby.** *Behavioral health; graduates; license exemption.* 2025. https://www.azleg.gov/legtext/57leg/1R/laws/0118.pdf.

21. **Arizona Board of Behavioral Health Services.** *Additional Information on HB2001: How to Continue Providing Behavioral Health Services at Your Practicum.* 2025. https://bbhe.az.gov/sites/default/files/2025-09/HB2001Correspondence.pdf.

22. **Kraemer Tebes, J., Martin, S., Migdole, S., Farkas, M., Money, R., Shulman, L. & Hoge, M.** *Providing Competency Training to Clinical Supervisors Through an Interactional Supervision Approach.* s.l. : Research on Social Work Practice, 21(2), 190-199., 2011. https://doi.org/10.1177/1049731510385827.

23. **Last, B., Crable, E., Khazanov, G., Scheinfeld, L., McGinty, E. & Purtle, J.** *Impact of U.S. Federal Loan Repayment Programs on the Behavioral Health Workforce: Scoping Review.* s.l. : Psychiatric Services, 75(7), 652-666, 2024. https://psychiatryonline.org/doi/10.1176/appi.ps.20230258.

24. **Colorado General Assembly.** *House Bill 22-1299: License Registration Fee Relief for Mental Health Professionals.* 2022. https://leg.colorado.gov/bills/hb22-1299.

25. **Oregon Health Authority.** *Clinical Supervision Expansion Program.* s.l. : Health Systems Division: Behavioral Health Services, 2023. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=299938.

26. **New Mexico Department of Health.** *Clinical supervision implementation guide (2nd ed.).* Santa Fe, NM: NMDOH. : s.n., 2024.

27. **American Psychological Association.** *Guidelines for clinical supervision in health service psychology.* s.l. : American Psychologist, 70(1), 33–46., 2015. https://doi.org/10.1037/a0038112.

28. **Health Resources and Services Administration.** *Behavioral health workforce education and training (BHWET) program.* s.l. : Department of Health and Human Services. https://bhw.hrsa.gov/.

29. **Oregon Health Authority.** *Behavioral health clinical supervision expansion program.* Salem, OR: OHA. : s.n., 2023. https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=6941#:~:text=The%20Program%20offers%20grants%20to%20organizations%2.

30. **California Health Care Access and Information.** *Behavioral health programs.* Sacramento, CA: HCAI. : s.n., 2023. https://hcai.ca.gov/.

31. **Borders, L. D., Glosoff, H. L., Welfare, L. E., Hays, D. G., DeKruyf, L., Fernando, D. M., & Page, B.** *Best practices in clinical supervision: Evolution of a counseling specialty.* : The Clinical Supervisor, 33(1), 26-44., 2014.

32. **Rural Health Information Hub.** *Scholarships, Loans, and Loan Repayment for Rural Health Professions.* 2024. https://www.ruralhealthinfo.org/topics/scholarships-loans-loan-repayment.

33. **Centers for Medicare & Medicaid Services.** *COVID-19 emergency declaration blanket waivers for health care providers.* s.l. : U.S. Department of Health and Human Services., 2022. https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf.

34. **Substance Abuse and Mental Health Services Administration.** *Mental Health Technology Transfer Center Cooperative Agreements.* s.l. : SAMHSA, n.d. https://www.samhsa.gov/grants/grant-announcements/sm-18-015.

35. **Oregon Health Authority.** *Primarily Medicaid directed payment guidance.* s.l. : OHA, 2024.

https://www.oregon.gov/oha/HSD/OHP/CCO/ORCY25BH_PrimarilyMedicaid_Directed_Payment_Guidance%2012242024%20final.pdf .

36. —. *OHA works to protect quality health care across Oregon.* s.l. : OHA, 2025. https://www.oregon.gov/oha/erd/pages/oha-works-to-protect-quality-health-care-across-oregon.aspx?form=MG0AV3#:~:text=Cost%20containment&text=While%20OHA%20established%20directed%20behavioral,1%2C%202026.

37. **Kemble SB, Kahn JG.** *Optimizing Physician Payment for a Single-Payer Healthcare System.* s.l. : Int J Soc Determinants Health Health Serv, 53(4):543-547, 2023. doi: 10.1177/27551938231176358.

38. **O'Connell, W. P., Renn, B. N., Areán, P. A., Raue, P. J., & Ratzliff, A.** *Behavioral Health Workforce Development in Washington State: Addition of a Behavioral Health Support Specialist.* : Psychiatric Services, 75(10), 1042–1044, 2024. https://doi.org/10.1.

39. **Stolarchuk, C., Gupta, A., Kumar, P., Lionis, C., Anastasaki, M., Conde, M. G., Chowdhury, M., Andoko, D., Gauchan, B., & Awankem, B.** *Optimizing Healthcare Delivery: Strategies for Workforce Retention and Resource Allocation.* s.l. : Journal of Surgical Specialties and Rural Practice, 6(1), 3-8., 2025. DOI: 10.4103/jssrp.jssrp_7_25.

40. **Advancing a Healthier Wisconsin Endowment.** *Advancing a Healthier Wisconsin Endowment Invests $5.6 Million in Wisconsin Health Workforce Well-Being.* s.l. : Medical College of Wisconsin Newsroom, 2025.

41. **Massachusetts Child Psychiatry Access Program (MCPAP).** *MCPAP 2022 annual report. Executive Office of Health and Human Services.* : Massachusetts Department of Mental Health, 2022. https://www.mass.gov/doc/massachusetts-child-psychiatry-access-project-mcpap.

42. **Arora, S., Kalishman, S., Thornton, K., Komaromy, M., Katzman, J., Struminger, B., & Rayburn, W. F.** *Project ECHO (Project Extension for Community Healthcare Outcomes): a national and global model for continuing professional development.* s.l. : Journal of Continuing Education in the Health Professions, 36, S48-S49., 2016.

43. **Colorado Department of Public Health and Environment.** *CO-CARES: Colorado Alliance for Resilient and Equitable Systems.* 2022. https://cdphe.colorado.gov/co-cares.

44. **Substance Abuse and Mental Health Services Administration.** *Assertive community treatment: Building your program.* s.l. : DHHS Publication No. SMA08-4344. U.S. Department of Health and Human Services, 2008. https://library.samhsa.gov/sites/default/files/sma08-4.

45. **Oregon Health Authority.** *ACT Program Operational Standards.* s.l. : Health Systems Division: Behavioral Health Services , 2025. https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=325280.

46. **Bond, G. R., & Drake, R. E.** *The critical ingredients of assertive community treatment.* s.l. : World Psychiatry, 14(2), 240–242. , 2015. https://doi.org/10.1002/wps.20234.

47. **Bruns, E. J.** *Wraparound research summary 2024 update. National Wraparound Initiative,.* s.l. : Portland State University., 2024. https://nwi.pdx.edu/pdf/wraparound-research-summary-10-2024.pdf.

48. **Coldiron, J. S., Bruns, E., Hensley, S., & Paragoris, R.** *Wraparound implementation and practice quality standards: A comprehensive guide to wraparound fidelity and outcomes.* s.l. : National Wraparound Initiative, 2020. https://nwi.pdx.edu/pdf/Wraparound-implementation-and-practice-quality-standards.pdf.

49. **National Academy of Medicine.** *National plan for health workforce well-being. .* Washington, DC : National Academies Press, 2022. https://nam.edu/publications/national-plan-for-health-workforce-well-being/.

50. **Shanafelt, T. D., & Noseworthy, J. H. .** *Executive leadership and physician well-being: Nine organizational strategies to promote engagement and reduce burnout.* s.l. : Mayo Clinic Proceedings, 92(1), 129–146., 2017. https://doi.org/10.1016/j.mayocp.2016.10.004.

51. **Substance Abuse and Mental Health Services Administration.** *National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit Executive Summary.* s.l. : SAMHSA,

2020. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf.

52. **Richard, O., Jollant, F., Billon, G., Attoe, C., Vodovar, D. & Piot, M.A.** *Simulation training in suicide risk assessment and intervention: a systematic review and meta-analysis.* s.l. : Medical Education Online, 28(1), 2023. https://doi.org/10.1080/10872981.2023.2199469.

53. **Gomez E, Gyger M, Borene S, Klein-Cox A, Denby R, Hunt S, Sida O.** *Using SBIRT (Screen, Brief Intervention, and Referral Treatment) Training to Reduce the Stigmatization of Substance Use Disorders Among Students and Practitioners.* s.l. : Substance Abuse, 16(17), 2023. doi: 10.1177/11782218221146391.

54. **Virginia's CTE Resource Center.** *Mental Health Assisting Careers.* Henrico, VA : The CTE Resource Center, n.d. https://www.cteresource.org/career-clusters/human-services/17594/.

55. **Substance Abuse and Mental Health Services Administration.** *National Guidelines for a Behavioral Health Coordinated System of Crisis Care.* s.l. : SAMHSA, 2025. https://988crisissystemshelp.samhsa.gov/sites/default/files/2025-04/national-guidelines-crisis-care-pep24-01-037.pdf.

56. **Thangada, M.S. & Kasoju, R.** *A systematic review of suicide risk management strategies in primary care settings.* s.l. : Front Psychiatry, 2024. doi: 10.3389/fpsyt.2024.1440738..

57. **Oregon Workforce Partnership.** *Reentry Program.* s.l. : Oregon Workforce Partnership, n.d. https://oregonworkforcepartnership.org/reentry/.

58. **Department of Labor.** *Pathway Home 4.* s.l. : US Department of Labor. https://www.dol.gov/sites/dolgov/files/general/grants/PH4-Outreach-FactSheet2.pdf.

59. **Oregon Legislature Assembly.** *Senate Bill 1545.* s.l. : Oregon State Legislature, 2022. https://olis.oregonlegislature.gov/liz/2022r1/Downloads/MeasureDocument/SB1545/Enrolled.

60. **Oregon Health Authority.** *Substance Use Disorder 1115 Demonstration Waiver.* s.l. : OHA, 2025. https://www.oregon.gov/oha/hsd/medicaid-policy/pages/sud-waiver.aspx.

61. **Chisholm, J., & Petrakis, M.** *Peer Worker Perspectives on Barriers and Facilitators: Implementation of Recovery-Oriented Practice in a Public Mental Health Service.* s.l. : Journal of Evidence-Based Social Work, 20(1), 84–97., 2022. https://doi.org/10.1080/26408066.2022.2118006.

62. **Substance Abuse and Mental Health Services Administration.** *Core Competencies for Peer Workers in Behavioral Health Services.* s.l. : SAMHSA, 2015. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf.

63. **National Research Institute (NRI).** *Peer Specialists Working in State Behavioral Health Systems, 2023-2024 (Draft).* s.l. : NRI, 2024. https://nri-inc.org/media/ve5b3e5e/use-of-peer-specialists-in-state-bh-service-settings-2023.pdf.

64. **Staatz, Colleen.** *Registered Apprenticeships for Community Health Workers and Dually Certified Peer Recovery Specialist–Community Health Workers (Strategy Spotlight).* s.l. : Mathematica for U.S. DOL CEO, 2021. https://www.mathematica.org/publications/registered-apprenticeships-for-community-health-workers-and-dually-certified-peer-recovery.

65. **Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., Laudet, A., et al.** *Peer-Delivered Recovery Support Services for Addictions in the United States: A Systematic Review.* s.l. : Journal of Substance Abuse Treatment, 63, 1-9, 2016. https://doi.org/10.1016/j.jsat.2016.01.003.

66. **New York State Office of Addiction Services and Supports (OASAS).** *OASAS Services: General Provisions.* New York, NY : OASAS, 2022. https://oasas.ny.gov/system/files/documents/2022/09/800.pdf.

67. **Shook, C. B., Wray, L. O., Dollar, K. M., Matthieu, M. M., Peeples, A. D., Chinman, M., Goldberg, R. W., & Pomerantz, A. S.** *Implementation of peer specialists in Veterans Health Administration primary care: Improving program fidelity through enhanced*

preimplementation support. s.l. : Psychological Services, 22(4), 736–748, 2025. https://doi.org/10.1037/ser0000911.

68. **Bingham, D., & Kelley, A.** *Rethinking recovery: A qualitative study of American Indian perspectives on peer recovery support.* : Journal of Ethnicity in Substance Abuse, 23(2), 237–250, 2024. https://doi.org/10.1080/15332640.2022.2082620 .

69. **Substance Abuse and Mental Health Services Administration (SAMHSA).** *Tribal Training and Technical Assistance Center: Promoting Mental Health and Substance Use Recovery in Native Communities.* s.l. : U.S. Department of Health and Human Services., 2021. https://www.samhsa.gov/tribal-ttac.

70. **Lombardi, B. M., de Saxe Zerden, L., & Fraher, E.** *Aligning Training, Regulation, and Payment Policy to Advance the Behavioral Health Workforce.* s.l. : Health Affairs Scholar, 2024. https://doi.org/10.1093/haschl/qxae148.

71. **Substance Abuse and Mental health Services Administration (SAMHSA).** *SAMHSA State Program Improvement Technical Assistance.* s.l. : SAMHSA, n.d. https://www.samhsa.gov/sites/default/files/samhsa-state-ta-brochure.pdf.

72. **Aarons, G. A., Ehrhart, M. G., Moullin, J. C., Torres, E. M., & Green, A. E.** *Implementation leadership: Leveraging leadership to improve implementation outcomes in behavioral health.* s.l. : Administration and Policy in Mental Health and Mental Health Services Research, 44(2), 278-291, 2017. https://doi.org/10.1007/s10488-016-0752-3.

73. **Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., ... & Hensley.** *Outcomes for implementation research: conceptual distinctions, measurement challenges, and research agenda.* s.l. : Administration and policy in mental health services research, 38(2), 65-76., 2011.

74. **Colorado Behavioral Health Administration.** *Behavioral Health Reform: Annual Report.* s.l. : Colorado Behavioral Health Administration, 2023. https://bha.colorado.gov.

75. **Oregon Health Authority.** *Evaluation of the Oregon Certified Community Behavioral Health Clinic (CCBHC) Program: Final Report.* s.l. : OHA, 2023. https://www.oregon.gov/oha/hsd/bhp/pages/community-bh-clinics.aspx.

76. **Health Resources and Services Administration (HRSA).** *Behavioral Health Workforce Shortage Designations and Data Dashboard.* s.l. : HRSA, 2023. https://data.hrsa.gov.

77. **National Association of State Mental Health Program Directors (NASMHPD).** *State Strategies for Behavioral Health Systems Reform: Flexibility, Accountability, and Innovation.* : NASMHPD, 2023. https://www.nasmhpd.org.

78. **Montana Department of Public Health and Human Services (DPHHS).** *Behavioral Health Workforce Incentive Program.* s.l. : DPHHS, 2023. https://dphhs.mt.gov.

79. **Alaska Department of Health and Social Services (DHSS).** *Rural Differential Pay Policy for Behavioral Health Providers.* s.l. : DHSS, 2022. https://health.alaska.gov.

80. **National Academies of Sciences, Engineering, and Medicine.** *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being.* Washington, DC : The National Academies Press., 2022. https://doi.org/10.17226/25521.

81. **Bipartisan Policy Center.** *Filling the Gap in the Behavioral Health Workforce.* s.l. : Bipartisan Policy Center, 2023. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2023/01/BPC_2022_Behavioral-Health-Integration-Report_RV3.pdf.

82. **Minnesota Department of Health.** *FY26 Health Professionals Clinical Training Expansion Grant Program.* s.l. : Minnesota Department of Health, 2025. https://www.health.state.mn.us/facilities/ruralhealth/funding/grants/docs/hpcerfp.pdf.

83. **CMS/Medicaid.** *State Health Official Letter SHO 25-004 (crisis system implementation context).* s.l. : Medicaid, 2025.

84. **Oregon Health Authority.** Common Credentialing Program Ends. 2020, ttps://www.oregon.gov/oha/hpa/ohit-occp/pages/index.aspx.

85. **Ohio Department of Medicaid.** *Centralized Credentialing Frequently Asked Questions.* s.l. : Ohio Department of Medicaid, 2022. https://dam.assets.ohio.gov/image/upload/managedcare.medicaid.ohio.gov/PNM/Centralized-Credentialing-FAQ.pdf.

86. **Mississippi Division of Medicaid.** *Recredentialing and Revalidation.* s.l. : Mississippi Division of Medicaid, 2023. https://medicaid.ms.gov/recredentialing-and-revalidation/.

87. **Nevada.** *Credentialing Frequently Asked Questions (FAQs).* n.d. https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Providers/FAQs.pdf.

88. **McKinney, K., El Ibrahimi, S., Van Burnham, B., Sloan, S., Martin, E., Hildebran, C. & Wacker, L.** *MHACBO 2025 Annual Behavioral Health Workforce Report.* 2025. https://www.mhacbo.org/media/filer_public/7b/61/7b61bfc3-9059-400a-82b1-3180c51e6b29/2025mhacbobhworkforceanalysisfinalversionweb0101.pdf.

89. **Last, B., Crable, E., Khazanov, G., Schenfield, L., McGinty, E. & Purtle, J. .** *Impact of U.S. Federal Loan Repayment Programs on the Behavioral Health Workforce: Scoping Review.* s.l. : Psychiatric Services, 2024. https://psychiatryonline.org/doi/10.1176/appi.ps.20230258.

90. **Office of the Governor of Virginia.** *Governor Glenn Youngkin Issues Executive Order 51 Launching First-in-the-Nation Agentic Artificial Intelligence (AI) Empowered Statewide Regulatory Review.* s.l. : Governor of Virginia, 2025. https://www.governor.virginia.gov/newsroom/news-releases/2025/july/name-1053152-en.html.

91. —. *Governor Glenn Youngkin Issues Executive Order Reforming Virginia's Regulatory Process.* s.l. : Governor of Virginia, 2022. https://www.governor.virginia.gov/newsroom/news-releases/2022/june/name-936308-en.html.

92. **Sadeh-Sharvit, S. & Hollon, S.** *AI Integration in Behavioral Healthcare: A Practical Framework for Clinicians.* s.l. : Journal of Technology in Behavioral Science, 2025. https://doi.org/10.1007/s41347-025-00532-z.

93. **Bracken, A., Reilly, C., Feeley, A., Sheehan, E., Merghani, K. & Feeley, I.** *Artificial Intelligence (AI) – Powered Documentation Systems in Healthcare: A Systematic Review.* s.l. : Journal of Medical Systems, 2025. https://doi.org/10.1007/s10916-025-02157-4.

94. **James, A.** *Reducing Admin Burden in Adult Mental Health Fidelity Programs.* s.l. : Oregon Health Authority (Unpublished Report), 2025.

95. **Substance Abuse and Mental Health Services Administration.** *Types of Certified Community Behavioral Health Clinics and Pathways to Becoming One (PEP25-01-007).* s.l. : SAMHSA, 2025. https://library.samhsa.gov/sites/default/files/ccbhc-pathways-fact-sheet-pep25-01-007.pdf.

96. **Zhang, Y., Stokes, J., Anselmi, L., Bower, P., & Xu, J.** *Can integrated care interventions strengthen primary care and improve outcomes for patients with chronic diseases? A systematic review and meta-analysis.* s.l. : Health Research Policy and Systems, 23(1), 2025. https://doi.org/10.1186/s12961-024-01260-1.

97. **Bao, Y., Chan, Y.F., Eggman, A., Ryan, A., Bruce, M., Pincus, H., Hafer, E., & Unutzer, J.** *Value-based payment in implementing evidence-based care: the Mental Health Integration Program in Washington state.* s.l. : The American journal of managed care, 2017. https://pmc.ncbi.nlm.nih.gov/articles/PMC5559616/.

98. **Chapman, S., Blash, L., Mayer, K. & Spetz, J.** *Emerging Roles for Peer Providers in Mental Health and Substance Use Disorders.* s.l. : American Journal of Preventive Medicine, 2018. doi: 10.1016/j.amepre.2018.02.019.

99. **Oregon Health Authority.** *Value-Based Payment Roadmap for Coordinated Care Organizations.* Salem, OR : OHA, 2019. https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Roadmap.pdf.

100. **Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P.** *Collaborative care for depression and anxiety problems.* s.l. : Cochrane Database of Systematic Reviews, (10), CD006525, 2012. https://doi.org/10.1002/14651858.CD006525.pub2.

101. **Bogo, M., Paterson, J., Tufford, L., & King, R.** *Interprofessional clinical supervision in mental health and addiction: Toward identifying common elements.* s.l. : Clinical Supervisor, 30(1), 124–140, 2011. https://doi.org/10.1080/07325223.2011.564955.

102. **Substance Abuse and Mental Health Services Administration .** *Certified Community Behavioral Health Clinics (CCBHCs).* s.l. : SAMHSA, 2023. https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics.

103. **Oregon Health Authority.** *Value-Based Payment Roadmap and Implementation Toolkit.* s.l. : OHA, 2022. https://www.oregon.gov/oha/HPA/dsi-tc/Pages/VBP-Toolkit.aspx.

104. **Maryland Health Care Commission.** *Investing in Maryland's Behavioral Health Talent: Behavioral Health Workforce Assessment Report.* s.l. : Maryland Health Care Commission, 2024. https://health.maryland.gov/pophealth/Pages/Behavioral-Healthcare-Workforce-Development-and-Expansion.aspx.

105. **Child Health & Development Institute.** *Strengthening the Behavioral Health Workforce for Children, Youth, and Families: A Strategic Plan for Connecticut.* New Britain, CT : Child Health & Development Institute, 2023. https://plan4children.org/wp-content/uploads/2023/11/CHDI_Workforce-Strategic-Plan_Report_CT-Plan-4-Children_V11.FINAL_.pdf.

106. **Washington State Legislature.** *Final Bill Report: HB 1946 — Expanding the Behavioral Health Loan Repayment Program.* Olympia, WA : s.n., 2024. https://lawfilesext.leg.wa.gov.

107. **U.S. Government Accountability Office.** *Health Care Workforce: Programs Target Rural Areas but Opportunities Exist to Improve Data and Evaluation Efforts (GAO-23-105524).* 2023. https://www.gao.gov/products/gao-23-105524.

108. **Oregon Legislative Assembly.** *Enrolled House Bill 2949: Relating to behavioral health workforce.* : Oregon State Legislature, 2021. https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2949/Enrolled .

109. **Mental Health & Addiction Certification Board of Oregon.** *MHCABO 2025 Annual Behavioral Health Workforce Report.* s.l. : MHACBO, 2025. https://www.mhacbo.org/media/filer_public/7b/61/7b61bfc3-9059-400a-82b1-3180c51e6b29/2025mhacbobhworkforceanalysisfinalversionweb0101.pdf.

110. **Central Oregon Community College.** *Addiction counseling and behavioral health.* n.d. https://cocc.edu/directory/departments/human-services.

111. **Chemeketa Community College.** *Tuition & Fees: Behavioral health AAS degree.* n.d. https://www.chemeketa.edu/cost-aid/tuition-fees/#:~:text=Oregon%20and%20border%20state%20students,353%20tuition%20+%20$38%20universal%20fee.

112. **Mt. Hood Community College.** *Cost of Attendance: Mental and social health services programs.* : s.n., n.d. https://www.mhcc.edu/tuition-admission/tuition/cost-of-attendance.

113. **Portland Community College.** *Family and human services.* n.d. https://www.pcc.edu/programs/family-human-services/.

114. **Oregon Health Authority.** *Request for Grant Application/SHOI-Like Scholarship Programs-Health Care Provider Incentive Program.* s.l. : Oregon Buys, 2022. https://oregonbuys.gov/bso/external/bidDetail.sdo?docId=S-44300-00003567&external=true&parentUrl=close.

115. **Lewis & Clark Graduate School of Education and Counseling.** *Tuition and costs: Paying for graduate school.* s.l. : Lewis & Clark College. , 2025. https://graduate.lclark.edu/offices/admissions/paying_for_graduate_school/tuition-and-costs/.

116. **Waddell, E. N., & Rainer, S.** *Oregon Substance Use Disorder Services Inventory & Gap Analysis: Estimating the need & capacity for services in Oregon across the continuum of care.* s.l. : Oregon Alcohol and Drug Policy Commission., 2023. https://www.oregon.gov/adpc/SiteAssets/Lists/MeetingEvents/EditForm/OHSU%20Gap%20Analysis%20Oregon%20ADPC.pdf .

117. **Oregon Health Authority.** *Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon.* s.l. : OHA, 2025. https://www.oregon.gov/oha/HPA/HP-HCW/Documents/HCPIP-Evaluation-Report-2025.pdf.

118. —. *Behavioral Health Workforce Incentives.* s.l. : OHA, 2021-2022. https://www.oregon.gov/oha/hsd/amh/pages/workforce-initiative.aspx.

119. —. Oregon's Behavioral Health Workforce: Presented to the House Interim Community on Behavioral Health. 2025, https://olis.oregonlegislature.gov/liz/2025I1/Downloads/CommitteeMeetingDocument/310744.

120. —. *BHWI Dashboard.* s.l. : OHA (Unpulished Data from the BHWI Dashboard), n.d.

121. **Oregon Legislative Assembly.** *Enrolled House Bill 2024: Relating to the behavioral health workforce.* s.l. : Oregon State Legislature. https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/HB2024/Enrolled .

122. —. *Behavioral Health Care Provider Incentives.* s.l. : Oregon State Legislature, 2024. https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/HB2024/Enrolled.

123. **New Mexico Legislature.** *Senate Bill 1: Behavioral Health Trust Fund.* Santa Fe, NM : s.n., 2025. https://www.nmlegis.gov/Legislation/Legislation?Chamber=S&LegNo=1&Year=25.

124. **Maryland Senate.** *Senate Bill 283/House Bill 418: Behavioral Health Workforce Investment Fund—Establishment & Purpose.* s.l. : Maryland General Assembly, 2023. https://mgaleg.maryland.gov/2023RS/bills/sb/sb0283E.pdf.

125. **Brenner, M., & Schmidt-Brenner, A.** *Inspiring Careers in Mental Health: Piloting a Pipeline Program for Underserved High School Students.* s.l. : Academic Psychiatry, 48(6), 593-597., 2024.

126. **Stacciarini, j. Rosa, A., Ortiz, M., Munari, D., Uicab, G. & Balam, M.** *Promotoras in Mental Health: A Review of English, Spanish, and Portuguese Literature.* s.l. : Family & Community Health 35(2):p 92-102, 2022. DOI: 10.1097/FCH.0b013e3182464f65.

127. **National Academy of State Health Policy.** *State strategies to increase diversity in the behavioral health workforce.* 2024. https://nashp.org/state-strategies-to-increase-diversity-in-the-behavioral-health-workforce.

128. **Yun, B., Gilbert, A., Li, H.-F., Scanlan, J. M., & Coleman, A.** *Nurse practitioner and physician associate mentorship: Improving retention and employment experiences.* s.l. : Journal of the American Association of Nurse Practitioners., 2025. https://doi.org/10.1097/jxx.0000000000001093.

129. **Substance Abuse and Mental Health Services Administration.** *Hispanic/Latino behavioral health equity playbook (2nd ed.).* s.l. : U.S. Department of Health and Human Services, 2024. https://hispaniclatinobehavioralhealth.org.

130. **Healthforce Center at UCSF.** *How to increase diversity in the health care workforce now.* s.l. : University of California, San Francisco, 2024. https://healthforce.ucsf.edu/news/how-increase-diversity-health-care-workforce-now.

131. **Taylor, C., Green, M., & Anderson, J.** *Growing and supporting Black, African American, and Hispanic/Latinx professionals in California's health workforce.* : Urban Institute, 2022. https://www.urban.org/sites/default/files/2022.

132. **Milbank Memorial Fund.** *Seeking representation and diversity in the health workforce and pipeline.* 2024. https://www.milbank.org/2024/01/seeking-representation-and-diversity-in-the-health-workforce-and-pipeline.

133. **Chirimwami, Bryant &.** *Yay writing!* 2025.

134. **Office of the Governor of Virginia.** *Governor Glenn Youngkin Announces Achieving 25% Reduction Target for Regulatory Requirements.* s.l. : Governor of Virginia, 2025. https://www.governor.virginia.gov/newsroom/news-releases/2025/july/name-1053020-en.html.

135. **Pacific University.** *Tuition and financial aid: Clinical Psychology PsyD program.* 2025. https://www.pacificu.edu/clinical-psychology-psyd/tuition-financial-aid .

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