MINNESOTA BOARD OF BEHAVIORAL HEALTH AND THERAPY
TIERED LICENSURE WORKING GROUP
MEETING MINUTES
May 22, 2013; 10:00 a.m.
Conference Room A, Fourth Floor, 2829 University Avenue SE, Minneapolis, MN

BBHT Committee Members Present: Judi Gordon, Marlae Cox-Kolek

Staff Present: Kari Rechtzigel, Executive Director; Samantha Strehlo, LADC Licensing Coordinator

Working Group Members Present: **Jonathan Lofgren**, Minneapolis Community and Technical College/Adler Graduate School/Minnesota Association of Resources for Recovery and Chemical Health; **Julie Rohovit**, University of Minnesota; **Charlie Mishek**, Minnesota Department of Human Services; **Roy Kammer**, MSU-Mankato; **Naomi Ochsendorf**, MARRCH and MATD; **Dustin Chapman**, Fairview; **Ted Tessier**, MARRCH.

Working Group Members Absent: **Liz Reid**, Turning Point; **Nelson Perez**, Century College.

Members of the Public Present: Deb W. (last name illegible on sign-in sheet), University of Minnesota.

Duties of the Working Group:

Sec. 43. REPORT; BOARD OF BEHAVIORAL HEALTH AND THERAPY.
(a) The Board of Behavioral Health and Therapy shall convene a working group to evaluate the feasibility of a tiered licensure system for alcohol and drug counselors in Minnesota. This evaluation shall include proposed scopes of practice for each tier, specific degree and other education and examination requirements for each tier, the clinical settings in which each tier of practitioner would be utilized, and any other issues the board deems necessary.
(b) Members of the working group shall include, but not be limited to, members of the board, licensed alcohol and drug counselors, alcohol and drug counselor temporary permit holders, faculty members from two- and four-year education programs, professional organizations, and employers.
(c) The board shall present its written report, including any proposed legislation, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services no later than December 15, 2015.
(d) The working group is not subject to the provisions of Minnesota Statutes, section 15.059.

1. **Introductions.** Judi Gordon, Chair of the Tiered Licensure Working Group, convened the meeting at 10:35 a.m. Ms. Gordon asked those present to introduce themselves and all those present did so.

Chair Gordon summarized the assignments from the last meeting. Each person was assigned to study the licensure or certification requirements for five states. The information was due May 17, 2013. Chair Gordon reported that 5 out of 9 persons reported the required information. Ms. Strehlo consolidated the information received into a chart. Chair Gordon emphasized that the duty of the working group is to evaluate the *feasibility* of tiered licensure. Chair Gordon read directly from the legislative language. Chair Gordon stated that the requirement is to submit a report, but not necessarily to propose legislation to change the licensure requirements in Minnesota.

Chair Gordon reported that DHS Division Director of ADAD Kevin Evenson and Charlie Mishek met with Gordon, Strehlo and Rechtzigel regarding **agenda item 5, influence of the Affordable Care Act (ACA).** Evenson reported that he was going to Colorado to meet with the Center for Medicare & Medicaid Services (CMS) and representatives from other states. CMS will provide the federal qualifications to receive reimbursement related to integration of care services. Evenson stated that "we are in a medical community."

4. **BBHT Demographics.** Item 4 was removed from the agenda. Meaningful demographic information from applicants and licensees is difficult to obtain because it is voluntary for persons to provide the information.

2. **Feasibility of Tiered Licensure System and**
3. **Review and discuss research from other states.**

Lofgren: With respect to the elements needed to evaluate the feasibility of developing a tiered licensing system, Lofgren noted that academic standards need to be examined (degree and content of coursework); 270 clock hours seems to be a basic popular benchmark.

Rohovit: Rohovit suggested looking at the content to drive the number of training hours. Scope of practice is missing from other state information; data is hard to find.

Kammer: Master's level practitioners can diagnose; others have the ability to provide diagnostic impressions.

Mishek: With respect to 2000, 4000 or 6000 hours – are these supervised practice hours or just work hours? What is the definition of supervision? How much is required? Kentucky example: 6000 hours/300 hours under the supervision of a LADC with two years of experience.

Lofgren: Scope relates to privilege to do certain things.

Kammer: Scope also is tied to the location of where a service can be provided.

Mishek: Definition of independent practitioner needs to be established. Most practitioners have to work in a program setting.

Gordon/Mishek: CMS pays for services. Medicare only covers services in a hospital setting. Medicaid/consolidated fund pay for all types of CD treatment services.

Chapman: CMS is very specific on who can diagnose. In the future, if community based providers align with a hospital, they will be eligible for Medicare payments. CMS billing is heavily scrutinized.

Gordon: Reimbursement drives how services are provided in a medical system.

Lofgren: Certification states (IC&RC) define supervision requirements, e.g. 300 hours of supervision for 2000, 4000, 6000 practice hours, etc.

Gordon: There are 2451 LADCs at the present time.

Chapman/Mishek: There are other professionals providing alcohol and drug counseling services (those exempt from licensure or possessing dual licensure). If a tiered licensure system is created, will it increase the number of LADCs? Estimates related to the Affordable Care Act suggest that there will be a 10% increase in the number of clients seeking services.

Mishek: 54,000 additional people may have access to treatment because of the ACA. The treatment center silo (only place from which to bill) is problematic. When practitioners can't bill, they change professions to LPCC, LMFT, etc.

Rohovit: The competency of clinicians in dual disorders is critical. They must be proficient in treating co-occurring disorders. It is a matter of professional preservation for LADCs. Substance abuse clients are some of the most complex to treat.

Lofgren: Connecticut requires co-occurring disorders training.

Rohovit: Testing/national examinations need to be included in licensure requirements.

Mishek: If practice tiers are created, some people will select a lower tier because they only want to practice in certain areas in certain settings (career path).

Rohovit: Rohovit reiterates the importance of exposure to and training in co-occurring disorders.

Ochsendorf: There should be more education on co-occurring disorders as the education level increases.

Gordon: Gordon suggested multiple tiers ranging from associate degree preparation to master's level education, with the knowledge of mental health issues increasing with each level.

Kammer: Has a concern with adding mental health training requirements.

Rechtzigel: Reminds those present that Minnesota already has 4 mental health licenses (psychologist, clinical social worker, professional counselor/professional clinical counselor, marriage and family therapist).

Lofgren: Delaware. Look at endorsement criteria for addictions specialization and mental health license.

Rohovit: With respect to Delaware, how were criteria created? Reimbursement?

In Minnesota, master's level providers are not reimbursed at a higher rate than bachelor's level providers.

Cox-Kolek: Having both the LPCC and LADC licenses results in more individual therapy referrals. The master's level license is needed for individual therapy.

Chapman: Dual licensure is needed for work in a primary care clinic. Is the CD field going to expand in Minnesota to include in-home services?

Lofgren: If practice tiers are created, all must include training in co-occurring disorders. The scope will define what a practitioner can do, e.g. can they diagnose or not.

Gordon: What if only master's level practitioners can diagnose?

Mishek: Rule 31/diagnostic impression; need diagnosis to bill. Mishek pointed out that for 60 years we have been doing treatment in Minnesota in a certain way. If the working group decides on tiers, it will take time – years.

Gordon: Yes, a phase-in will be necessary.

Mishek: The profession must be able to bill for services. On behalf of Kevin Evenson, Mishek reported that a future goal will be to have LADCs be independent practitioners who can bill just like mental health professionals.

Kammer: Kansas. Kammer reported that Kansas licensing staff members were guarded in their replies to him. It was noted that the Kansas Association of Social Workers was applying pressure on the ADC board there.

Rechtzigel: The easiest way to avoid challenges from other professions is to require dual licensure.

Ochsendorf: Increased requirements will affect rural clients. There are not enough providers at the higher level.

Chapman: Telemedicine is a possibility.

Rohovit: If there is a master's level tier, how would that tier change bachelor's level training?

Kammer: If a bachelor's degree is required to provide alcohol and drug counseling services, then the master's level tier would include the mental health treatment piece. It raises the question, however, of whether having a master's degree makes the provider a better chemical dependency counselor.

Rechtzigel: Rechtzigel asked how bachelor's and master's level courses differ. Rohovit explained that master's level courses are more in depth and require more critical thinking.

Cox-Kolek: Dual licensure allows for more flexibility in diagnosing (use of abuse for example).

Strehlo: Keep in mind that licensure is a balance. Minimum standards need to be established; not ideal standards. It does not make sense to have overly complicated standards which no one can meet.

Chapman: It is fine to look at other states, but we need to look at what is going on in Minnesota. The idea of substance abuse being a subset of mental health treatment has not been widely successful. In the Golden Age of substance abuse treatment years ago, the admitting psychiatrist did not immediately make a mental health diagnosis but waited until after the patient was in treatment long enough to evaluate it. A mental health diagnosis may change when a person is sober. Practitioners need a good understanding of both substance abuse and mental illness.

Gordon: The DSM V includes new areas. For example, memory loss is a mental illness.

Mishek: We need to create requirements to assure competence. Six dimensions and risk readings; DSM V – continuum; DSM V will complicate how treatment services are provided.

Ochsendorf: Life experience is a great teacher. Book learning/education is only one way of learning.

Rohovit: The January 24, 2013 Hyde report points out the need for a baseline across all states. We need to see Minnesota as part of the whole national structure. Rohovit will email BBHT a link to the report.

Strehlo: There is so much diversity in requirements across the states; it will be difficult to reach agreement. Rohovit will also send a link related to INCASE international and NASAC accreditation.

Cox-Kolek: Suggests developing a survey to elicit who would choose a master's degree in the addiction counseling specialty versus a master's degree for a mental health counseling license instead.

Gordon: Other items to think about include Minnesota ACT teams and rural practice.

The **next meeting** is scheduled for **June 26, 2013, at 10:00 AM** in Conference Room A, 4th Floor, 2829 University Avenue SE, Minneapolis, MN.

Assignment for next meeting: turn in all information on other states' requirements.

At the next meeting, the group will develop a month-by-month task list/plan. Benchmarks for the next 16 months will be developed in order to meet the goal of submitting a report to the Legislature in December of 2014.