MINNESOTA BOARD OF PSYCHOLOGY
February 21, 2025
Board Meeting

Order of Business

PUBLIC SESSION:

1. **Call to Order**
2. **Adoption of Tentative Agenda**
3. **Announcements**
    - **A. Web Ex Meeting Link**
4. **Approval of the Board Minutes**
    - **A. Approval of Board Meeting Minutes**
5. **Consent Agenda**
    - **A. Staff Delegated Authority Report**
6. **New Business**
    - **A. Variance Request 18-0169**
    - **B. CE Variance Request**
    - **C. Master's Licensing Update**
    - **D. Executive Director's Report**
    - **E. Board Administrative Terminations**
7. **Committee Reports**
8. **Adjournment**

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 2/21/2025

SUBMITTED BY: Assistant Executive Director

TITLE: Web Ex Meeting Link

INTRODUCTION TO THE TOPIC:

Meeting link:
https://minnesota.webex.com/meet/samuel.sands

Meeting number:
966 811 163

Join from a video conferencing system or application
Dial: samuel.sands@minnesota.webex.com
You can also dial 173.243.2.68 and enter your meeting number.

Join by phone
+1-415-655-0003 United States Toll
Access Code: 966 811 163

Global call-in numbers
https://minnesota.webex.com/minnesota/globalcallin.php?MTID=m0f8b8d96df6f1583dab9f301a08c30ac

BOARD ACTION REQUESTED:

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 2/21/2025

SUBMITTED BY: Assistant Executive Director

TITLE: Approval of Board Meeting Minutes

INTRODUCTION TO THE TOPIC:

The Board Meeting minutes for January 2025 are respectfully submitted.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
January 2025 Board Meeting Minutes	2/14/2025	Cover Memo

MINNESOTA BOARD OF PSYCHOLOGY

MINNESOTA BOARD OF PSYCHOLOGY
Minutes of the January 24, 2025 Board Meeting

Board Members and Staff in Attendance:

Sonal Markanda, Sebastian Rilen, Salina Renninger, Daniel Hurley, Michelle Zhao, Jill Idrizow, Nancy Cameron, Pamela Freske, Michael Thompson, Sam Sands, and Trisha Hoffman.

Guests: Nick Lienesch, Lindsey Franklin, Kim Navarre, and Johanna Gangl.

PUBLIC SESSION

1. Call to Order

Sonal Markanda called the meeting to order at 9:35AM. The meeting was held in a hybrid format with some individuals in attendance in person and others online. Voting was held by roll call.

A. WebEx MeetingLink

2. Adoption of Tentative Agenda

Salina Renninger moved, seconded by Daniel Hurley Motion: to adopt the tentative agenda. There being 8 “ayes” and 0 “nays” the Motion Passed.

3. Announcements

4. Approval of the Board Minutes

Michael Thompson moved, seconded by Daniel Hurley Motion: to adopt the November 22, 2024 Board Meeting Minutes. There being 7 "ayes" and 0 "nays" the motion Passed.

Seb Rilen moved, seconded by Salina Renninger Motion: to adopt the December 13, 2024 Board Meeting Minutes. There being 8 "ayes" and 0 "nays" the motion Passed

5. Consent Agenda

A. Staff Delegated Authority Report

Michael Thompson provided a correction to the spelling of one name listed in the report.

6. New Business

A. Legislative Update

Lindsey Franklin provided a legislative update. She noted that an ongoing power struggle over House leadership is causing uncertainty about how the session will proceed. The Board briefly discussed legislation passed in the previous session.

B. Health Professional Services Program Presentation

Kim Navarre and Johanna Gangl gave a presentation on the Health Professional Services Program, including recent trends relating to the services being provided.

C. Executive Director's Report

Trisha Hoffman provided an update on the work of the Licensure Unit as it continues to support the Mission and Vision of the Board, including licensing over 160 Behavior Analyst applicants since January 1, bringing the total to 530.

Sam Sands provided additional detail on Behavior Analyst licensing and an update on the work of the BA Advisory Council, noted that the Culturally Informed and Culturally Responsive Mental Health Task Force is seeking applicants, brought to the Board's attention a Legislative Report issued by the Psychedelic Medicine Task Force, and gave a financial update.

D. ASPPB Mid Year Meeting

Daniel Hurley moved, seconded by Salina Renninger Motion: to approve payment of the cost of attendance for two board members and two staff at the ASPPB Mid-Year Conference. There being 8 "ayes" and 0 "nays" the motion Passed

E. CE Variance Request

Nancy Cameron moved, seconded by Daniel Hurley Motion: to approve the CE variance request. There being 8 "ayes" and 0 "nays" the motion Passed.

F. Board Administrative Terminations

Salina Renninger moved, seconded by Seb Rilen Motion: to approve the Board Administrative Terminations. There being 8 "ayes" and 0 "nays" the motion Passed.

7. Committee Reports

8. Adjournment

Adjourned at 11:25 AM

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 2/21/2025

SUBMITTED BY: Assistant Executive Director

TITLE: Staff Delegated Authority Report

INTRODUCTION TO THE TOPIC:

The Board utilizes a consent agenda for routine financial, legal, or administrative matters that require Board action or inform the Board of action taken under authority delegated by the Board.

The items on the consent agenda are expected to be non-controversial and not requiring of a discussion.

The consent agenda is voted on in a single majority vote, but made be divided into several, separate items if necessary.

The items on the consent agenda will be considered early in the meeting. The Board chair will ask if any member wishes to remove an item from the consent agenda for separate consideration, and if so, the Chair will schedule it for later in the meeting.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
Behavior Analyst Consent Agenda	2/19/2025	Cover Memo
Psychology Licensure Consent Agenda	2/19/2025	Cover Memo

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BOARD OF PSYCHOLOGY

CONSENT AGENDA ITEMS: Staff Delegated Authority Report

Licensed Behavior Analyst (LBA)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Behavior Analyst (LBA) licensure pursuant to MN Statute 148.9983.

License Number	Licensee
LBA0519	Emily Bristlin
LBA0520	Nicole Nelson
LBA0521	Miranda Rushing
LBA0522	Julia Bruckner Grill
LBA0523	Jacob Deskovitz
LBA0524	Bethany Johnson
LBA0525	Lindsay McMillan
LBA0526	Marika Reese
LBA0527	Brande Smetana
LBA0528	Stephanie Lopez
LBA0529	Samiya Adem
LBA0530	Joseph Fette
LBA0531	Carissa Jivery
LBA0532	Jennifer Bozosi
LBA0533	Wendy Selnes
LBA0534	Sean Cai
LBA0535	Meagan Pittelko
LBA0536	Sophia Rizvi
LBA0537	Heather Wolfgang
LBA0538	Michele Traub
LBA0539	Miriam Rosansky
LBA0540	Rebecca Crockett
LBA0541	Chelsey Truty
LBA0542	Julia Curtis
LBA0543	Kelsey Kryszak
LBA0544	Kate Schroeder
LBA0545	Rivka Hoch
LBA0546	Casandra Meier
LBA0547	Melanie Bauer
LBA0548	Amanda Vatsaas
LBA0549	Emily Niemeyer
LBA0550	Ismael El-Tayuddin
LBA0551	Amy Robinson

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LBA0552	Presley Wanner
LBA0553	Emily Veroeven
LBA0554	Sally Sahebi
LBA0555	Amelia Palokangas
LBA0556	Christabel Dinwiddie
LBA0557	Anna Schulz
LBA0558	Jessica Nelson
LBA0559	Jaima Hajek
LBA0560	Jillian Dunn
LBA0561	Jamie Waldvogel
LBA0562	Sara Weinkauf
LBA0563	Brookelynn McCumber
LBA0564	Tanya Walker
LBA0565	Matthew Leal
LBA0566	Megann Phillippi
LBA0567	Marissa Novotny
LBA0568	Ashley Casillas
LBA0569	Alsberg Dorvilus
LBA0570	Zoe King
LBA0571	Claudia Blohm
LBA0572	Dehazard Allen
LBA0573	Bobbi Waters
LBA0574	Danielle McGill
LBA0575	Samira Ahmed

Licensure Progression Statistics

The following data is a summary of the length of time it takes for an applicant to obtain licensure as a Behavior Analyst with the Minnesota Board of Psychology.

Total Number of LBA Applications Filed Since Last Council Meeting: 25

Of applications filed, number of LBA applications that have satisfied all license fees: 17

Of these applications, number submitted to CBC program (anticipated timeline to process CBC is 30 days): 17

Of all applications filed (and paid fees), number in compliance review: 6

Average days for license to be granted (time counted from staff review to license application approved): 1

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Of applications filed, number of Behavior Analyst License applications still in review: 1

Reasons for continued review: additional information needed

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CONSENT AGENDA ITEMS: Staff Delegated Authority Report

Admission to Examination for Professional Practice in Psychology (EPPP)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Admission to the Examination for Professional Practice in Psychology (EPPP) pursuant to Minnesota Rules 7200.0550.

Applicant(s) Granted Admission to the (EPPP) Exam
Dale Golden, Ph.D
Emily Hilton, Ph.D
Grace Hanvey, Ph.D
Amelia Sorensen, Psy.D
Michael Tindall, Psy.D
Hannah Flannery, Ph.D
Lauren Gould, Psy.D
Lindsay Bergeson, Psy.D
Kathleen Peterson, Psy.D
Rebecca Carr, Psy.D
Katherine Picard, Psy.D
Jessica Wilbur, Psy.D
Drea Tuott, Psy.D
Badeh Dualeh, Psy.D

Admission to Professional Responsibility Examination (PRE)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Admission to the Professional Responsibility Examination (PRE) pursuant to Minnesota Rules 7200.0550.

Applicant(s) Granted Admission to the (PRE)
Billie Gray, Psy.D
Lindsey Merritt, Psy.D
Lauren Gould, Psy.D
Lauren Bradel-Warlick, Ph.D
Kathleen Peterson, Psy.D
Rebecca Pruitt, Ph.D
Margo Abrams, Psy.D
Endora Crawford, Ph.D

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Licensed Psychologist (LP)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Licensed Psychologist (LP) licensure pursuant to Minnesota Statutes, section 148.907 and the administrative rules of the Psychology Practice Act.

License Number	Licensee
LP7154	Carolyn Quisenberry, Psy.D.
LP7155	Patrick Michaels, Ph.D.
LP7156	Nicholas Beller, Psy.D.
LP7157	Susan Pyle, Psy.D.
LP7158	Leslie Davis, Ph.D.
LP7159	Allison Siroky, Ph.D.
LP7160	Alexandra Rehovsky-Bennewitz, Ph.D.
LP7161	Jyothi Ramakrishnan, Ph.D.
LP7162	Lauren Bradel-Warlick, Ph.D.
LP7163	Laura Burlingame-Lee, Ph.D.
LP7164	Katarina Marsh, Psy.D.
LP7165	Bridget Sova, Ph.D.
LP7166	Billie Gray, Psy.D.
LP7167	Quyen Ngo, Ph.D.
LP7168	Breanna Guthmiller, Psy.D.
RL00102	Faith Miller

Guest Licensure (GL)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Guest Licensure (GL) pursuant to Minnesota Statutes, section 148.916 and the administrative rules of the Psychology Practice Act.

License Number	Licensee

Licensure for Voluntary Practice (L-VP)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Licensure for Volunteer Practice (LPV) pursuant to Minnesota Statutes 148.909 and the administrative rules of the Psychology Practice Act.

License Number	Licensee

Emeritus Registration (Em.)

Under delegated authority from the Board, Board staff approved the following applicant(s) for Emeritus Registration pursuant to Minnesota Statutes, section 148.9105.

License Number	Licensee
ER00193	Karin Hampton

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Voluntary Terminations (VT)

Under delegated authority from the Board, Board staff terminated the following License's pursuant to Minnesota Rules 7200.3700.

License Number	Licensee
LP2005	John Pucel
LP2102	Lucinda Cummings
LP2165	Max Trenerry
LP2118	Karin Hampton
LP4270	Gregory Lamberty
LP3599	Susan Persons
LP6642	Kayla Nalan-Sheffield

Continuing Education Variance Requests

Under delegated authority from the Board, Board staff approved the following licensee(s)' requests for a six (6) month continuing education variance pursuant to Minnesota Rules 7200.3860, D.

License Number	Licensee
LP2139	Virginia Mcdermott
LP2106	Daniel Doshan

Licensure Progression Statistics

The following data is a summary of the length of time it takes for an applicant to obtain licensure with the Minnesota Board of Psychology. The starting point is staff review; when the applicant has submitted all required documents for the specific type of license application.

Number of Initial, Reciprocity and Mobility LP applications filed since last Board meeting: 16

Of applications filed, number of LP applications still in review: 0

Reasons for continued review: N/A

Initial, Reciprocity, and Mobility applications days to license: 9

Number of Guest License applications filed since last Board meeting: 0

Of applications filed, number of Guest License applications still in review: 0

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Reasons for continued review: N/A

Guest License applications days to license: N/A

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 2/21/2025

SUBMITTED BY: Application Review Committee

TITLE: Variance Request 18-0169

INTRODUCTION TO THE TOPIC:

Reasons for variance request of waiver requested	I respectfully request a variance in the EPPP score requirement, as strict adherence to the rule has imposed a significant and multifaceted burden on my ability to progress professionally. As an individual diagnosed with Type 1 Diabetes, I experience regular hypoglycemic (low blood sugar) episodes, which occurred during my last two attempts at the EPPP. During which, I scored 490 (06/21/2019) and 485 (09/10/2019). During my last attempt at the exam, I was also pregnant, a condition that further complicates diabetes management and contributed to additional physical and cognitive challenges. As indicated in the letter provided by my Endocrinologist, Dr. Luke Benedict, (included), low blood sugars are directly tied to cognitive function and impact the communication between neurons. While my Type 1 Diabetes is well-controlled, I do experience hypo-unawareness, which means that I often do not recognize my lows until it has become very low and it can take over an hour to bring me back to a place where thinking clearly is possible. While I rely on a continuous glucose monitor (CGM) to manage these episodes, I was not permitted to use my CGM reader device during exams and was limited to a small quantity of glucose tablets; therefore, I had to step out to address my low blood sugar, losing valuable exam time while the clock continued to count down. In addition, to leave the testing room, I was required to be processed out and processed back in, thereby taking away additional time from the exam. This contributed to substantial challenges during the testing process and compromised my ability to fully demonstrate my knowledge and skills, despite having successfully completed a Masters and Doctoral program accredited by the American Psychological Association (APA). My journey to prepare for the EPPP has been resource-intensive, with close to $5,000 spent on exam costs, study materials, and a 1:1 coach to maximize my readiness. Due to being unable to practice, I have lost years of potential savings and benefits and, as a result, am not prepared to take on the financial burden yet again. Despite these investments, my ability to apply for clinical and academic roles requiring licensure has been restricted for the past five years, significantly limiting my career opportunities and causing me to leave the counseling/clinical field altogether. I recently began working as an Assistant Professor with Saint Mary's University of Minnesota's PsyD program, a position that, until recently, was unavailable to those without an active LP status. At the current time, I will be unable to progress into a full-fledged Professorship role and cannot teach courses related to the treatment of mental health conditions until I possess an active LP status in Minnesota. In addition, I am unable to practice as an independent provider, also limiting my career opportunities and

	contributing to the ongoing shortage of mental health providers.
Not adversely affect public welfare	Granting this waiver will not adversely affect public welfare. I have demonstrated a longstanding commitment to professional ethics and public welfare throughout my education and subsequent career. My background includes completing an APA-accredited PsyD program in Counseling Psychology, with a GPA of 3.9 (confirm this). During my PsyD program, I was asked to work as the first-ever Teaching Assistant in a Cognitive Assessment course, which I did for multiple years. During my post-doc, I was supervised by Scott Fischer, PhD, LP and Robin McLeod, PhD, LP. Both were present during the time in which I attempted to take the EPPP and can attest to both the anxiety and subsequent emotional impact I experienced after having been so close to a passing score, as well as the quality of my direct work with clients. Dr. Scott Fischer has written a letter (included) to share his experience of supervising my work in forensic psychology. In addition, I contributed to the APA accreditation process for both the PsyD program, as well as for a local internship site, both of which were awarded several years of APA-accreditation. I have continued to be an active participant in the community, serving as a Board member and President of the Suicide Prevention Collaborative since 2018. I previously served on the Minnesota Psychological Association's executive board, governing council, Legislative Committee, and as Chair of the Multicultural Division and Diversity Committee. In 2022, I was awarded the Presidential Citation for Outstanding Contribution to Psychology by MPA and received an Employee Excellence award for Employee of the Year. I have been asked to present on mental health topics at numerous conferences and private clinics, all indicating the trust and belief in my competence that my licensed colleagues have placed in me. Although I transitioned into Industrial/Organizational Psychology due to my inability to obtain licensure, my work continues to integrate psychological principles with my consulting business, Apidae Consulting, applying psychology to improve business practices. I currently hold a full-time position as a Professor at Saint Mary's University of Minnesota's PsyD program, contributing to the training and development of future practitioners, though my upward mobility remains restricted by licensure requirements. I have been entrusted with the role of supervising research, advising doctoral students, and teaching the following courses: Quantitative Research and Statistical Methods Vocational Assessment and Career Counseling Consultation in Counseling Psychology Contemporary Practice Industrial Organizational Psychology Dissertation Proposal, Analysis, and Writing A colleague and Director of Clinical Training, Dr. Ann Schissel, has provided a letter highlighting her experience working with me in this capacity (included). Furthermore, while the EPPP is intended to be a measure of foundational knowledge, ASPPB

	has explicitly stated that its predictive validity is not intended to determine readiness for independent practice. The Standards for Educational and Psychology Testing (2014) indicate: “Criterion-related evidence is of little applicability because credentialing examinations are not intended to predict individual performance but rather to provide evidence that candidates have acquired the knowledge, skills, and judgment required for effective performance.” (pp. 175-176) My track record in academic and professional roles attest to my competency, knowledge, skills, judgment, and dedication to ethical practice, underscoring my preparedness to contribute positively to the field. It is important to note that all standardized tests, including the EPPP, have a standard error of measurement (SEM), which reflects the inherent variability in test scores due to various factors, as exemplified in the previous question. This indicates that an individual’s observed score may not precisely represent their true level of knowledge or competence and, while the SEM is not publicly available for the 2019 exam, I am confident that my background has prepared me to obtain scores that fall within this range. In light of these factors, I kindly ask for the Board’s consideration in granting this variance, allowing me to continue contributing to the field of psychology without compromising public welfare.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
Medical Provider Letter	2/14/2025	Cover Memo
Schissel Letter of Support	2/14/2025	Cover Memo
Fischer Letter	2/14/2025	Cover Memo

[redacted]

Allina Health

Allina Health United Medical Specialties Clinic
225 Smith Ave N
[redacted]

Regarding:
[redacted]

November 1, 2024

To Whom It May Concern:
This letter is regarding my patient and the undue burden placed upon her while taking her EPPP board exam. I have been [redacted]'s treating Endocrinologist for nearly a decade. She has Type 1 Diabetes, which is well-controlled. At times, this leads to hypo-unawareness (or times in which she does not recognize her low until it becomes too low). In addition, brain functioning is closely tied to glucose levels and, if there is not enough glucose present in the brain, neurotransmitters are not produced and the communication between neurons is impacted.
She uses a Continuous Glucose Monitor (CGM), which tests her blood sugar continuously and helps warn her of pending low blood sugars so she can treat them before they require the assistance of another person or healthcare provider. The use of a CGM, a device is required. This can be an external Bluetooth-enabled device that connects only to the CGM or her cell phone, in which the "reader" is located.
In addition, it is necessary that [redacted] bring with her sources of glucose to treat her low blood sugars. The amount of glucose required is dependent on the level of her low. Low blood sugars, in particular, can be dangerous to her health and require immediate treatment. The treatment of low blood sugar can take 15 or more minutes, depending on the level of the blood sugar. Because of this, I have continually recommended that she use this device at ALL times. Allowing her to use her device during examinations and to bring with her sources of glucose to treat her low blood sugars is imperative.

[redacted] MD 11/1/2024 1:28 PM

November 14, 2024

Dear Minnesota Board of Psychology,

I am writing a letter on behalf of my colleague, Dr. [redacted], in support of her variance request for licensure without completion of the EPPP.

I have been a core faculty member in the Counseling PsyD program at Saint Mary's University of Minnesota since May 2020. During this time, I have gotten to know Dr. [redacted] first as an adjunct instructor in this program and now as a core faculty and colleague. Dr. [redacted] has demonstrated a high degree of professionalism, flexibility, intelligence, knowledge, and interpersonal skill during her time in this program.

Dr. [redacted] 's professionalism has been displayed in multiple ways. She creates excellent learning environments for students, providing guidance and feedback to help students develop their skills and knowledge. She has taught several research and quantitative courses in our program, which are classes that tend to create anxiety in many students. She has handled the students' needs and anxiety with care and consideration, creating tailored learning environments to best fit their needs.

She has also taken an active role in managing our program's dissertation processes. She has become very active as both a chair and committee member on several dissertations and has been managing the dissertation courses and overall processes on a macro level. She is developing and instituting new policies to help improve our research and dissertation processes, which helps other faculty immensely. She is a great team player who uses her organizational skills to create and manage complex systems.

Dr. [redacted] 's experience in Industrial/Organizational (I/O) psychology has given our students an additional perspective and source of information and mentorship in our program. Most of our faculty engage in clinical practice, but Dr. [redacted] 's I/O work has given students another view of the type of work individuals with doctoral degrees can complete. She brings her professionally developed expertise into the classroom, giving students insight and support in developing in this area.

She is responsible, thoughtful, circumspect, and skilled in this academic environment. She is highly engaged with both students and other faculty members. She comports herself with the level of professionalism appropriate for a psychologist.

While health issues have compromised Dr. [redacted] 's ability to take the EPPP (due to limitations on managing medical issues during the test itself), these issues are well-managed outside of the testing room and have not impacted her work in our academic environment. She remains responsible and active while simultaneously managing her medical needs.

In conclusion, Dr. [redacted] has a high degree of professionalism consistent with our expectations of a licensed psychologist. The medical needs that have made EPPP completion difficult do not impact her professionalism and engagement in her work, and I would be enthused to see Dr. [redacted] receive her license and continue advancing in her career.

Please feel free to contact me if you had additional questions.

Kind regards,

Ann M. Schissel, PhD, LP

821 Raymond Avenue, Suite 130 C
St. Paul, MN 55114

ACUMEN
PSYCHOLOGY

651-354-3371
651-203-3511 fax
www.acumenpsychology.com

January 20, 2024

Sam Sands

Minnesota Board of Psychology

335 Randolph Avenue, Suite 270

St. Paul, MN 55102

sent via email

Samuel.sands@state.mn.us

Dear Mr. Sands:

I am writing to you on behalf of [redacted] Psy.D., who is under consideration by the Application Review Committee for a waiver or variance request later this week. I have no position on whether it is appropriate for the Board to waive EPPP score results, but I have a strong position on Dr. Fleming's competence and professionalism.

Dr. [redacted] worked under my supervision between September of 2018 and March of 2020. [redacted] was obtaining supervised postdoctoral hours at the time. At the time, I had a group forensic practice with 6 to 8 licensed psychologists and 2 postdoctoral supervisees. Dr. [redacted]'s responsibilities included completing psychological evaluations, primarily for individuals involved in child protection cases. [redacted] also participated in group consultation meetings.

I observed [redacted] to be a responsible and diligent professional. [redacted] was able to complete detailed written reports in a timely manner, sometimes under pressure of deadline. There were no concerns regarding [redacted] interactions with examinees and her contacts with me and the other associates in the practice were, without exception, positive and professional. [redacted] writing was generally clear, and [redacted] demonstrated an understanding of psychological testing, diagnosis, and recommendations which I would characterize as well above average for a person with [redacted] level of training at the time. [redacted] accepted feedback gracefully and made good use of supervision time. I found [redacted] to be capable, competent, and personable and have no reservations in recommending her for licensure.

I do not have any insight as to why she has been unable to pass the EPPP. I was surprised when [redacted] didn't pass because of [redacted] general level of competence and the clinical understanding and expertise [redacted] demonstrated in working at my practice. Hopefully, [redacted] can address this issue directly with the ARC.

If more detailed information would be helpful to you or the committee, please feel free to contact me.

Sincerely,

Scott A. Fischer, PhD, LP, ABPP

Licensed Psychologist

Board Certified in Forensic Psychology

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 2/21/2025

SUBMITTED BY: Kelly Finn - Program Administrator

TITLE: CE Variance Request

INTRODUCTION TO THE TOPIC:

Licensee is requesting a second CE Variance to complete CEU's that were not completed during her first CE Variance.

Ordinance	7200.6000
Reasons for variance or waiver requested	I have been licensed since 1978 and, although I am 85, I want to maintain my license because I am still doing forensic work, I no longer do therapy but I review documents, forensic interviews, police interrogations, and write reports and testify in court, I have always completed my continuing education requirements, primarily by attending and presenting at conferences and writing articles. However, in the last two years I have not done so. I have had two cataract operations along with several medical appointments for osteoarthritis in my hip. I had a friend living with me whose health was declining, and I helped care for him until he died in December. I plan to attend a psychology conference this spring and also to take online courses and read books and get my 40 hours completed in the next six months,
Not adversely affect the public welfare	A variance will not affect the public welfare, Although I haven't formally completed my continuing education requirements, I keep up with the relevant literature,
Written plan of alternative practices	I plan to attend the Annual Forensic Psychology Symposium from March 20-23 in San Diego. This annual symposium presented by the American College ofForensic Psychology provides up to 25 continuing education credits which are approved by the American Psychological Association for psychologists, In addition I plan to take online classes that are approved by the APA for continuing education credit, If I am unable to attend the symposium I will dedicate the next few months to online classes and/or programs that allow psychologists to read books and pass tests for continuing education credit.
Rationale for the rule	Although I haven't formally completed my continuing education requirements, I keep up with the relevant literature,

BOARD ACTION REQUESTED:

Approve or Deny the request

ATTACHMENTS:

Description	Upload Date	Type
CE Variance Rquest	2/11/2025	Cover Memo

FAX COVER SHEET

Institute for Psychological Therapies
5263 130th Street East
Northfield, MN 55057-4405
Fax Number: (507) 645-8883
Voice Number: (507) 645-8881

Date: 2-3-25 Time: 12:00 Number of Pages: 32
(not including this cover sheet)

Receiving Fax Number: 651 797-1372

Originals to follow by 1st Class Mail: _____

From: Hollida Wakefield

Deliver Immediately To: Kelly Finn-Searles
Board of Psychology

APPROVED FOR PAPER RENEWAL 1/30/25 C.X.

MINNESOTA
BOARD OF PSYCHOLOGY

335 Randolph Ave, Ste. 270 | St. Paul, MN 55102
Telephone: 612-617-2230 | Fax: 651-797-1372
MN Relay Service: 1(800) 627-3529
Email: psychology.board@state.mn.us
Website: https://mn.gov/boards/psychology

VARIANCE/WAIVER REQUEST FORM

Section A

1. LAST NAME	FIRST:	MIDDLE:	2. DATE:
Wakefield	Hollida	Zetta	Feb. 2, 2025

3. REQUESTING (check one) [X] VARIANCE [ ] WAIVER OF: Continuing education

(rule number: refer to MN Psychology Practice Act)

My reasons for making this variance or waiver request are:

Adherence to the rule would impose an undue burden on the petitioner (Minn. R., part 7200.6000, subp. 1, item A). Please explain why below:

I have been licensed since 1978 and, although I am 85, I want to maintain my license because I am still doing forensic work. I no longer do therapy but I review documents, forensic interviews, police interrogations, and write reports and testify in court. I have always completed my continuing education requirements, primarily by attending and presenting at conferences and writing articles. However, in the last two years I have not done so. I have had two cataract operations along with several medical appointments for osteoarthritis in my hip. I had a friend living with me whose health was declining, and I helped care for him until he died in December. I plan to attend a psychology conference this spring and also to take online courses and read books and get my 40 hours completed in the next six months.

Section B

The granting of a variance or waiver will not adversely affect the public welfare (Minn. R., part 7200.6000, subp. 1, item B). Please explain why below:

A variance will not affect the public welfare. Although I haven't formally completed my continuing education requirements, I keep up with the relevant literature.

MINNESOTA
BOARD OF PSYCHOLOGY

335 Randolph Ave, Ste. 270 | St. Paul, MN 55102
Telephone: 612-617-2230 | Fax: 651-797-1372
MN Relay Service: 1(800) 627-3529
Email: psychology.board@state.mn.us
Website: https://mn.gov/boards/psychology

Section C

In the case of a variance, the rationale for the rule in question can be met by alternative practices or measure specified by the petitioner (Minn. R., part 7200.6000, subp. 1, item C). And must include a written plan listing the activities including the dates and the number of hours for each activity offered to meet the requirement. Please explain why below:

I plan to attend the Annual Forensic Psychology Symposium from March 20-23 in San Diego. This annual symposium presented by the American College of Forensic Psychology provides up to 25 continuing education credits which are approved by the American Psychological Association for psychologists.

In addition I plan to take online classes that are approved by the APA for continuing education credit. If I am unable to attend the symposium I will dedicate the next few months to online classes and/or programs that allow psychologists to read books and pass tests for continuing education credit.

Section D

Signature: Yolanda Wakefield **Date:** February 3, 2025

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 2/21/2025

SUBMITTED BY:

TITLE: Master's Licensing Update

INTRODUCTION TO THE TOPIC:

Documents prepared by ASPPB related to Master's Level Licensure in the states.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
Announcement Letter	2/20/2025	Cover Memo
Process Letter	2/20/2025	Cover Memo
Model Act Language	2/20/2025	Cover Memo
Model Regulations Language	2/20/2025	Cover Memo

ASPPB
Association of State and Provincial Psychology Boards

Supporting member jurisdictions in fulfilling their responsibility of public protection

February 10, 2025

Dear Colleagues,

Enclosed are documents developed by ASPPB's Potential Regulatory Implications of Licensing Master's-Trained Individuals Task Force (PRI-LM). The PRI-LM was convened in 2023 in response to the APA's decision to accredit graduate programs leading to a terminal master's degree in Health Service Psychology and its ongoing efforts to determine the title and scope of practice for such individuals. Both the Board Administrators/Registrars Committee (BARC) and the Board and College Chairs Committee (BCCC) recognized that defining title and scope of practice falls within the purview of regulatory bodies in psychology. The ASPPB Board of Directors agreed and charged the PRI-LM with the following:

1. Survey the regulatory community about their licensing of individuals with master's-level education and training in psychology, including if they license at the master's level, and if so, the title, scope of practice, and rationales for what is done.

2. Using the information gathered from member jurisdictions, develop, define, and propose to the ASPPB Board of Directors an appropriate title and scope of practice for people with master's training.

3. After review and approval by the ASPPB Board of Directors, convey a statement regarding its findings to the APA Working Group dealing with title and scope of practice.

Following a survey of the psychology regulatory community, the PRI-LM developed an initial version of these documents, which were then distributed for public comment. The PRI-LM received over 170 responses from psychology regulators, educators, practitioners in specialty areas, and other stakeholders invested in the potential implications of licensing master's-level practitioners in psychology. The attached documents reflect modifications made based on this valuable feedback.

These materials are intended for psychology regulatory bodies that either currently license master's-level Health Service Psychology practitioners or are considering doing so. By using these documents as guidelines or adopting them in part or in full, jurisdictions can help establish greater consistency in qualifications, thereby facilitating mobility for licensed master's-level psychology practitioners. These documents will be incorporated into the ASPPB Model Act and Model Regulations to assist regulatory bodies as they see fit, in developing or revising language related to master's-level psychology licensure.

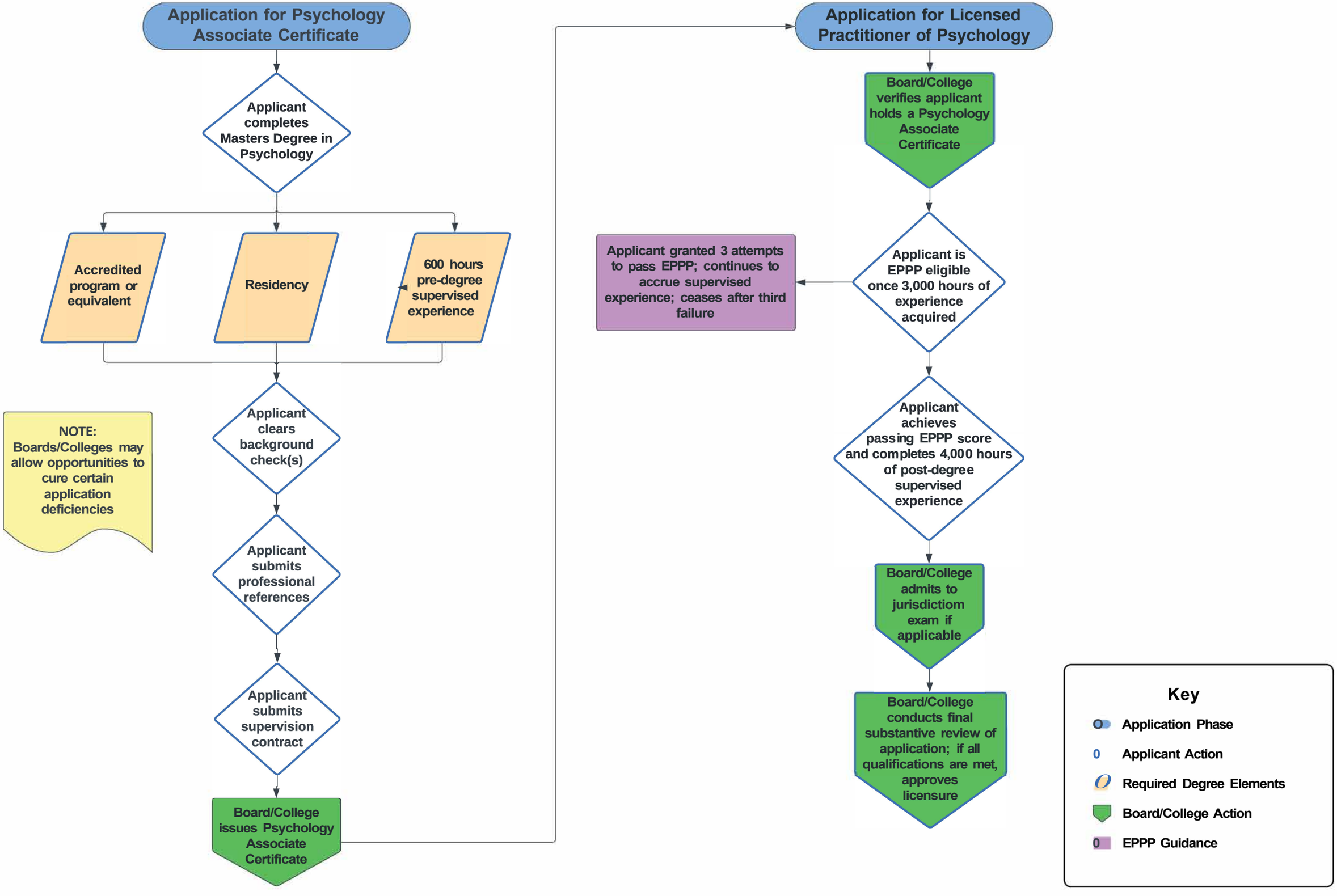
The work of PRI-LM is ongoing. The next phase will focus on developing sample forms to assist regulatory bodies in reviewing master's-level licensure candidates credentials, including a Post-Degree Verification Form, Supervision Contract, and Supervisor Report/Verification Form.

We appreciate your continued engagement in this important discussion and welcome further input as this work continues.

Sincerely,

The ASPPB Board of Directors

Association of State and Provincial Psychology Boards
Masters-Level Licensed Practitioner of Psychology Process



Part Two

Model Statutory Language

I. Definitions

A. Psychology Associate: An individual who is authorized to practice psychology under the supervision of a Licensed Psychologist while attaining further requirements for licensure, as described further in the rules of this Board/College.

B. Licensed Practitioner of Psychology: An individual licensed under this Act and thereby authorized to independently practice psychology at the master's level of education.

II. Practice of Psychology at the Master's Level

A. Intervention:

1. The following provisions regarding scope of practice apply to intervention activities performed by those individuals authorized to practice with a master's degree, regardless of application or licensure status, and regardless of the requirement of supervision.

2. Intervention includes observation, description, diagnosis, interpretation, prediction, and modification of human behavior by the application of psychological principles, methods, and procedures, for the purposes of:

   a. preventing, eliminating, or predicting symptomatic, maladaptive, or undesired behaviors

   b. facilitating the enhancement of individuals or groups of individuals including personal effectiveness, adaptive behavior, interpersonal relationships, and work and life adjustment.

3. Scope of Practice for Intervention:

   a. An initial assessment intake shall be conducted on individuals, couples, families, or individual members of a group for treatment planning. It includes assessments for clients of the psychology practitioner or for a group practice or organization to which the psychology practitioner belongs. Referrals for

assessments for other purposes, or under other referral circumstances, are included in Testing and Assessment.

b. An initial assessment intake includes interviewing and screening methods for the purpose of case formulation, diagnosis, and treatment planning. An initial assessment intake does not include personality measures, neuropsychological assessment, or forensic assessment measures.

c. Continuing assessment for treatment planning includes the use of screening measures for patient status within the scope of a continuing therapeutic relationship.

B. Testing and Assessment:

1. The following provisions regarding scope of practice apply to all Testing and Assessment activities performed by those individuals authorized to practice with a master's degree, regardless of application or licensure status, and regardless of the requirement of supervision.

2. Scope of practice in Testing and Assessment includes and is limited to those practices which inform:

   a. mental health treatment planning for treatment planning for patients/clients of other mental health professionals.

   b. educational planning and placement.

3. Scope of practice is both determined by, and limited by, three types of considerations:

   a. The purpose of the referral or request for assessment.
   b. The source of the referral.
   c. The types of measures that may be utilized to respond to the referral.

4. Scope of practice does not include indirectly related purposes, such as determining liability and extent of damages in litigation, appropriateness of medical and surgical interventions, or determining fitness for duty. These types of assessments do not directly serve the purposes of treatment planning or occupational planning and placement.

5. The scope of practice includes assessments of individuals only, and does not include evaluations of families, groups, or organizations.

6. Nothing in this Act is intended to undermine or contradict standards of practice which have been established for specialty or sub-specialty areas of practice. For example:

   a. individuals authorized to practice psychology with a master's degree shall not identify themselves as neuropsychologists, accept referrals for neuropsychological evaluations, or perform neuropsychological evaluations.

b. Individuals authorized to practice psychology with a master's degree in psychology shall not identify themselves as forensic psychologists, accept referrals for forensic evaluations, or perform forensic evaluations. Psychological specialties are defined at the doctoral degree.
c. Individuals authorized to practice psychology with a master's degree in psychology shall not identify themselves as specialists in other specialty areas of psychology which are defined at the doctoral level.

7. Nothing in this Act is meant to preclude individuals authorized to practice psychology with a master's degree from utilizing screening instruments, questionnaires, rating scales, or interview guides, which are generally available to all mental health professionals. Examples include brief screening instruments of orientation and current mental status, repeated measures of symptoms related to depression and anxiety, and general measures of aptitude and interest.

8. Regardless of the nature or source of a referral for psychological testing or assessment, individuals authorized to practice psychology with a master's degree shall not engage in the interpretation of personality assessment or projective measures. This Act does not preclude the administration or scoring of such measures, where the psychology practitioner serves on a team of, or under the supervision of, a licensed professional who is authorized to interpret such measures.

III. Supervised Experience:

A. Pre-degree supervised experience: As further described and limited by the rules of the Board/College, pre-degree supervised experience includes a minimum of 600 hours of supervised psychology practice which occurs while an individual is enrolled in a graduate course of study in a master's degree psychology program.

B. Post-degree supervised experience: As further described and limited by the rules of the Board/College, post-degree supervised experience consists of a minimum of 4,000 hours of supervised psychology practice pursuant to a supervision contract approved by the Board/College. Post-degree supervised experience must include an integrated course of didactic education.

IV. Examinations:

A. The Examination for Professional Practice in Psychology (EPPP)

B. Other examinations as determined by the Board or College

V. Requirements for Licensure:

A. Application for Psychology Associate Certificate:

1. Education: An Initial Application must demonstrate that the applicant has received a master's degree from a psychology training program.

a. The Board/College shall adopt rules implementing and defining these provisions, including, but not limited to, such factors as residence in the program, internship and related field experiences, number of

course credits, course content, numbers and qualifications of faculty, and program identification and identity.

b. Internationally Trained Graduates: Applicants trained in institutions outside the United States or Canada must show satisfactory evidence of training and degrees substantially equivalent to those required of applicants trained within the United States and/or Canada, pursuant to the rules of the Board/College.

2. Verification of pre-degree supervised experience

3. Professional references

4. Disciplinary and background checks and other requirements by Board/College

5. Post-degree supervised experience contract

B. Application for Licensed Psychology Practitioner

1. When an applicant has met the requirements in Paragraph A above and has accrued 3,000 of the total 4,000 hours of required post-degree supervised experience, the applicant may apply to the Board or College for admission to take the Examination for Professional Practice in Psychology (EPPP).

2. An applicant for Licensed Practitioner of Psychology must receive a passing score* on the EPPP within three attempts. The Board/College shall promulgate rules for the timing of admission to the examination.

   a. If an applicant for Licensed Practitioner of Psychology does not receive a passing score on the initial attempt of the EPPP, the applicant must submit a supervisor's report of the applicant's status and progress during post-degree supervised experience.

   b. When a Psychology Associate continues to accrue post-degree supervision hours while attempting to obtain a passing score on the EPPP, upon accrual of 4,000 hours, the applicant shall submit a new supervision contract to the Board/College for the accrual of further post-degree supervision hours.

   c. The Board/College shall promulgate rules describing the requirements for items a. and b., above.

3. After three attempts at the EPPP without a passing score, or after four years since the initiation of post-degree supervised experience, whichever occurs first, a Psychology Associate must cease practice.

VI. Cessation of the Practice of Psychology

A. After three attempts at the EPPP without a passing score*, or after four years since the initiation of post-degree supervised experience, whichever occurs first, a Psychology Associate must cease practice within 30 days of the official receipt of the last EPPP score, consistent with further requirements set forth in the rules of the Board/College.

B. An applicant who was required to cease the practice of psychology may reapply for licensure after 12 months since the date the applicant was required to cease practice. All rules and regulations in effect at the time of re-application will apply to the reapplication process. An applicant who has been required to cease practice may not practice psychology, including under supervision, until authorized by the Board/College after reapplication. Cessation of practice under these terms does not constitute a disciplinary action.

VII. Representation

A. Psychology Associate: A person represents themselves to be a Psychology Associate if that person uses the title Psychology Associate in a description of services offered or provided, or in any description of services incorporating the practice of psychology. An individual practicing psychology as a Psychology Associate shall not use the term "independent" nor imply the status of independence regarding the offer or provision of psychological services.

B. Licensed Practitioner of Psychology: A person represents themselves to be a Licensed Practitioner of Psychology if that person uses the title Licensed Practitioner of Psychology in a description of services offered or provided, or in any description of services incorporating the practice of psychology. No person other than those authorized under this Act shall represent themselves to be a Licensed Practitioner of Psychology.

VIII. Exemptions

A. Other licensed professionals: Nothing in this Act shall be construed to prevent members of other recognized professions that are licensed, certified, or regulated under the laws of the jurisdiction from rendering services consistent with their professional training and code of ethics, if they do not represent themselves to be psychology associates, licensed practitioners of psychology, psychologists, or describe their services as including the practice of psychology.

B. Clergy: Nothing in this Act shall be construed to prevent duly recognized members of the clergy from functioning in their ministerial capacities, provided that they do not represent themselves to be psychology associates, licensed practitioners of psychology, psychologists, or describe their services as including the practice of psychology.

C. School Psychologists:

1. School psychologists who are appropriately credentialed by state/provincial education agencies or an appropriate regulatory body ("state/provincial education regulatory body") shall be able to provide the range of school psychological services under the title described by the credentialing/regulatory body and within the practice settings authorized by the state/provincial education regulatory body. Such individuals may use the title "School Psychologist" or another title including the term "psychology" or "psychological," but shall not use the titles "Psychology Associate," "Licensed Practitioner of Psychology," "Licensed Psychologist," or any other equivalent term.
2. Nothing is this Act shall be construed to permit the practice of psychology outside the scope of practice or outside the settings described by the state/provincial education regulatory body by any individual who is not licensed under the provisions of this Act.
3. Nothing in this Act shall be construed to permit individuals who are not credentialed by the state education regulatory body to practice psychology within the scope of practice or within the settings described by the state/provincial education regulatory body.

4. It shall remain within the discretion of the state/provincial education regulatory body to establish requirements for credentialing by such body. For example, the education regulatory body's inclusion of independent contractors, whether local or interjurisdictionally, shall determine whether those individuals are exempt from licensure under this Act, to practice psychology within the scope of practice and within the settings described by the state/provincial education regulatory body.

5. Nothing in this Act shall be construed to affect the requirements or acceptability of psychological assessments for those uses described by the state/provincial education regulatory body within the settings described by the state education regulatory body. Nor shall this Act be construed to affect students' rights to independent evaluations described in state or federal regulations as specifically applicable to uses within public education settings.

D. Graduate Students and Interns: Nothing in this Act shall be construed to prevent persons from engaging in activities defined as the practice of psychology, provided that they are supervised in accordance with the rules and regulations of this Board/College. Such persons shall not represent themselves by the titles "Licensed Practitioner of Psychology" or "Psychologist." Individuals training to be psychologists or psychology practitioners may use the terms "psychological trainee," "psychological intern," "psychological resident," or other term denoting their training status, provided that such persons perform their activities under the supervision and responsibility of a licensed psychologist in accordance with the rules and regulations of this Board/College. This section applies to the following graduate students and interns:

1. A matriculated graduate student whose activities constitute a part of the course of study for a graduate degree in psychology at an institution of higher education.

2. An unlicensed individual pursuing postdoctoral training or experience in professional psychology, to fulfill the requirements for licensure under the provisions of this Act.

3. Individuals who hold a Psychology Associate certificate or a Licensed Practitioner of Psychology credential can use that title while working under the supervision of a licensed psychologist in areas of practice outside the scope of their credentials.

E. Business Consultants and Human Resource Professionals: This Act is for the regulation of the practice of psychology only and does not prevent human resource professionals, business consultants, and other such persons from providing advice and counseling in their organizations or affiliated groups, or to their companies or employees of their companies, or from engaging in activities performed in the course of their employment.

F. Master's-Level Practitioners in Psychology who are already licensed to practice psychology: Jurisdictions will need to address potential exemptions and/or other provisions for master's-level practitioners in psychology who are already licensed in their jurisdiction (i.e., grandparenting).

G. Nothing in this Act prevents a licensed Psychologist or a Licensed Practitioner of Psychology from employing unlicensed individuals, who are appropriately trained and qualified, to perform the following services under the supervision of the licensee:

1. transcribing psychological reports

2. inputting and/or transferring patient or client test responses or scores

3. administering and scoring standardized objective tests where the supervisor is immediately available

* The recommended passing score for the EPPP was determined by a sample of psychology practitioners working both independently and under supervision. The recommended passing score for Licensed Practitioner of Psychology is currently the passing score for supervised practice.

Part Three

Model Regulatory Language

I. Application for Psychology Associate

Upon completion of education, training and granting of the degree, applicants shall apply to the Board/College for a Psychology Associate certificate which will enable the applicant to acquire post-master's supervised experience. Applicants have four (4) years to complete their supervised experience and take the Examination for Professional Practice in Psychology (EPPP).

An application for Psychology Associate must include documentation that the following requirements have been met:

A. Education

1. A master's degree in psychology shall be obtained from an institution of higher education that was, at the time the degree was awarded, regionally accredited by bodies approved by the United States Department of Education; or recognized by Universities Canada, formerly known as the Association of Universities and Colleges of Canada; or, alternatively, one of the following:

    a. A university recognized by the designated provincial or territorial authority.

    b. An international college or university deemed to be equivalent by an international credential evaluation service that is a member of the National Association of Credential Evaluation Services.

2. The psychology master's program was, at the time the degree was awarded, accredited by the APA Commission on Accreditation (CoA).

3. The master's program includes a minimum of two academic years of graduate-level study (includes credits or competencies needed).

4. The graduate program may have included distance education, but a minimum of one (1) continuous year of the program shall have consisted of residency. This residency requirement is not met by:

    a. programs that use physical presence, including face-to-face contact for durations of less than one (1) continuous academic year (e.g., multiple long weekends and/or summer intensive sessions).

b. programs that use video teleconferencing or other electronic means as a substitute for physical presence.

5. At least 50% of the credit toward the master's degree was earned in the graduate program awarding the master's degree. No more than two courses may be transferred from the undergraduate level, and under no circumstances may undergraduate courses in assessment, intervention, or ethics be counted.

6. If not accredited, the psychology master's program must have met equivalent standards by demonstrating that, in addition to the above, it contained the following elements:

a. All training included the Integration of psychological science and practice.

b. Training was sequential, cumulative, increasing in complexity, and designed to prepare students for practice at the master's level.

c. The program engages in actions that indicate respect for and understanding of cultural and individual differences and diversity.

7. If the program was not accredited, applicants are required to obtain a base of general knowledge in the field of psychology, broadly construed, to serve as a foundation for further training in the practice of health service psychology from the following core competency areas, but that knowledge does not have to be a course-by-course requirement, and may be satisfied by courses that integrate several knowledge areas:

a. Affective Aspects of Behavior, including topics such as affect, mood, and emotion. Although courses in psychopathology or specific disorders may be included in this category, they and mood disorders do not by themselves fulfill this category.

b. Biological Aspects of Behavior, including multiple biological underpinnings of behavior, such as neural, physiological, anatomical, and genetic aspects of behavior. Although neuropsychological assessment and psychopharmacology may be included in this category, they do not, by themselves, fulfill this category.

c. Cognitive Aspects of Behavior, including topics such as learning, memory, thought processes, and decision-making. Although cognitive testing and cognitive therapy may be included in this category, they do not, by themselves, fulfill this category.

d. Developmental Aspects of Behavior, including transitions, growth, and development across an individual's life. Coverage limited to one developmental period (e.g., infancy, childhood, adolescence, adulthood, or late life) is not sufficient.

e. Social Aspects of Behavior, including topics such as group processes, attributions, discrimination, and attitudes. Individual and cultural diversity and group or family therapy do not, by themselves, fulfill this category.

f. Consumption of Research, including the reading and interpretation of primary source literature, attending to trustworthiness in qualitative and validity in quantitative research with an under-

standing of sampling issues, parametric assumptions, design confounds, basic inferential statistics, and meta-analyses.

g. Psychometrics, including topics such as theory and techniques of psychological measurement, scale and inventory construction, reliability, validity, evaluation of measurement quality, classical and contemporary measurement theory, and standardization.

h. Psychotherapy and Psychological Interventions, including a variety of evidence- based treatments used to help identify and change individuals' negative emotions, thoughts, and behaviors.

i. Ethics and Professional Responsibility

B. Pre-degree Supervised Experience:

The pre-degree supervised experience shall:

1. be planned by the educational program faculty and by staff of the supervised training experience, rather than by the student.

2. be a planned and directed program of training for the practice of psychology, in contrast to on-the job training, and shall provide the trainee with a planned and directed sequence of training that is integrated with the educational program in which the student is enrolled.

3. have had a written description of the program of training, or a written agreement, developed prior to the time of the training, between the student's educational program and the supervised training experience site, detailing the responsibilities of the student and the supervised training experience site. The agreement shall be approved by the student's educational program prior to the beginning of the supervised training experience.

4. have designated a licensed psychologist as a primary supervisor, who remains responsible for the supervised training experience and who arranges incidental or temporary delegation of supervisory responsibility to another licensed mental health professional as necessary.

5. apply any of the following terms to the trainee: an "intern," "extern," or "practicum student," or a title that denotes a training status for the practice of psychology

6. provide a minimum of 12 weeks, consisting of at least 600 hours of supervised training. At least 400 hours of the training shall be in the direct practice of psychology.

7. be completed within a period of 12 consecutive months at not more than two supervised training experience sites.

C. Professional References provided to the Board/College

1. One reference must be from the primary supervisor of the applicant's pre-degree supervised experience.

2. One reference must be from a faculty member from the applicant's degree program who is familiar with the applicant's education, training, and experience.

D. Criminal and disciplinary background checks and any other background checks as required by the Board/College.

E. A signed supervision contract for post-degree experience that is acceptable to the Board/College and includes the following elements:

1. Supervisor:

a. is a licensed psychologist.

b. has a relationship with the site that provides for the supervisor's significant presence and ability to be responsive to the trainee when needed.

c. has access to all client records.

d. has had training in clinical supervision, as evidenced by graduate coursework, continuing education, or continuing professional development experiences, within five years of the date of the supervisor's first supervision contract and at intervals of every five years thereafter.

e. has competence to supervise trainees for their post-degree supervised experience, as evidenced by the primary supervisor's education, training, and experience.

f. establishes the parameters of supervision and articulates the supervisor's and trainee's responsibilities, including the primary supervisor's legal, professional, and ethical responsibility for the work performed by the trainee under supervision.

g. provides a minimum of one (1) hour per week of individual supervision per 20 hours of psychology experience, at least one hour of which is provided by the primary supervisor, with assurance that when an additional hour(s) is delegated for clinical purposes, or when an hour(s) must be delegated incidentally and temporarily, the primary supervisor shall retain oversight responsibility for the trainee's supervision.

h. arranges for the didactic portion of the post-degree supervised experience to enhance the competence of the supervisee. The didactic portion of the post-degree supervised experience shall consist of educational activities, such as continuing education and continuing professional development activities, which provide relevant additional information and training related to the practice of psychology.

i. does not supervise more than four (4) supervisees at any one time.

j. is responsible for ensuring that the terms of the supervision contract are maintained and address any circumstances that may arise which impede that, and for protecting the trainee from exploitation or harm by anyone involved in the setting.

k. has no active disciplinary status with any jurisdiction. If the supervisor has had a previous disciplinary status or action but is no longer under such status, the supervisor must report that to the Board/College.

2. Elements of the Contract:

a. identify the site where the supervised experience will take place and include a brief description of the client populations, and the services typically provided.

b. designate the primary supervisor, including the supervisor's licensure status, and relationship with the site.

c. provide for didactic experiences at an average rate of three (3) hours per week for a 40-hour week, prorated for the actual hours the trainee accrues psychology experience.

d. provide that the primary supervisor will direct, oversee, and integrate the didactic experience with the trainee's clinical experience.

e. indicate that the supervised experience will provide the supervisor the opportunity to review the trainee's performance through means such as direct observation of the trainee's clinical work, written materials, and video and audio recordings.

f. indicate that direct supervision and other interactions will include a discussion of clients' cases, oversight, and guidance regarding service to clients, and evaluation of clients' progress with periodic evaluation of whether treatment goals are being met and if changes in direction are needed.

g. indicate that direct supervision and other interactions will include legal, ethical, social, and cultural dimensions related to clinical practice and the supervision relationship.

h. indicate that the trainee's supervised experience will occur at a rate of no more than 40 hours per week and no less than 16 hours per week.

i. indicate that the primary supervisor and the trainee do not have a multiple relationship, such as a family relationship, significant social relationship, or other relationship outside of their roles in the post-degree supervision setting.

j. ensure that the trainee is provided an appropriate experience and is protected from mistreatment or exploitation including the following:

i. Trainees shall not be charged a fee for supervision.

ii. Preference is for trainees to be provided a formal internship that includes supervision and didactic instruction.

iii. Trainees shall be compensated according to a pre-agreed upon contract that shall not be based on productivity and that may be in the form of a stipend or employment.
Trainees shall carry no more than 60% of the clinical caseload expected of licensed staff, and their clinical schedule should accommodate their didactic schedule.

k. goals, expectations, and methods of evaluation for the experience are identified and shared with the supervisee and attested to by signing the Supervision Contract.

*The Board/College has the authority to accept or reject a supervisor or any elements of the Contract.

II. Application for Licensed Practitioner of Psychology:

A. An application for Licensed Practitioner of Psychology shall demonstrate to the Board/College's satisfaction that the applicant has:

1. previously been certified as a Psychology Associate

2. completed any additional jurisdictional examinations or other requirements.

3. demonstrated through submission of a Supervision Verification Form provided by the Board/College and completed by the primary supervisor of the post-degree supervised experience that:

a. the applicant has completed a minimum of 4000 hours of post-degree supervised experience.

b. the post-degree supervised experience was completed in a minimum of 24 months and a maximum of 48 months.

c. more than 50% of the post-degree supervised experience was spent in direct service activities that prepare the trainee for licensure as a Licensed Practitioner of Psychology.

d. individual supervision occurred face-to-face, at least 60% of the time in person, with any tele-supervision for the remaining 40% of the time being conducted through interactive, synchronous means.

e. individual supervision occurred at a rate of one hour per 20 hours of psychology experience, with at least one hour per week being provided by the primary supervisor and the remaining hour(s), if delegated to another licensed healthcare professional(s), occurred under the oversight of the primary supervisor.

f. within the total hours of post-degree supervised experience, the applicant received didactic education and training at an average of three hours per week for a 40-hour week, prorated to the hours per week the applicant engaged in supervised experience.

g. the applicant has received satisfactory ratings from the primary supervisor on the Supervisor Report Form provided by the Board/College.

4. submitted two professional references, based on observations of the applicant during their recent post-degree experience.

5. received Board/College approval of an updated criminal and disciplinary background check and any other background requirements by the Board/College.

6. provided any other information requested by the Board/College.

7. received the recommended passing score on the EPPP*.

B. The Examination for Professional Practice in Psychology (EPPP):

1. To apply to take the EPPP, the applicant must submit to the Board/College documentation that they have completed at least 3000 of the 4000 required hours of post-degree supervision and is in good standing with the Board/College with their supervision contract.

2. Upon receipt, acceptance, and approval of all materials described in Section A (i- xii) above, the Board/College shall authorize the applicant to take the EPPP.

a. The EPPP shall be administered by ASPPB or by its designee in accordance with its established policies.

b. Upon authorization, the candidate for the EPPP shall schedule a test date with the test vendor according to Board/College and test vendor policies within the recommended time frame.

3. Candidates seeking accommodation(s) for the EPPP based on identified conditions under the Americans with Disabilities Act (ADA) in the United States or the Human Rights Legislation or Accessible Canada Act (ACA) in Canada, shall submit a form provided by the Board/College and have the accommodations approved before the testing appointment is made.

4. ASPPB reserves the right to reject any accommodation request that, in the sole opinion of ASPPB, would jeopardize the integrity, validity, and/or security of the examination. In such situations, ASPPB reserves the right to deny access to the examination.

5. If ASPPB denies access to the examination, the Board/College may offer a suitable alternate method of examination appropriate for the applicant.

6. The passing score on the EPPP shall be the ASPPB recommended passing score for master's-level practice. *

7. Candidates who pass the EPPP prior to completing the required 4000 hours of supervised experience shall continue to practice under supervision as a Psychology Associate and are not otherwise authorized to practice psychology.

8. If the candidate does not receive a score at the recommended pass point on the EPPP, the candidate shall seek authorization from the Board/College to retake the exam within 90 days of notification of the candidate's score on the exam.

a. At the discretion of the Board/College, the candidate shall submit a supervisor's report of the status and progress of the post-degree supervised experience, including a general description of the applicant's performance, any specific concerns noted by the supervisor, and the supervisor's recommendations for remediating the concerns.

b. While the Board/College review of the supervisor's report is pending, and while the candidate awaits re-admittance to the EPPP, the candidate may continue accruing post-degree supervised experience.

c. Upon receipt of the supervisor's report, the Board/College, in its discretion, may require the candidate to pause the accrual of post-degree supervised experience until the candidate has passed the EPPP or until other concerns raised by the supervisor's report have been remediated. All hours accrued before the pause may be counted toward the total hours required.

9. Candidates who can document that they have met the required 4000 hours of supervised experience but have not passed the EPPP may continue to practice under a supervision and a new Supervision Contract until they either pass the EPPP and are issued an independent license or fail to meet that requirement, and their supervised license is terminated according to the requirements of this statue.

10. A candidate who does not receive the recommended passing score* on the EPPP after three attempts, or after two (2) years since the date of initial authorization to take the EPPP, whichever happens first, must cease their post-degree supervised experience. The cessation of practice for this reason does not constitute disciplinary action.

a. If a candidate has failed to achieve the recommended passing score* on the EPPP in three (3) attempts, the Board/College shall notify the candidate's primary supervisor of that fact.

b. The candidate must cease the practice of psychology within 30 days of official notification of the score for the third attempt at the EPPP or on the date that marks two (2) years since the candidate was first admitted to the EPPP.

c. A candidate required to cease practice under this subsection shall:

i. provide immediate notice to their primary supervisor at the post-degree supervised experience that they are required to cease practice within 30 days of having received notification of their EPPP score.

ii. assist the supervisor and the training site in the transfer of client care.

III Scope of Practice

The scope of practice for psychological services authorized for applicants, Psychology Associates, and Licensed Practitioners of Psychology shall apply regardless of whether payment is received or whether the services are rendered in person or via electronic means.

Licensees shall only initiate services when they determine by information available to them that the services required to maintain standards of practice are within their scope of competence. If, during the course of providing professional services, the licensee determines that the services required to maintain standards of practice, or the needs of the individual(s) receiving services, are beyond the licensee's boundaries of competence, the licensee shall be responsible for seeking supervision, training, or referring the individual(s) to an appropriate service provider. If a Board/College determines that a licensee knows or should have known that they were not competent to provide the services needed by the client(s), a board/college may take disciplinary action.

A. Intervention:

1. includes the observation, description, diagnosis, interpretation, prediction, and modification of human behavior by the application of psychological principles, methods, and procedures, for the purposes of:

a. preventing, eliminating, or predicting symptomatic, maladaptive, or undesired behaviors.

b. facilitating the enhancement of individuals or groups of individuals including personal effectiveness, adaptive behavior, interpersonal relationships.

2. An initial assessment intake shall be conducted on individuals, couples, families, or individual members of a group for treatment planning. It includes assessments for clients of the psychology practitioner or for a group practice or organization to which the psychology practitioner belongs. Referrals for assessments for other purposes, or under other referral circumstances, are included in the scope of practice for Testing and Assessment.

B. Testing and Assessment:

1. Treatment Planning:

a. The scope of practice includes testing and assessment to inform mental health treatment planning by other professionals, such as psychologists and psychology practitioners, medical or other healthcare professionals, psychiatrists, and counselors in professions other than psychology.

b. Testing and assessment for mental health treatment planning by other health professionals is limited to mental health treatment planning by those professionals.

c. The scope of practice does not include treatment planning in domains other than mental health treatment planning, such as risk assessment or appropriateness of organ transplant or other surgical interventions.

2. Educational Planning and Placement:

a. The scope of practice includes testing and assessment that is requested by educational institutions where the individual being assessed receives services or is enrolled. The purposes of the assessment may include eligibility for services, clarification of educational needs, remediation planning, and disability manifestation determinations related to school-based discipline.

b. The scope of practice includes testing and assessment requested by individuals and organizations other than educational institutions where the referral and the assessment serve the purposes of educational planning and placement for the individual being assessed.

c. The scope of practice is limited to measures of cognitive ability and potential, adaptive functioning, academic achievement, and data from parent and teacher reports of behavioral and school functioning. Parent and teacher reports may be obtained by standardized measurement or structured or unstructured interview.

d. The scope of practice does not include testing and assessment for determinations other than educational planning and placement, such as institutional liability for failure to meet a student's needs.

3. Occupational Planning and Placement:

a. The scope of practice includes referrals from individuals or educational institutions to assess an individual's interest in or goodness of fit for occupational fields or career paths.

b. The scope of practice does not include referrals from employers, licensing boards, or other sources of privileges to determine an individual's fitness for duty, fitness for practice, fitness for tenure, or fitness for continued service.

c. Scope of practice does not generally include evaluation of an individual's eligibility for disability, based on the individual's scope of abilities and limitations in the workplace, including the individual's needs for accommodations in the workplace. Notwithstanding this general limitation, individuals authorized to practice psychology as a Licensed Practitioner of Psychology may apply for credentialing by public agencies where those agencies provide their own requirements for credentialing, which include practice with a master's degree, and where the Licensed Practitioner of Psychology practices within the scope provided by the public agency. Examples may include contributions to determination of an individual's eligibility for Social Security disability benefits or an individual's eligibility for veteran's benefits. Individuals authorized to practice psychology as a Licensed Practitioner of Psychology or Psychology Associate may not provide second opinions or other consultations outside the purview of credentialing provided by the public agency.

d. The scope of practice does not include referrals for assessments related to wrongful termination, compensation and damages, failure to provide accommodations, discrimination, or other personal injury, regardless of the referral source.

*The passing scores for the EPPP were developed using a sample consisting of individuals practicing independently and those practicing under supervision. The recommended passing scores for provisionally licensed and licensed psychology practitioners are the passing scores for supervised practice.

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 2/21/2025

SUBMITTED BY: Executive Director

TITLE: Executive Director's Report

INTRODUCTION TO THE TOPIC:

The Executive Director Report communicates, in advance, information that brings board members up to date on what has occurred since the last board meeting and is intended to lead to engagement and interaction at the next board meeting. The Executive Director Report seeks to offer reminders to board members on upcoming commitments, relevant dates and events, and to raise issues for board members to address during the board meeting. The Executive Director Report is also intended to give board members information that is useful in their role as board members and in stakeholder outreach.

BOARD ACTION REQUESTED:

ATTACHMENTS:

Description	Upload Date	Type
Wilder Report for Master's Professions	2/14/2025	Cover Memo
Atlantic Article	2/20/2025	Cover Memo
Culturally Informed and Culturally Responsive Mental Health Taskforce	2/21/2025	Cover Memo
EIDBI DHS Recommendation	2/21/2025	Cover Memo
SF971	2/21/2025	Cover Memo
ED Report	2/21/2025	Cover Memo

Unfinished Business: Examining Barriers to Obtaining Mental Health Licensure Among Minnesota Graduates

Findings and Recommendations

Authors: Melissa Serafin, Miamoua Vang, Roy Kammer, Kari Much, and Morgan Olson

FEBRUARY 2025

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Key findings and recommendations

There is a severe shortage of mental health providers in Minnesota, with 72% of Minnesota counties federally designated as mental health provider shortage areas (Abderholden, 2024; Health Resources & Services Administration, 2024; Minnesota Department of Health, 2022; NAMI Minnesota, 2022). A significant area of opportunity is the licensure process, as about half of graduates in Minnesota who complete a master's degree necessary for mental health licensure do not complete the process (Leibert & Fritsma, 2017).

To better understand the barriers that master's-level graduates face during the licensure process, Wilder Research (Wilder) and the Blue Cross and Blue Shield of Minnesota Center for Rural Behavioral Health at Minnesota State University, Mankato (CRBH) conducted a survey and interviews with graduates in 2023-2024. Graduates were eligible to participate if they had graduated from their program within the past seven years. This summary describes the project's findings, the recommendations for addressing these barriers and improving the licensure process, and whether each recommendation would be best addressed by licensure boards or regulatory agencies, payers, employers, and/or graduate programs.

The mental health system and social safety nets are inadequately resourced

While not the focus of this project, many respondents described how broader social and economic conditions negatively impact their clients and their ability to effectively provide mental health services. Specifically, they described issues with inadequate insurance coverage and high costs of services; how under-resourced school settings leads to expanding the roles and responsibilities of school-based providers; inadequate transportation systems; lack of internet access; poverty; a lack of crisis services; a lack of support to help families and caregivers develop positive communication and caregiving skills; and how rural areas are particularly under-resourced. Additionally, some respondents mentioned how licensing boards are understaffed and under-resourced.

> *Sometimes what my clients need is access to money and food and resources. And all I can really do is point them to resources… [We're told to] help your clients reframe their thinking. But it's like, okay, well, they don't have enough money to live.*

> *As a school social worker, I'm seen as an extra body, a lunch lady, all these extra things. It's hard to use my profession to actually get people what they need. Everyone is understaffed... This year has been one of the worst years I've been in the field.*

Despite challenges, providers find fulfillment in their work

While this report focuses on challenges faced by mental health providers, study respondents emphasized that they also greatly enjoy their work and find fulfillment in providing mental health services.

> *It's the best job on earth, and I feel blessed. But we can basically do anything else and get paid better, and that is a shame.*

> *I love my job. I really enjoy it. But I think this generation of clinicians is going to be burnt out very fast. I think compassion fatigue is going to seep in really hard… People are burning out left and right because they're working a crap ton of hours and only getting paid for 40 of those hours.*

> *I feel like I'm meant to do this work. I get confirmation that I'm good at my job, people find value in working with me [as a mental health provider]… [Employers say], "We support self-care. What can we do?" And we're like, "More pay." And they're like, "No, here's a pizza party."… I get resentful for doing such meaningful work [for such little pay].*

Reduce costs associated with becoming a mental health provider, increase wages, and provide financial assistance.

Challenges related to finances and costs were commonly identified by this study's participants. In addition to tuition and student loans from their master's program, graduates are required to pay a wide range of fees throughout the licensure process, including the licensure application fee, licensure renewal fees, licensure exam fees, and background study and fingerprinting fees. Graduates also often have to pay out of pocket to complete their required supervision hours, continuing education units (CEUs), and any additional trainings in specific interventions or modalities. Additionally, graduates emphasized the significant amount of unpaid labor expected within the mental health field, including unpaid time spent receiving supervision, studying for exams, filling out licensure applications and other paperwork, completing the insurance company credentialing process, and completing clinical notes and other paperwork.

Graduates suggested reducing fee amounts, introducing sliding scale or tiered fee levels based on a provider's identity and/or the populations they serve (i.e., reduced costs for providers who hold marginalized identities or serve marginalized communities), and removing fees altogether. They also suggested providing financial assistance to pay for supervision, providing free licensure exam preparation materials, and reducing administrative responsibilities and streamlining administrative processes to minimize time spent on unpaid labor.

Recommendations regarding costs and financial assistance

	Licensure boards or regulatory agencies	Payers	Employers	Graduate programs
Reduce or eliminate licensure application, renewal, and exam fees and/or introduce sliding scale or tiered fee levels based on providers' identities or the populations they serve	☑			
Provide financial assistance to pay for supervision hours	☑	☑	☑	☑
Reduce tuition				☑
Create new opportunities for student loan forgiveness	☑			
Provide free licensure exam preparation materials	☑			☑
Reduce administrative responsibilities and streamline administrative processes to minimize time spent on unpaid labor	☑	☑	☑	☑

Streamline licensure application processes and provide graduates with comprehensive resources and real-time support.

Respondents described the licensure application process as excessively burdensome and confusing across the three different types of licensure (i.e., social work, counseling, and marriage and family therapy). They shared that the application is tedious, lengthy, and requires providing the same information multiple times. They specifically mentioned challenges related to tracking and documenting required hours and their overall progress toward licensure requirements, the inconvenient and burdensome background study and fingerprinting process, and the processes involved in registering for and taking licensure exams. They also mentioned communication issues with licensure boards and graduate programs, including confirming whether boards have received the correct documentation required for licensure and receiving inconsistent information from different sources (e.g., receiving different information from licensure boards and graduate programs). Additionally, respondents identified the long time it takes for licensure applications to be processed and delays they experienced, particularly during the COVID-19 pandemic. Lastly, respondents noted that many of these challenges may be at least partially due to licensure boards being underfunded and understaffed.

They stressed the importance of providing one-on-one and real-time guidance throughout the licensure process, providing clear and concise written and online resources to guide graduates through the process, ensuring information and guidance are consistent regardless of the source, and offering an online portal to submit documents and check progress toward licensure. They suggested that licensure boards, regulatory bodies, and graduate programs provide more assistance understanding and completing the licensure process, such as regular drop-in sessions.

Recommendations regarding the licensure application process and related guidance

	Licensure boards or regulatory agencies	Payers	Employers	Graduate programs
Streamline the application and remove requirements to submit duplicative information	☑			
Create an online portal to allow graduates to submit documents and track progress toward licensure	☑			
Identify ways to simplify the background study and fingerprinting process	☑			
Prioritize responsivity to licensure process questions from graduates	☑			☑
Advocate for additional funding and staffing to improve application processing efficiency	☑			
Provide direct assistance to graduates throughout the licensure process and create effective written and online guidance resources	☑			☑

Increase the flexibility of licensure requirements.

Respondents emphasized how strict licensure requirements complicate and lengthen the licensure process. They mentioned requirements to obtain hours working with specific populations that graduates don't plan on working with after licensure (e.g., families, youth, adults), the short amount of time allowed to complete requirements, requirements that supervision hours occur in person, limitations regarding who is allowed to provide supervision, and that previous related experience cannot be counted toward licensure requirements.

Some respondents mentioned that these requirements are more difficult for providers with specific identities, including those who work in rural areas and may find it more difficult to build a caseload, and providers who have other responsibilities (e.g., employment, caregiving) that reduce the amount of time they can dedicate to meeting licensure requirements.

Recommendations regarding licensure requirements

	Licensure boards or regulatory agencies	Payers	Employers	Graduate programs
Identify areas to increase flexibility in meeting licensure requirements, such as lengthening the amount of time allowed to complete requirements or reducing the number of hours serving specific populations	☑			

Prioritize alignment between licensure types and state portability.

Respondents described how the licensure process is further complicated by the differences between licensure types and state regulations. They described the significant similarities in the work of mental health providers regardless of licensure, but that the differences in licensure requirements and processes make systems more difficult to navigate (e.g., differences in hours requirements, exams, and in how providers are able to bill for services).

They also identified challenges related to state portability, as each state has different regulations and licensure requirements. Respondents described how these differences and state-based telehealth restrictions prevent providers from serving clients across state lines, and how providers often need to complete the entire licensure process again if they wish to practice in a different state.

Note that the Minnesota legislature passed a bill during the 2024 legislative session that creates interstate compacts, allowing professionals with certain licensures in other states to practice in Minnesota, including social workers and professional counselors, and vice versa (American Counseling Association, 2024; Bryant, 2024).

Recommendations regarding aligning licensure types and portability

	Licensure boards or regulatory agencies	Payers	Employers	Graduate programs
Increase alignment between licensure types	☑			
Allow licensure portability between states and consider opportunities for licensure reciprocity between states	☑			

Provide support to help graduates find supervisors and prioritize supervision quality.

Respondents described challenges with finding a high-quality supervisor and supervisors with expertise in the interventions, modalities, or populations supervisees hope to specialize in, and identified a lack of supervisors who represent diverse identities (Black, Indigenous, and People of Color; LGBTQ+; speaks a specific language). They shared how time-intensive finding information about potential supervisors is and how little guidance graduates receive about identifying and selecting a supervisor. Respondents suggested creating a database or directory of licensed supervisors that would include additional information to inform a provider's decision (e.g., specializations).

Quality concerns were also identified, such as supervisors who provide incorrect information, fail to complete paperwork requirements on time, lack familiarity with their responsibilities as a supervisor, and cancelled or cut supervision sessions short. Some respondents also described supervisors who acted inappropriately or discriminatorily. Suggestions to address quality concerns included strengthening oversight of supervisors and ensuring training requirements are effective.

Recommendations regarding supervision

	Licensure boards or regulatory agencies	Payers	Employers	Graduate programs
Create a directory or database of approved supervisors with detailed information (e.g., specializations, identities they hold, populations they work with, availability to supervise)	☑			
Assess pathways to becoming a supervisor and identify barriers that may prevent providers of diverse backgrounds from becoming supervisors	☑			
Provide guidance regarding the process of assessing and selection a supervisor	☑			☑
Assess requirements to serving as a supervisor and identify and address gaps in oversight, accountability, and training	☑			

Align licensure exams with their intended purpose and provide more exam preparation support.

Respondents described several challenges related to the licensure exam process, including that the exam is too difficult and graduates need more support to prepare. They also mentioned how the required waiting time before someone can retake the exam after failing is too long and delays the overall licensure process.

Moreover, respondents expressed skepticism regarding how well licensure exams assess provider competency, skill, and ability to ethically provide mental health services. They reported that they felt like the exam process primarily helped them pass the exam rather than contributed to skill development, how bias is embedded in standardized tests, and how the "correct" responses conflict with how mental health services function in reality.

Similarly, respondents expressed concerns with the wording of exam items, including how some exam items are excessively confusing, use overly complicated or statutory language, or use problematic language. Respondents also emphasized how licensure exams may pose more significant barriers to providers from marginalized backgrounds, such as providers with lower levels of English fluency.

They suggested providing resources and support to help graduates prepare for the exam, offering alternative ways of demonstrating competency, and revisiting exam content to address bias and equity concerns, simplify wording, and ensure items effectively assess clinical skills.

Recommendations regarding licensure exams

	Licensure boards or regulatory agencies	Payers	Employers	Graduate programs
Provide exam preparation resources and support	☑			☑
Identify alternative ways for providers to demonstrate competency	☑			
Assess exam content to address equity concerns, simplify wording, and ensure the exam effectively assesses clinical skills	☑			
Ensure graduates have the option of taking exams in languages other than English	☑			

Support work well-being and minimize administrative burden.

Throughout this study, respondents described a wide range of challenges related to work well-being. These included low pay, low reimbursement rates, excessive administrative burdens, unpaid labor, burdensome workloads, and the lack of benefits afforded to many mental health provider positions. They also described how providers often experience compassion fatigue and secondary trauma due to the nature of their work. Additionally, respondents expressed frustration with the lack of attention to provider well-being, and how self-care messaging often feels performative.

Recommendations regarding work well-being

	Licensure boards or regulatory agencies	Payers	Employers	Graduate programs
Provide sufficient wages, benefits, and work well-being resources to providers			☑	
Streamline and minimize administrative requirements	☑	☑	☑	
Ensure reasonable caseload expectations			☑	

Address diversity, equity, and inclusion issues within the behavioral health field and support providers from marginalized backgrounds.

Respondents emphasized the lack of providers and supervisors from marginalized backgrounds and how these shortages negatively impact the mental health and well-being of providers themselves and marginalized communities more broadly. They also described how the mental health workforce system fails to sufficiently prioritize diversity, equity, and inclusion issues and provide enough support for providers who hold marginalized identities. Lastly, they reported that the challenges identified in this study are often even more problematic for providers who hold marginalized identities, and how providers often experience discrimination in their roles.

Recommendations regarding diversity, equity, and inclusion

	Licensure boards or regulatory agencies	Payers	Employers	Graduate programs
Provide resources specifically tailored to providers from marginalized backgrounds, including resources in languages other than English (e.g., grants, written materials, assistance finding a supervisor that holds a specific identity)	☑	☑	☑	☑
Assess exam content and wording to address equity concerns and offer exams in languages other than English	☑			

Rural perspectives

While this study collected input from graduates regardless of the geographies they serve, respondents also described challenges that are particularly problematic for rural areas, including:

- **Lack of employers, obtaining enough hours, and obtaining specific types of hours.** Respondents described how rural areas have fewer employer options available and how it can be more difficult and take longer to build a caseload in areas with smaller populations.
- **Inadequately resourced mental health system and social safety nets.** While health and social support systems are inadequately funded overall, respondents shared that rural systems are particularly under-resourced (e.g., fewer providers, fewer clinics, inadequate transportation systems, lack of access to technological resources and the internet).
- **Finding a supervisor.** Respondents reported that there are fewer supervisor options in rural areas, and that telehealth limitations regarding supervision restrict options even further or require providers to travel long distances to receive supervision.
- **Licensure portability and reciprocity.** Respondents shared how state-based licensure restrictions often negatively impact access to mental health services in rural areas, since providers are generally only allowed to serve clients in the states the provider is licensed in, and many people in rural areas live near state borders.
- **Lack of providers from diverse backgrounds.** Respondents reported that the lack of providers from diverse backgrounds (e.g., Black, Indigenous, and People of Color, LGBTQ+) is even worse in rural communities.
- **Travel distance to complete requirements.** Some licensure requirements need to be completed in person (e.g., fingerprinting), which often means providers in rural areas need to travel farther.

  The drive is a lot, it's a two-hour commute. The rural areas don't have the mental health care they need because of the distance… [We need] more money to address mental health in rural populations and better technology for virtual services.

  It gets challenging. For a lot of rural sites in [border state], we were it. If [residents] didn't have access to us, they didn't have access to anyone… If you have a Minnesota licensure, you should be able to practice in other states.

  In a rural area, if anything went wrong, you're just on your own… Sometimes I had no cell service. I had a hard time getting my notes done because you're trying to see people rurally and having to drive almost an hour.

  [Barriers for people from marginalized backgrounds] are really tough, especially entering the rural workforce… Serving individuals in this region that have those identities, trying to connect them with people who look like them, have a similar background as them, that is extremely difficult.

Contents

Figures

Project background

In 2023-2024, the Blue Cross and Blue Shield of Minnesota Center for Rural Behavioral Health at Minnesota State University, Mankato (CRBH) partnered with Wilder Research (Wilder) to conduct a study to better understand the barriers that master's level mental health providers face during the licensure process. The study included a brief review of existing literature and research; a survey of 144 graduates from master's programs in Minnesota that lead to licensure in social work, counseling, or marriage and family therapy; and interviews with 41 graduates who opted in to participate after completing the survey. Graduates were eligible to participate if they had graduated from their program within the past seven years.

See the Appendix for more information about the study methods and participants.

Mental health licensure types

There are many types of professional licensure that allow individuals to provide mental health services to clients. The current study focused on master's level licensures within the social work, counseling, and marriage and family therapy fields, which include:

- Social Work: Licensed Independent Clinical Social Worker (LICSW), Licensed Independent Social Worker (LISW), and Licensed Graduate Social Worker (LGSW)
- Counseling: Licensed Professional Clinical Counselor (LPCC) and Licensed Professional Counselor (LPC)
- Marriage and Family Therapy: Licensed Marriage and Family Therapist (LMFT)

Additionally, note that some providers hold bachelor's level licensures, including Licensed Alcohol and Drug Counselor (LADC).

The licensure process

While specific requirements vary between licensure types, and the process differs if a provider is already licensed in another state, licensure requirements generally involve:

- Academic master's degree in social work, counseling, and/or marriage and family therapy (degree titles vary)
- Clinical hours providing mental health services directly to clients. This includes hours requirements for completing a master's degree program and hours requirements for earning licensure after graduation
- Supervision hours receiving clinical supervision from an approved supervisor
- Licensure exam(s)
- Criminal background check

Findings

This section presents the findings from this project organized into several topic areas: the application and overall process of seeking licensure, working in the mental health field, supervision, and licensure exams. Each finding corresponds to one of the key recommendations, and these are noted throughout in callout boxes.

Previous research

There is very little existing research examining the barriers that mental health providers face during the licensure process. However, research has identified many of the challenges described in this report and their negative impacts on the mental health workforce, including:

- Burdensome, confusing, and costly state portability and reciprocity processes (Atanackovic et al., 2024; Elliott et al., 2019; NAMI Minnesota, 2022; Page et al., 2017)
- Low wages, low reimbursement rates, and high costs of the licensure process (Hallett et al., 2023; HealthForce Minnesota, 2015; Last & Crable, 2024; Leibert & Fritsma, 2017; Mian & Glutting, 2022; NAMI Minnesota, 2022)
- Burdensome and costly process of finding a supervisor, including supervisors with specific identities (HealthForce Minnesota, 2015; Leibert & Fritsma, 2017; NAMI Minnesota, 2022)
- High caseloads and administrative burdens (Fukui et al., 2021; Hallett et al., 2023; HealthForce Minnesota, 2015; Last & Crable, 2024; NAMI Minnesota, 2022; Singh et al., 2020)
- Supervision quality concerns, including cultural competency (Atanackovic et al., 2024; HealthForce Minnesota, 2015; Schriger et al., 2020)
- Compassion fatigue and secondary trauma (Fukui et al., 2020; Hallett et al., 2023; Last & Crable, 2024; Ray et al., 2013)

Overview of findings

This section presents the findings from the interviews and surveys, organized by barrier category. Figure 1 provides an overview of the themes from each data source and their corresponding category. Themes from the interviews were reported if they were mentioned by at least five respondents. Survey response options included not a problem at all, a minor problem, a moderate problem, and a significant problem.

1. Overview of survey and interview themes

Barrier category	Interview themes mentioned by 5+ respondents	Survey item	Moderate or significant problem (survey; N=138-144)
Application and overall process	Burdensome and confusing application process	Application paperwork is excessive (N=141)	42%
		Complicated or confusing process (N=142)	39%
		Application process is too difficult (N=140)	31%
	Communication with licensure boards and tracking requirements	Poor communication from licensure boards (N=142)	30%
	Cost of application and licensure renewals	Cost of application (N=141)	58%
	Obtaining hours	Obtaining enough hours (including specific types of hours, like relational hours), serving enough clients, and/or no shows (N=141)	35%
		Finding a job that provides required hours (N=141)	21%
	Background check process and fingerprinting	N/A	N/A
	Application processing length and delays	Licensure application processing delays or wait times (N=140)	28%
	Strict requirements	N/A	N/A
	Communication with graduate programs	N/A	N/A

■ Blue filled cells indicate interview themes reported by at least 20 interview respondents.

1. Overview of survey and interview themes (continued)

Barrier category	Interview themes mentioned by 5+ respondents	Survey item	Moderate or significant problem (survey; N=138-144)
Working in the mental health field	Low pay, low reimbursement rates, and unpaid labor	Low pay for services provided after obtaining licensure (N=138)	58%
		Low or no pay for hours required to apply for licensure (N=140)	48%
	Burdensome workloads and excessive documentation requirements	N/A	N/A
	Lack of attention to provider well-being	N/A	N/A
	Lack of providers from diverse backgrounds and insufficient prioritization of diversity, equity, and inclusion issues	Language barriers (N=142)	4%
	Costs of becoming a mental health provider generally	N/A	N/A
	Licensure inconsistency	N/A	N/A
	Compassion fatigue and secondary trauma	Burnout or compassion fatigue (N=142)	61%
	State portability and reciprocity issues	State reciprocity issues (N=139)[a]	30%
	Continuing education credit requirements	N/A	N/A
	Caregiving responsibilities	Other responsibilities or personal concerns, such as caregiving or illness (N=141)	33%
	N/A	Not liking the profession (N=142)	6%
Supervision	Finding a supervisor, being assigned a supervisor, and lack of choice	Finding a supervisor that meets the requirements for my license (N=144)	22%
	Quality concerns and lack of supervisor oversight	Unreliable or low-quality supervision (N=143)	29%
	Cost of supervision and unpaid time spent receiving supervision	Unpaid time spent to receive supervision (N=143)	34%
		Cost of paying for supervision (N=143)	32%
	Strict supervision requirements	N/A	N/A
	Confusing supervision requirements	N/A	N/A
	Lack of supervisors from diverse backgrounds	Lack of supervisors who have an identity I would want in a supervisor (e.g., BIPOC, LGBTQ+, speaks a specific language; N=141)	14%

[a] Note that this survey item was asked within the context of the licensure application process

■ Blue filled cells indicate interview themes reported by at least 20 interview respondents.

1. Overview of survey and interview themes (continued)

Barrier category	Interview themes mentioned by 5+ respondents	Survey item	Moderate or significant problem (survey; N=138-144)
Licensure exams	Cost of licensure exam and study materials	Cost of licensure exam or study materials (N=142)	61%
	Difficulty of exam, inadequate preparation, and need for more preparation resources	Licensure exam is too difficult (N=142)	23%
	Exams ineffective at measuring competency	N/A	N/A
	Confusing and biased wording of exam questions and language barriers	N/A	N/A
	Burdensome and confusing registration process	N/A	N/A
	Unpaid time required to study	Time to study and take licensure exam (N=142)	35%
	Accommodations process and testing center environment	N/A	N/A
	Testing center location options	N/A	N/A

Blue filled cells indicate interview themes reported by at least 20 interview respondents.

Application and overall process

Burdensome and confusing application process

Key recommendation

Streamline licensure application processes and provide graduates with comprehensive resources and real-time support.

Respondents described the burdensome and confusing nature of the licensure application process and documentation requirements. Specifically, they mentioned the overall stress they experienced during the application process, the tediousness and excessive length of the application, providing the same information multiple times (e.g., describing coursework while also submitting syllabi, providing the same documentation when applying for a new licensure), and submitting information on paper and through the mail rather than online. Furthermore, respondents spoke about how boards should already know which programs are accredited and which courses meet licensure requirements, and they stressed the general lack of support or guidance throughout the entire process.

> *I started therapy last year to deal with the stress of surviving everything, to get all the application [materials] submitted.*
>
> *Let me just tell you. The application is 20 pages long. For both LPC and LPCC. There's no way for them to convert, like you don't have to redo this 20-page application because we already have it.*
>
> *Syllabi from classes, and some of these classes were from 2010… [That requirement] is obnoxious. If you pass an accredited program, then what do you need them for? What are they even looking for when they review it? It just feels like busywork on my end.*
>
> *You have to do these forms by hand. You put your courses into little boxes. We don't live in the 1980s, but that process is like the 1980s.*
>
> *I'm a good reader, and I'm a good writer. English is my first language. And that application made me cry… No wonder they can't find providers.*
>
> *Navigating the order of all of those things. What was supposed to happen, making sure that information was sent from the place that did my background check to everywhere it needed to be sent, all of that was opaque to me. I didn't really understand how to make sure that it was happening the way it was supposed to happen.*

Several respondents specifically mentioned how tracking hours was particularly confusing and burdensome.

> *All the hours, differentiating couple and family hours and non-couple and family hours. I remember not being super clear on what kind of supporting documentation they needed. I know they needed my supervisor to sign off, but the format was Excel [so I didn't know how to get it signed]… I bought a subscription for an hours tracking app.*

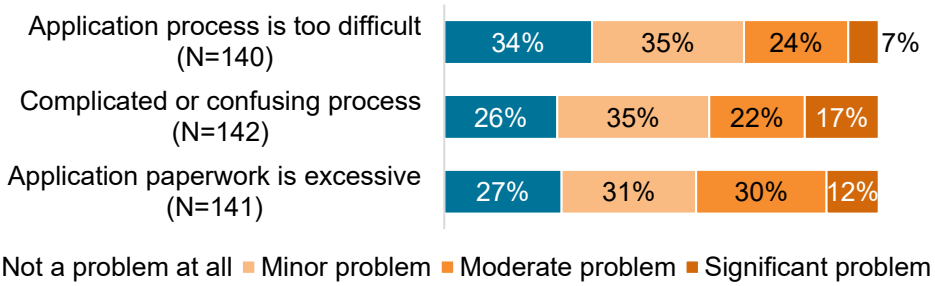
> *How many supervision hours, and how many overall hours? We would look through the statutes, and it was so confusing to figure out what the actual requirements are. Surely you could summarize this in two bullets.*
>
> *The 1,800 hours, I found that surprisingly confusing. Because what my supervisor landed on was probably not what all suprvisors land on. Some therapy sessions are 30 minutes long, and some are two hours long. If I'm doing 30 minute or 45 because it's with kids, am I doing 1,800 sessions? Or literal hours?*
>
> *It asks what percent of my work week is direct patient care. That part was confusing… In your plan, you have to talk about different diagnoses and treatment modalities. Are we talking about the time spent doing that work? What are you specifically asking for there?*

Respondents also made several suggestions to better support graduates through the application process, including providing one-on-one assistance and improved written and online resources.

> *I really wish there was one place to go to get all my questions answered, or have one email address or phone number to reach out to with all my questions related to the licensure process. Whether it's the state-specific application for licensure or the exam, it would be so helpful to have one touch point.*
>
> *A walkthrough video, clicking which buttons, a FAQ section. User-friendly.*
>
> *The State [should have] a better outline of clinical hours [requirements]. I relied pretty heavily on [school's] grid and trusted that they were correct. I didn't really have a good way to verify they were correct.*
>
> *I wish that there was somebody at the [board] whose job it was to help providers. Not whose job it is to just enforce the rules… They represent the schools and the bureacracy.*

About a third or more of survey respondents agreed it was at least a moderate problem for them that the application paperwork is excessive (42%), the licensure process was complicated or confusing (39%), and that the process is too difficult (31%; Figure 2).

2. How much of a problem have each of the following licensure application barriers been for you while pursuing licensure? Application process and paperwork



Communication with licensure boards and tracking requirements

Key recommendation

Streamline licensure application processes and provide graduates with comprehensive resources and real-time support.

Respondents described communication problems with licensing boards, particularly the lack of clear and accessible information on board websites, inconsistent information, sharing and confirming documentation with boards, and the lack of board responsivity. Respondents expressed confusion and experienced delays in the application process due to these communication complications.

> *The information on the website versus the information I got from calling to ask about background studies weren't aligned. I could have moved faster if I had called first instead of trusting the website… It definitely delayed licensure for me.*
>
> *Their website, there's a lot going on. The language they use, they're talking in statutes. You're just trying to decipher what the heck all of this means.*
>
> *There were mixed messages coming from the [board] and my university about which exam I needed to take, and even which license I needed to get. I ended up getting a LPC, which no insurance would accept, and then like a year later, having to get the LPCC which had a separate exam. So I had to pay for both exams, pay for student materials for both exams.*
>
> *I called [the board], and they weren't sure what I was even asking, even though I was directed there to figure out where [my exam results were] at.*
>
> *When [the board] came to speak, we asked how we could communicate. [They said], we get this many calls and emails, your best bet is to email us and then email us again. [We asked], "Can I call you?" [And they said], "No, I'm too busy." That's not very inviting.*
>
> *In my experience, the board is not timely with their replies… Sometimes weeks to get a response.*

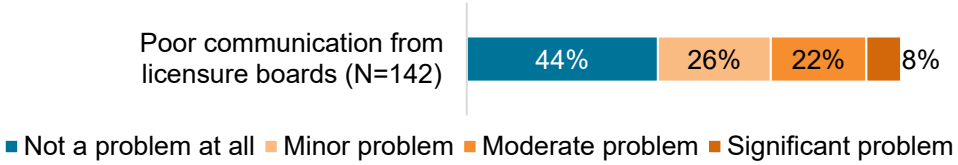
They suggested providing a way for graduates to share documentation with boards on a rolling basis throughout the duration of the licensing process rather than all at once at the end, providing a way to check on one's progress toward licensure, allowing online documentation submission rather than hard copies, and real-time assistance or sessions with the board. Some respondents noted that boards are under-resourced and under-staffed, contributing to communication issues.

> *It would be nice to have some sort of way within your profile to put it in as you go… A rolling process of submitting that information, instead of at the end.*
>
> *There should be a portal where you can check, like okay, we got your fingerprints, they look good. We got your three references, that looks fine.*
>
> *My program recommended Time to Track [to track hours]… That's another cost you have to pay for… I would imagine the board could somehow contract with Time to Track.*

> *[It should be like] how people get into treatment. Any door, just come in. Stop trying to make it so difficult for someone to get help… One phone number, and we'll take care of you.*
>
> *Being more up front or giving that information instead of you having to reach out. Just a drop-in session every month.*

Similarly, almost a third of survey respondents identified poor communication with licensure boards as a moderate or severe problem (30%; Figure 3).

3. How much of a problem have each of the following licensure application barriers been for you while pursuing licensure? Communication from licensure boards



Cost of application and licensure renewals

Key recommendation

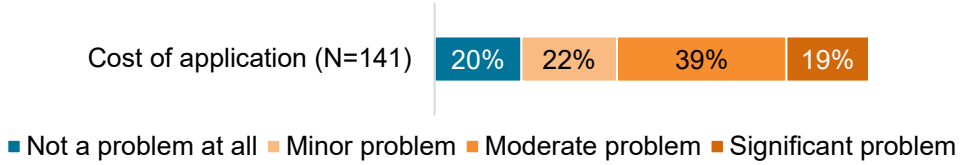
Reduce costs associated with becoming a mental health provider, increase wages, and provide financial assistance.

The costs associated with applying for and renewing licensure were also identified as a challenge. Respondents suggested removing these fees altogether, providing sliding scales or tiered fee levels based on income levels and/or the populations the provider is working with (i.e., reduced fees if providers work with underserved communities).

> *The cost of the application is ridiculous. And I have to be dual-licensed… It should be a sliding scale [based] on income or something if we absolutely have to have licensure fees. I think ideally it would be free.*
>
> *Some level of financial support depending on individual's financial situation. Maybe some type of tiered level of licensure fee depending on income level.*
>
> *The cost is $250 a year to just renew your LPCC license and the LADC is $200 every two years… There needs to be support or something in legislation to help cover with funding for underserved, underprivileged communities where they may be doing a lot of pro-bono work.*
>
> *It's very expensive… I happened to be married to a spouse who has a full-time job. I don't think I could have afforded this if I didn't have that.*

More than half of survey respondents agreed that the cost of the licensure application was at least a moderate problem (58%; Figure 4).

4. How much of a problem have each of the following licensure application barriers been for you while pursuing licensure? Application cost



Obtaining hours

Key recommendation

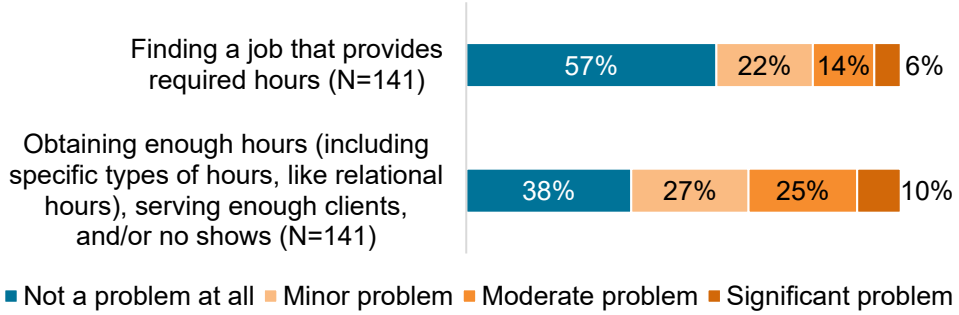
Increase the flexibility of licensure requirements.

Respondents described challenges with meeting the hours requirements for licensure, including finding a position that provides enough hours and specific types of hours (e.g., relational hours required for MFT licensure). They also mentioned difficulties with building a caseload when providers are first starting out as a provider, getting more administrative and documentation hours than client contact hours, and geographic barriers.

> *The relational hours piece is tough, especially when you're first starting… And clients tend to not want to go to someone who is right out of school for couple's therapy.*
>
> *I had a lot of administrative and documentation hours, but the one-on-one contact was very low, because you're starting as a new clinician and building a caseload.*
>
> *It's been really difficult to get enough hours [because I live in a rural area]… It's pretty hard for someone to go to Minneapolis to build all their hours, and then go back home [after getting licensed]. That's not really realistic.*
>
> *I work with adults, and so getting the adolescent and child hours was more of a barrier for me.*
>
> *Sometimes you have cancellations or now shows, and so those were hours that I was missing hours, prolonging my process.*
>
> *At times it does feel like I can't take any time off because you're just trying to get your hours in, and it's not good for your self-care.*

Among survey respondents, 20% reported that finding a job that provides the required amount of hours was at least a moderate problem, while obtaining enough hours was at least a moderate problem for more than one-third of respondents (35%; Figure 5).

5. How much of a problem have each of the following barriers about the overall process been for you while pursuing licensure? Obtaining hours



Background check process and fingerprinting

Key recommendations

Streamline licensure application processes and provide graduates with comprehensive resources and real-time support.

Reduce costs associated with becoming a mental health provider, increase wages, and provide financial assistance.

Respondents mentioned the costs related to the background check and fingerprinting process as another barrier to the licensure process. They said that the process is inconvenient and burdensome; involves mailing physical copies of documents; and can require travelling long distances, traveling during inconvenient times, or taking time off to complete the process.

> *If you've done a FBI background study before, don't make people do it again. It feels really redundant, especially if you're already in the system.*
>
> *[I] had to get fingerprinted, and they have to do a background check, and go get a passport photo taken. [And you attach] it to the application, get it notarized… Taking hours out of my day to figure out how to do these things.*
>
> *I also needed to receive a background check that also had a cost and paperwork associated with it, which required me to go to a specific location. I didn't have a car at the time, but luckily I lived in the cities close-ish to the place… But that was time and money, as well as just figuring out transportation.*
>
> *I would like a more accessible way to go about fingerprinting. I had to travel 25 miles to get to a location where I could get fingerprinted.*

Application processing length and delays

Key recommendation

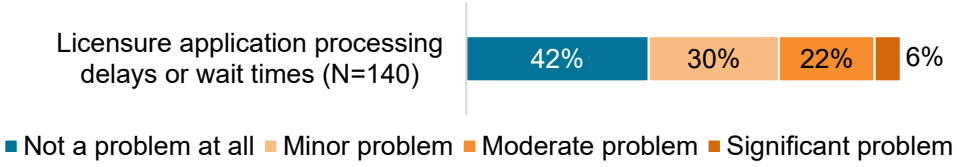
Streamline licensure application processes and provide graduates with comprehensive resources and real-time support.

Respondents identified challenges with the length of time needed for application processing and delays. Some respondents noted that delays were likely partially due to the COVID-19 pandemic.

> *The biggest barrier was just the time it took. From when I submitted my application to when it finally got approved, it felt like a really long time.*
>
> *I think I submitted my application in May of 2020, and we know what the world was like at that point… It took a few months, which we were warned about. I don't know what can be done about that. Mental health professionals are in short supply, so we would like it if it could go faster.*
>
> *At the time I applied for [licensure], there was a huge delay in getting background studies processed. I didn't know where everything was at. It was very anxiety provoking. I didn't know if what was needed was received.*
>
> *There was a huge delay [in processing my application], because seats were empty on the board. So that took a lot of time.*

More than a quarter of survey respondents reported that application processing delays or wait times were at least a moderate problem for them (28%; Figure 6).

6. How much of a problem have each of the following licensure application barriers been for you while pursuing licensure? Application delays



Strict requirements

Key recommendation

Increase the flexibility of licensure requirements.

Respondents described challenges with meeting strict licensure requirements. They mentioned requirements to obtain hours working with specific types of clients that graduates aren't interested in working with in their career (e.g., families, youth, adults), that the amount

of time allowed to complete requirements is too short, and requirements that a certain proportion of supervision hours need to be completed in person. Respondents also expressed how previous related experience (including internships and practicums required by graduate programs) cannot be counted toward post-graduate licensure requirements and how students should be allowed to start obtaining hours while still in school.

> *How many people are working part time? What if people are working full time? How about making it a little bit easier for people to worry less about a deadline?*
>
> *At least to get your LPC, I feel like [the number of required hours] should be reduced… I understand why that's there, you don't want people who aren't skilled treating mental health illnesses, but we've already pursued our Master's degree, we've had our internship and practicum, we've graduated, we've passed a test… It feels like a burden that's too heavy.*
>
> *Lowering how many relational hours [MFTs] need in order to get licensed, because they are so much harder to get.*
>
> *We were doing eight hours a week of supervision in order to meet face-to-face time with patients and our supervisor to make sure we were getting our hours in, which is a whole work day. You're away from direct patient care, and that adds up quickly… There were quite a few nights where I would work until 7pm, 12 hour days.*
>
> *There could be a way that you could start working on accumulating hours for licensure in some level during [school].*
>
> *During my required internship, I was given a lot of client contact and supervision hours… [And] I was working in the field doing therapy while I was still in my grad program... Unfortunately, none of those were able to be counted toward licensure, even though I was doing the exact same work.*

Communication with graduate programs

Key recommendation

Streamline licensure application processes and provide graduates with comprehensive resources and real-time support.

Respondents also mentioned communication issues with their graduate programs, including how graduate programs could provide more education and preparation to students regarding the licensure process and instances of poor communication regarding documentation of graduation requirements.

> *When I finished at [graduate program], I hadn't turned in my final hours for practicum, but I had hit them in January. No one told me. So they withheld my degree, and I randomly found out that I hadn't graduated… I couldn't count any of those hours [I obtained after that] toward licensure.*
>
> *One of my biggest challenges was verifying my clinical hours with [graduate program]. Between me and [professor], it took easily four and a half months of going back and forth. Resubmitting paperwork, her saying it was wrong, wrong years, wrong scale… I would call her and email her, it would take four, five tries to get a response from her.*

> *Ensuring [programs] have a sit down with each student prior to graduation. This is the clock area that you're in, these are the classes you need to take. By the time I realized I was lacking things, I had to go back to admit for one class.*
>
> *I didn't know who I could go to with a specific question or to help me with a specific portion of the process. I did technically have an advisor, but it was changed a number of times without my knowledge, and I was never given an opportunity to meet them.*

Working in the mental health field

Low pay, low reimbursement rates, and unpaid labor

Key recommendations

Reduce costs associated with becoming a mental health provider, increase wages, and provide financial assistance.

Support work well-being and minimize administrative burden.

Respondents described challenges related to low pay in the mental health field, including low or no pay for practicums or internships required to complete their graduate program, low reimbursement rates, and the lack of benefits afforded to many mental health providers (e.g., retirement savings accounts and paid time off). They also mentioned how mental health services are structured in a way that relies on billed services. Accordingly, providers often spend unpaid (i.e., unbillable) time on administrative tasks, and they are often not paid for no-show appointments.

Additionally, they described how some of the revenue generated from services they provide goes to their employer and/or supervisor, and they expressed how this proportion is too high.

Some respondents also described how low reimbursement rates lead to providers not accepting insurance coverage for their services. Accordingly, these providers only serve individuals who can afford to pay for services out-of-pocket, further limiting access to care for individuals who cannot afford out-of-pocket services. Others described how low pay leads to providers taking on a larger number of clients than they can ethically serve.

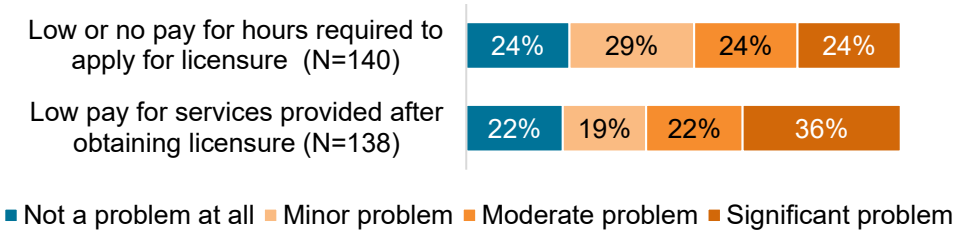
Some respondents specifically mentioned the privilege of providers who are able to bear these financial burdens, while people with marginalized identities may be more likely to experience financial barriers.

> *I have a master's, but I could go back to my position at the nursing home, with no degree, and get paid $4 more an hour.Financial gatekeeping. I recognize my privilege as a white, middle class person. But a person of color trying to enter the field, how could you? If you're trying to move up economically from whatever socioeconomic status you're born into, good luck. I gave 1,000 hours of my life away for free.*

> *Pay is low for the amount of labor. Contract work is more flexible, but there's a caveat of not being secured in retirement funds. How the health care system views the profession… is insulting.*
>
> *[Internships are] generally unpaid, while going to school… If we are a social justice-focused profession, why are we expecting people to give free labor? Especially if we want to diversify the field?*

About half of respondents agreed that the low or no pay they receive for services required to apply for licensure and the low pay they receive for services after obtaining licensure are at least moderate problems (48% and 58%, respectively; Figure 7). Most respondents reported that low or no pay for the hours required to apply for licensure was a challenge (77%).

7. How much of a problem have each of the following barriers about working in the mental health field generally been for you? Low or no pay



Burdensome workloads and excessive documentation requirements

Key recommendation

Support work well-being and minimize administrative burden.

Respondents reported how burdensome workloads are, including high caseload expectations and excessive documentation requirements.

> *The amount of clients people are expected to see in a week is insane. It's just too much. 32 patients a week.*
>
> *Completing legally and clinically appropriate documentation, so that you don't get audited, get in trouble, lose your license… It's just such an incoherent system. One agency will ask for one thing, another agency will ask for another thing. And if you call [regulatory body], you will get two or three or four different answers.*
>
> *I was working 55-60 hours a week on average, for a 40-hour salary in residential treatment because there were so many requirements… It's just cumbersome. There's so much and super overwhelming.*

Several respondents specifically mentioned how burdensome and tedious the credentialing process is. Examples included submitting duplicate information to every payer, poor communication with payers, the additional administrative burden while billing for services,

and how the length of the process delays pay increases once a provider becomes licensed. They also suggested payers credential providers automatically once they are licensed.

> *Get rid of credentialing… That is the one part of the process that I literally thought, "I'm not cut out for this work. I can't do it." And if I didn't have somebody helping to earn and pay the bills at home, if English wasn't my first language, if I didn't feel comfortable calling people begging them to help me, if I didn't know other people in the field… If I didn't have all of those things for myself, I couldn't have done it.*
>
> *Every insurance has a different requirement? Why? Why? Why can't they just get together and agree on one single form? Why do I have to be credentialed with every insurance company?*
>
> *The Minnesota credentialing system actually has phone lines that are disconnected, answering machines that are full. A website that has two slightly different ways to enter [information].*
>
> *It was more work, because I would have to send some to my supervisor [if I wasn't credentialied with their insurer] and some back to myself… At that point, you feel like you finally finished [the licensure] process, but it's a whole other thing.*
>
> *My license went active August 1st, and I didn't get fully credentialied until November, October. That was annoying. Obviously I wanted my pay increase.*

Lack of attention to provider well-being

Key recommendation

Support work well-being and minimize administrative burden.

Respondents described how mental health providers are often encouraged to prioritize self-care and their well-being, but that workforce systems pose significant challenges. Specifically, these challenges included high workload expectations, lack of benefits such as paid time off, low pay and unpaid labor, bureaucracy, and financial costs required to become licensed and maintain licensure. Several respondents mentioned a need for more experienced providers to model self-care and well-being behaviors, and how self-care messaging often feels performative.

> *What I experience to be exhausting as a mental health professional, is that there is ongoing social and cultural commentary about how important mental health is, and then we don't get paid well… [And providers are] overextending themselves, but they get clapped for that. We're encouraging them to martyr themselves.*
>
> *Your well-being is an ethical responsibility. You are ethically required to do self care. But then we're told, "We're going to need you to work longer, and this person left their job, and we're going to have to close if you don't take up your work." You're ethically mandated to do this, but we're not going to provide an iota of support.*
>
> *The bottom line is that we're humans working with other humans… In the mental health field, you would think that you would want to provide support to make sure you're keeping their well-being happy. But the gatekeeping, financial burdens, a lot of people can't shoulder.*
>
> *What is contributing to the burnout is the, "Here's our productivity expectation. If you're not meeting it, we're going to take away your benefits."*

Lack of providers from diverse backgrounds and insufficient prioritization of diversity, equity, and inclusion issues

Key recommendation

Address diversity, equity, and inclusion issues within the behavioral health field and support providers from marginalized backgrounds.

Respondents described challenges related to the lack of diversity in the mental health workforce, including: insufficient prioritization of diversity, equity, and inclusion issues; the lack of support for providers who hold marginalized identities; discrimination in the field and throughout the licensure process; and licensure barriers that pose more of a challenge to providers who hold marginalized identities.

> *They say, we don't have enough African American providers. We don't have enough non-English speaking providers. You don't have those things on purpose because you make it too hard. And if you're not fixing it, it's because you don't care about having those kinds of people [as providers].*
>
> *[People from marginalized backgrounds] don't have somebody else helping to pay the bills, can't take a day or a couple days off to do the stupid credentialing process. It requires so much time, effort, and [resources] that only people of privilege have.*
>
> *I am very confident that being white, living in Minneapolis, in the city, speaking English as first language, and having grown up in the U.S., all of those things have significantly made it easier to navigate the whole system.*
>
> *Being queer and disabled made it much harder to navigate those systems, especially when it comes to finding a work environment that didn't exhaust me as a disabled person, was challenging. Finding supervisors and employers who respect and understand me as a queer person can be challenging.*
>
> *There were even students in class saying homophobic things related to class materials presented. One of my coworkers told me that I can pass for straight as long as I don't move.*

Cost of becoming a mental health provider generally

Key recommendation

Reduce costs associated with becoming a mental health provider, increase wages, and provide financial assistance.

Respondents spoke to the high costs related to becoming a mental health provider as a whole, including tuition and student loans, supervision, licensure exams and related resources, background checks, application and renewal fees, insurance coverage, and

continuing education units (CEUs). Several respondents noted that these barriers are particularly challenging for individuals from marginalized backgrounds.

> *People budget, "Oh, I'm going to go to grad school, and I'm going to pay $40,000," or whatever it might be, and they don't understand that there's actually an additional $6,000 to $10,000 they're going to need to pay in clinical supervision and other costs.*
>
> *You're asking people to drop a lot of money to do the test, background checks, applying to the state, liability insurance, everything else that goes into this.*
>
> *People coming out with student loans, financial obligations, housing. Life has become much more costly… Some sort of support, stipend to help people fulfill their financial obligations.*

Licensure inconsistency

Key recommendation

Prioritize alignment between licensure types and state portability.

Respondents spoke to the challenges related to the several different types of licensures mental health providers can hold. They described how this creates confusion and makes regulations more difficult to navigate, the significant similarities and overlap in services provided across all licensures, how providers under different licensures sometimes receive different training, how certain positions are only open to providers with specific licensures, limitations in how providers are able to bill for services, and how different licensures require different exams.

> *The difference [between licensures] is like four classes. And yet you have to do another exam, thousands of hours of supervision. I'm not a therapist, I'm a recovery coach, but I'm doing the same things… LADCs work with mental health all of the time.*
>
> *The difference between LPC and LPCC is also convoluted… What do I do to get licensed? Do I send this in? No, I send that somewhere else. And here's another form. It's painful.*
>
> *Social workers are kind of used as a blanket, they can do everything… [But] they don't get as much training in therapy… I could do case management [as a social worker], but that door is closed for LPCCs, MFTs.*
>
> *I would like to see something that's more universal for the country. A universal licensure, something all states recognize.*

Compassion fatigue and secondary trauma

Key recommendation

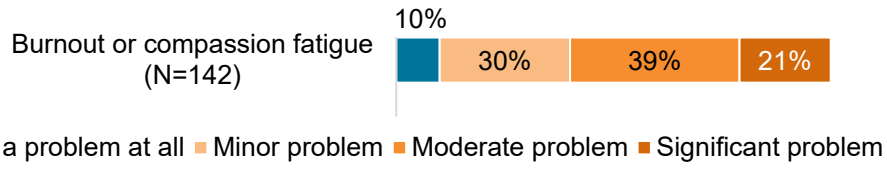
Support work well-being and minimize administrative burden.

Respondents mentioned challenges related to compassion fatigue and secondary trauma, how they are often discussing trauma and other difficult experiences as part of their work, and how providing mental health services can be emotionally intense.

> *Having emotional space… As a mental health professional, you are a sponge. You're being an emotional support sponge. And you still have to live a life. It's difficult. We're all just people.Sometimes looking around me, it looks like the sick helping the sick.*
>
> *The work we do can seem effortless. Like we're just, quote unquote, sitting and talking to people. But it is very emotionally and cognitively draining. And the idea that we're expected to do 8 hours of it, five days a week… It's a very difficult job.*
>
> *We're doing really hard work. Entry level therapy positions are some of the hardest jobs in the whole field. I worked in crisis management. I know folks who work in ARMHS… Working with some of our highest need, most challenging populations because their struggles and suffering is so, so profound.*

More than half of survey respondents reported that burnout or compassion fatigue was at least a moderate problem (60%; Figure 8). Note that respondents may have interpreted "burnout" in different ways (e.g., burdensome workloads).

8. How much of a problem have each of the following barriers about working in the mental health field generally been for you? Burnout or compassion fatigue



State portability and reciprocity issues

Key recommendation

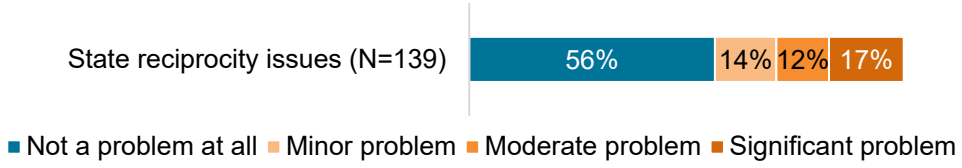
Prioritize alignment between licensure types and state portability.

Respondents expressed frustration with how licensure processes and requirements differ by state. Specifically, they described how providers need to go through the entire licensure process again if they want to serve clients in another state, how some licensure exams are state-specific and do not transfer across states, and how state-based telehealth restrictions limit access to care.

> *The Minnesota and Wisconsin licensing boards should have some sort of reciprocity agreement… I could not have been the first that worked in Wisconsin and tried to get licensed in Minnesota, but it sure felt like they were addressing it like it was a novel situation. It was a year of back and forth.*
>
> *Nationalize the licensure process so it's not redundant. In [the state I moved to], I had to do supervision all over again because it had to be someone licensed in the state. And in Minnesota, a lot of people commute from Wisconsin, so they would have to find someone with dual licensure to be able to get licensed.*
>
> *Another barrier that was realized during the pandemic is telehealth and the convoluted guidelines… And it's different across states, like the client has to be here, but the clinician doesn't, and other states say you both have to be in the same state. It's really confusing.*

More than a quarter of survey respondents agreed that state reciprocity issues were at least a moderate problem for them (29%; Figure 9).

9. How much of a problem have each of the following barriers about working in the mental health field generally been for you? State reciprocity issues



Continuing education credit requirements

Key recommendation

Reduce costs associated with becoming a mental health provider, increase wages, and provide financial assistance.

Respondents mentioned continuing education units (CEUs) as a barrier, including the high costs, unpaid time required to complete them, and quality concerns.

> *Getting additional training in specific types of therapy… They are super expensive. EMDR is $2,000, which is a lot of money for someone who doesn't get paid very well.*
>
> *CEUs are so important to the process. It needs to be more accessible and actually cover [helpful] content. Some that are free don't actually cover the necessary materials.*
>
> *You're spending so much money… And after licensure, you still have to keep up CEUs.*

Caregiving responsibilities

Key recommendations

Reduce costs associated with becoming a mental health provider, increase wages, and provide financial assistance.

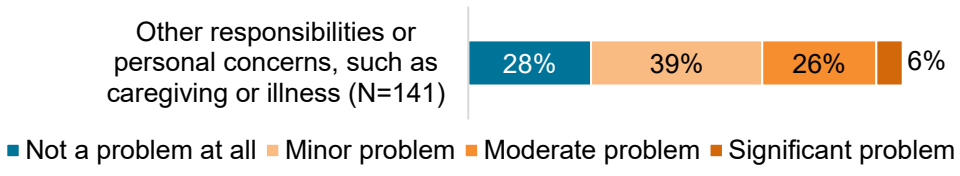
Support work well-being and minimize administrative burden.

Some respondents described challenges working in the mental health field while also meeting caregiving responsibilities.

> *I'm also a mom, I have a baby, I'm supporting a child. And I'm paying hundreds of dollars a month [for supervision]. It's not economically feasible… And then having client responsibilities. Having emotional space to wear many hats.*
>
> *I'm a primary caregiver for my mom... As a contract employee, I don't have any PTO of any kind, so when I need to take time off to take care of my mom, that's just time that I'm not making any money, which is really hard.*
>
> *I have three little kids, and I often say that if I had known the emotional toll this job would have on me I wouldn't have done it. I feel like I have so little give at the end of the day to give to my kids. My job asks so much of me. I feel like I'm meant to do this work… [But it] means you have nothing left.*

About a third of survey respondents agreed that responsibilities or personal concerns, such as caregiving or illness, have been at least a moderate problem (32%; Figure 10).

10. How much of a problem have each of the following barriers about working in the mental health field generally been for you? Other responsibilities



Supervision

Finding a supervisor

Key recommendation

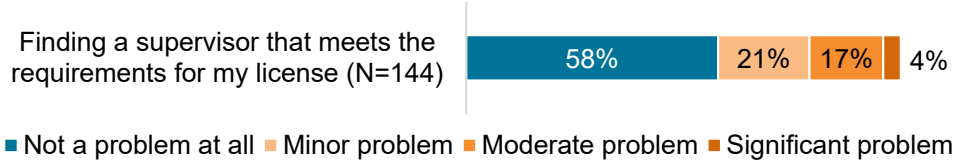
Provide support to help graduates find supervisors and prioritize supervision quality.

Interview respondents identified challenges with finding a supervisor. They described how difficult and time-intensive it is to find information about potential supervisors, such as their availability or specializations, and how finding a supervisor is often more difficult in rural areas of Minnesota. Some respondents also mentioned the lack of guidance graduates receive about how to identify and select a supervisor. Several respondents suggested creating a database or directory of approved supervisors that includes information that would help guide their choice of a supervisor.

> *Knowing who is qualified to be a supervisor… Some of the supervisors you find [online] will say "certified supervision for Minnesota clinical counseling," but I also know that anybody can put that. I wouldn't know how to check on that… [We need] a list of state recognized licensed counselors.*
>
> *I was just lucky to be the white, middle-class lady who happened to know somebody who was a supervisor that I went to high school with… When I went to look for a list of supervisors, I couldn't find anything, anywhere, that said, "Here is where you can find supervisors."*
>
> *[In northern Minnesota], there are so few options for places to work and options to be supervised… I don't have a lot of options for who my supervisor could be.*
>
> *I wish there was something like Psychology Today, where I could go and search for supervisors… What kind of supervision do they offer? What kind of availability do they have? And it isn't just a list of names in alphabetical order. Instead, it's, "Hi, I'm supervisor Jane Doe, and I would like to offer supervision. I have some hours in my schedule. I offer supervision for people who want to learn more about internal family systems…" And I could look them up and connect with them.*

Similarly, 21% of survey respondents indicated that finding a supervisor that meets their requirements for their license was at least a moderate problem (Figure 11).

11. How much of a problem have each of the following supervision barriers been for you while pursuing licensure? Finding a supervisor



Assigned supervisor and lack of choice

Several respondents described situations in which their employer provided a supervisor, which allows providers to avoid finding and paying for a supervisor independently. While they described the related benefits, they also identified challenges, including a lack of choice; how this can introduce conflicts of interest and dual relationships, as supervisors often serve as clinical supervisors and work supervisors; a lack of supervision capacity within their employer; and how it can limit exposure to how other clinics and providers operate. Some respondents described how their employer would require them to pay back the costs of supervision if they leave their position earlier than agreed upon.

> *We don't have to pay for [supervision], and we do it on paid time… But it's also a detriment, because my supervisor was always my direct supervisor as well. So it created a conflict of interest between my ability to do my work and ability to review clinically. It was like, "You left early today, why was that?" Rather than, "Tell me about this person and the clinical work you did."*
>
> *[My employer] only wanted me to receive supervision from someone who had no experience with social work and had never worked in child welfare.*
>
> *Part of the compensation package was that I would get supervision to help me achieve licensure, and that it would be as long as I continued to work for them… What happened in reality, was that I didn't begin receiving supervision until probably nine or ten months into my employment because they didn't have capacity.*
>
> *Being paired with whoever happens to be free at the agency. Which is not the same as being connected with someone who can really help grow and address your clinical interests and needs… If you want higher quality supervision, you have to have the time, energy, and capacity to find and seek those supervisors.*

Quality concerns and lack of supervisor oversight

Key recommendation

Provide support to help graduates find supervisors and prioritize supervision quality.

Supervision quality was also identified as a concern. Respondents described experiences with supervisors that didn't complete paperwork on time, provided incorrect information, weren't familiar with their responsibilities as a supervisor, regularly cancelled or cut supervision sessions short, failed to model self-care, blamed their supervisee for no-shows, and exhibited inappropriate or discriminatory behavior or communication. This also included how differences in theoretical orientations or specializations and disagreements or conflicts between supervisors and supervisees can negatively impact quality. Additionally, respondents shared that the high cost of supervision can lead to providers seeking group-based instead

of individual supervision, or supervision that is provided for free at their work place, leading to lower quality.

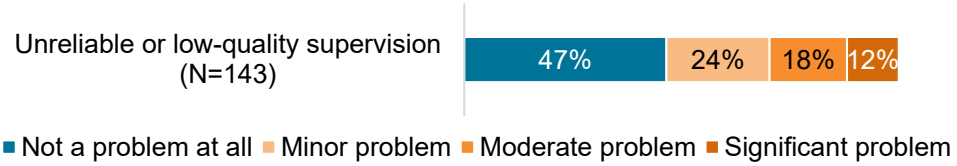
> *[My supervision] was low quality… It didn't necessarily feel like I was being challenged or pushed to grow. I sometimes felt like supervision ended up being just administrative… Just a manager making sure I was going to work and fulfilling my paperwork requirements.*
>
> *How do you know someone is an ethical clinician because they paid someone for 250 hours [to complete the requirements to become a supervisor]? I don't know how that translates.*
>
> *My supervisor didn't provide weekly supervision to process things or go over anything. It was mostly done on the fly. Didn't give any challenges. Just gave directions.*

Some respondents also identified a need to strengthen oversight of supervisors and ensure supervisor accountability. Respondents specifically mentioned ensuring supervisors are well-trained and are expected to continue learning, take trainings, and/or complete additional testing. They also described the tension between ensuring that the process of becoming a supervisor is accessible with minimal barriers while also ensuring supervisors are well-trained and able to provide high-quality supervision.

> *I don't like the idea of testing, but they need to prove competency… We just need to take one ethics class and then supervision CEUs.*
>
> *Making sure they're not just signing off on hours. Not using that as a replacement for making sure they're doing well.*
>
> *I like the idea of supervision being more accessible… But I also see the value in having a more consistent, well-vetted training that is required for all supervisors. And maybe the opportunity for supervisors to have their own community where they're talking more consistently about what comes up for them in supervision.*

Nearly one-third of survey respondents agreed that unreliable or low-quality supervision was at least a moderate problem (30%; Figure 12).

12. How much of a problem have each of the following supervision barriers been for you while pursuing licensure? Low-quality supervision



Cost of supervision and unpaid time spent receiving supervision

Key recommendation

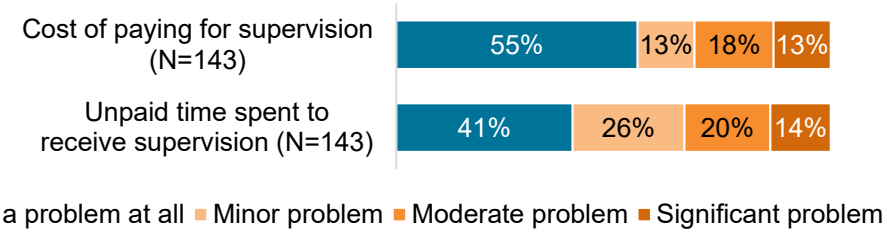
Reduce costs associated with becoming a mental health provider, increase wages, and provide financial assistance.

Respondents described paying for supervision out of pocket, how the time spent on supervision is unpaid and reduces the amount of time they have available to bill for services, and how supervisors who charge lower rates may also provide lower quality supervision. They suggested providing financial assistance to providers to pay for supervision.

> *Supervision costs are significant and have really impaired a lot of people from continuing on this path. I've felt really lucky to be able to financially support myself, but had I not had a partner who is working in the private sphere, I would not have been able to do this financially.*
>
> *Providing financial support would be helpful, to have some sort of incentive from the board or the state to provide supervision. Because it's time out of [supervisors'] schedules as well. So the graduate doesn't have to pay.*
>
> *A grant or scholarship for people to get those supervision hours would be really helpful. Jobs out of school were quite low paying. Like really low paying.*
>
> *It's another hour out of my week that I can't see clients. And seeing clients is how I get paid.*

About a third of survey respondents agreed that unpaid time spent receiving supervision (34%) and paying for supervision (31%) were at least moderate problems (Figure 13).

13. How much of a problem have each of the following supervision barriers been for you while pursuing licensure? Supervision cost and unpaid time



Strict supervision requirements

Key recommendation

Increase the flexibility of licensure requirements.

Respondents identified challenges with meeting supervision requirements. They mentioned specific licensure requirements that supervisors need to meet, how telehealth limitations make it more difficult to receive supervision, the short amount of time or frequency required to complete supervision hours, and how supervision requirements are excessive generally.

> *[Eventually after COVID, the board] started pushing back that X% [of supervision hours] had to be in person… It was frustrating because we were still able to see clients virtually and [the board] was operating virtually themselves… Before, I could just block off an hour in my work week to meet with my supervisor, which was relatively easy. But when doing it in-person, I would have to block off half a day to make that happen.*

> *Being able to receive supervision by phone or video. Especially in rural areas, there was no supervisor for many miles that was board approved.*
>
> *To say, we know you have a master's, but we want an extra layer of supervision, it's excessive. I'm a lifelong learner, I want a mentor… You work hard, take the tests, pass the exam, go to work, and then they say, we don't quite trust that… I've already showed you. Get rid of this whole supervision, 200 hours thing.*
>
> *With the way it's structured now, 75% of your hours must come from [someone with] LICSW... The most helpful [supervision I received] was from a licensed psychologist, but I only could write down a certain amount of hours.*

Confusing supervision requirements

Key recommendation

Streamline licensure application processes and provide graduates with comprehensive resources and real-time support.

Respondents identified challenges understanding specific requirements for supervision, including identifying providers who are approved to provide supervision and the number of hours that need to be or can be completed within a certain amount of time.

> *Standardize how supervisors are responding to questions… A lot of people are getting [hours] back and not understanding what they did wrong. Depending on your supervisor, they will have a template for you to use, but another supervisor will use a completely different template.*
>
> *Much more transparency and clarity about what the process looks like… People leave graduate school and are just sort of sent out into the world to do counseling or therapy work. And even though supervisors are licensed, it feels very piece meal.*

Lack of supervisors from diverse backgrounds

Key recommendation

Address diversity, equity, and inclusion issues within the behavioral health field and support providers from marginalized backgrounds.

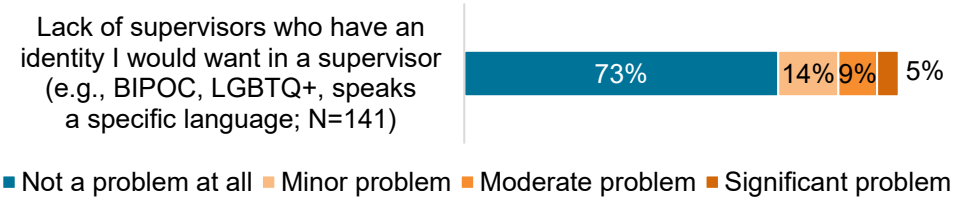
Respondents described a lack of supervisors from diverse backgrounds, and how this prevents providers from finding a supervisor that has a shared identity.

> *In the same way there are shortages of providers that look like their clients and community members, it just keeps going up the chain. Those supervisors may not have supervisors, and so on. It's ultimately very white.*
>
> *I have not found a supervisor that matches my own personal identity. A lot of mine were white women… I'm only learning about certain views.*

> *I mostly work with people who have experienced trauma, and with queer and trans people. While I know that there are a lot of people who have those areas of expertise, it's been harder to find supervisors who are really knowledgeable.*
>
> *I am not straight, and finding anyone to provide supervision [that is LGBTQ+] is not even remotely possible… And when there are supervisors that fit that bill, do they have the capacity to support that need? Because they still need to make money too.*

Some survey respondents reported that the lack of supervisors who had an identity they would want in a supervisor (e.g., BIPOC, LGBTQ+, speaks a specific language) was at least a moderate problem (14%; Figure 14).

14. How much of a problem have each of the following supervision barriers been for you while pursuing licensure? Lack of supervisors from diverse backgrounds



Licensure exams

Cost of licensure exam and study materials

Key recommendation

Reduce costs associated with becoming a mental health provider, increase wages, and provide financial assistance.

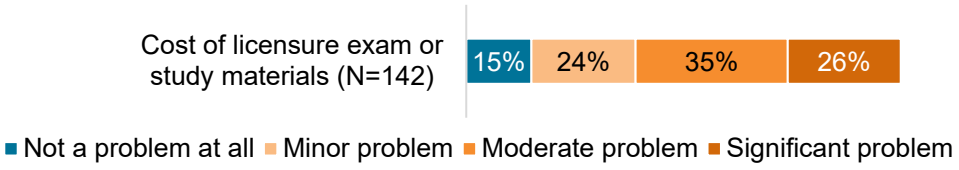
Respondents described how expensive it is to study and take the exams, including the registration fee, study materials, tutoring costs, rescheduling fees, and costs to send test scores to licensing boards. Several respondents described how failing the exam means paying for the exam multiple times. They made several suggestions, including making the test free or reducing the cost, reducing the cost specifically for providers from marginalized backgrounds, making the test free for the first attempt, and providing free study materials and resources.

> *The price, of course, is a barrier. Honestly, therapists, especially pre-licensed, are not paid very well… Maybe free for the first try. I think that would incentivize people to study more and just get it done with the first try.*

> *I've taken it three times and failed… I'm sitting here, like, "I can't even afford this." The financial piece, trying to pay for this exam. I have a newborn and two other children at home, and we are barely making it. We just lost our state insurance. I've debated taking the Wisconsin exam, because I've heard it's easier.*
>
> *I paid for a one-on-one tutor. I probably spent a couple thousand dollars on just studying for the exam.*
>
> *My demographics, I'm very privilieged, passed the exam the first time… Other clinicians who have neurodivergence or other racial or cultural backgrounds [may have] to take it multiple times, pay each time for retakes… It discourages people who would probably make good social workers… I would love for it to be free.*

More than half of respondents agreed that the cost of the licensure exam or study materials was at least a moderate problem (61%; Figure 15).

15. How much of a problem have each of the following licensure exam barriers been for you while pursuing licensure? Exam cost



Difficulty of exam, inadequate preparation, and need for more preparation resources

Key recommendation

Align licensure exams with their intended purpose and provide more exam preparation support.

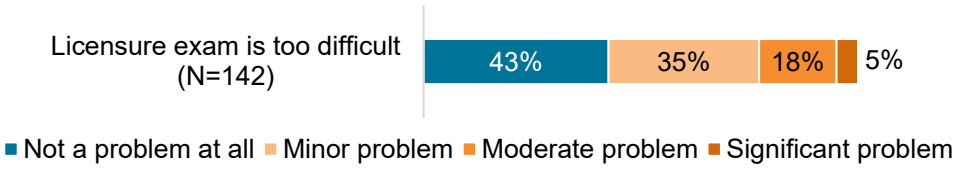
Respondents described challenges with the difficulty level of the exams and the need for more support to prepare for the exam. Some respondents described the waiting period required between failing the exam and being allowed to take it again, and how this delays the overall licensure process, and how graduates aren't informed about which items they got wrong. Additionally, several respondents specifically mentioned they felt unprepared for exam items related to medication. They suggested providing more guidance and resources to help providers study and pass exams.

> *I had no idea what was going to be on the test except they say anything can be on it. That's not fair. I'm okay if they tell me what will be on it. I will study it.*
>
> *I don't remember [graduate program] telling us anything about the exam.*
>
> *I'm always one who has struggled with school. My family didn't even think I would go to college. Test taking was one of the biggest issues for me… I've taken it three times and failed.*
>
> *Even an introductory, drop-in session that the board could provide would be helpful.*

> *I don't understand the rationale behind why you have to wait [after failing]... [They should be] giving them more resources about how to be more successful.*
>
> *I barely understood what [the test was] asking, and I got a bunch wrong. And I had no idea which ones were wrong.*
>
> *It's hard to find exam study materials… And the book I got was not accurate to the national exam. So the practice questions were nothing like what was actually on the exam… It was hard to tell online which ones are reputable.*
>
> *Having more free resources for study materals would be helpful.*
>
> *Have study groups… So no one is doing everything by themselves. Structured time and a network of people to share resources.*
>
> *When I found out I passed it… I just started to sob in my car. Because it was this flood of relief that this is off my radar, finally. It was really, really hard.*

Almost a quarter of survey respondents reported that the difficulty of the licensure exam was at least a moderate problem (23%; Figure 16).

16. How much of a problem have each of the following licensure exam barriers been for you while pursuing licensure? Exam difficulty



Exams ineffective at measuring competency

Key recommendation

Align licensure exams with their intended purpose and provide more exam preparation support.

Respondents expressed skepticism regarding the extent to which licensure exams accurately measure competency and providers' abilities to ethically serve clients. They described how the studying process only helped them pass the exam rather than improve clinical skills; how standardized tests are biased and test-taking skills vary depending on the person and their identities, including how exams are often more difficult for those from marginalized backgrounds; how exams are redundant given all the other licensure requirements; and how the content and "correct" responses don't align with how mental health service provision functions in reality. Respondents suggested offering alternative ways of demonstrating competency; revisiting each exam item to assess purpose, relevancy, and clarity; and getting rid of the exam requirement altogether

> *Ultimately, I felt like I learned how to take the test… It wasn't meaningful.*

People say, "Well this is what I would actually do, but here's what you should say on the exam." It was just extremely confusing, and it made me feel like the exam was not actually a reflection of my clinical skill, and my ability to be a social worker. It was a reflection of my ability to memorize information that might not even be applicable to my work.

It seems wild to me that the ability to pass a grad program and the ability to pass the exam are two separate hurdles that we have to overcome when it seems they should be intrinsically related. If everyone is actually doing their job of determining whether we're qualified to be social workers, the people making that decision at the master's program level should echo the decision that would be made by the test, so I don't understand why both are necessary.

"Hurry up and answer what you would do with this person." Number one, I don't need to do something in that moment. I can wait until next week. The question is a forced environment. I can get input from someone else… In the test, there is a definite answer. But no, there's not [in reality]. But we're going to say there is.

It's not the only way to measure competency. I know social workers especially have been fighting for BIPOC, LGBT, English learners [since marginalized groups may have lower pass rates]… You can be horrible at taking a test but be a great social worker.

I go to take the exam, [it's] asking me about all these medications, and that's related to a different department… It's not like I need to know what they are 24/7. If I have that in my notes, I can go back and see the diagnosis, the meds… You're not going to remember everything.

I am shocked there is no oral exam [option]. We work with people, interpersonal skills, but [the process of demonstrationg competency] is all written.

Confusing and biased wording of exam questions and language barriers

Key recommendation

Align licensure exams with their intended purpose and provide more exam preparation support.

Respondents reported that the exam questions are biased, worded poorly, or use confusing language. They specifically mentioned questions that have multiple "correct" answers but require the exam taker to select the "most correct" answer, questions that use complicated or statutory language, how these challenges are more problematic for providers with lower levels of English fluency, and how the wording of certain items is problematic.

I was given the advice at [graduate program] to take the test as a middle-aged white woman who is worried about getting sued.

Discrimination in the test… Having a standardized test, you'll get standardized people getting through.

One question on the exam was about someone who was queer and [the wording was problematic]… The people who are writing the exam are not able to be inclusive.

> *There is a lot of data on [people of marginalized identities] failing more often… [It's] not culturally responsive. The academic language [is] not helpful for our field. It's not okay. Do we have BIPOC people, marginalized people, making these exams? I don't know.*
>
> *And all the questions that are "all of these are right but one is the best." … My perspective is that we can't focus on one single solution, it's going to be different solutions for different clients.*
>
> *The questions feel like they're trick questions. A lot might understand the content and not the question. You have to focus a lot on setence structure… It seems like it's written in the most difficult way possible.*

Burdensome and confusing registration process

Key recommendation

Streamline licensure application processes and provide graduates with comprehensive resources and real-time support.

The registration process was also identified as problematic. Respondents described the process as confusing and complicated with too many steps and organizations or agencies involved. They described technical challenges with logging in to register and challenges with Pearson Vue's customer service.

> *The number for Pearson Vue was really hard to find.*
>
> *I had some problems with the Pearson website… The [customer service] technician who was on the phone scheduled the exam in a place that was four hours from my house.*
>
> *I took forever to register, because there were all these confusing rules about registering… We had to apply to be able to take the exam. Two separate applications, one to take it, and then providing that we could take it, and then one for scheduling. It was three or four months ahead because it was a busy test center. So confusing.*

Unpaid time required to study

Key recommendation

Reduce costs associated with becoming a mental health provider, increase wages, and provide financial assistance.

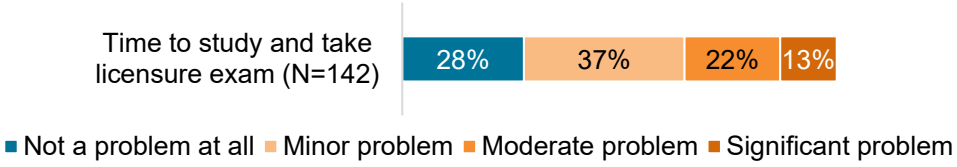
Respondents described how the time they spend studying is unpaid. Additionally, this time spent studying reduces the amount of time they can serve clients, reducing their income.

> *It's very hard to have a life, a full-time job, studying for these exams, cranking out treatment plans.*

> *I'm studying during the time that I could be either working or being compensated for that work or resting from work. I think it probably made me a worse therapist at the time, because I was practicing as I was studying during my internship.*
>
> *Time to study. By the time you're done with sessions, you just want to veg. But you're supposed to study all weekend and all nights. It's a lot.*

More than a third of survey respondents reported that the time to study and take the licensure exam was at least a moderate problem (35%; Figure 17).

17. How much of a problem have each of the following licensure exam barriers been for you while pursuing licensure? Time to take exam



Accommodations process and testing center environment

Key recommendation

Streamline licensure application processes and provide graduates with comprehensive resources and real-time support.

Respondents identified issues with obtaining accommodations to take the exam. They shared that the process can be long and cumbersome, with excessive documentation requirements.

Additionally, they described challenges about the testing environment. They described how the setting and requirements felt dehumanizing, including how exam takers are forbidden to breast pump and bring water in, and that the time limit should be extended.

> *I technically should have gotten accommodations because I have ADHD, but the process did not feel worth doing… You have to ask two months ahead, prove medical needs… Make it easier to request accommodations.*
>
> *Taking the exam itself is kind of intense. You sign in, put your stuff away, check in at the front. When they call you back, they pat you down to make sure you're not bringing in anything, then you sit down at a station, and you're monitored. The environment is stressful.*
>
> *There should be more time allotted. I finished in time, but I think being able to give people as much time as they can.*
>
> *With my struggle with school, test taking was one of the biggest issues for me… Sitting for an hour, let alone four hours, was extremely difficult. We're isolated, not allowed to literally even have water… The environment gives me a lot of anxiety.*
>
> *I was a nursing mom and couldn't take breaks to pump and couldn't bring water in. I think that's absolutely insane and inhumane… Treat people like human beings.*

Testing center location options

Key recommendation

Streamline licensure application processes and provide graduates with comprehensive resources and real-time support.

The limited options for testing center locations was also identified as a challenge. Respondents described how some of the locations require significant travel, and how these limitations are further complicated by how infrequently the exam is offered.

> *Before the exam, they emailed me that I need to reschedule. They don't give a reason. And they had no openings in Minnesota, so I had to look at Wisconsin and North Dakota. And we only had a window of six months... I had to take it in Madison, not sleeping in my own bed [staying in a hotel].*
>
> *I had to drive really far when I finally did take it. Accessibility, more dates, more locations [would be helpful].*

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Appendix

Methods

To create the sample, CRBH and Wilder identified the graduate programs in Minnesota that can lead to licensure in social work, counseling, or marriage and family therapy. In fall 2023, the study team invited all 31 programs on this list to participate and sent multiple reminders to unresponsive programs. Ultimately, 14 programs agreed to invite graduates of their programs to participate in the study.

The study team sent all participating programs language they could use to invite their graduates to complete the survey. We requested that programs send three invitations total: one initial invitation and two reminders. Two hundred graduates completed the survey; however, 56 responses were removed due to declining participation in the study, attending programs outside of the desired timeframe, and incomplete surveys (i.e., did not respond to the multiple-choice questions), for a final count of 144 respondents. Respondents completed the survey in Qualtrics. At the end of the survey, respondents had the option of being entered into a drawing for one of five $100 Visa gift cards. They were also asked whether they were interested in participating in an interview. Of the 101 survey respondents who expressed interest and were invited to participate in an interview, 41 graduates participated. Interview notes were taken in Microsoft Word and analyzed using Atlas.ti. Interview respondents received a $25 Amazon gift card to thank them for their time.

Limitations

Limitations of this study include:

- Only a selected number of programs in Minnesota opted to participate, and some programs had higher participation rates among their graduates. See Figure A7 for more information about participating schools and their respondents.
- Most respondents reported that they were pursuing or had obtained counseling licensure (65%), while fewer respondents reported pursuing or having obtained a social work license (17%) or marriage and family therapy license (5%). See Figure A11 for more information about respondents' licensure type.
- Survey respondents self-selected to participate, and interview respondents were selected from survey respondents.
- Most survey respondents identified as white (92%), women (78%), and straight or heterosexual (74%). Additionally, only small percentages of respondents reported being fluent in languages other than English (5% and under) (Figures A2, A5). Accordingly, these findings may

disproportionately represent the experiences and perceptions of people within these demographic categories.

However, the racial/ethnic identity percentages and sex/gender identity percentages were relatively similar between survey respondents and the overall mental health workforce (Figure A1).

- Graduates were eligible to participate if they had graduated from their program within the past seven years. Since graduating, some licensure boards may have modified their processes or requirements, including those related to the challenges reported by graduates in this report.
- Lastly, not all interview respondents described challenges with every barrier category, and some shared positive experiences. However, this report focuses on describing barriers and potential solutions to barriers to maximize utility of the findings and recommendations.

A1. Demographics of the Minnesota mental health workforce and survey respondents

	Minnesota mental health workforce	Survey respondents (N=144; select all that apply)
Race/ethnicity[a]		
African/Black/African American	3%	4%
American Indian/Alaskan Native	<1%	6%
Asian	2%	3%
Hispanic	1%	1%
Middle Eastern/North African (response option not included in survey)	<1%	N/A
Other	1%	<1%
Two or more races	4%	N/A
White	88%	92%
Sex and gender[b]		
Male/Man	15%	15%
Female/Woman	85%	78%
Non-binary or genderfluid	N/A	5%
Transgender	N/A	1%
Prefer not to answer	N/A	1%
Not listed	N/A	1%

Source. Data are from 2021 and come from the Minnesota Department of Health's Healthcare Workforce survey (https://www.health.state.mn.us/data/workforce/hcwdash), which is administered at the time of provider license renewal. Data include alcohol and drug counselors, marriage and family therapists, professional counselors, and social workers.

[a] While the mental health workforce data include a distinct "two or more race" category, the survey data do not. Instead, respondents were counted under every race/ethnic identity they selected. Accordingly, these percentages do not total 100%.

[b] The mental health workforce data only include female and male categories, while the survey included woman, man, non-binary or genderfluid, transgender, prefer not to answer, and not listed options. Survey respondents were also allowed to select more than one identity. Accordingly, these percentages do not total 100%.

Survey and interview respondent demographics and characteristics

A2. Respondent race/ethnicity and language fluency

	Survey % (N=144)	Interview % (N=41)
Race/ethnicity (select all that apply)		
American Indian, Native American, or Alaska Native	6%	2%
Asian	3%	2%
Black or African American	4%	0%
Hispanic or Latino	1%	2%
Native Hawaiian or other Pacific Islander	0%	0%
White	92%	95%
Prefer not to answer	3%	2%
Not listed	1%	0%
Language fluency (select all that apply)		
English	97%	100%
Hmong	0%	0%
Karen	0%	0%
Somali	0%	0%
Spanish	5%	12%
Prefer not to answer	0%	0%
Not listed	1%	0%
Missing	3%	0%

A3. Geographic area respondents practice in or plan on practicing in (Select all that apply)

	Survey % (N=144)	Interview % (N=41)
Minneapolis and/or Saint Paul	34%	71%
Suburbs of the Twin Cities (e.g., Brooklyn Park, Plymouth, Bloomington, White Bear Lake)	47%	59%
Medium-sized city or town in greater Minnesota (e.g., Duluth, Rochester, Mankato)	20%	29%
Small town in greater Minnesota	29%	37%
I do not plan on practicing once I obtain licensure	1%	0%
Another state or country	22%	15%
Prefer not to answer	0%	0%
Missing	1%	0%

A4. Disability or chronic medical or mental health condition among respondents

	Survey % (N=144)	Interview % (N=41)
Yes, please describe (e.g., attention deficit/hyperactivity disorder, traumatic brain injury, post-traumatic stress disorder, migraines, rheumatoid arthritis, ulcerative colitis, depression, endometriosis, Crohn's disease, generalized anxiety disorder, learning disability, autism, thyroid issues, borderline personality disorder, bipolar disorder, Meniere's disease, trigerminal neuralgia, eating disorder, mild cognitive impairment, irritable bowel syndrome, gastroesophageal reflux, Parkinson's disease, and autoimmune disease)	27%	27%
No	60%	54%
Prefer not to answer	13%	20%
Missing	1%	0%

Note. Percentages may not total 100% due to rounding.

A5. Respondent gender identity and sexual orientation

	Survey % (N=144)	Interview % (N=41)
Gender identity (select all that apply)		
Woman	78%	81%
Man	15%	17%
Non-binary or genderfluid	5%	0%
Transgender	1%	0%
Prefer not to answer	1%	2%
Not listed	1%	0%
Missing	1%	0%
Sexual orientation (select all that apply)		
Bisexual	10%	12%
Gay	4%	5%
Lesbian	2%	2%
Queer	5%	5%
Straight/heterosexual	74%	73%
Prefer not to answer	4%	5%
Not listed	4%	2%
Missing	1%	0%

A6. Respondent graduation year

	Survey % (N=144)	Interview % (N=41)
2023	16%	10%
2022	15%	17%
2021	19%	17%
2020	14%	22%
2019	9%	7%
2018	13%	5%
2017	5%	10%
2016	9%	12%

A7. Respondent institution

	Survey % (N=144)	Interview % (N=41)
Adler Graduate School	1%	0%
Augsburg University	5%	7%
Bethany Lutheran College	0%	0%
Bethel University	11%	7%
Capella University	0%	0%
College of Saint Scholastica	0%	0%
Crown College	19%	15%
Hazelden Betty Ford Graduate School of Addiction Studies	11%	17%
Metro State University	3%	2%
Minnesota State University, Mankato	13%	15%
Minnesota State University - Moorhead	7%	2%
North Central University	0%	0%
Saint Mary's University of Minnesota	6%	10%
St. Catherine University	0%	0%
St. Cloud State University	0%	0%
University of Minnesota, Duluth	0%	0%
University of Minnesota, Twin Cities	1%	0%
University of St. Thomas	22%	24%
Walden University	0%	0%
Winona State University	1%	0%
Other	1%	0%

Note. Percentages may not total 100% due to rounding.

A8. Respondent academic award or degree type and modality

	Survey % (N=144)	Interview % (N=41)
Type		
Master's degree	99%	100%
Certificate	0%	0%
Other type of academic award (i.e., doctorate degrees)	1%	0%
Prefer not to answer	0%	0%
Modality		
Online	30%	32%
On campus	33%	39%
Hybrid	35%	29%
Other	1%	0%
Prefer not to answer	0%	0%

Note. Percentages may not total 100% due to rounding.

A9. Respondent licensure status at time of survey completion

	Survey % (N=144)	Interview % (N=41)
I obtained Minnesota licensure within the required amount of time	49%	61%
I obtained Minnesota licensure but needed a variance to lengthen the amount of time I had to obtain licensure	2%	0%
I am still pursuing licensure	24%	17%
I planned on pursuing Minnesota licensure but gave up	1%	0%
I am pursuing or have obtained licensure in another state or country outside of Minnesota	12%	7%
I never planned on obtaining Minnesota licensure (e.g., I planned on obtaining doctoral-level licensure, I never planned on practicing, I planned on practicing under a supervisor's license indefinitely)	1%	0%
Another situation	10%	15%

Note. Percentages may not total 100% due to rounding.

A10. Length of time between graduation and obtaining licensure among licensed respondents

	Survey % (N=73)	Interview % (N=25)
Under 2 years	43%	40%
2-4 years	53%	60%
5-7 years	4%	<1%
More than 7 years	0%	0%

Note. Percentages may not total 100% due to rounding.

A11. Type of licensure among respondents (select all that apply)

	Survey % (N=144)	Interview % (N=41)
Licensed Professional Counselor or Licensed Professional Clinical Counselor (LPC or LPCC)	65%	61%
Licensed Marriage and Family Therapist (LMFT)	5%	7%
Licensed Graduate Social Worker (LGSW), Licensed Independent Social Worker (LISW), or Licensed Independent Clinical Social Worker (LICSW)	17%	24%
Licensed Alcohol and Drug Counselor (LADC)	17%	20%
Another type of licensure not listed here	10%	7%
I am not pursuing any licensure	3%	0%

Survey data tables

A12. How much of a problem have each of the following barriers been for you while pursuing licensure?

	Not a problem at all	Minor problem	Moderate problem	Significant problem	Moderate or significant problem
Application process					
Cost of application (N=141)	20%	22%	39%	19%	58%
Low or no pay for hours required to apply for licensure (N=140)	24%	29%	24%	24%	48%
Application paperwork is excessive (N=141)	27%	31%	30%	12%	42%
Complicated or confusing process (N=142)	26%	35%	22%	17%	39%
Obtaining enough hours (including specific types of hours, like relational hours), serving enough clients, and/or no shows (N=141)	38%	27%	25%	10%	35%
Application process is too difficult (N=140)	34%	35%	24%	7%	31%
Poor communication from licensure boards (N=142)	44%	26%	22%	8%	30%
State reciprocity issues (N=139)	56%	14%	12%	17%	30%
Licensure application processing delays or wait times (N=140)	42%	30%	22%	6%	28%
Finding a job that provides required hours (N=141)	57%	22%	14%	6%	21%

Note. Percentages may not total 100% due to rounding.

A12. How much of a problem have each of the following licensure exam barriers been for you while pursuing licensure? (continued)

	Not a problem at all	Minor problem	Moderate problem	Significant problem	Moderate or significant problem
Working in the mental health field					
Burnout or compassion fatigue (N=142)	10%	30%	39%	21%	61%
Low pay for services provided after obtaining licensure (N=138)	22%	19%	22%	36%	58%
Other responsibilities or personal concerns, such as caregiving or illness (N=141)	28%	39%	26%	6%	33%
Not liking the profession (N=142)	68%	25%	5%	1%	6%
Language barriers (N=142)	73%	23%	3%	1%	4%
Supervision					
Unpaid time spent to receive supervision (N=143)	41%	26%	20%	14%	34%
Cost of paying for supervision (N=143)	55%	13%	18%	13%	32%
Unreliable or low-quality supervision (N=143)	47%	24%	18%	12%	29%
Finding a supervisor that meets the requirements for my license (N=144)	58%	21%	17%	4%	22%
Lack of supervisors who have an identity I would want in a supervisor (e.g., BIPOC, LGBTQ+, speaks a specific language; N=141)	73%	14%	9%	5%	14%
Licensure exams					
Cost of licensure exam or study materials (N=142)	15%	24%	35%	26%	61%
Time to study and take licensure exam (N=142)	28%	37%	22%	13%	35%
Licensure exam is too difficult (N=142)	43%	35%	18%	5%	23%
Exam is not available in the language I feel most comfortable using (N=142)	97%	1%	1%	0%	1%

Note. Percentages may not total 100% due to rounding.

A13. How have these barriers impacted your pursuit toward licensure?

	% (N=144)
They have not impacted my pursuit toward licensure	31%
Gave up on pursuing licensure altogether	4%
Delayed progress toward licensure	44%
Another impact, please describe (e.g., quit job, currently considering leaving the field, negative financial impact, stress or burnout)	15%
Missing	6%

A14. If there was one thing you could change to improve the licensure process, what would it be? (Open-ended)

	% (N=31)
Provide guidance about the licensure process (e.g., one-on-one assistance, provide more and/or clearer information about the process)	45%
Reduce costs of becoming a mental health provider (e.g., lower licensure application fees, lower exam fees, reduce cost of supervision)	23%
Simplify and/or streamline the process	19%
Make requirements less strict (e.g., allow previous experience to be counted toward hour requirements, reduce the number of client contact hours)	13%
Improve communication with licensure boards	10%
Pay students during their internships/practicums	7%
Get rid of licensure exam requirement	7%

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The Blue Cross and Blue Shield of Minnesota Center for Rural Behavioral Health at Minnesota State University, Mankato is dedicated to improving access to behavioral health care for residents in outstate Minnesota to include Tribal Communities through research, workforce development, continuing education and customized training. The center is housed in the university's College of Allied Health and Nursing, which strives to improve the quality of life for individuals, families, and communities through preparation of health and wellness professionals to meet the needs of the region.

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IDEAS

Why No One Can Fix the Broken Licensing System

Scholars and activists haven't paid enough attention to the role that state boards play in perpetuating both over- and under-regulation.

By Rebecca Haw Allensworth

Illustration by Matteo Giuseppe Pani / The Atlantic

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The most important intervention in the United States labor market is not unionization or the minimum wage. It is professional licensing—government-required permission to work in a particular profession, earned after significant education and testing—that covers twice as many workers as unionization and federal wage laws combined. And the system that oversees it is broken.

Researchers have known for decades that professional licensing is a bad deal for consumers and workers. High-profile critiques of licensing go back to at least 1945, when Milton Friedman's Ph.D. thesis presented some of the earliest evidence that licensing costs consumers dearly. In the decades since, economists and journalists have developed a body of evidence supporting these critics' views. The idea that licensing raises barriers to professions that are far higher than necessary to protect the public has remained a focus of "libertarian" and "liberaltarian" causes alike, giving rise to a bipartisan reform movement that aimed at reducing barriers to work for people with criminal records, lowering the price for health care, and making starting a new business easier.

But despite these efforts—and despite the clarity of the problem—very little has been done to meaningfully roll back licensing. In fact, the institution of professional licensing has only grown in its reach and outlandishness. More and more new professions are becoming licensed, such as art therapists and, most recently and most absurdly, fortune tellers.

Jerusalem Demsas: Permission-slip culture is hurting America

Reform efforts haven't worked because none of them addresses the center of the problem: the regulatory boards that control professional licensing. When a state

makes a licensing law—a rule that only practitioners who have jumped through certain hoops can practice—it usually also creates a board to interpret and implement the law. Each state has dozens of these boards; almost 1,800 have been established nationwide. They are powerful engines of professional regulation, deciding who is in and who is out, setting the terms of what you can do as a provider and, ostensibly, disciplining professionals for misbehavior.

Importantly, most statutes require that most board seats go to part-time volunteers working in the very profession they are supposed to regulate. The seats on these boards can be hard to fill, because serving can be a big time commitment and offers no pay; often, only those already involved in advocacy through professional associations are willing to sign up.

For anyone interested in licensing reform, ignoring boards is akin to someone interested in criminal-justice reform ignoring the role of courts and judges. And in this case, the boards have all the wrong incentives for public protection. Licensing works to protect consumers only if it doesn't go too far. If getting into a profession is too hard, or the rules are too strict about what professionals can and can't do, professional service will be expensive and scarce. But for those already licensed, more is more. The harder that entering and practicing are, the less competition those professionals face, which can mean better pay, a better lifestyle, and more prestige.

As an antitrust professor who has studied how companies act when they have control over who competes with them and how, I had a guess about how boards stacked with advocates for their profession would behave when given control over licensing. They would act like a cartel—keeping competition down and profits high. I thought board members would struggle to "change hats" from professional to regulator. When I

RECOMMENDED READING

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ARTHUR C. BROOKS

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SARAH ZHANG

decided to write a book about professional licensing, I started attending licensing-board meetings in my home state to see whether I was right.

The Panopticon Is Already Here

ROSS ANDERSEN

Read: The onerous, arbitrary, unaccountable world of occupational licensing

Some of what I saw confirmed this hypothesis. For example, I watched the Tennessee Board of Alcohol and Drug Abuse Counselors nix a proposed reform that would relax a requirement that applicants need to have majored in a behavior-health field, a rule that all but foreclosed the profession to anyone who hadn't decided to be a counselor when they were a teenager. The reasons they gave had nothing to do with the sort of public protection licensing ostensibly serves. Rather, they wanted "to protect what we've got." Another said anything less than a "fully robust" license would mean less pay and prestige for counselors. One put it simply: "It's our responsibility to make sure we are looking out for this profession."

That has it exactly backwards. A licensing board's responsibility is to look out for the public and to implement decisions made by legislatures, including efforts to dial down licensing. But time and again, I saw licensing reform initiated by a state government die in these board meetings. For example, in 2019, Arizona passed a "universal recognition" law that purportedly allowed anyone licensed in any state in most professions to practice in Arizona. The law was touted as promoting interstate mobility and cutting the red tape of a state-by-state licensing system. But a member of Arizona's psychology board later told me her board had functionally killed it, at least with respect to psychologists, by interpreting it narrowly. Similarly, in Tennessee, the legislature responded to the crisis of too few physicians by streamlining the licensure process for applicants from foreign medical schools. The licensing board flat-out refused to implement it.

Boards not only resist efforts to reduce licensing barriers; they actively work to increase them. They do this by lobbying the very legislatures that are supposed to

oversee them, even using their licensing fees to fund their efforts. In these efforts, licensing restrictions are often portrayed as a win-win for the profession that lobbies for them and for the consumers who get more public protection.

But this ratchet isn't always good for consumers, because professional services can become scarce and expensive as a result. Returning to the example of alcohol- and drug-abuse counselors, one used to need 1,500 hours of practical experience to be a counselor; then that doubled to 3,000. Today one needs 6,000 hours—as much as a medical residency—to qualify for a license in Tennessee. That and the college-major requirement have made this an exceedingly difficult profession to enter. Only about 400 counselors practice in Tennessee, a state where about 70,000 people deal with opioid addiction.

Some of what I saw, however, seemed to refute my theory that what amounted to industry self-regulation at the licensing boards would work to keep down the number of professionals.

An example: The medical-board disciplinary case of an ob-gyn who had lost his license the year before. He had had sexual relationships with a number of his patients. He had written some of them (and others) off-book prescriptions for controlled substances, in at least one case prescribing a quantity so large that he later said he had come to believe the patient was selling it on the street. He also admitted to occasionally having done drugs at work with his patients. Only six months after his license was revoked, he asked the board for it back, as a changed man with a new commitment to be a better physician. The board voted to grant him a new license the day of his hearing, a fresh start for a physician who sees mostly Medicaid patients in inner-city Memphis. Much of the board discussion focused on whether a chaperone requirement could be imposed on the newly relicensed physician without raising an alarm among his patients.

Read: The disappearing right to earn a living

My theory that boards would keep out unwanted competitors could not explain why the board didn't bar this doctor from the profession for good. There seemed to be more to the story of self-regulation than cartel-like behavior. When it came to dealing out disciplinary measures, board members' professional identity and years of advocacy created blind spots where they could not see the worst of their profession. Their professional associations, too, encouraged board members to give their peers the benefit of every doubt and to believe a fellow professional who promised to do better next time. This generosity of spirit was particularly notable in the healing professions, where doctors and nurses were dispositionally inclined to see practically every provider before them as capable of redemption. The effects of this dynamic have been devastating: For example, these impulses contributed to the opioid crisis, as prescribing practices went unchecked by professional licensing boards until too late.

The diagnosis is old: Professional licensing needs to be rolled back, to be used only where necessary to protect the public and where lighter regulatory touches—that don't so severely impact consumers and workers—aren't effective. And where we need professional licensing, such as in many health-care professions and in law, a lighter regulatory touch will keep professional services affordable and accessible.

But the prescription is new: States need to overhaul their licensing-board systems to eliminate the self-regulation that has made licensing a lose-lose for workers and consumers alike.

ABOUT THE AUTHOR

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Rebecca Haw Allensworth is a professor at Vanderbilt Law School. She is the author of *The Licensing Racket: How We Decide Who Is Allowed to Work, and Why It Goes Wrong*.

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Contents

April 26, 2024

Re: Report from Culturally Informed Culturally Responsive Mental Health Task Force

We are pleased to submit a report prepared per Minnesota Statute section 245.4902 that called for the creation of the Culturally Informed and Culturally Responsive Mental Health Task Force ("Task Force"). The Task Force was established to evaluate and make recommendations on improving the provision of culturally informed and culturally responsive mental health services throughout Minnesota.

Consisting of five representatives from state boards and DHS, and seven appointments by Governor Tim Walz, Task Force members represent various professional backgrounds and communities. Preparing these recommendations was a participatory process in which the Task Force offered a wealth of insight based on their professional backgrounds and lived experiences combined with a literature review and engagement of mental health professionals.

This report was written collaboratively with members of the Task Force and DeYoung Consulting Services, the latter of which was charged with facilitating both Task Force meetings and the overall process of this effort. It was important to represent the diverse perspectives gathered throughout the overall effort. We hope that the legislature will find it useful, and we look forward to working together to make progress in this area. We appreciate the opportunity.

I. Executive Summary

Minnesota Statute section 245.4902 called for the creation of the Culturally Informed and Culturally Responsive Mental Health Task Force ("Task Force"). The Task Force was established to evaluate and make recommendations on improving the provision of culturally informed and culturally responsive mental health services throughout Minnesota.

Consisting of five representatives from state boards and DHS, and seven appointments by Governor Tim Walz, Task Force members represent various professional backgrounds and communities. This report was prepared collaboratively by the Task Force members and DeYoung Consulting Services, the latter of which was charged with facilitating both Task Force meetings and the overall process of this effort.

Task Force Vision Statement

The Task Force members envision a mental health workforce that is racially and culturally diverse with careers that are accessible to all. They envision mental health care that is equitable, and accessible, fosters the elimination of stigma, and responds to diverse cultural needs. This is done while, as appropriate for each client, honoring and centering cultural practices rooted in traditional forms of healing. Based on historical evidence, they believe the current mental health systems are steeped in white supremacy. They envision systems that continuously assess the current evidence-based approaches with a lens for cultural appropriateness, letting impacted communities define what quality care looks like for them. The Task Force is committed to working collaboratively, communicating honestly, and listening to learn from each other, to develop collective and viable solutions.

Reading This Report

It was determined that the elements that lead to recommendations would be divided into:

- The Current State
- Barriers
- Recommendations

Current State

The Task Force believes that there is minimal emphasis on diversity and cultural responsiveness as a priority in the mental health field. Several factors contribute to this low emphasis, including a lack of shared understanding and shared definitions of important concepts, including a definition of mental health that is inclusive of Black, Indigenous, and People of Color (BIPOC) communities, which have been traditionally marginalized in the field of mental health. Task Force members also perceive systems in the field to be white-centered, emphasizing a one-size-fits-all approach; this can result in inequitable experiences for both BIPOC professionals and clients. The following themes emerged from the Task Force's overall insight into the current state:

- There is a lack of BIPOC representation in the mental health field. The low representation has had a negative impact on community members who need services.
- There is insufficient and ineffective education provided to prepare students and professionals for responding to cultural differences.
- The term "cultural competence" suggests that a provider or an organization can attain true mastery in something as dynamic and fluid as culture. Instead, the Task Force recommends assessing the extent to which mental health organizations embrace diversity and demonstrate proficiency in culturally informed and responsive services. The Task Force acknowledges attempts by some mental health provider organizations to recognize the importance of diversity and cultural responsiveness but perceives that these attempts are often performative and lack depth. The result is a harmful impact on BIPOC communities.
- Some technical assistance is available to increase the number of BIPOC-led organizations, but overall, the Task Force perceives a significant need for more resources and support.

Barriers

The Task Force members believe that, within the field of mental health, the lack of prioritization of diversity and cultural responsiveness and the resulting low rate of investment in BIPOC professionals are barriers to moving forward. They also see a lack of accountability measures as a barrier to making progress. The following themes emerged from the Task Force's overall insight into barriers:

- There are barriers in the pipeline to recruiting and retaining BIPOC professionals in the mental health field. They can be found in the education system, licensing system, and the workplace.
- There is a lack of high-quality learning opportunities related to diversity and cultural responsiveness. In addition, there is a lack of prioritization of further learning in this area, as well as very little accountability.
- A barrier in this area is the overall practice of one-size-fits-all.
- Few resources are accessible to BIPOC professionals in the field, including capital, education, and networks.

Recommendations

The Task Force offers multiple recommendations that align with the four categories of the statute, including:

1. Create and support new ways to enter and grow a mental health career, including routes to licensure, career pathways, and awareness of career possibilities. It recommends providing financial support that attracts and retains BIPOC professionals in the field, including a thorough examination of reimbursement rates and other compensation.
2. Improve the authenticity and quality of training already offered, particularly by inviting culturally proficient experts and community members to lead these changes. Enhance the training offered as well as access to it and elevate cultural responsiveness training as a high priority.

3. Collect data to track, evaluate, and share progress in this area. Support systems change, including a policy analysis and formation of an accrediting body to assess culturally informed practices. Outside perspectives, including community voices, must be engaged in making changes.
4. Enhance funding support to BIPOC-led organizations, including an examination of grantmaking processes, an enhancement of current programs, and increased reimbursement. Intentionally build these organizations' capacity.

Conclusions

The Task Force sees that diversity and cultural responsiveness in the field of mental health are not prioritized. There is a lack of the investment needed to build awareness of the need for cultural responsiveness, to educate practitioners in their skills to effectively serve BIPOC clients, to support and retain BIPOC professionals and leaders in this field, and to build infrastructure, including accountability measures, which can elevate diverse communities' voices and meet their needs. This lack of investment and the resulting low diversity and cultural responsiveness in the field has an inequitable and harmful effect on BIPOC communities.

To pursue the vision that the mental health workforce is diverse, accessible, and responds respectfully to cultural needs, the Task Force makes multiple recommendations that imply action needed on the part of the state legislature, licensing boards, state agencies, and mental health organizations.

II. Legislation

The Cultural Informed and Culturally Responsive Mental Health Task Force was established by Minnesota Statute 245.4902 and was charged with evaluating and making recommendations on improving the provision of culturally informed and culturally responsive mental health services throughout Minnesota. This report is the first set of the Task Force's recommendations, as required by statute.

Minnesota Statute 245.4902

245.4902 CULTURALLY INFORMED AND CULTURALLY RESPONSIVE MENTAL HEALTH TASK FORCE.

Subdivision 1. **Establishment; duties.** The Culturally Informed and Culturally Responsive Mental Health Task Force is established to evaluate and make recommendations on improving the provision of culturally informed and culturally responsive mental health services throughout Minnesota. The task force must make recommendations on:

(1) recruiting mental health providers from diverse racial and ethnic communities;
(2) training all mental health providers on cultural competency and cultural humility;
(3) assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services; and
(4) increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color.

Subd. 2. **Membership.** (a) The task force must consist of the following 16 members:

(1) the commissioner of human services or the commissioner's designee;
(2) one representative from the Board of Psychology;
(3) one representative from the Board of Marriage and Family Therapy;
(4) one representative from the Board of Behavioral Health and Therapy;
(5) one representative from the Board of Social Work;
(6) three members representing undergraduate- and graduate-level mental health professional education programs, one appointed by the governor, one appointed by the speaker of the house of representatives, and one appointed by the senate majority leader;
(7) three mental health providers who are members of communities of color or underrepresented communities, as defined in section 148E.010, subdivision 20, one appointed by the governor, one appointed by the speaker of the house of representatives, and one appointed by the senate majority leader;
(8) two members representing mental health advocacy organizations, appointed by the governor;
(9) two mental health providers, appointed by the governor; and
(10) one expert in providing training and education in cultural competency and cultural responsiveness, appointed by the governor.
(b) Appointments to the task force must be made no later than June 1, 2022.
(c) Member compensation and reimbursement for expenses are governed by section 15.059, subdivision

Subd. 3. **Chairs; meetings.** The members of the task force must elect two cochairs of the task force no earlier than July 1, 2022, and the cochairs must convene the first meeting of the task force no later than August 15, 2022. The task force must meet upon the call of the cochairs, sufficiently often to accomplish the duties identified in this section. The task force is subject to the open meeting law under chapter 13D.

Subd. 4. **Administrative support.** The Department of Human Services must provide administrative support and meeting space for the task force.

Subd. 5. **Reports.** No later than January 1, 2023, and by January 1 of each year thereafter, the task force must submit a written report to the members of the legislative committees with jurisdiction over health and human services on the recommendations developed under subdivision 1.

Subd. 6. **Expiration.** The task force expires on January 1, 2025.

III. Introduction

Background and Purpose

Minnesota Statute section 245.4902 called for the creation of the Culturally Informed and Culturally Responsive Mental Health Task Force. The Task Force was established to evaluate and make recommendations on improving the provision of culturally informed and culturally responsive mental health services throughout Minnesota. The Task Force must make recommendations on:

> (1) recruiting mental health providers from diverse racial and ethnic communities;
>
> (2) training all mental health providers on cultural competency and cultural humility;
>
> (3) assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services; and
>
> (4) increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color.

Consisting of five representatives from state boards and DHS, and seven appointments by Governor Tim Walz, Task Force members represent diverse professional backgrounds and communities. Members are listed below.

- Alex Espadas, Co-chair
- Talee Vang, Co-chair
- Bharati Acharya
- Jennifer Mohlenhoff
- Sam Sands
- Angie DeLille
- Tera Nelson
- Eric Abu
- Jessica Gourneau
- Hoinu Bunce
- Sue Abderholden
- Neerja Singh
- Sonya Smith
- Tom Howley, Equity Director
- Kaley Kobbervig

This report was prepared collaboratively by the Task Force members and DeYoung Consulting Services, the latter of which was charged with facilitating Task Force meetings and the overall process of this

effort. To prepare the report, the Task Force split into four subgroups, each charged with providing insight, including data and relevant examples, for one category of the statute.

Vision and Definitions

The Task Force collaboratively developed a vision statement that represents the impact that this work will have on the field of mental health.

Task Force Vision Statement

The Task Force members envision a mental health workforce that is racially and culturally diverse, with careers that are accessible to all. They envision mental health care that is equitable, and accessible, fosters the elimination of stigma, and responds to diverse cultural needs. This is done while, as appropriate for each client, honoring and centering cultural practices rooted in traditional forms of healing. Based on historical evidence, they believe the current mental health systems are steeped in white supremacy. They envision systems that continuously assess the current evidence-based approaches with a lens for cultural appropriateness, letting impacted communities define what quality care looks like for them. The Task Force is committed to working collaboratively, communicating honestly, and listening to learn from each other, to develop collective and viable solutions.

To ensure a shared understanding of language, the Task Force also agreed on the following definitions of culture, racism, and anti-racism:

Culture

A social system of meaning and custom developed by a group of people to assure its adaptation and survival, resiliency, and healing. These groups are distinguished by a set of unspoken rules that shape values, beliefs, habits, patterns of thinking, behaviors, and styles of communication.

Racism

A system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call "race"), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources. *(Adapted from Dr. Camara Jones and* racialequitytools.org*.)*

Anti-racism

The active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices, and attitudes, so that power is redistributed and shared equitably (NAC International Perspectives: Women and Global Solidarity).

Cultural Competence

The term “cultural competence” is used in the statute. The Task Force believes that this term implies a sense of having arrived at a final state of knowing. To that end, in the report below, “cultural

competence" is only used when referencing the statute. In describing its own insight, the Task Force prefers to use other terms such as "cultural responsiveness," which implies a more ongoing, dynamic state of learning.

Reading This Report

It was determined that the elements that lead to recommendations would be divided into:

- The Current State
- Barriers
- Recommendations

The report is organized into the above three sections. Within each section, the Task Force offers insight into each of the four categories of the statute (listed above). Following this insight is a summary of the process to continue this work and fulfill the Task Force's charge.

It should be noted that the focus of the Task Force was solely on culturally informed and culturally appropriate mental health care and services; it did not focus on culturally informed or appropriate research methods or practices. Although the current Task Force did not discuss the topic of culturally informed and appropriate research methods and practices, this is a significant topic that warrants further investigation.

This report builds upon the report that was submitted to the Minnesota Legislature in 2023. It represents the Task Force members' own observations, insights, and suggestions integrated with insights gathered from a literature review and engagement of additional professionals in the mental health field. It should be noted that the content of this report is based on the insight gathered from the Task Force members themselves as well as others, based on their professional and lived experiences. Considering the body of research historically lacking perspectives of BIPOC communities, this insight should be valued as a critical missing piece when reviewing other sources of data. The recommendations are aligned with the four categories of the statute:

(1) recruiting mental health providers from diverse racial and ethnic communities
(2) training all mental health providers on cultural competency and cultural humility
(3) assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services
(4) increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color

IV. Current State

The Task Force believes that there is minimal emphasis on diversity and cultural responsiveness as a priority in the mental health field. A lack of shared understanding and shared definitions of important concepts, including a definition of mental health that is inclusive of BIPOC communities, contribute to this low emphasis. Task Force members also perceive systems in the field to be white-centered, emphasizing a one-size-fits-all approach; this can result in inequitable experiences for both BIPOC professionals and clients.

A. Statute Category 1: Recruiting mental health providers from diverse racial and ethnic communities

The Task Force sees a lack of BIPOC representation in the mental health field. The low representation has had a negative impact on community members who need services.

- There is a severe lack of representation of BIPOC mental health professionals/practitioners in most areas of mental health.
- There are too few BIPOC mentors/supervisors in the field. The Mental Health Cultural Community Continuing Education Grant Program (MHCCC), authorized by Minnesota Sessions Law, 2021, Chapter 7, section 44, was established to assist mental health professionals from communities of color or underrepresented communities to become qualified to serve as supervisors for mental health practitioners pursuing licensure.
- Compared to other medical professions, mental health professionals are compensated less and reimbursed at lower rates.
- The lack of BIPOC mental health professionals has adversely affected access to culturally responsive service provision from historically marginalized patients/clients. When people cannot access culturally informed services in a timely way, it can lead to individuals needing higher-intensity services, which cost more.
- There is not enough information provided at the high school level to educate and expose students to topics on mental health, much less to careers in mental health.

B. Statute Category 2: Training all mental health providers on cultural competency and cultural humility

The Task Force believes there to be insufficient and ineffective education provided to prepare students and professionals for responding to cultural differences.

Undergraduate and graduate education requires very little coursework related to cultural differences

- Very little is required regarding cultural education at the undergraduate and graduate levels. While accrediting bodies in general are beginning to place more emphasis on cultural education (e.g., equity, decolonization, diversity), more could be done to support and incentivize this content, as well as to integrate policy-level guidelines. As an example, in the 2022 "Educational Policy and Accreditation Standards for Baccalaureate and Master's Social Work Programs," one policy directs programs to "recognize the pervasive impact of white supremacy and privilege and prepare students to have the knowledge, awareness, and skills necessary to engage in anti-racist practice."[1]
- Regarding graduate programs, outside of the minimum requirements of diversity credits set by accrediting bodies, the students themselves determine whether they want to learn further in this area, and it is often BIPOC students who decide to expand their education in this way.

The School of Education staff at the University of Redlands appealed to students to grow their own multicultural competence:

*"*Courageously opening yourself to step aside from your worldviews allows you to become a stronger ally to the client, building a more authentic, trusting relationship. This takes extensive honest self-reflection to understand where you may differ from your client and how those differences could impact your ability to provide services."

Continuing education requirements related to cultural understanding are cursory, lack depth, and are ineffective.

- Effective July 1, 2023, Minnesota statute requires continuing education for psychologists, Licensed Marriage and Family Therapists (LMFTs), social workers, and Licensed Professional Clinical Counselors (LPCCs) to include at least four hours on addressing the psychological needs of individuals from diverse socioeconomic and cultural backgrounds. Topics include understanding culture, its functions, and strengths that exist in varied cultures; understanding clients' cultures and differences among and between cultural groups; understanding the nature of social diversity and oppression; and understanding cultural humility. (SS Chapter 7, Article 4, Sec. 12)
- Once individuals have completed their graduate education and attained licensure, continuing education is required to maintain the license to practice. All licensees of the four behavioral health licensing boards are required to complete Ethics and Cultural Competency continuing education for each reporting period. However, there are no accountability measures to ensure the quality or appropriateness of the proposed cultural or diversity training.
    - Within the continuing education curriculum, diversity, equity, and inclusion (DEI) training is cursory and may prove to be more performative than substantive.

[1] 2022 EPAS Educational Policy and Accreditation Standards

    - Without any mechanisms for employers to hold learners accountable, the effectiveness of training is limited.
    - Culture and diversity are not commonly defined across licensing boards, and there is no clear expectation that mental health providers must include in their continuing education at least one activity related to culturally appropriate or informed mental healthcare, specific to BIPOC communities. This can result in licensees obtaining diversity continuing education credits by taking classes on topics such as working with ADHD, learning disabilities, or polyamorous relationships, rather than any racial or ethnic-specific diversity training.
    - Other than continuing education requirements, there is no formal tracking of culture-specific training offered.
    - There is a requirement for continuing education hours. For example, for a licensed social worker, the requirement is: "72 clock hours (20 percent) in social work values and ethics, including cultural context, diversity, and social policy; and 18 clock hours (5 percent) in culturally specific clinical assessment and intervention."
- Not enough training is happening in the workplace. Training in this area is often online, cursory, lacking depth, and white-centered.

New state law includes new requirements. The following applies to psychologists and is offered as an example (the other boards have similar requirements):

At least four of the required continuing education hours must be on increasing the knowledge, understanding, self-awareness, and practice skills to competently address the psychological needs of individuals from diverse socioeconomic and cultural backgrounds. Topics include but are not limited to:

(1) understanding culture, its functions, and strengths that exist in varied cultures

(2) understanding clients' cultures and differences among and between cultural groups

(3) understanding the nature of social diversity and oppression

(4) understanding cultural humility

(5) understanding human diversity, meaning individual client differences that are associated with the client's cultural group, including race, ethnicity, national origin, religious affiliation, language, age, gender, gender identity, physical and mental capabilities, sexual orientation, and socioeconomic status.

The current training and education have a harmful impact on communities.

- Because there is no common definition of “cultural diversity” across licensing boards, these training programs do not necessarily touch on racial or ethnic diversity. This does not create an inclusive mental health field for BIPOC people or communities.
- Impactful culturally responsive work with BIPOC communities (e.g., mezzo- and macro-level work) may not be considered “clinical” and therefore will not be credited toward clinical

licensure. Issues that may be considered are kinship, collective, and community-based mental health interventions.

- People whose perspectives and worldviews align with Western medicine viewpoints and who are not affected negatively are less likely to prioritize learning about other perspectives. Therefore, if a client with a different worldview relates to a therapist who has not taken the time to continue to learn about other viewpoints, there is a risk of harm.

C. Category 3: Assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services

The term "cultural competence" suggests that a provider or an organization can attain true mastery in something as dynamic and fluid as culture. Instead, the Task Force recommends assessing the extent to which mental health organizations embrace diversity and demonstrate proficiency in culturally informed and responsive services. The Task Force acknowledges attempts by some mental health provider organizations to recognize the importance of diversity and cultural responsiveness but perceives that these attempts are often performative and lack depth. The result is a harmful impact on BIPOC communities.

Some structural support exists to embrace cultural responsiveness (examples given below), but these supports are not adequately implemented.

- The World Health Organization Assessment Instrument for Mental Health Systems (2005) recommends 10 components of mental health system development. One component is: "Involve communities, families and consumers" but there is no discussion of culture.
- Minnesota law requires supervisors to consider the impact of the client's culture on providing treatment; supervisors are responsible for assessment. The extent to which supervisors are held accountable for implementing this, and the degree to which client voices are sought and represented when planning treatment, are unknown.
- There are currently no standards to assess the extent to which organizations embrace diversity, equity, and inclusion. Practitioners subjectively define their own familiarity and skills in this area.
- State law addresses expectations of clinical supervision. Supervisors are to educate potential mental health professionals on the cultural norms or values of the clients and communities that the provider serves, as well as the impact that a member's culture has on providing treatment. The clinical supervisor is charged with reviewing each of their assessments, treatment plans, and progress notes for accuracy and appropriateness. However, the extent to which clinical supervisors can use an appropriate cultural lens, and the degree to which clients are engaged in developing their own culturally responsive treatment plan, are unknown.

- National CLAS Standards provide 15 standards related to culturally and linguistically appropriate services. They describe the staff and other supports that are needed to make sure a provider organization is culturally responsive, including language support services. For example, clients should be asked if they prefer services or materials to be provided in an alternative language of their choice even if they speak English.

The Mental Health Uniform Services Standards Act (2451) says little about culture. It mentions "(4) culturally responsive treatment practices" but does not refer to a number of hours or other expectations.

CHAPTER 245I. Mental Health Uniform Service Standards Act Webpage

Some organizations attempt to be culturally responsive, but follow-through and commitment are lacking.

- Sometimes organizations make assumptions about what is a culturally informed practice, and they overgeneralize.
- Some mental health programs close or are ended because they reportedly didn't work; however, the community may not have known that the program was available to them.

Often, when larger, white-led organizations compete for grant funds, they propose partnering with smaller, culturally focused organizations. However, when they are awarded the grant, the smaller organizations often don't receive any of the funds. This leaves the sense that these organizations are "checking a box" but are not committed to a deep partnership with cultural communities.

The lack of proficiency in culturally responsive mental health care results in harmful client experiences.

- Minnesota has among the highest rates nationally of racial disparities related to the social determinants of health.[2]
- Many BIPOC clients have relatively more negative experiences with mental health care than white clients. They are misdiagnosed or undiagnosed more often, many do not feel welcome, and some are accused of seeking care solely to receive pain medication. This results in more harm than help being done.

Racial disparities in Minnesota (Sourced from "Building Racial Equity into the Walls of Minnesota Medicaid: A focus on U.S.-born Black Minnesotans" (DHS):

- The state of Minnesota has the second biggest income inequality gap between Black and white people in the entire nation. Compared to white Minnesotans, Asian people earn 94 cents on the dollar, Black people earn 71 cents, Latino people earn 70 cents and Indigenous people earn 68 cents.

[2] Https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8209A-ENG

- Minnesota has one of the widest homeownership gaps in the nation. While 77 percent of white households own their home, 57 percent of Asian, 46 percent of Native American, 45 percent of Latino, and just 24 percent of Black households own their home (Minnesota House of Representatives, 2020).
- In Minnesota, Indigenous students are ten times more likely to be expelled or suspended than their white peers. Black students are eight times more likely to be expelled or suspended than their white peers (Minnesota House of Representatives, 2020).
- Black and Latino Minnesotans have reported food insecurity at more than double the rate of white Minnesotans (Wilder Foundation, 2020).
- Black Minnesotans have been disproportionately affected by a loss of employment during the COVID-19 pandemic (MN Gov, 2021)
- Black, Indigenous, and Latino Minnesotans have lower COVID-19 vaccination rates statewide (Minnesota Department of Health, 2021a) and among age-eligible Minnesota Medicaid enrollees (Infogram, 2021)
- Total mortality increased in 2020 by 14 percent for non-Hispanic white Minnesotans and 41 percent for BIPOC (Black, Indigenous, and people of color) Minnesotans (Wrigley-Field et al., 2021).

D. Category 4: Increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color

Some technical assistance is available to increase the number of BIPOC-led organizations, but overall, the Task Force perceives a significant need for more resources and support.

- There are no programs that specifically support BIPOC professionals in building their business skills within the profession. Few mentorship programs exist to guide professionals. Overall, there is a lack of knowledge about business practices.
- To the knowledge of this Task Force, there are no graduate courses available to educate professionals about opening private practices or cultivating BIPOC-led organizations.
- Overall, there is low generational knowledge, generational wealth, and a lack of support networks to support opening a business and provide resources when it faces challenges.
- It is unknown how many programs offer courses about addressing family trauma.
- The Office of Equity in Procurement serves as a resource, providing technical assistance to small organizations.
- Disparities exist between BIPOC and dominant culture practitioners regarding their existing networks and generational wealth (financial knowledge, access to capital). To that end, fewer BIPOC practitioners are willing to strike out on their own into private practice.
- The National Standards for Culturally and Linguistically Appropriate Services (CLAS) include three standards related to governance, leadership, and the workforce:[3]

[3] National Standards for Culturally and Linguistically

    - "Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
    - Recruit, promote, and support culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
    - Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis."
- The Cultural and Ethnic Minority Infrastructure Grant (CEMIG) program was established to "(provide) culturally-specific, trauma-informed mental health and substance use disorder services within targeted cultural and minority communities in Minnesota" and to "(expand) these services by increasing the number of licensed mental health professionals and licensed alcohol and drug counselors, as well as other behavioral health supports such as Peer/Family Specialists and Recovery Peer Specialists, from ethnic and cultural minority communities."[4] As of 2023 this program is in state statute and is s funded through general fund appropriations with additional federal funding available at the discretion of DHS.

V. Barriers

The Task Force members believe that, within the field of mental health, the lack of prioritization of diversity and cultural responsiveness and the resulting low rate of investment in BIPOC professionals are barriers to moving forward. They also see a lack of accountability measures as a barrier to making progress.

A. Category 1: Recruiting mental health providers from diverse racial and ethnic communities

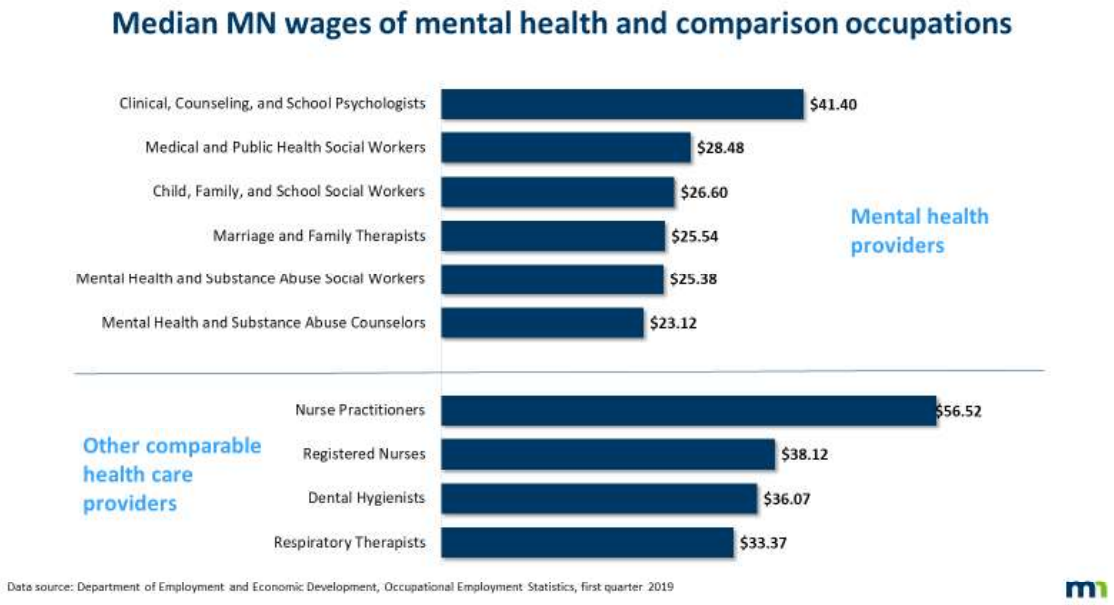
The Task Force sees barriers in the pipeline to recruiting and retaining BIPOC professionals in the mental health field. They can be found in the education system, licensing system, and the workplace.

There are barriers to entry into the field beginning in high school and continuing throughout the education system.

- "High school students rarely see career options in mental health fields."
- BIPOC students see very few professors in the mental health field whose cultural or racial identities match their own.
- Jobs are low paying. Salary rates/reimbursement rates for behavioral health providers can affect whether individuals seek to become mental health professionals (all individuals, not just BIPOC individuals). The historical undervaluing of mental health services and the profession, as evidenced by the lower compensation and high student loan costs, discourages BIPOC

[4] Culturally Specific Mental Health and Substance Use Disorder Services

individuals from pursuing a career in mental health even if they are interested and positioned to seek out a career in the medical field. The graph entitled "Median MN wages of mental health and comparison occupations" compares mental health professionals' median wages with those of other jobs.[5]



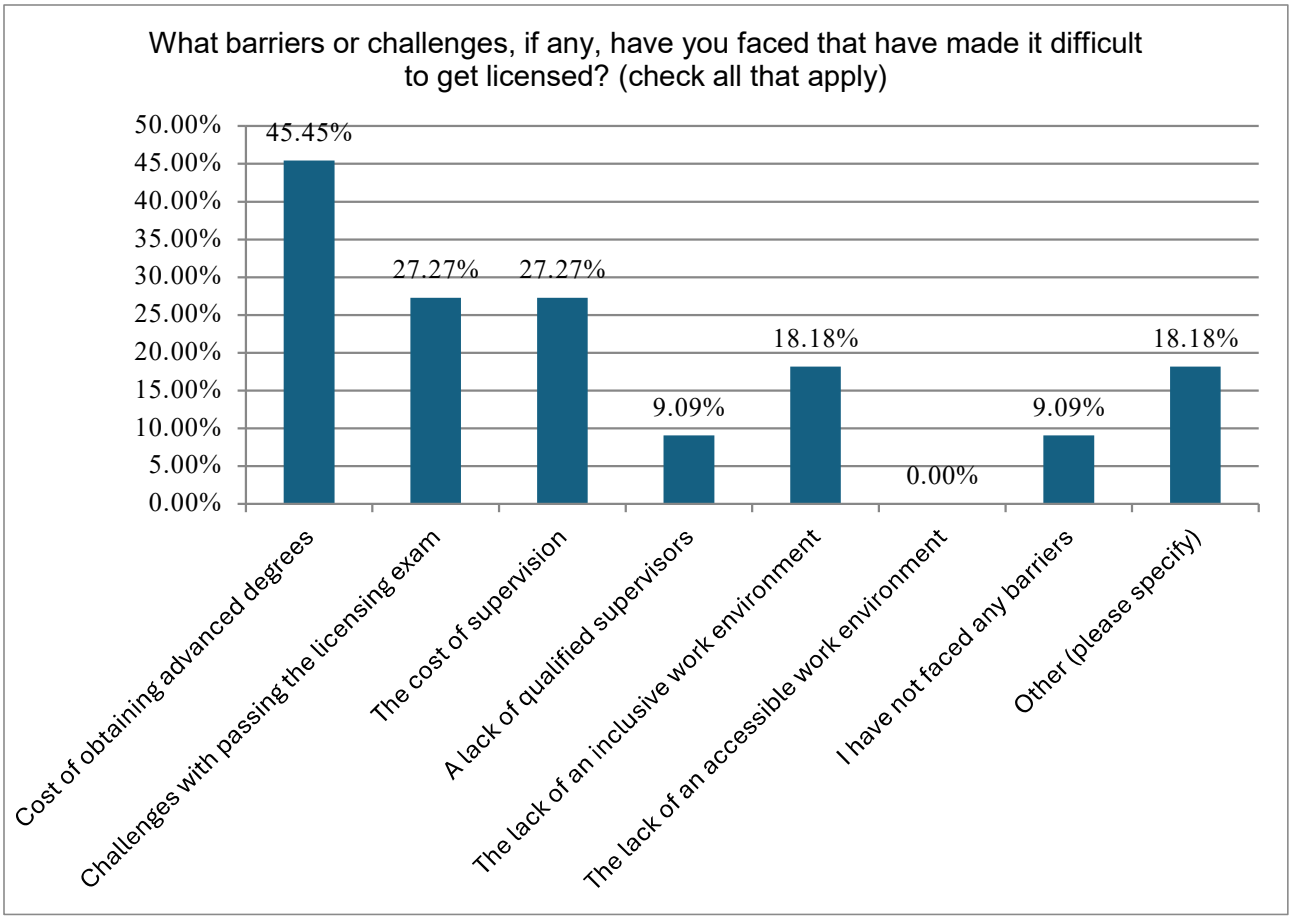
- Cost makes the pursuit of mental health education prohibitive. According to findings published in the report "The Social Work Profession:"[6]

  "Debt from their social work education was substantially higher for Black/African Americans than for whites (mean debt $66,000 vs. $45,000) and for Hispanics compared with non-Hispanics ($53,000 vs. $48,000). The mean total debt for all education was $92,000 for Black/African Americans and $79,000 for Hispanics. This is quite high given that the mean starting salary for new MSWs was only $47,100."

The graph below represents responses from the survey distributed by the task force to mental health professionals. Results indicate that the cost of obtaining a degree was a top challenge to entering the field. (See full survey results in appendix.)

[5] Teri Fritsma, Ph. D, "An overview of Minnesota's mental health workforce" PowerPoint presentation, 2019.

[6] Workforce Studies[1]



- The perception of the mental health professional as low status is a "turn-off" to some immigrant or BIPOC families.
- Power differentials exist in the field, making it difficult to navigate for those lacking in power.
- Access to data (for example, information about current students in mental health undergraduate and graduate programs) is a barrier to understanding the level of diversity in the field.
- Racial disparities exist throughout childhood education and are important factors that negatively impact the workforce pipeline, e.g., quality of childcare, school suspension rates, high school graduation rates, college completion, etc. Disparities in high school graduation rates are an important factor (that is, there are lower rates of BIPOC students who are prepared to go to college).
- Holding an undergraduate degree in a mental health field does not guarantee job security in the mental health profession; a master's or a doctorate is necessary to provide mental health care. Thus, potential students require enough assurance that they will be admitted into accredited graduate programs and that they can complete the unpaid practicums required and pass licensing exams before committing to pursue this career path. The many points at which systemic barriers can block progress deter BIPOC people from embarking on or completing the long journey to licensure.

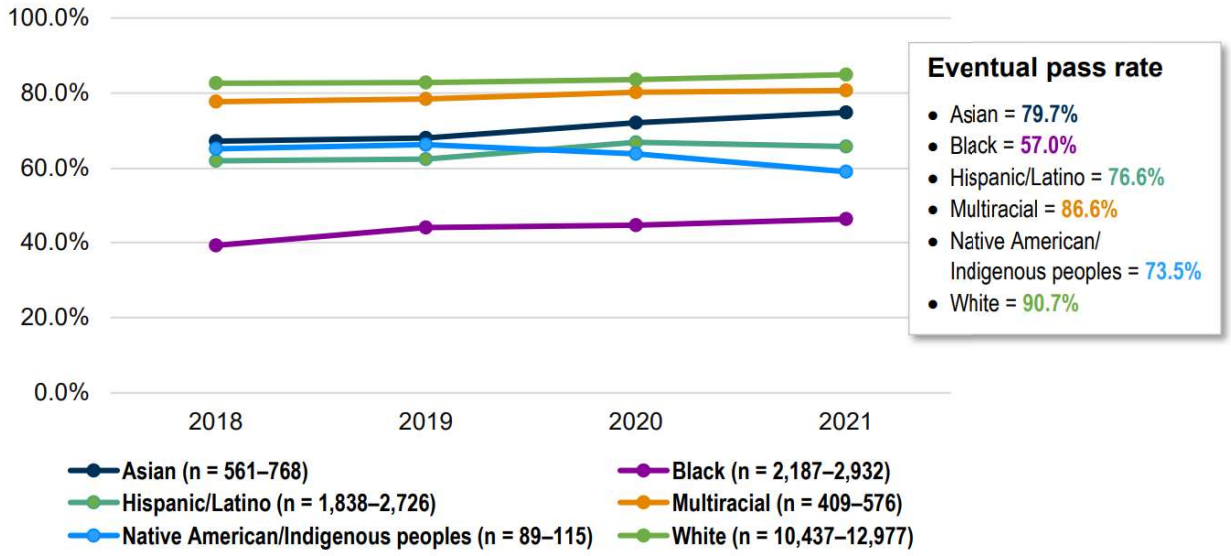
There is a perception that attending to one's mental health is a "white thing." This is reinforced by the lack of BIPOC people in the mental health field, as well as by the way the dominant culture defines what attending to "mental health" is. Issues to consider include cultural norms, providing mentors, and BIPOC supervision (paid).

Barriers exist to satisfying requirements for licensure and passing the licensing exams.

- Multiple costs associated with licensure pose a significant barrier, including the cost of supervision to get licensed, the cost of the licensure exams, and the cost of required graduate education. The cost of supervision, when compared to salary or reimbursement rates for behavioral health professionals, could be perceived as too high for everyone, not just BIPOC communities.
- People who do not pass the licensure exams end up paying more to get licensed than those who tend to pass the first time.
- It should be noted that criminal convictions are not often a barrier to licensure.
- Licensing exams written in English are a barrier to English Language Learners (ELL), though the Board of Marriage and Family Therapy does allow extra time for ELL/English as a Second Language candidates to take licensing exams.
- There are persistent racial disparities among clinic exam pass rates, as shown in the figure below.[7]
- There is a question of the tests' validity, including improper test structure, constructs that do not reflect day-to-day knowledge and questions that do not accurately reflect cultural perspectives. Some exam developers don't collect demographic information to be able to evaluate potential bias.

[7] Association of Social Work Boards report "2022 ASWB Exam Pass Rate Analysis."

Figure 2. 2018–2021 Clinical exam first-time pass rates by year and eventual pass rates by race/ethnicity



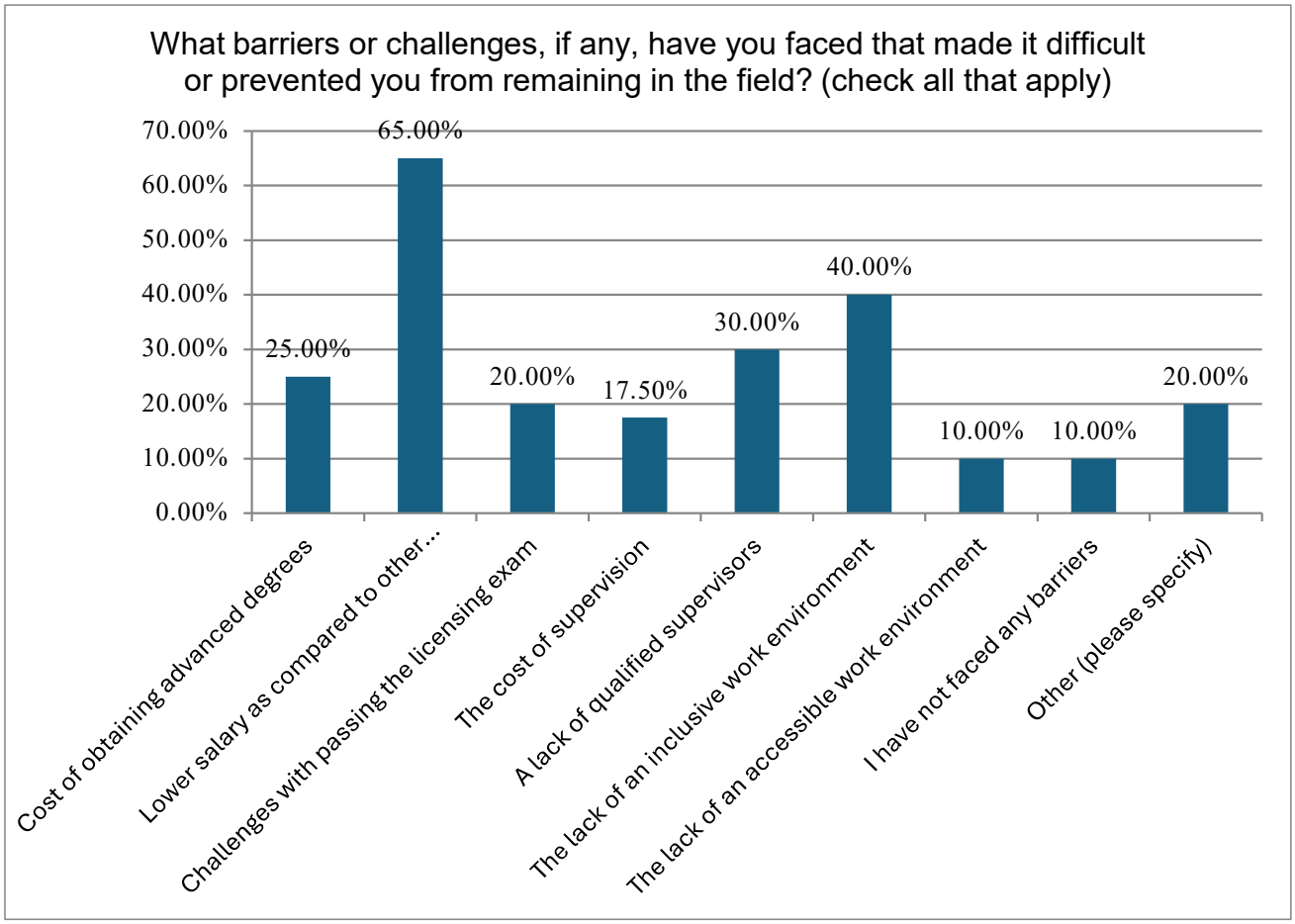
Professionals who may be interested or ready to rise to leadership positions face barriers. Retention of BIPOC professionals overall is a challenge.

- It is challenging to develop a definition that fully captures what is considered leadership within BIPOC communities, and how these leadership qualities are, or are not, represented in mental health settings.
- The MN Board of Marriage and Family Therapy does not have racial/ethnic data for Licensed Marriage and Family Therapists who are approved supervisors, making it difficult to determine representation.
- Barriers to becoming supervisors or mentors include lack of time and remuneration. The financial burden is a combination of costs and low pay.
- BIPOC practitioners may experience cognitive dissonance related to the pressure to exclusively espouse mental health interventions that have their roots in white, dominant culture. They may be aware of other practices/interventions that are life-giving and mental health-affirming. Feeling this disconnect may lead some away from supervision, as there is a sense that this reality is not affirmed in graduate programs, and therefore mentees are looking for something more "mainstream." In essence, it is a challenge to be a proponent of a system that pathologizes people's responses to experiences of injustice and oppression. This dynamic causes some to feel isolated and stressed, in part due to a lack of their own cultural belonging and the sense that a white-dominant culture doesn't prioritize the care they want to provide.

- Leaders of color encounter micro-invalidations and micro-aggressions from white colleagues regularly.

- Retention of BIPOC professionals can be hindered in part because BIPOC employees don't necessarily get the encouragement from white-owned organizations that they need to succeed.
- Some providers who are motivated to work with lower-income clients feel that their efforts are devalued in their workplaces and not supported by the reimbursement structure. In addition, the culturally specific approaches that some wish to provide are not accessible, in part due to course fees.

The graph below represents responses from the survey distributed by the task force to mental health professionals. Results indicate that the top factors keeping respondents from remaining in the field were low salaries (65%), lack of an inclusive environment (40%), and lack of qualified supervisors (30%). (See full survey results in the appendix.)



B. Category 2: Training all mental health providers on cultural competency and cultural humility

The Task Force has found a lack of high-quality learning opportunities related to diversity and cultural responsiveness. In addition, there is a lack of prioritization of further learning in this area, as well as very little accountability.

- Diversity-related training lacks depth. For example, training is often "one and done" each year.
- Medical licensing and nursing have practices that meet the definition of behavioral health practices. More information is needed on the continuing education requirements related to cultural responsiveness.
- There is a lack of culturally responsive providers who can provide quality training due to a limited pool of trainers and the time that is required.
- Boards have a process for reviewing cultural training, but an assessment of efficacy or quality may be missing.
- SS Chapter 7, Article 4 requires licensing boards for psychologists, Licensed Marriage and Family Therapists, and Licensed Professional Counselors to have members from outside of the seven-county metro, people of color, and underrepresented communities (defined as a group that is not in the majority concerning race, ethnicity, national origin, sexual orientation, gender identity, or physical ability). While the law now requires the licensing boards to be more diverse, they are not always reflective of or do not represent, the diverse communities they serve, which limits their ability to assess the quality of culturally related training.

The only accountability mechanism is the state-mandated continuing education requirements related to culture. There is a lack of accountability regarding ongoing education in the workplace and how trainers deliver content.

C. Category 3: Assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services

A barrier in this area is the overall practice of one size fits all. Social scientists have assessed whether diagnostic assessments and criteria are culturally appropriate (see "Issues in the Assessment and Diagnosis of Culturally Diverse Individuals" by Francis G. Lu, M.D., Russell F. Lim, M.D., and Juan E. Mezzich, M.D., Ph.D.)[8] As social scientists continue to see evidence that cultural perspective influences reported symptoms, the Cultural Formulation Interview was added to the Diagnostic and Statistical Manual of Mental Disorders (DSM) and is currently in the DSM-5. Although the DSM-5 is an evidence-based tool used to assist in providing a culturally informed perspective on assessing mental disorders, it

[8] Issues in the Assessment and Diagnosis of Culturally Diverse Individuals

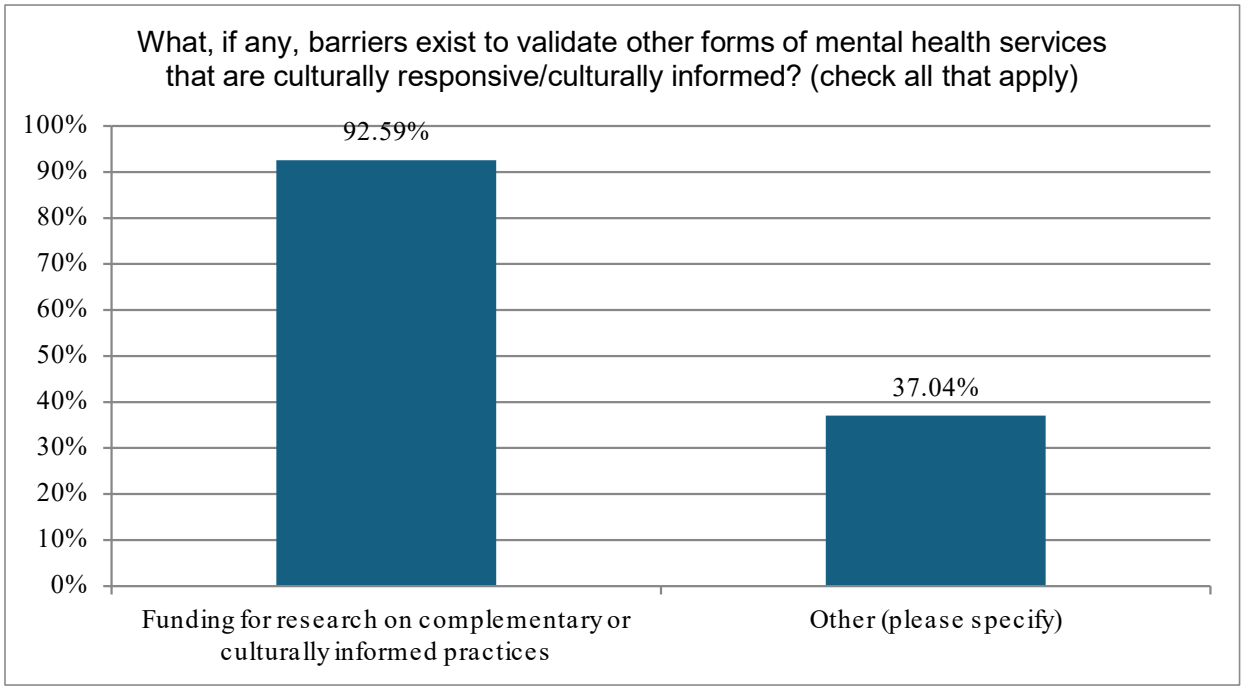
is but one step that is optional for providers (The DSM-5 Cultural Formulation Interview and the Evolution of Cultural Assessment in Psychiatry.[9])

Another barrier is a lack of awareness and empathy from providers. When providers do not acknowledge that there are racial or cultural differences, or deny the influence of race, racism, or prejudice, clients feel judged and invalidated.

To truly assess the extent to which organizations embrace diversity and demonstrate proficiency in culturally informed and responsive services would require an approach that combines qualitative and quantitative methods, whereby different organizations undergo an audit specifically on diversity, equity, and inclusion related to the racial composition of their staff, leaders, patient populations, policies, procedures, and the training those organizations have provided.

In addition, current policies may present barriers such as diagnostic standards, required treatment modalities, and insurance reimbursement.

Respondents to the task force's survey validated that funding for research on complementary or culturally informed practices is a barrier (see graph below). Other barriers found were a lack of support for other practices, access to culturally informed training, and the cost to clients of quality care.



[9] The DSM-5 Cultural Formulation Interview and the Evolution of Cultural Assessment in Psychiatry

D. Category 4: Increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color

Few resources are accessible to BIPOC professionals in the field, including capital, education, and networks.

- There are few, if any, opportunities for financial and business education in this area.
- There is little access to networks and capital to support BIPOC leaders.
- If there is funding for BIPOC practitioners to grow their businesses, it is not well publicized.
- The low level of funding provided through the Cultural and Ethnic Minority Infrastructure Grant program (CEMIG) is an overall barrier to supporting the development of BIPOC mental health professionals as well as building the infrastructure needed to effectively serve diverse communities. There has been a consistent expectation to expect more than what is feasible with the dollars provided.

VI. Recommendations

A. Category 1: Recruiting mental health providers from diverse racial and ethnic communities

The Task Force recommends creating and supporting new ways to enter the mental health field and grow a career, including routes to licensure, career pathways, and increasing awareness of career possibilities. It recommends providing financial support that attracts and retains BIPOC professionals in the field, including a thorough examination of reimbursement rates and other compensation.

A1. Support licensure and career pathways

a) Given that the research demonstrates unequal pass rates by race and possible racial bias in licensing exams (e.g., the Board of Social Work has a provisional license, which is another pathway for licensure for those who have failed and for whom English is not their native language and were born in a foreign country), explore alternative routes to licensure This should be done while continuing to support the exam pathway, to address barriers to passing licensure exams.
   i. Review what all boards and professional associations have already proposed as alternative licensure pathways.
   ii. Support the BOSW with funding in its proposal to expand the provisional licensure to all statuses.

iii. Support the Association of Martial and Family Therapy (AMFTRB) in proposing alternatives to the national exam.
iv. Consider alternatives to a standardized licensure exam, e.g., count work experience.
v. Support licensing boards with funding to come together and propose specific pathways.
vi. State agencies to review policies.

b) Build additional career pathways to allow for different levels of degrees and/or credentials. Explore how to create pathways for paraprofessionals to be compensated for their contributions toward filling important needs.
   i. Create a career pathway for non-licensed individuals at different degree levels to work alongside those with a license.
   ii. Create and support other opportunities toward which non-doctoral levels can grow.
   iii. The legislature and professional associations collaborate to define expanded/additional career pathways.

c) Create more career pathways for individuals with a bachelor-level degree.
   i. Agencies and mental health organizations conduct an updated job analysis to determine if the required qualifications could be revised.

d) Increase reimbursement rates to address barriers to financial sustainability. Demand for mental services is increasing and we need to bring in more professionals.
   i. Increase rates associated with assessment, diagnosis, treatment, group treatment, and facilities.
   ii. Expand those who may be reimbursed (roles/individuals). Work is happening, such as interventions, and not everyone is getting reimbursed for it.
   iii. Expand the number of services that are considered mental health interventions so that they can be reimbursed. Explore researching traditional forms of healing to include them in evidence-based or empirically supported mental health interventions.

e) Build awareness among youth of the opportunities to enter the mental health field.
   i. Fund a mentorship structure for high school youth (e.g., graduate-level students go to schools).
   ii. Require a psychology course in the public-school curriculum. Require a lesson on careers that include mental health professions.
   iii. Establish a pool of speakers or presenters who can visit schools.
   iv. Provide funding to higher education institutions to implement initiatives to recruit and admit students from underrepresented racial/cultural backgrounds into their programs. Without these efforts, the boards' licensing applicants will not be diverse. Higher education needs targeted funding to intentionally recruit particular students to their programs.

A2. Provide financial support to attract mental health professionals to the field and to retain them

a) Examine the overall compensation of mental health providers, including reimbursement rates, to better reflect the current demand for mental health services. The status of mental health has now been determined to be a crisis. Working in community mental health, where many BIPOC clients are, often puts clinicians in a position of serving as advocates. Clients in these contexts have complex needs that must be attended to; this often detracts from the billable "therapy hour."

b) Paying competitive wages is active allyship. Organizations that espouse values of dignity, equity, etc. can practice their values in this way.
   i. Establish higher reimbursement rates overall that reflect a fair price and require larger organizations to compensate their behavioral health professionals at a higher rate.
   ii. Expand the DHS program that provides grants to mental health providers for whom at least 25% of their clients are on public insurance (MA, MinnesotaCare) and who primarily serve underrepresented communities.
   iii. When determining eligibility for loan forgiveness, consider the intensity of the work required to serve mental health clients; revise what counts as billable hours. Include case management tasks as billable time, including efforts like providing housing resources and coordinating care.
   iv. Establish mechanisms for mental health organizations to emphasize a total benefits package that includes professional development, which can help offset the low salary. Certain certifications may come with an increased reimbursement rate from insurance companies.
c) Revise the RFP process to prioritize mental health-related grant applications.
   i. Secure federal grant money for scholarships for people who are not eligible for mental health licensure, encouraging targeted communities to enter the mental health field (build upon the Rochester School-Based Mental Health Scholars Program).
d) Reduce the financial barriers to passing licensing exams.
   i. The legislature can continue to provide grant funding for the Mental Health Provider Supervision Grant Program and similar programs that cover licensure exam fees and licensure prep for underrepresented groups.

B. Category 2: Training all mental health providers on cultural competency and cultural humility

The Task Force would like to see numerous improvements to training. It recommends improving the authenticity and quality of training already offered, particularly by inviting culturally proficient experts and community members to lead these changes. It recommends enhancing the offered training as well as access to it; elevating culturally responsive training is a high priority.

B1. Improve authenticity and quality of training

a) To improve the accuracy and overall quality of training content and delivery, invite specific community members to lead training development and delivery. It is important that the state not be the author of the training content. The leadership of community voices in developing these offerings is critical. Consult with communities and community leaders to define cultural humility and what culturally informed care would look like in each community.
   i. Engage BIPOC communities and frontline mental health workers to define mental health.
   ii. Ensure training in cultural competency includes an intersectional focus (gender identity, sexual orientation, age, ability, etc.)

iii. Seek out and engage with experts who are currently proficient in providing culturally specific care to capture their expertise and increase the accuracy of training.
iv. Develop the trainers' capacity to navigate the system and structure their content by assisting them in aligning it to CE's expectations.
v. Support boards with the funding needed to provide CE opportunities that are free and culturally accurate to the community being served to ensure quality education; boards should work with BIPOC organizations to ensure CEs are accepted.
    i) Partnerships might include healing justice organizations, South Asian wellness organizations, African American organizations, etc.

b) Create a speakers bureau comprised of leaders from diverse communities (identified by each cultural community) that could provide appropriate training. Trainers should be compensated for their knowledge.
    i. Create high-quality, culturally informed, community-vetted training and an open-source format to enhance the standardized culturally appropriate content.

c) Examine the content of culture-related training courses and the extent to which instructors adhere to the curriculum content.
    i. Support licensing boards with the funding needed to evaluate culturally specific CEs to ensure quality and appropriate culturally informed training. They should consult with an expert from the communities represented.
    ii. Review what accrediting bodies currently require.

d) Bring clarity to the varied definitions of "culture" and establish guidelines so that licensing boards can be specific in their requirements. Clearly define what qualifies as cultural continuing education credits. Standardize this definition across all mental health boards.

e) Set a minimum standard for all continuing education being submitted, not just culturally specific training, to build in a culturally diverse and specific case scenario that is informed by people who are from those cultures.

B2. Enhance training offerings and access to them

a) Make available and encourage more ongoing continuing education courses regarding DEI.
    i. Establish BIPOC/cultural-specific initiatives and programming.
    ii. Provide more training to clinics about using interpreters, ensuring smaller clinics have access.
    iii. Make training courses about cultural considerations when working with specific cultures available to mental health professionals.
    iv. Support licensing boards with the funding needed to work together to organize the training offered and share courses with other boards.
    v. DHS should develop the infrastructure/framework of the training so it is cost-effective for the boards; boards should adapt it for their providers.

b) Increase access to DEI and culturally related training offerings. Free training will reach more people.
    i. Provide free culturally appropriate online training. For example, a free monthly continuing education course on culture could be offered to the provider community. State agencies should fund the cost of training.
    ii. Incentivize participants with the opportunity to earn CEUs, including virtually.

c) Explore mentorship as an informal learning opportunity in addition to formal training.
   i. Pay BIPOC mental health providers to provide mentorship to other BIPOC professionals working toward licensure, as well as to allies working in those communities. Compensation is important, and it is also important that compensation be targeted to BIPOC individuals.
   ii. Establish a referral list of BIPOC mental health professionals who can provide professional advice regarding working with specific cultural communities. The compensation of these advisors is important.
d) Work with senior leadership to address implicit bias and racism at this level of their organizations.
e) Create a library of culturally aware and culturally appropriate training courses that are endorsed by all boards – and vetted by specific communities; shared with all licensees.
   i. Support licensing boards with funding to appropriate toward culturally appropriate BIPOC organizations to develop and disseminate CEs for mental health professionals.

B3. Prioritize the importance of training in cultural responsiveness

a) Respond to current and projected demographic changes in Minnesota by advocating for intentional training in this area instead of a primary focus on CEUs. This will help to eliminate long-standing disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds, improve the quality of services and primary care outcomes, and decrease the likelihood of liability/malpractice claims. Evidence suggests that better outcomes result when training shifts away from white-centered models.
   i. RFPs that are currently issued do not truly address disparities. Ensure use of and adherence to DHS' Equity Analysis Toolkit and BIPOC representation in the development of RFPs, especially in the early phases..
   ii. Advocate at the state level for de-colonizing the evaluation process for BIPOC organizations so the data is more accurate, meaningful, and culturally appropriate for that community.
b) Require a set percentage of diversity related CEUs to be specific to BIPOC, that is, race and ethnicity.
   i. Licensing boards should ensure that licensees and non-licensed mental health workers take CEUs related to race and ethnicity, allowing for virtual offerings.
c) Require agencies, organizations, and corporations that claim to serve a majority of BIPOC individuals to show that a high proportion of their staff have received specific continuing education related to these populations.
d) Support advocates in the field outside of legislation to create programs that help providers serve clients better.
e) Hold educational institutions accountable for taking action that demonstrates they value cultural responsiveness in the mental health field.
   i. Establish guidelines for training in graduate school and incorporate the expectations through to licensing boards.
f) Provide funding and require boards to intentionally discuss how to define culturally competent vs culturally responsive training and codify that definition in the board rules; trainers must be required to meet those criteria.

g) Provide licensing boards with funding needed to collect data on completed continuing education related to cultural responsiveness and submit that data for approval. It would be helpful to see trends in what is being approved or denied.

C. Category 3: Assessing the extent to which mental health provider organizations embrace diversity and demonstrate proficiency in culturally competent mental health treatment and services

The Task Force recommends collecting data to track, evaluate, and share progress in this area. It also recommends several ways to support systems change, including a policy analysis and the formation of an accrediting body to assess culturally informed practices. In addition, the task force recommends that outside perspectives including community voices be engaged in making changes.

C1. Collect data and track progress

a) Legislatively mandate and provide the funding needed for licensing boards to collect demographic data. Knowing and understanding the data will help providers target people who need additional support.
   i. Licensure boards should collect data and review data that identifies who is accepted into programs.
b) Require standard program evaluation and reporting in this area.
c) Decolonize the processes for evaluating data that addresses any health disparities in BIPOC communities. Decolonized evaluation research should inform future RFPs to address disparities in those respective communities.
   i. Collaborate with BIPOC evaluators who can provide evaluations that are specific to targeted BIPOC communities.
   ii. MDH and DHS should have appropriate people from the community involved in informing the process.
d) Where data is collected, share it transparently and effectively and find ways to support the conversation about disparities.

C2. Support systems change

a) Analyze and identify policies that may dictate how mental health organizations address issues of cultural responsiveness, for example, diagnostic standards, required treatment modalities, insurance reimbursement, etc. A literature review may be necessary.
   i. Build accountability measures into any assessment so words reflect practice.
   ii. Intentionally include diverse voices in defining minimum standards and throughout implementation, e.g., community forums.
b) Mandate that mental health organizations engage in pay equity and leadership equity for BIPOC professionals.
c) Educate the public and licensees about courses of action to take when complaints of racism come in; establish a system to track complaints.
d) Identify organizations that serve diverse cultural communities to explore and discover an interest in forming an accrediting body that would assess culturally informed practices.

C3. Engage outside perspectives

a) Generate ways clinicians can work with traditional healers from the community; establish a system to track these partnerships and collaboration.
b) Gather feedback from clients regarding their treatment plans to ensure they receive care that is aligned with their cultural values.
    i. Offer clients a regular survey to evaluate the quality of care. This may be included in the review of treatment plans, for example, ask "Do you believe you received care aligned with your culture?"
    ii. Involve communities in the definition and development of culturally informed practices.
c) Increase the awareness of mental health programs in communities by using more targeted marketing.

D. Category 4: Increasing the number of mental health organizations owned, managed, or led by individuals who are Black, Indigenous, or people of color

The Task Force sees a critical opportunity to invest in resources and structures that will support the growth of BIPOC-led organizations. It recommends enhancing funding support to these organizations, including an examination of grantmaking processes, enhancement of current programs, and increased reimbursement. It also has specific recommendations for building organizations' capacity.

D1. Enhance funding opportunities

a) Given the competitiveness of funding and the risk of those who need it most not getting served, intentionally fund those who are most underserved. Be clear with language that funding is to intentionally prioritize BIPOC-owned (for-profit) organizations and BIPOC-led organizations (nonprofit).
    i. Ensure BIPOC representation in the RFP planning process before the RFP is made public so it more adequately addresses the issues and creates an RFP that is more representative of communities' needs.
b) Look at grant criteria, requirements, and other structural elements to avoid unintentionally excluding BIPOC-led and owned organizations from funding opportunities.

i. DHS should evaluate how it scores grant proposals, particularly from small or new organizations. Organizations that propose a one-size-fits-all approach should be identified and flagged as potentially unable to meet diverse needs.

c) Continue and enhance funding to pay BIPOC mental health professionals to become supervisors.
   i. Expand the Cultural and Ethnic Minority Infrastructure Grant program (CEMIG) to further compensate BIPOC supervisors. To support BIPOC supervisors in the completion of the required education/training to be a board-certified supervisor, provide funding needed for boards to track which supervisors were funded as well as program outcomes.
   ii. Examine the reach of the Mental Health Cultural Community Continuing Education Grant Program (MHCCC), which is intended to help BIPOC mental health professionals become supervisors.
   iii. Create a statewide diversity and equity incentive program that rewards organizations for hiring or promoting leaders who represent BIPOC communities (leadership roles in grants, funding opportunities, etc.).
d) Collect data on how this funding has been used to date, e.g., how many people have achieved supervisor status, and the services they provide.
e) Reimburse BIPOC-owned businesses that provide culturally specific services at an enhanced rate.

D2. Build internal capacity

a) Provide technical support to build infrastructure, knowledge, and capacity of BIPOC-owned and led organizations.
   i. Working with the Department of Administration, establish a hub for smaller providers to share resources, support their capacity-building, and provide ideas for shaping policies.
   ii. Provide education regarding how to write competitive grants to have a sustainable business, board development, etc.
   iii. The MN Department of Employment and Economic Development should provide consultation services around business processes.
b) Build an infrastructure to foster partnerships between smaller practices and larger organizations. Invite large, successful organizations to mentor clinicians of color as a part of their own DEI initiatives.

VII. Conclusions

The Task Force sees that diversity and cultural responsiveness in the field of mental health are not adequately prioritized. There is a lack of investment needed to build awareness of the need for cultural responsiveness, to educate practitioners on their skills to effectively serve BIPOC clients, to support and retain BIPOC professionals and leaders in this field, and to build infrastructure. This includes accountability measures that can elevate diverse communities' voices and meet their needs. This lack of investment and the resulting low diversity and cultural responsiveness in the field has an inequitable and harmful effect on BIPOC communities.

To pursue the vision that the mental health workforce is diverse, accessible, and responds respectfully to cultural needs, the Task Force makes multiple recommendations that detail the actions that should be taken by the state legislature, licensing boards, state agencies, and mental health organizations.

DEPARTMENT OF HUMAN SERVICES

Legislative Report

EIDBI Licensing Recommendations

Disability Services Division

January 2025

For more information contact:

Minnesota Department of Human Services
Disability Services Division
P.O. Box 64967
St. Paul, MN 55164-0967

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انتباه. إذا احتجت الى مساعدة مجانية في ترجمة هذه الوثيقة، اتصل بالرقم الموجود في المربع أعلاه. Arabic

মেনাযোগ দিন। যিদ আপিন বিনামূলেয এই নিথটির বযাযার জেনয সহায় চান তাহেল উপেরাকত বাকেস থাকা নমবরটিতে কল করুন। Bengali

သတိပြုရန်။ ဤစာတမ်းကို ဘာသာပြန်ဆိုရန်အတွက် အခမဲ့အကူအညီ လိုအပ်ပါက, အထက်ဖော်ပြပါ အကွက်ရှိ နံပါတ်ကို ခေါ်ဆိုပါ။ Burmese

ការយកចិត្តទុកដាក់។ ប្រសិនបើអ្នកត្រូវការជំនួយឥតគិតថ្លៃក្នុងការ បកស្រាយឯកសារនេះ សូ មេហៅទូរសព្ទទៅលេខក្នុងប្រអប់ខាងលើ។ Cambodian

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Cantonese (Traditional Chinese)

wáŋ. héčiŋhaŋ niyé wačhíŋyAŋ wayúiyeska ki de wówapi sutá, ečíyA kiŋ wóiyawa ed ophíye waŋ. Dakota

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સાવધાન. જો તમને આ દસ્તાવેજને સમજવા માટે નિ:શુલ્ક મદદની જરૂર હોય, તો ઉપરના બૉક્સ પૈકીના નંબર પર કૉલ કરો. Gujarati

ध्यान दें। यदि आपको इस दस्तावेज़ की व्याख्या में निशुल्क सहायता की आवश्यकता है, तो ऊपर बॉक्स में दिए गए नंबर पर कॉल करें। Hindi

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Lus Ceeb Toom. Yog tias koj xav tau kev pab txhais lus dawb ntawm cov ntaub ntawv no, ces hu rau tus nab npawb xov tooj nyob hauv lub npov plaub fab saum toj no. Hmong

ဟ်သူဉ်ဟ်သး. နမ့ၢ်လိဉ်ဘဉ် တၢ်မၤစၢၤကလီလၢ ကကျိးထံလံာ်တီလံာ်မီတဖဉ်အဃိ, ကိးနီဉ်ဂံၢ်လၢ အအိဉ်ဖဲတၢ်လွံၢ်နၢဉ် လၢတၢ်ဖီခိဉ်အပူၤတက့ၢ်. Karen

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تکایە سەرنج بدە. ئەگەر بۆ وەرگێڕانی ئەم بەڵگەنامەیە پێویستت بە یارمەتی بێبەرامبەرە، ئەوا پەیوەندی بەو ژمارەیەوە بکە کە لە بۆکسەکەی سەرەوەدایە. Kurdish Sorani

Baldarî. Ger ji bo wergerandina vê belgeyê hewcedariya we bi alîkariya belaş hebe, ji kerema xwe bi hejmara li qutiya jorîn re telefon bikin. Kurdish Kurmanji

Hoȟpíŋ. Tóháŋ waŋží thí wíyukčaŋpi kiŋ yuhá níyuŋspe héčha čhéya, lé tkíčhuŋ kiŋ k'é náŋpa opáwiŋyaŋ. Lakota

ເອົາໃຈໃສ່. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອຟຣີໃນການຕີຄວາມເອກະສານນີ້, ໃຫ້ໂທຫາເບີທີ່ຢູ່ໃນປ່ອງຂ້າງເທິງ. Lao

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Pa̱lɛ rɔ piny: Mi gööri luäk lɔrä kɛ luɔ̱c kä mɛmɛ, yɔtni nämbär ɛmɔ tëë nhial guäth ɛmɛ. Nuer

Mah Biz'sin'dan.
Keesh'pin nan'deh'dam'mun chi'wee'chi'goo'yan chi'nis'too'ta'man oo'weh ooshii'be'kan.
Ishi'kidoon ah'kin'das'soon ka'ooshi'bee'kadehk ish'peh'mik ka'shi ka'ka'kak. Ojibwe

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ልቢ በሉ፡ ነዚ ሰነድ ንምትርጓም ነፃ ሓገዝ እንተ ደልዮም፣ በቲ ኣብ ላዕሊ ኣብ ውሽጢ ሰደቓ ተቐሚጡ ዘሎ ቁጽሪ ይደውሉ። Tigrinya

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LB (7-24)

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $100,565.

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Contents

I. Executive summary

The Early Intensive Developmental and Behavioral Intervention (EIDBI) benefit was created in 2013, initially to serve children with autism spectrum disorder (ASD) and related conditions up to age 18; the benefit was subsequently expanded to serve young people up to age 21 who are enrolled in a Minnesota Health Care Program (MHCP) such as Medical Assistance or MinnesotaCare. It is estimated that roughly 1.9 percent of 4-year-old children (or one in 53 4-year-old children) in Minnesota have ASD.[1] There is significant need for EIDBI services and a shortage of providers available to provide needed services.

The Minnesota Department of Human Services (DHS) licenses or certifies several different provider types. Members of the community identified a need for a service specific to ASD around 2012. In response, DHS collaborated closely with community providers, partners and families to develop the EIDBI service. The Legislature authorized DHS to seek federal approval and implement EIDBI however a licensing framework was not included. This has left EIDBI agencies neither licensed nor certified, leading to concerns about monitoring the quality, safety and integrity of services provided. These concerns were exacerbated by the pandemic, when site visits which help ensure at least minimum provider enrollment standards are met were put on hold. DHS recognizes how vital EIDBI services are for children and families. The goal of this study is to identify solutions to these concerns while balancing access, equity and safety.

This report draws on both an environmental scan of similar licensed DHS providers and an extensive engagement process with interested parties, as well as data provided by DHS, to inform recommendations. The scan of licensed DHS providers shows that licensed providers are required to comply with significantly more fundamental program requirements to ensure client safety and monitored for their compliance against these requirements.

This report includes a set of recommendations to put EIDBI provider agencies on a path toward licensure as expeditiously as possible as well as recommendations for interim measures to improve program integrity and compliance. Proposed recommendations include an approach to establishing licensure of EIDBI provider agencies that would incorporate clinical oversight from DHS to evaluate various aspects of provider agency operations and delivery of medically necessary services. Proposed topics to be included in a system of licensure include the following nine areas:

- Health and safety standards.
- Investigating, reporting and acting on alleged violations of program standards.

[1] Minnesota Autism Developmental Disability Monitoring Network

- Administrative and clinical structure.
- Supervision standards.
- Caseload limits.
- Treatment modalities and provider qualifications.
- Initial and ongoing training.
- Verifying licensure and/or certification and scope of practice.
- Removing providers from MHCP enrollment based on inactivity.

These recommendations are made in the context of soaring growth in the number of enrolled EIDBI provider agencies and substantial increases in client participation and program costs. Implementation of these recommendations will accomplish three things:

- Protect the interests of children being served through the EIDBI benefit.
- More clearly inform prospective and current operators of EIDBI provider agencies what their responsibilities are.
- Put safeguards in place that will provide stronger accountability for state and federal funds invested in these vital services.

II. Legislation

Laws of Minnesota 2023, chapter 61, article 1, section 63.

EARLY INTENSIVE DEVELOPMENTAL AND BEHAVIORAL INTERVENTION LICENSURE STUDY.

(a) The commissioner of human services must review the medical assistance early intensive developmental and behavioral intervention (EIDBI) service and evaluate the need for licensure or other regulatory modifications. At a minimum, the evaluation must include:

1) an examination of current Department of Human Services-licensed programs that are similar to EIDBI;
2) an environmental scan of licensure requirements for Medicaid autism programs in other states; and
3) consideration of health and safety needs for populations with autism and related conditions.

(b) The commissioner must consult with interested stakeholders, including self-advocates who use EIDBI services, EIDBI providers, parents of youth who use EIDBI services and advocacy organizations. The commissioner must convene stakeholder meetings to obtain feedback on licensure or regulatory recommendations.

III. Introduction

This report explores the need for licensure of EIDBI provider agencies. It is the third in a series about EIDBI services commissioned by DHS at the direction of the Legislature. The first report, completed by Community Research Solutions, included a scan of other DHS licensed programs and their required standards. It also incorporated information about other states' Medicaid services for youth with autism and related conditions. The second report, completed by Courageous Change Collective, summarized an extensive engagement process for interested parties involving EIDBI providers and family members of children participating in EIDBI services. The findings from these first two reports are summarized at the outset of this report as well as referenced in other relevant sections.

Purpose of report

This report explores the need for licensure of EIDBI provider agencies. The report explains why licensure is needed and how it would address numerous emerging challenges across EIDBI provider agencies. It provides background information about the EIDBI benefit and program growth. It provides recommendations to the Legislature and DHS to establish licensure addressing at least nine core areas as well as a description of the timeline and resources that would be needed to do so. The document also recommends the Legislature and DHS take interim steps to improve oversight of EIDBI provider agencies until licensing can be implemented.

The report was required under Laws of Minnesota 2023, chapter 61, article 1, section 63. It was prepared by Katie Burns 10,000 Lakes Consulting under contract with the Minnesota Department of Human Services.

IV. An overview of work to date

Environmental scan of DHS licensed programs

The environmental scan of other DHS licensed programs includes summarized information about the following licensed providers:

- Outpatient mental health
- Center-based child care
- Family child care
- Adult day center
- Foster care
- Home and community-based services
- Children's residential facilities.

While insights and details are shared throughout this report in various relevant sections, a clear take away from the scan of DHS licensed programs is that licensed providers are required to meet an array of standards to provide services and their compliance with those standards is monitored and enforced through licensing. By comparison, EIDBI provider agencies are held to comparatively fewer standards and DHS lacks authority and appropriate staffing to enforce compliance with those existing standards.

Summary of provider and family engagement process

The engagement process, conducted by Courageous Change Collective, gathered feedback from two important partners: providers of EIDBI services and professionals in related fields as well as families and caregivers of children with autism and related conditions. The engagement process occurred over four months with substantial outreach. Courageous Change Collective facilitated six focus groups involving 75 providers; 114 providers responded to surveys. Four focus groups were held for family and caregiver representatives involving 35 participants; 52 families submitted survey responses.

The goals of the engagement process were to identify what is working well with EIDBI services; what areas of EIDBI services need improvement; solicit input on key topics that could potentially be addressed as part of licensure; and document concrete suggestions for improvement.

Families expressed appreciation of EIDBI services and the difference those services made in the lives of their children. They also expressed a need for more support; parents and guardians spend enormous time and energy navigating systems for coverage of EIDBI services and finding care. They voiced concern about lack of effective collaboration between providers and schools, often finding themselves as the coordinator between the two and reluctance on the part of schools for more active support of needed services.

As part of the feedback process, providers expressed their support for DHS establishing clear standards for EIDBI agencies. They particularly voiced support for physical health and safety standards as well as caseload limits. Other providers felt that clearer guidance from DHS would help new providers establish themselves successfully.

Some interested parties expressed reservations about a potential system of licensing because of its inherently more structured and defined approach to oversight of services. They are concerned the EIDBI care system may become too rigid if EIDBI becomes too regulated; other interested parties expressed concern that licensing officials might have inconsistent expectations. Regulations might especially be challenging for providers from underserved communities that face cultural and linguistic barriers to providing services. Interested parties also express concern about DHS administrative capacities and processes to support existing provider enrollment processes; they would like to know DHS is better positioned to support providers through state-required processes before going down the path of licensure where greater interaction will need to occur between DHS and providers.

Families noted the licensing process can take a lengthy time and that requirements for completing documentation and going through the licensing process might become a barrier to providers. They also expressed concern about when licensors would conduct site visits to evaluate services and whether this process might interrupt the provision of high-quality services. Families in rural areas are concerned about measures that might exacerbate the severe shortage of provider centers in outstate Minnesota. They wondered whether the licensing rules would result in accreditation requirements or required hours for staff training. Families were skeptical about whether state officials who would be involved in creating the licensing rules have any experience as EIDBI providers. Families would like any potential licensing process to be a collaborative one between individual providers, agencies and the Department of Human Services. They think it is critical for providers to have an opportunity to provide input and inform both any initial licensing process as well as changes into the future.

Limitations of licensing

It should also be noted that licensing would address many issues explored during the engagement process, but not all of them. Licensing typically is a tool for establishing minimum standards across provider agencies, which is critical. However, licensing will not address issues such as effective coordination of services with schools, which is a significant issue for families and providers. Licensure will help DHS to identify and potentially prevent program integrity issues; however, even licensing cannot eliminate the risk of some program integrity concerns.

V. Why should DHS license EIDBI provider agencies?

EIDBI is an outlier among other Minnesota Health Care Programs for its lack of licensure of provider agencies in comparison to similar other human services providers that offer intensive intervention services in centers, clinics and other community-based settings to vulnerable populations. Licensing provides a toolkit of potential approaches for responding to, addressing and escalating concerns based on the severity and chronicity of issues occurring. Licensing helps to ensure program quality by establishing "the threshold or floor of quality below which no program should be permitted to operate."[2]

Because EIDBI provider agencies are not licensed, they are subject only to minimal health and safety standards unless they happen to be licensed as a different kind of provider entity (which might be the case, for example, if the provider agency also offers certain community-based mental health services). Staff are not required to participate in continued training and education to stay current on developments in this evolving field. This is out of step with other types of human services programs and concerning because of the complex needs of the population being served.

The population of young people served by the EIDBI benefit are a vulnerable population. The average age of children receiving EIDBI services is currently 8.8 years old[3]. Some participants are non-verbal. Children with ASD or related conditions are more prone to behaviors that could put them in danger, such as wandering or running away. Provider agencies serving children with ASD and related conditions need facility safety standards and procedures in place to address these concerns.

Because EIDBI provider agencies are not licensed, DHS has no authority and processes to conduct maltreatment investigations. A recorded incident of maltreatment of a 3-year-old child participating in EIDBI services occurred at a provider agency in May 2024[4] and raised concerns. The child was repeatedly forcefully pushed to the ground by an employee on her first day of unsupervised interactions with children. That employee was subsequently charged with malicious punishment of a child after the incident. DHS had no authority to send its own investigators to this EIDBI provider agency.

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[2] Fiene, Richard. National Association for Regulatory Administration. "Licensing Measurement and Program Monitoring Systems" webinar.

[3] DHS data, October 2024.

[4] CBS News. "Video shows toddler repeatedly thrown to the ground at Minnesota autism center." May 3, 2024.

When a program is licensed, DHS has processes in place to triage a complaint and determine who should follow up on the report along with standard timelines, depending on the nature of the report. This is a different and more focused process operationally than for unlicensed programs.

This also provides greater opportunity for DHS to identify concerns that may, for example, involve a larger provider organization with locations scattered across different counties. When concerns are investigated by a centralized, statewide entity such as DHS, there are opportunities to "connect the dots" across various complaints to see they are associated with a single provider organization. An ability to see these types of patterns provides DHS staff an opportunity to view these complaints with heightened concern and escalate investigating and responding to them accordingly.

EIDBI services are in high demand and the program is growing in all critical dimensions – the number of children and young people being served; the number of provider agencies and individual providers enrolling to provide services through MHCP; as well as both average and total costs.

Local and national media have reported federal and state regulators are investigating EIDBI providers. The Federal Bureau of Investigation began investigating potential EIDBI provider fraud concerns at least as early as June 2024.[5]

The Star Tribune reported that, as of mid-September 2024, the Minnesota Department of Human Services' Office of Inspector General (OIG) had 29 open investigations underway of EIDBI service providers for review of fraud or abuse of Medicaid funds. In addition, among recently completed investigations, the state is in the process of recovering more than $86,000 from an Edina-based provider and both recovered $192,000 from and levied a $5,000 fine against a provider located in St. Paul.[6]

In addition to the recovered payments, the OIG has withheld payments to seven providers over the past six years: five due to credible fraud allegations, one because a provider refused to give DHS access to records and one to safeguard the public welfare and MHCP.[7]

While there is a significant shortage of individual providers, the number of EIDBI provider agencies enrolled as MHCP providers has more than quadrupled since 2020. As the number of agencies enrolling has increased, average costs per service and total program costs have grown exponentially.

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[5] Winter, Deena. "FBI investigates Minnesota autism centers, which have exploded in growth since 2018: DHS studying whether it should begin licensing autism facilities." Minnesota Reformer. June 18, 2024.

[6] Van Berkel, Jessie. "Minnesota Medicaid fraud investigators examining more autism service providers." Star Tribune. Sept. 18, 2024.

[7] Winter, Deena. "FBI investigates Minnesota autism centers, which have exploded in growth since 2018: DHS studying whether it should begin licensing autism facilities." Minnesota Reformer. June 18, 2024.

Although the number of children being served through EIDBI is also increasing, the degree of increase is not keeping pace with the significant increase in program costs. A system in which provider agencies are licensed would give DHS additional capacity and set protocols to address program integrity concerns.

DHS sees indications that capacities for appropriate clinical oversight of services are under strain.

A number of individual providers with the qualifications needed to oversee services appear to be simultaneously employed by a large number of agencies. At a certain point, it is difficult to appropriately monitor clinical services of individual providers if a care supervisor is attempting to do so across a large number of individual providers or across too many provider sites.

The rapid increase in the number of EIDBI provider agencies and individuals enrolling to serve children with ASD and related conditions has led to some operational inconsistencies. Some providers who participated in the interested party engagement process indicated they need more direction from DHS and that some EIDBI provider policies are not clear to them. While some providers report challenges with the DHS provider agency enrollment process, it is crucial to address these challenges to ensure that newly enrolled agencies are fully operational and prepared to deliver high-quality services.

When provider agencies complete the enrollment process, they are listed as MHCP providers in DHS' provider directory. The issue of providers completing enrollment, but not becoming operational, results in a provider directory including providers that don't offer services. This is a frustration to families searching for providers for their children. The provider directory also includes providers who no longer offer services, which is also frustrating to families. DHS' current process for enrolled providers does not allow for providers to be removed when they are inactive over a lengthy period. DHS currently requires EIDBI providers to revalidate their enrollment every five years. Under current process, providers are only removed from the provider directory if they fail to revalidate their enrollment or if DHS has other grounds to remove them. This means both providers who never became operational or who are dormant linger on the MHCP provider directory for a lengthy period before they are removed.

DHS staff report some basic components of business operations are lacking among some EIDBI provider agencies. For example, staff have called the phone number listed for an agency only to have someone answer the phone in a manner that suggests the phone number is a personal phone rather than that of a professional client-serving agency. Similarly, some EIDBI provider agencies lack websites or have providers who use email addresses that appear to be personal email addresses. The use of personal email addresses for conveying protected, sensitive health information to families or other providers is a serious concern. Provider agencies should have basic components of a professional business in place, such as a business phone number, a business website and business email addresses for their employees that allow employees to communicate via secure email. The presence of these business tools conveys a minimally expected level of professionalism to families and other providers.

Some EIDBI treatment protocols call for up to 40 hours per week of intensive services. A child receiving that level of services in a center-based environment is essentially spending at least as much time at a provider agency as a child enrolled in full-time day care. The lack of more rigorous controls around this program has some concerned that a portion of provider agencies may be acting more as daycare operators, but bill for more expensive EIDBI services instead without providing medically necessary services.[8] To the extent this is true, this is a disservice to families seeking services and an egregious form of provider fraud.

Licensing will help ensure higher quality of services by creating standards and enforcing compliance with them, which will likely lead to better outcomes for the children being served.

While EIDBI services are clearly needed by families, this high growth program needs additional guardrails and oversight. Unless the concerns described in this report are concretely addressed through a clear system of standard-setting and enforcement of those standards through licensure, these issues are likely to continue to grow in scale.

[8] Winter, Deena. "FBI investigates Minnesota autism centers, which have exploded in growth since 2018: DHS studying whether it should begin licensing autism facilities." Minnesota Reformer. June 18, 2024.

VI. Background

Evolution of EIDBI services in MHCP

The EIDBI benefit was created in 2013, initially to serve children with ASD and related conditions up to age 18; the benefit was subsequently expanded to serve young people up to age 21. There is significant need for EIDBI services and a shortage of providers available to provide needed services.

Minnesota is unique among states for allowing a variety of treatment modalities to be offered as part of the EIDBI benefit. Most states rely solely on Applied Behavioral Analysis (ABA), which is widely recognized as the gold standard for care of children with ASD. It is the most rigorously tested and evidence-based intervention and is recognized by the Surgeon General[9] and the National Institute for Mental Health (NIMH)[10] as the most effective approach for treating ASD. Other key organizations, such as the American Academy of Pediatrics[11], the Centers for Medicare & Medicaid Services[12] and the Behavior Analysis Certification Board[13] also recognize ABA as an effective, evidence-based treatment approach. ABA also has the most extensive education and experience requirements for providers as compared to other treatment modalities.

In addition to ABA, Minnesota permits the following modalities to be used in MHCP:

- Developmental, Individual Difference, Relationship-based (DIR)/Floortime model.
- Early Start Denver Model (ESDM).
- PLAY Project.
- Relationship Development Intervention (RDI).
- Early Social Interaction (ESI).

[9] U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services

[10] National Institute of Mental Health. (2021). Autism Spectrum Disorder: *Treatments and Therapies*. Bethesda, MD: NIMH.

[11] American Academy of Pediatrics. (2020). Autism Spectrum Disorder: Guidelines and Standards. *Pediatrics*, 145 (Supplement 1), S1-S11.

[12] Centers for Medicare & Medicaid Services (CMS). (2014). *Clarification of Medicaid Coverage of Services to Children with Autism*. Baltimore, MD.

[13] Behavior Analyst Certification Board (BACB). (2022). *Professional and Ethical Compliance Code for Behavior Analysts*.

Current status of EIDBI licensure, certification and accreditation in Minnesota

It is important to understand the baseline of licensure and certification requirements in place for EIDBI providers in Minnesota:

- **Agencies offering EIDBI services are not licensed**. This report recommends DHS adopt a licensure framework for these agencies.
- **Individual providers are not currently required to be licensed**; however, this is changing effective Jan. 1, 2025, for the most highly credentialed individual providers offering Applied Behavioral Analysis (ABA) services. This includes board certified behavior analysts (practitioners with a master's degree) and board-certified behavior analysts – doctoral (practitioners with a doctoral degree).
    - The Minnesota Board of Psychology will manage the licensing process for these providers. Thirty-five states already required licensure of BCBAs[14] before Minnesota law was changed to require this.
    - This licensure process will increase oversight and regulation of professional and ethical standards of ABA practice, which should be helpful in ensuring and increasing fidelity of ABA service provision in the state.
    - DHS does not license individual providers practicing the other five permitted EIDBI treatment modalities and there are currently no plans to do so.
- **Individual providers may be certified to offer a variety of EIDBI treatment modalities** permitted to be used and billed under MHCP as noted above. Certifications are offered through private credentialing organizations or public entities and are distinct from licensure, which gives a provider authority to operate in a state or to provide services through a state Medicaid program. Certification means an individual has completed the requisite education and training requirements needed to meet that private organization's standards. It should be noted significant variation exists in the rigor of these professional organizations' standards, including those related to initial training to obtain certification, continuing education requirements, oversight protocols and ethical standards.
- **Licensing and/or certification for individual providers do not fill the gap of a lack of required licensure for EIDBI agencies.** Agencies employ individual providers and, under a licensing framework, would be held to a more robust set of standards around how they operate.
- **Accreditation by a credible external entity typically relies on more rigorous standards than licensing.** Effective licensing creates standard requirements to achieve at least a certain minimum level of program quality, whereas achieving accreditation from a respected external entity is generally indicative of meeting standards associated with higher levels of quality.

[14] Licensure of Behavior Analysis in the United States, https://www.bacb.com/u-s-licensure-of-behavior-analysts/

- A national organization called the Autism Commission on Quality (ACQ) recently created an accreditation program provider agencies. Thirty I program sites across the nation have achieved accreditation through ACQ (none of those accredited agencies are located in Minnesota). Massachusetts recently took a significant step forward by requiring Medicaid managed care organizations in the commonwealth to contract only with accredited agencies to offer medically necessary services to children with autism and related conditions.[15]

[15] Oct. 1, 2024. "MassHealth Announces Accreditation Requirement for Applied Behavior Analysis Providers." https://autismcommission.org/press-release/20241001-masshealth-announces-accreditation-requirements-for-aba-providers/

How much EIDBI care is provided through MHCP?

This section of the report provides important baseline information about EIDBI service provision in Minnesota. It shares data provided by DHS about the following metrics:

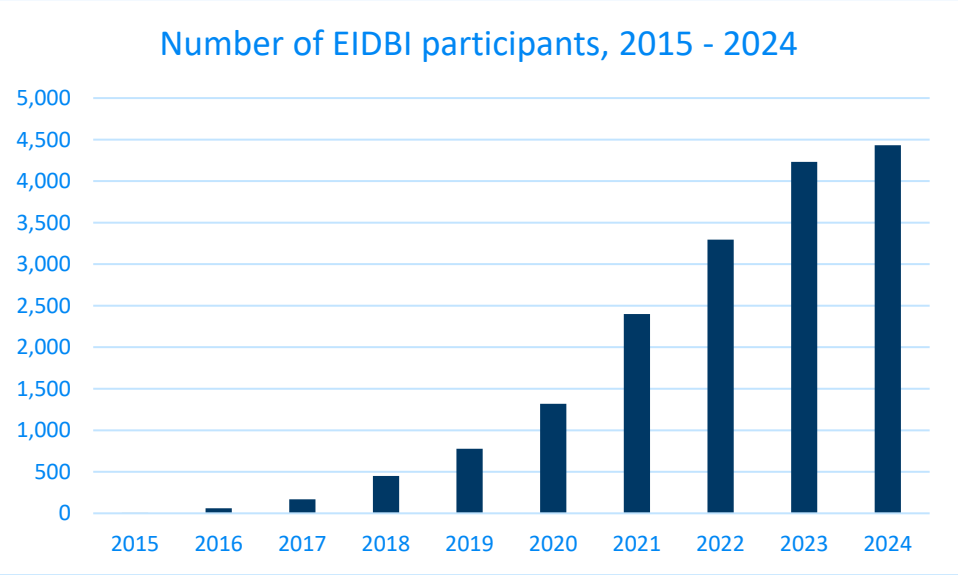
- Number of children receiving services.
- Number of service units billed on an annual basis.
- Number of units billed per client on an annual basis.
- Average annual spending per client per year.
- Units billed by provider type.
- Average cost of service over time.
- Number of EIDBI provider agencies over time.

All metrics show significant growth, which is to be expected when a new program is launched and in its early years of operation. It is important to understand information about increased program costs in the context of anticipated growth and participation in a relatively new benefit. It must be noted, however, this growth is occurring in a largely unregulated care system; this lends urgency to the need for licensure to safeguard program participant health and safety as well as to ensure program integrity.

Number of EIDBI clients served

As expected with a new program, the number of children receiving EIDBI services has grown significantly since the benefit became operational in 2015. In 2023, a total of 4,232 Minnesota children received EIDBI services as compared to 3,296 in 2022; this represents a 28 percent growth in the number of participants in a year and more than a tripling of program participants since 2020.

Figure 1: Number of EIDBI participants over time



Units of EIDBI services billed

The amount of care being provided is increasing over time as well on a per-client-served basis and in total. The number of total EIDBI service units billed annually has increased in part because of an increasing number of program participants each year as well as some success in addressing provider shortages. Strategies to allow alternative types of credentials to attract more care providers into the care system are working at least to some extent, particularly among EIDBI Level II providers.

Figure 2: Units billed by calendar year

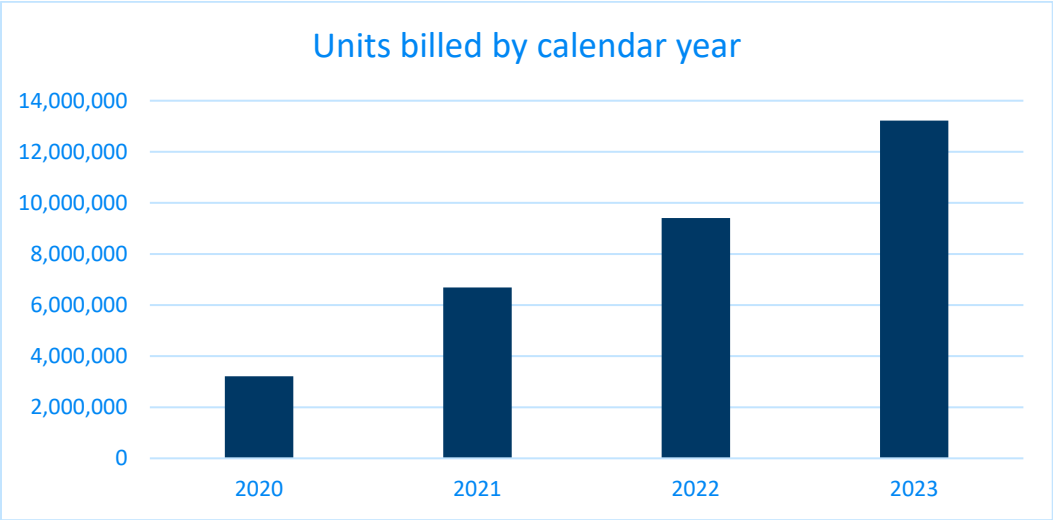
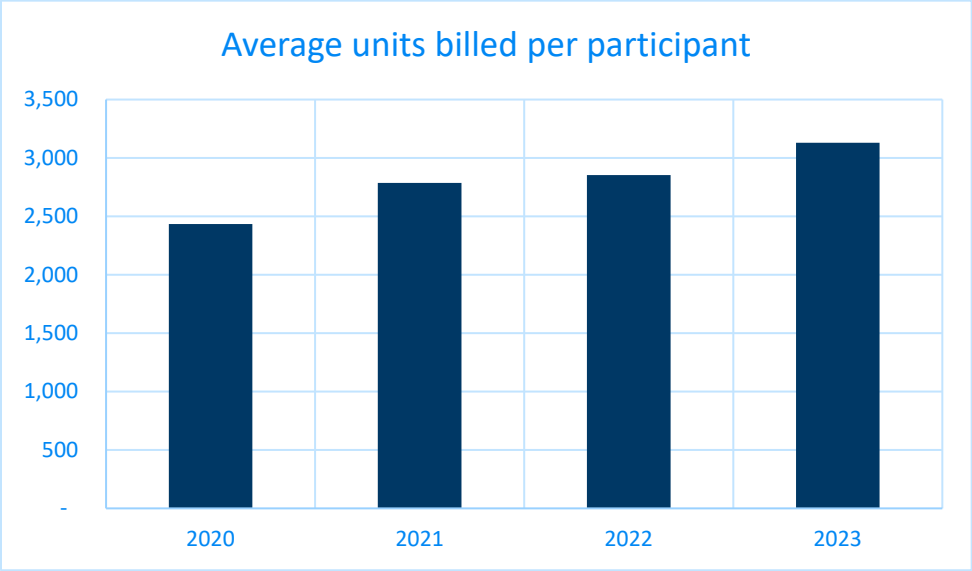


Figure 3: Average units billed per participant

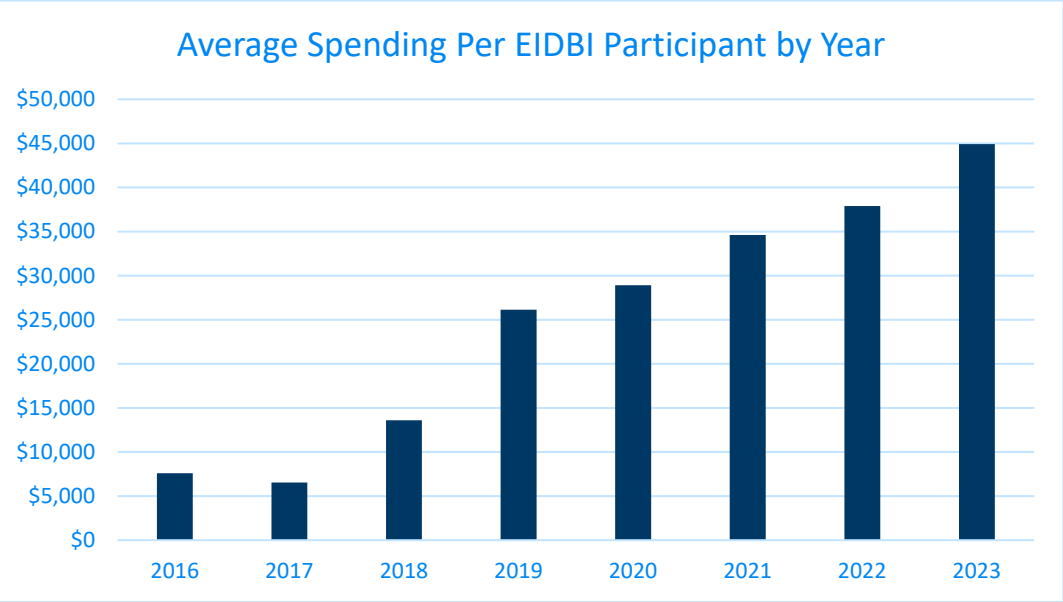


Examining the number of units of services billed per participant sheds light on treatment intensity. The average growth rate over a four-year period of the average number of units billed per participant is nearly 29 percent. While this is a significant increase, program growth as measured in number of participants served, total units billed and cost growth are all much higher.

Spending and cost growth

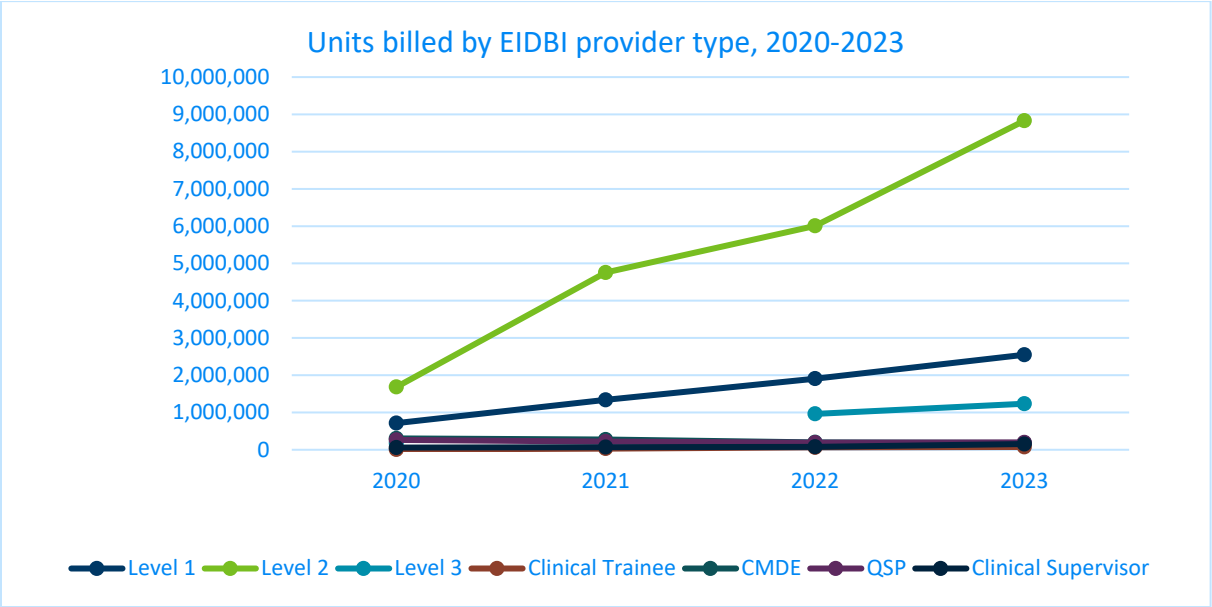
Average spending per EIDBI client served has increased sharply over the life of the program.

Figure 4: Average spending per EIDBI participant by year



To better understand what factors are contributing to cost growth, we looked at which provider types are billing for services and average cost growth as well as how these metrics are changing over time.

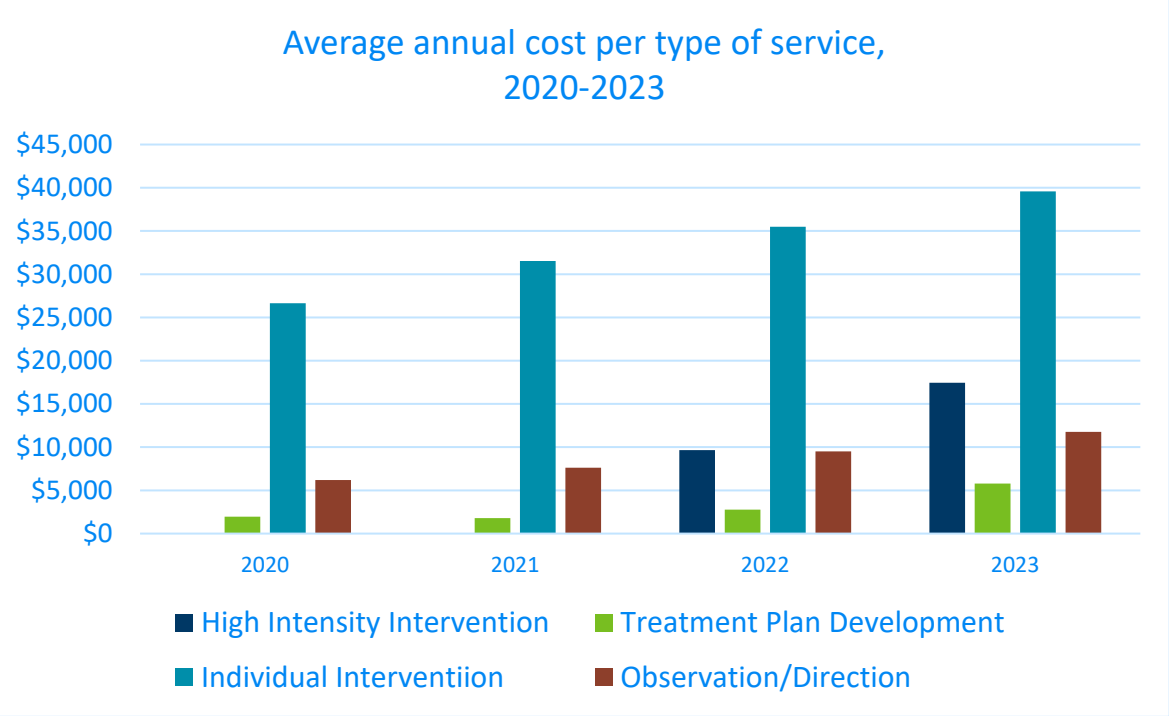
Figure 5: Units billed by provider type



As Figure 5 depicts, the sharpest increase in numbers of units billed has occurred among Level II providers. This has some impact on cost growth as more experienced Level II providers have higher payment rates as compared to Level III providers.

Average annual cost for certain types of EIDBI services have increased significantly over time. It should be noted there are logical reasons for average costs to increase, such as increases in payment rates. A significant occurrence in the evolution of the EIDBI program over time, for example, was the finalization of current procedural terminology (CPT) billing codes in 2018, which drove a jump in average cost in services.

Figure 6: Average cost per service, 2020-2023



Several average cost trends are noteworthy and merit additional examination, particularly in the context of growth in the number of EIDBI provider agencies; how many qualified supervising professionals (QSPs) and advanced certification providers are available to provide clinical supervision; and enormous growth in telehealth claims in the post-pandemic period:

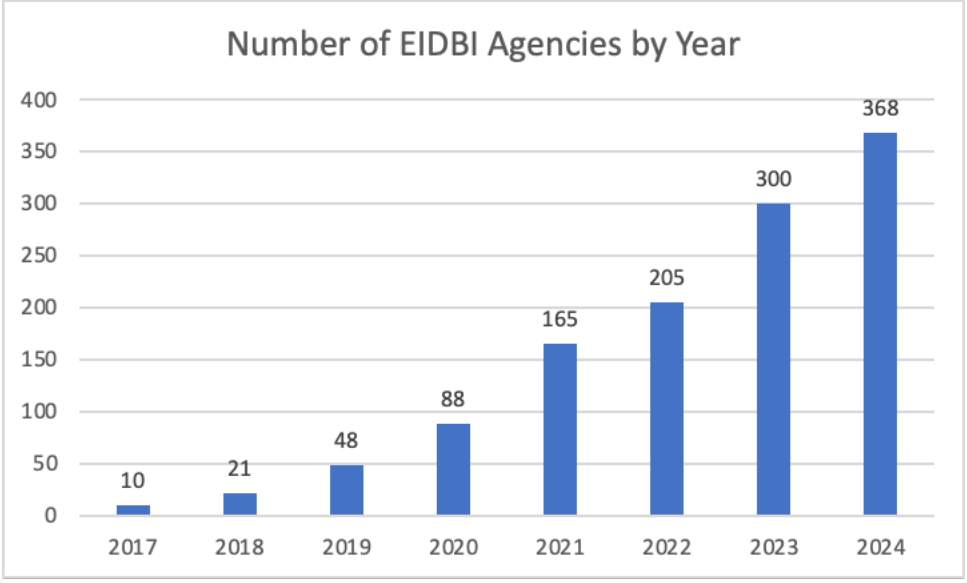
- The average cost for individual intervention services was almost $40,000 per client in 2023.
- The average cost of higher intensity interventions and development of individual treatment plans have grown substantially over the past several years. Average cost for individual treatment plans grew by 54 percent in 2022 and by 109 percent in 2023 as compared to prior year average costs. Average costs for high intensity interventions grew by 81 percent from 2022 to 2023.
- This growth in average cost has occurred when the number of claims made for services provided via telehealth have increased substantially as well. It should be noted growth in telehealth occurred following the COVID-19 pandemic, not during the pandemic. The number of claim lines for “out of home” telehealth services nearly tripled over a two-year period between January 2022 and January 2024.

EIDBI provider agencies

The number of EIDBI provider agencies enrolled as MHCP providers has more than quadrupled over a four-year period from 2020 through 2024.

To date in 2024, approximately 220 provider agencies have provided services and billed for them through MHCP. There are roughly 100 additional provider agencies enrolled through MHCP that are not billing for services. This is a very strong indication the provider agency is not actually providing services. This is a disconcertingly high percentage of EIDBI provider agencies (32 percent) that appear inactive in terms of providing EIDBI services.

Figure 7: Number of EIDBI provider agencies by year



Each provider agency must employ at least one QSP and advanced certification provider to provide clinical supervision for all care provided by less experienced providers at that location. The number of QSPs working in the state is not growing at nearly the same rate as the number of provider agencies. This means the workforce is being stretched over a larger number of EIDBI provider agencies.

As of November 2024, 24 QSPs with out-of-state addresses were registered as MHCP providers, which raises concerns about how knowledgeable those QSPs are about care being provided at a Minnesota EIDBI provider agency (see Appendix 1 for additional details). Eleven of those out-of-state QSPs have an address in a bordering state of North Dakota, South Dakota, Iowa or Wisconsin, while the remaining 13 out-of-state QSPs report addresses as far away as Arizona, Florida, Texas and Georgia. While supervision may legally be provided via telehealth, if a QSP is literally never physically present at a care location, the overall quality of supervision is likely substantially weaker than when an advance certification provider is on site at least some of the time to observe daily clinical operations.

Information about the EIDBI Benefit

Types of EIDBI services

Providers may provide and bill for the following EIDBI services under MHCP:

Comprehensive multidisciplinary evaluation (CMDE)

The CMDE is a first required gateway to services for children with ASD or related condition and who are enrolled in MHCP. This is a diagnostic assessment conducted by a highly trained professional.

Individual treatment plan development and progress monitoring

An individual treatment plan (ITP) is developed for every participant of EIDBI services based on information gathered as part of the comprehensive multidisciplinary evaluation. It summarizes the overall goals and objectives that will be targeted throughout intervention services and specifies the type and intensity of services the child will receive. The ITP service also includes ongoing monitoring of the person's progress. A QSP must create the ITP for each child before a provider may begin to deliver services to that child. Level I and II providers may support the QSP in the initial development of the plan and, over time, in incorporating progress updates in the plan and updating it.

Coordinated care conference

A coordinated care conference is a voluntary meeting between the person who receives services, their family, EIDBI provider(s), other service professionals and/or other people the person/family requests. The purpose of the meeting is to review the comprehensive multidisciplinary evaluation (CMDE) or ITP and integrate and coordinate services across providers and service-delivery systems to develop and implement the ITP.

Intervention – individual, group and higher intensity

Interventions are the medically necessary, intensive and individually designed services delivered to children to achieve goals established as part of their treatment plan. These services may be offered on an individual basis to one child at a time; in a group setting involving two to eight children; or through a higher intensity mode, which may be needed for a child's or provider's safety or both. Higher intensity interventions are distinct because they involve two or more providers implementing therapy with a single child under the direction of an on-site (e.g., in person or via telehealth) and available QSP or Level I provider.

Interventions take place during a "session," which is a defined time period with a predetermined start and end time and involves only the delivery of covered EIDBI services.

Interventions may be delivered in a variety of settings, including in a center, clinic or office, the child's home or another community-based setting such as a school or park.

Intervention observation and direction

Given the varying levels of education and professional expertise of different levels of providers, observation and direction is needed to ensure treatment is being delivered consistent with established clinical protocols and to inform whether any modifications need to be made. This is a clinical service provided for the direct benefit of the person receiving services. A qualified provider offers these services by either working directly with the child (without another EIDBI provider present) to observe behavior changes or troubleshoot treatment or by joining the child and another EIDBI provider during a group, individual or higher-intensity intervention session.

Family or caregiver training and counseling

Family and caregiver training helps parents, caregivers and other family members to support a child receiving EIDBI services at home. Family/caregiver training may involve both direct and indirect activities. Direct family training and counseling includes activities such as spending time with the family/caregiver as they work to put the learned strategies in action to give feedback and support or providing instruction, modeling, feedback and role-playing strategies to teach skills and reduce unwanted behaviors. Indirect family training may include activities such as assisting a parent or caregiver to make calls to the person's case manager or schedule referral appointments or to set up environmental adaptations in a family home, such as visual cues, timers or safety equipment.

Telehealth

Certain EIDBI services may be provided through telehealth as clinically appropriate for the individual and family, including:

- The CMDE
- Coordinated care conferences
- Family/caregiver training and counseling
- ITP development and progress monitoring
- Individual intervention, group intervention and observation and direction.

Travel time

Travel time is covered when an EIDBI provider travels to either a person's home or to a community setting that is not an EIDBI office, center or clinic to deliver any of the following services:

- Family/caregiver training and counseling
- Intervention

- Observation and direction
- Coordinated care conference
- ITP progress monitoring

EIDBI agencies' responsibilities under current law

Although EIDBI provider agencies are not licensed, they are required to carry out certain responsibilities under Minnesota Statutes 256B.0949 to provide services to MHCP enrollees. Prospective owners and managers of EIDBI agencies must complete the MHCP provider enrollment process and demonstrate compliance with federal and state law related to EIDBI services. A complete list of EIDBI provider agency requirements is outlined in Appendix 2[16]. Without licensure, however, there is no mechanism for assessing or enforcing compliance with these standards.

Current process for enrolling as a MHCP EIDBI provider agency

Individuals interested in opening an EIDBI provider agency must successfully complete DHS' provider enrollment process. This involves submitting numerous forms, including an application form, a fee-for-service or HMO in-network provider agreement, disclosure of ownership and control interest form and a provider agency assurance statement to DHS for their review. DHS relies heavily on the provider agency assurance statement at this stage of the process. An agency must employ and list a QSP on the agency quality assurance statement and must pay an application fee. This information may be submitted through the Minnesota Provider Screening and Enrollment portal or by fax. At the individual provider level, Provider Enrollment staff check resumes to verify clinical staff have required degrees; however, they do not comb through resumes to determine whether staff have required field experience.

Providers must ensure a criminal background study using NETStudy 2.0 is completed for all individuals, including subcontractors, volunteers and temporary staff, who will have direct contact with people receiving services or their legal representatives.

Once the application is complete and DHS has finished its review, DHS conducts a site visit within 60 days. The pre-enrollment site visit is quite limited in scope and very different than a licensing site visit. During the pre-enrollment site visit, DHS checks to ensure a physical location exists where services will be provided; verifies ownership and control of the provider entity; and calls the listed QSP to verify the QSP is employed at the provider agency at that specific address. If the provider passes the site visit, the provider becomes an enrolled MHCP provider and is listed in the MHCP provider directory.

[16] Minnesota Statutes 256B.0949

The provider will be considered enrolled for a five-year period, regardless of whether they begin to provide or maintain EIDBI services.

Providers report mixed experiences in working through MHCP provider enrollment processes. The high number of agencies enrolling each month suggests the process is not unduly burdensome. Many providers, however, say the process is confusing and doesn't sufficiently help providers understand what their obligations are either to complete the enrollment process or to get their new center up and running successfully. Providers are also concerned about antiquated technology, such as use of fax machines and what they perceive as slow response times from DHS.

Provider qualifications

DHS specifies roles for both provider agencies and five individual types of providers with varying levels of qualifications and responsibilities in providing EIDBI services. Those individual provider types include CMDEs, QSPs and Level I, II and III providers. CMDEs are not required to be affiliated with a provider agency; however, all other types of providers must be employed by an agency to provide and bill for services. A description of each provider type and requisite qualifications for each are included in Appendix 3.

VII. Issues and recommendations

This next section of the report turns to nine topic areas that should be addressed as part of a licensure process. Each section below explains the topic and provides recommendations on the issue.

Recommendation Topic #1: Health and safety standards for various treatment settings

Health and safety standards include a variety of topics, including sanitation, security, fire safety, medication administration and safeguards against abuse of children receiving services. As compared to licensed DHS programs, EIDBI provider agencies lack required health and safety standards. We strongly recommend that DHS establish such standards for EIDBI provider agencies.

Because of the variety of settings in which EIDBI services are delivered, we recommend proposed health and safety standards to be tailored to the environment in which services are provided. Centers and clinics should be held to a different set of health and safety standards than a home-based environment, which is, of course, in the purview of parents and legal guardians. Individual providers working in both center-based and home settings should also have some safety standards for their benefit.

Facility standards for other licensed programs typically include the following requirements[17]:

- Maintain equipment, vehicles, furniture, supplies and materials in good condition.
- Comply with all applicable state and local fire, health, building and zoning codes.
- Ensure that areas used by participants are free from debris, loose plaster and peeling paint.
- Be kept clean and free from accumulated dirt, grease, garbage, mold and infestations.
- Install handrails and nonslip surfaces on interior and exterior runways, stairways and ramps.
- Keep stairways, ramps and corridors free of obstructions.
- Shield or enclose heating, ventilation, air conditioning units and other hot surfaces and moving parts of machinery.
- Keep exterior stairs and walkways free of ice and snow.
- Maintain a comfortable indoor temperature.
- Keep outside property free from debris and safety hazards.

EIDBI agencies providing center-based services should also be required to abide by these same standards.

[17] Holm–Hansen, Cheryl. “Minnesota EIDBI Benefit Set: Review of human services licensing guidelines.” February 2024.

Table 1: Health and safety standards established for EIDBI in comparison to licensed DHS programs[18]

Health and safety topic	EIDBI	Outpatient mental health[19]	Center child care	Family child care	Adult day center	Foster care	HCBS	Children's residential
Medication administration	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Transportation of participants	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Access to telephones	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Emergency preparedness plan	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Presence of pets/service animals	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Access to first aid kit	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Facility standards for maintenance and upkeep	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

[18] Holm–Hansen, Cheryl. "Minnesota EIDBI Benefit Set: Review of human services licensing guidelines." February 2024. (Table reproduced in its entirety).

[19] While there is less specific guidance in statute related to health and safety standards for outpatient mental health, there is a general requirement that programs have "policies and procedures to ensure the health and safety of each staff person and client during the provision of services, including policies and procedures for services based in community settings."

Health and safety topic	EIDBI	Outpatient mental health[19]	Center child care	Family child care	Adult day center	Foster care	HCBS	Children's residential
Guidelines for food provision and safety	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Sanitation	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Storage of dangerous items	**No**	**No**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

The lack of health and safety standards is particularly disconcerting given that some children with ASD and related conditions are prone to wandering or running away; some may be nonverbal; and many children with ASD have other co-occurring conditions that necessitate administration of medication or potentially put them at greater health risk overall. Facilities should have at least some basic requirements in place to address these issues to protect children and youth receiving services.

Notably, EIDBI service providers involved in the engagement process recommended the establishment of such protocols. In the engagement process, providers gave concrete suggestions for ensuring the safety of children receiving EIDBI services. When asked how to protect children from abuse, providers suggested the following strategies[20]:

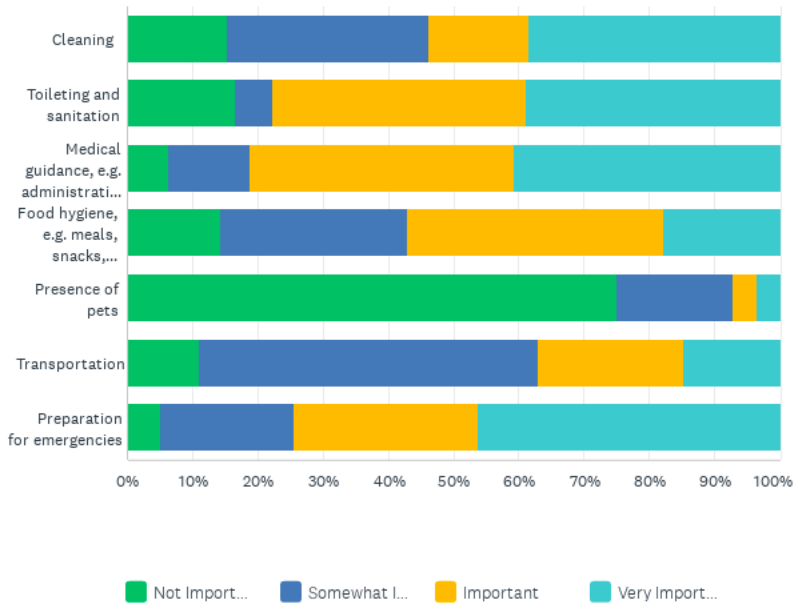
- Require all providers to participate in annual training and professional development focusing on abuse, mandated reporting, alternative restrictive methods and crisis intervention.
- Establish regulatory standards regarding abuse prevention, including credentials, caseload limits, supervision requirements and protocols for identifying, reporting and addressing instances of abuse.
- Require greater oversight of centers and staff (role of supervisors, observation of staff, drop-in site inspections).
- Implement a DHS recertification process, which consists of assessing sites, observation and document review regularly.
- Hire licensed providers who successfully pass background checks and reflect the families served to investigate abuse complaints. Be sure to incorporate caregivers' feedback and communication.

[20] Courageous Change Collective. EIDBI Licensure Study Stakeholder Engagement Report. August 2024.

Although provider agencies are required to conduct background studies on all employees who will have direct contact with children receiving services, DHS does not monitor whether this is happening because EIDBI provider agencies are unlicensed. In a licensing review, DHS licensors conduct an on-site visit, request to see a provider roster of employees and check to see whether people who have contact with clients have passed a background check. Under a system of licensure, DHS has authority to levy fines against a provider for failure to meet these requirements and can take other steps depending on the severity and chronicity of the concerns. For example, a situation in which a very few employees have not undergone a background check would be addressed differently than a facility where the owner and/or most staff had not had a background check conducted. Without licensure, no DHS staff are on site to monitor, much less enforce, this critical safety issue.

More than 70 percent of providers involved in the engagement process said it was either "important" or "very important" for health and safety standards to address medical guidance, toileting and sanitation and preparation for emergencies. At least 50 percent of providers said it was "important" or "very important" for standards to be established for food hygiene and cleaning protocols. Fewer providers were as concerned with standards related to transportation (roughly 35 percent) or the presence of pets (less than 10 percent).

Figure 8: Health and safety issues prioritized by EIDBI providers



Recommendation Topic #2: Investigating, reporting and acting on alleged violations of program standards

It is important to ensure DHS has the authority and tools necessary to conduct proper oversight of EIDBI provider agencies and individual EIDBI providers. Among other issues, DHS currently has no authority to conduct investigations related to alleged child maltreatment incidents. This authority would be provided through licensure or provisional licensure. Licensing would also require more upfront assessment of potential providers and their level of preparedness to offer services and an easier process by which to work with providers on corrective action plans or require them to stop offering services if necessary.

DHS needs both to be able to establish standards related to ethical conduct, data privacy, health and safety and other program standards and the tools to investigate, report and act – swiftly, if necessary – on violations of these standards.

Similarly, a licensing system could create professional obligations for individual EIDBI providers to report alleged violations of program standards directly to DHS. DHS has processes in place to accept, triage and investigate complaints involving service providers it licenses. The same level of established protocols does not exist when providers are unlicensed.

Recommendation Topic #3: Administrative and clinical infrastructure

This section of the recommendations includes proposed requirements for centers related to administrative and clinical infrastructure to support provision of EIDBI services. This includes considerations related to health records; staff support for core administrative and clinical functions; and some basic business operations.

Health records

EIDBI provider agencies are already required to maintain a health record for every person receiving services from that agency and for every service that individual and their family receives. There is no oversight process in place, however, to assess whether such records are being maintained.

Each client's health system record should include foundational information, including:

- Personal information for the person and their legal representative.
- Contact information for the QSP and other primary treating provider(s), including phone numbers.
- Completed, signed and current CMDE.
- Completed, signed and current ITP and progress monitoring.

- Documented preferences of the parent(s) and/or primary caregiver(s) for EIDBI services, including their level of involvement, as identified in the ITP.
- Plan for how to provide clinical supervision and observation and direction to individual providers, when required and as identified in the ITP.
- Progress monitoring notes, data and summary results.
- Information about other services the person or legal representative receives.
- Transition and termination plan, as identified in the person's ITP.
- Signed DHS forms required for each client related to client rights and responsibilities and provider agency responsibilities.
- Case notes.
- Incident reports.

MHCP-enrolled providers may maintain their health record systems either in a paper format or electronically. Electronic health records (EHRs), while more expensive, have numerous benefits. EHRs designed to support EIDBI services prompt particular questions related to treatment of ASD and related conditions. Some EHRs might be integrated across health care provider systems, giving an opportunity to have an integrated electronic medical record for the client. This report does not recommend provider agencies be required to have an electronic medical record because of the expense of such systems. Imposition of such a requirement could be a barrier to entry for operators of EIDBI centers. However, families might be interested to know about whether a provider uses an electronic health record system.

There are no clear standards for how individual providers who work in client homes – and especially for individual providers who work exclusively in client homes – maintain client records. This is even more of an issue if the provider agency does not have an electronic health record system. To the extent providers have any paper documents, those need to be stored in a locked agency environment rather than in the provider's car or the provider's home. Electronic files need to be stored exclusively on an agency's secure system rather than possibly stored on a personal laptop.

DHS could also strengthen use of nonelectronic health record systems by creating a template for case notes for providers to use if they are maintaining client case notes in manual health record systems. Such templates would be helpful because they would include standardized fields for providers to complete.

As noted above, case notes are one of the items to be included in a client's health record. A provider is required to complete a case note for every service provided to a child or the child's family, which should provide a rich data source about services delivered to the child over time.

Table 2: Required contents of a case note[21]

Required contents of case notes	Potential applicable additional information
• Person's name. • Type of service provided (e.g., individual or group intervention, observation and direction, parent training). • Name, title (e.g., QSP, level I) and signature of the provider who delivered the service. • Date the service was provided. • Date the provider added the documentation in the person's health service record. • Session start and stop times. • Summary of the person's progress or response to treatment and any changes in the treatment or diagnosis.	• Coordination with or referrals to other professionals, including each professional's name and date of contact. • Current significant events the person might be experiencing. • Documentation of supervision. • Emergency interventions used. • New behaviors or symptoms. • Parent/primary caregiver concerns. • Protocol modification. • Summary of treatment effectiveness, prognosis, discharge planning, etc. • Test results and medications.

As part of a system of licensure, DHS should have staff with clinical qualifications visit provider agencies; pull a random set of sample files; and assess whether the provider agency is maintaining these types of records. The required contents are a baseline foundation of information about whether provider agencies are ensuring the creation and ongoing maintenance of detailed client files as required, which are needed to ensure a given individual provider understands what services a client needs. This is important across all EIDBI provider agencies, especially given concerns about potential program integrity issues and to provide a baseline assessment of the degree to which medically necessary services are being provided. This type of monitoring would also be helpful on a topic covered later in this report related to ensuring providers are operating within their scope of practice.

Staff capacity for core clinical and administrative functions

Under current program requirements, QSPs must be employed by the agency with whom they work. There are no limits on the number of provider agencies employing the same supervisory provider at the same time. This is emerging as a potential problem as DHS is seeing more supervising providers affiliated with multiple provider agencies or provider agency locations. It is not surprising this is occurring given the significant growth in number of provider agencies enrolling in MHCP; provider agencies are required to have a QSP to become enrolled and there is not proportionate growth in the number of highly trained clinicians to staff all of the new agencies.

[21] Early Intensive Development and Behavioral Intervention Manual - Health service records.

This is a potentially concerning indicator that some supervisory providers might be attempting to provide clinical supervision to too many clients, staff and/or at too many sites. DHS should establish limits related to the number of agencies and/or sites with which a single provider may be employed.

This issue requires substantial exploration and input from interested parties, with consideration given to striking a balance between preserving access (especially in rural areas and underserved communities) and establishing a reasonable maximum number of agencies employing the same QSP and/or advanced certification provider.

Given the numerous responsibilities of EIDBI provider agencies, DHS should also consider requiring provider agencies to have some administrative staff capacity to support the provision of medically necessary services. Mental health provider agencies are required to designate a coordinator, a manager and a compliance officer. DHS should consider requiring EIDBI agencies to have similar types of positions or roles in the agency. Licensing standards should also dedicate at least a portion of a staff person's time (or, for larger centers, requiring a full- time position) to human resources functions. This type of capacity is essential.

DHS should also consider requiring provider agencies to have dedicated support for billing and authorizations. This type of work involves a particular skill set and, importantly, would both help free up provider time to offer services and have another individual be involved manage billing and authorizations. This type of role within an EIDBI provider agency could also manage enrollment and credentialing issues. That capacity is especially helpful for new EIDBI providers without the staff capacity, skill set or time to review enrollment and credentialing requirements and follow the steps. This is even more necessary if a provider wishes to be credentialed with private health insurance agencies and managed care organizations. Each have different credentialing, billing and authorization requirements. This may also be a useful internal control at the EIDBI provider agency level.

Client service support tools

Provider agencies should be required to establish fundamental components necessary for client service, including a functional website, dedicated agency and employee phone numbers and a secure business email system for both sending and receiving communications.

Recommendation Topic #4: Supervision standards

EIDBI services – regardless of treatment modality – are offered by individual providers with varying degrees of experience and professional qualifications. Advanced certification providers need to offer clinical leadership, support and training for less experienced staff. In this tiered staffing model, the services provided by less experienced providers must be monitored by more experienced providers to ensure fidelity with treatment standards and protocols. This supervisory role is critical in the provision and oversight of high quality EIDBI services.

This is also a method by which more highly trained providers can monitor progress of children and youth receiving services to ensure the recommended treatment is effective. Given the shortage of providers, this model of care also extends the reach of available providers while – with proper safeguards – ensures that less experienced providers receive appropriate supervision.

The tiered staffing model has many advantages and can create a pipeline for staff to come into and advance within their position and within an organization as they become more experienced. Advanced certification providers can help train other staff on evolving evidence-based practices. This structure can help create more sustainable organizations with highly competent staff who are supported in their work and have a clear career path with opportunities for advancement, which is essential in a field where staff turnover and "burn out" are common.

Effective supervision is a central component of the tiered staffing model. However, without a system of licensing, DHS has only limited requirements[22] related to how frequently QSPs and advanced certification providers must supervise the care offered by less experienced providers. Providers participating in the engagement process recommended establishing more comprehensive requirements related to clinical supervision. DHS does have guidelines related to clinical supervision, which include the following:

DHS recommends each Level II and Level III provider receive at least one hour of direct clinical supervision per month and additional supervision as required by the EIDBI provider's enrolled level or professional license/board. This minimal recommended amount of supervision is most likely less than the Behavior Analyst Certification Board (BACB) standards suggest, depending on how many hours the Level II or Level III provider is working. The BACB standards suggest that one to two hours of supervision should be provided for every 10 hours of direct treatment using the ABA modality. This level of recommended supervision would include both direct (observing a staff member providing intervention services to a child) and indirect activities, such as facilitating a team meeting, reviewing case notes and data or role playing a new intervention. Table 3 translates the BACB guidelines on clinical supervision intensity for ABA services to staff working various numbers of hours each week.

[22] Under DHS provider shortage variance standards, a Level II provider must receive observation and direction from a QSP or Level I provider at least twice per month until they meet 1,000 hours of supervised clinical experience under the variance one standard or receive observation and direction from the advanced certification provider at least once per week until they meet 1,000 hours of clinical experience under the variance two standard.

Table 3: Translating BACB clinical supervision guidance into monthly comparative benchmarks

Number of hours per week a Level II or III provider provides direct care	Recommended supervision of ABA services per week and per month
30	3-6 hours per week 12 – 24 hours per month
20	2-4 hours per week 8-16 hours per month
10	1-2 hours per week 4-8 hours per month

The BACB suggests that one full-time (meaning working 40 hours per week) board certified behavior analyst might be able to provide 100-150 hours of case supervision each month to support 500-1,500 hours per month of direct treatment. According to the BACB Practice Guidelines, multiple factors affect the number of hours of supervision a BCBA may provide. Those factors range from characteristics about the individual provider (such as level of experience) to support from the provider agency (for example, the degree to which the agency provides administrative support for billing – which, by extension, allows a QSP to spend more of their time on providing supervision), to the needs of individual children receiving treatment. For example, whether the children whose care is being supervised have other co-occurring conditions; where those children are in the treatment process; and/or whether the children are experiencing other changes, such as a divorce of their parents.

While it might be important to provide some flexibility around supervision standards, it is also clear there should be some upper limits around the number of supervisory hours a single QSP may realistically provide.

Supervision provided on site vs. through telehealth

In addition to establishing more specific limits on supervision, we recommend that DHS establish a standard for a portion of supervisory time that must be conducted on site and in person. DHS is seeing some QSPs and advanced certification providers with out-of-state addresses, which raises questions about whether that individual provider is ever on site to meet staff in person, see the facility's environment, conduct some supervision in person and have an overall handle on how the center is run on a day-to-day basis.

This lack of on-site supervision might also occur with advanced certification providers in Minnesota. Supervision may be provided remotely through telehealth, which is essential in the context of provider shortages and especially in rural Minnesota. This report does not recommend eliminating supervision by telehealth; it does, however, recommend that some portion of supervisory time be spent on site at each site and conducting supervision in person at each site where a QSP is employed. There are differences in what a QSP can observe about an EIDBI provider center and its staff if the QSP is never on site.

Recommendation Topic #5: Caseload limits

DHS has no requirements related to the maximum number of clients to be served by a single provider or at each agency and/or location. These numbers might reasonably vary for a number of reasons, including the number of children receiving treatment by a particular location overall; the number of staff and, in particular, the number of supervisory staff employed at each provider agency location; whether children receive the treatment on site vs. at home or in a different community-based setting; and the number of children on site at any one time. It is notable that provider agencies participating in the engagement process recommended establishment of caseload limits.

Options for such limits might include the following approaches:

- Establishing an upper limit on total number of children to be served at a single provider location for center-based services at any one time (for example, physically on site at one time or total patient count at any one time).
- Formalizing a specific upper limit on the ratio of one staff person providing group intervention services to multiple children at any one time, which permit a provider to bill for group interventions involving between two and eight children. While this is already required for billing purposes, it is not otherwise noted as a program requirement or caseload standard.
- Establishing a specific caseload limit for the number of children served in a home and/or community-based setting by a specific provider

Comprehensive programs typically involve 30 to 40 hours of therapy per week, often with clients who have more significant support needs. In this type of program, the BACB recommends a BCBA should manage six to 12 clients. Focused programs, alternatively, involve fewer therapy hours, typically 10 to 25 hours per week and address more specific areas of need (e.g., social skills, communication). In this type of program, a BCBA should manage 10 to 15 clients. We recommend that DHS adopt these standards for caseload size.

Recommendation Topic #6: Treatment modalities and provider qualifications

Minnesota's EIDBI benefit is considerably more flexible than other states when it comes to the types of treatment modalities that may be used and billed for under the EIDBI benefit. Most states permit only applied behavior analysis, while Minnesota allows several additional treatment modalities. The full list of billable treatment modalities permitted under MHCP include:

- Applied behavior analysis (ABA)
- Developmental individual-difference relationship-based model (DIR/Floortime)
- Early start Denver model (ESDM)
- PLAY project
- Relationship development intervention (RDI)
- Early social interaction (ESI).

State statute also permits DHS to adopt revised treatment modalities provided the modalities meet certain criteria, including being evidence-based, individualized and developmentally appropriate among other criteria[23]. Should DHS wish to revise any of the allowed treatment modalities, the department must provide public notice of any proposed changes and conduct a 30-day public comment period on the proposal.

Not all approved modalities are being offered in Minnesota; three of them (Play Project, Early Start Denver Model and ESI) never have been. DHS could consider proposing removal of these from statute. The work needed to become certified in these approaches is substantially less than in ABA.

Other states have taken different approaches and many have not named specific allowable treatment modalities in statute. There are some disadvantages to naming specific modalities in statute, including that removing a modality requires a change in law.

Provider qualifications

The vast majority of Minnesota's EIDBI providers are certified in ABA. It should be noted that providers with advanced certification in modalities other than ABA are required to have substantially less education and training as compared to those with ABA credentials. While this report is not making specific recommendations to adjust any provider qualifications, this might be an area where DHS might consider developing quality metrics across various treatment modalities or agencies offering different approaches to care.

[23] Minnesota Statutes 256B.0949, subdivision 9.

Recommendation Topic #7: Training requirements for EIDBI provider agency staff

Training encompasses both initial competency-based standards and ongoing professional development activities for staff providing EIDBI services to clients. As compared to licensed providers, EIDBI provider staff are required to take substantially less training. This section of the report proposes that EIDBI agency staff should complete more initial and ongoing training than they are currently required to do as described below. These recommendations also propose that EIDBI agencies be required to establish a training plan for their employees, which helps employees anticipate required training and tracks whether employees complete required training. Documentation of the agency training plan and records of whether training was completed should be available during an on-site licensing review.

Initial basic training

EIDBI providers are required to take an initial on-line training offered through DHS after they complete the provider enrollment process. Their training requirements include the following topics:

- Their specific job responsibilities.
- Cultural Responsiveness in Autism Spectrum Disorder (ASD) Services.
- Vulnerable Adults Mandated Reporting (VAMR) online training and exam.
- Mandated Reporting Training – Minnesota Child Welfare Training Academy.
- Client rights and protections.
- Person-centered/family-centered care.
- State policy with respect to restraints, time out and seclusion.

DHS also strongly recommends all EIDBI providers take the following training:

- ASD Strategies in Action (especially helpful for providers on variances or with limited clinical experience and currently required for Level III providers).
- EIDBI 101: Overview of the Benefit (currently required for Level III providers).
- Coordinating Services and Supports for a Child with ASD or Related Conditions.
- Telehealth for Early Intervention.

Table 4 compares training requirements of EIDBI to those of other DHS licensed programs. It shows that EIDBI providers are required to take substantially fewer trainings when they are first hired by a center as compared to providers working in other types of licensed DHS programs. For example, operators of center-based child care are required to have initial training in a total of 14 areas, some of which overlap with EIDBI and some of which are different. Providers participating in the engagement process as part of this work supported expanding EIDBI provider training requirements, especially related to first aid/CPR and other training.

Table 4 : A comparison of topics required to be included in initial provider training across select DHS programs[24]

Orientation topics	EIDBI	Outpatient mental health	Center child care	Family child care	Adult day	Foster care	HCBS	Children's residential
Overview of agency and services	No	No	Yes	No	Yes	Yes	Yes	Yes
Specific job responsibilities	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Vulnerable adult/maltreatment of minors	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Drug and alcohol policies	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Emergency procedures/incident reporting	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Client rights and protections	Yes	Yes	No	No	Yes	Yes	Yes	Yes
Data privacy	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Health and safety procedures	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Professional boundaries	No	Yes	No	No	No	No	No	No
Behavior guidance standards	No	No	Yes	Yes	No	Yes	No	Yes
Infant safety guidelines	No	No	Yes	Yes	No	Yes	No	Yes

[24] Table 4 is taken in its entirety from Holm–Hansen, Cheryl. "Minnesota EIDBI Benefit Set: Review of human services licensing guidelines." February 2024.

Orientation topics	EIDBI	Outpatient mental health	Center child care	Family child care	Adult day	Foster care	HCBS	Children's residential
First aid/CPR	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Child development	No	Yes	Yes	Yes	No	No	No	Yes
Proper use and installation of child restraint systems in motor vehicles.	No	No	Yes	Yes	No	No	No	Yes
Mental health (e.g., crisis response, de-escalation, suicide intervention)	No	Yes	No	No	No	No	Yes	Yes
Fetal alcohol spectrum disorders	No	Yes	No	No	No	Yes	No	No
Trauma-informed care/secondary trauma	No	Yes	No	No	No	No	No	Yes
Person-centered/family-centered care	Yes	Yes	No	No	Yes	Yes	Yes	Yes
Co-occurring substance use disorders	No	Yes	No	No	No	No	No	Yes
Culturally responsive treatment practices	Yes	Yes	Yes	Yes	No	No	Yes	Yes
Restraints, time out and seclusion	Yes	No	No	No	Yes	Yes	Yes	Yes
Allergy prevention and response	No	No	Yes	Yes	Yes	No	Yes	No
Activities of daily living (residential care)	No	No	No	No	Yes	Yes	Yes	Yes

Orientation topics	EIDBI	Outpatient mental health	Center child care	Family child care	Adult day	Foster care	HCBS	Children's residential
Medication administration	No	No	Yes	Yes	Yes	Yes	Yes	Yes
Strategies to minimize risk of sexual violence	No	No	No	No	No	No	Yes	Yes
Use of needed medical equipment	No	No	No	No	Yes	Yes	Yes	Yes

Ongoing training and professional development

Individual providers in other licensed programs are required to take between 18 and 24 hours of training each year to stay current on developments in their field and/or to take refresher training on key topics. EIDBI provider staff currently have no ongoing annual training requirements for EIDBI services (although some providers may have training requirements through their licensing or certification board). It is recommended that EIDBI providers also participate in 18-24 hours of annual training or have the option to demonstrate knowledge on the required topics to bypass the training requirement. This is especially important because some EIDBI treatment modalities require substantially less training to obtain initial certification, making ongoing training even more critical. Providers already completing training through their licensing or certification boards should be able to count that training, so long as they provide documentation of it to their provider agency. In addition to training requirements, foster care programs and home and community-based programs are required to conduct knowledge testing or direct observation of staff as part of ongoing performance evaluations.

Recommendation Topic #8: Verifying licensure and/or certification and scope of practice

EIDBI agencies should be required to collect and maintain documentation verifying licensure, certification or other credentials of individual providers employed by the agency. Agencies need to ensure staff have obtained the proper education and training required to provide clinical supervision or to provide other levels of EIDBI services.

During a licensing review, DHS should examine the agency's employee roster to ensure all providers – and especially those working in a supervisory capacity – have obtained and maintained the credentials necessary for their level and have completed a required background study.

Agencies should regularly update their employee rosters for MHCP provider enrollment records to ensure DHS has reasonably current information about individual providers and at which provider agencies they are employed.

Some level of clinical auditing is also recommended as part of a licensure process. This would help to ensure providers are working within their scope of practice and to ensure other aspects of care are being carried out as designed in the client's individual treatment plan. For example, a required component of a licensing review could be to pull a sample of patient records to do the following:

- Ensure an appropriate level of detail is being captured in a child's progress notes.
- Assess whether the services being delivered are consistent with the modality and intensity level (number of hours) recommended in the treatment plan.
- Monitor whether the child is making progress with the services being offered.
- Ensure appropriate clinical supervision is occurring by the right level of professional.

Recommendation Topic #9: Removing providers from MHCP provider directories and enrollment based on inactivity

Historically, DHS monitored activity levels of providers to keep the enrolled provider list more current with only active providers. If DHS noted a provider had not billed over a considerable period, DHS would reach out to the provider to inquire about their intent to provide services to MHCP enrollees and subsequently disenroll them if the provider did not respond to the inquiry. DHS has revisited that policy across all MHCP providers and no longer conducts this process.

DHS conducts a periodic revalidation process for MHCP providers. If a provider fails to participate in the revalidation process, they are removed from the provider directory. Every MHCP provider type is assigned a risk level that helps determine how frequently this revalidation process must occur. EIDBI providers are currently assigned a "moderate" risk level, which means that after the provider enrolls and a site visit is done, their revalidation process will occur every five years. More monitoring will occur if there are concerns about fraud.

Given some of the challenges with EIDBI provider agencies completing the enrollment process, but not becoming operational and billing for services, it might be helpful for DHS to revisit its internal process for removing inactive providers. One strategy, for example, would be to advise prospective providers that DHS anticipates active providers to bill for services and that providers may be disenrolled from MHCP if they haven't billed for any services over a considerable period. According to DHS data, approximately 100 out of 315 EIDBI provider agencies have not been associated with a claim for services in the past year. This means roughly 32 percent of all EIDBI provider agencies listed in the MHCP provider directory are not actively providing services.

Licensing would create tools for DHS to keep its roster and directory of enrolled providers current. Minnesota Statutes 245A.044 provides authority to close a provider's license if the commissioner determines that a licensed program has not been serving any client for a consecutive period of 12 months or longer.

VIII. Planning and implementing a system of licensure

Key questions

This section of the report identifies key questions policymakers would need to consider if the Legislature granted authority to DHS to create a system of licensure for EIDBI provider agencies. DHS has substantial experience in developing and implementing other systems of licensure that would inform how the agency could approach this work for EIDBI provider agencies.

Should DHS adapt an existing licensing framework or design a new approach for EIDBI agencies?

Minnesota Statutes, chapter 245A is the Human Services Licensing Act. This is the basis for all DHS licensed programs, of which EIDBI provider agencies would be a part should the Legislature decide to give DHS authority and resources to license them. This chapter covers all foundational components of licensure, including who must be licensed, the application procedures, general record keeping, change of ownership, sanctions and appeal rights and maltreatment reporting requirements for vulnerable adults and children. Additional chapters of Minnesota Statutes, chapter 245 have been created over time to specify licensing requirements applicable to certain providers.

Should the Legislature provide DHS authority to license EIDBI providers, a decision would need to be made on whether an existing framework (likely either 245D for home and community-based services or 245I for uniform service standards for mental health) can serve as the foundation for licensure or whether a wholly new licensing structure is needed.

EIDBI does not fit neatly into any existing licensing framework. Choosing either 245D or 245I as the basis for EIDBI licensure would be strongly preferable to child care licensing, as that work will move to the Department of Children, Youth and Families whereas programmatic leadership for MHCP remains at DHS.

Decision-making on this issue requires a more in-depth look at how closely EIDBI services compare to mental health services or home and community-based waiver services, especially, for example, on issues such as development of treatment plans or clinical supervision. Another consideration is that EIDBI services, designed to treat ASD and related conditions that are considered neurodevelopmental disabilities, are currently part of the Disability Services Division. This is the same division within DHS overseeing home and community-based services.

It might make more sense for EIDBI services to be licensed like mental health services; however, mental health service oversight occurs in the Behavioral Health Division. There is also an enormous amount of work being done related to uniform service standards licensing implementation and it is perhaps too much to add EIDBI provider agencies to that system of licensing.

In addition, incorporating licensure of EIDBI provider agencies into a mental health licensing framework might take longer to execute for EIDBI agencies given the significant work still needed to complete licensure for mental health service providers.

Given the issues being raised related to EIDBI services, it is important to move forward expeditiously, choose a path and ensure DHS has the resources to design and implement a new system.

Implementation timeframes for existing vs. new provider agencies

At present, there are almost 400 EIDBI provider agencies enrolled as MHCP providers of EIDBI services. That number is likely to grow over time and, if recent trends persist, might continue to grow rapidly. It is likely to be very challenging to bring all agencies under licensure at a single point in time as well as new EIDBI provider agencies. It might be helpful to establish criteria for prioritizing which agencies are required to obtain licenses first. For example, DHS could first require new EIDBI provider agencies to become licensed before becoming operational and then move on to existing EIDBI provider agencies (and, perhaps establishing additional categories or prioritization among existing agencies). For new providers, licensing typically occurs before provider enrollment. DHS should consider provisional licensure, while working toward a full licensure framework.

High level timeline to implement licensure

Development of licensure would be a complex undertaking that would occur over a multiyear period. The high-level steps that would need to occur for DHS to implement licensure include the following:

2025:

- Developing and implementing full licensure would take significant time and resources. It would take DHS at least two years to begin issuing licenses. The Legislature could create authority for a provisional license as an interim regulatory measure while full licensure is developed.
- The Legislature would need to provide DHS authority to license EIDBI provider agencies. The Legislature would also need to appropriate sufficient funding to DHS to support a design team process to develop detailed requirements and future funding to support staffing levels needed to implement licensure. This could potentially happen in the 2025 legislative session.
- DHS would need to engage providers, participants and other interested parties in specifying program standards to be used in the licensure process. DHS would likely need to hire a new FTE staff person and potentially a technical contract to lead this work. DHS could begin the process after the conclusion of the 2025 legislative session.

2026:

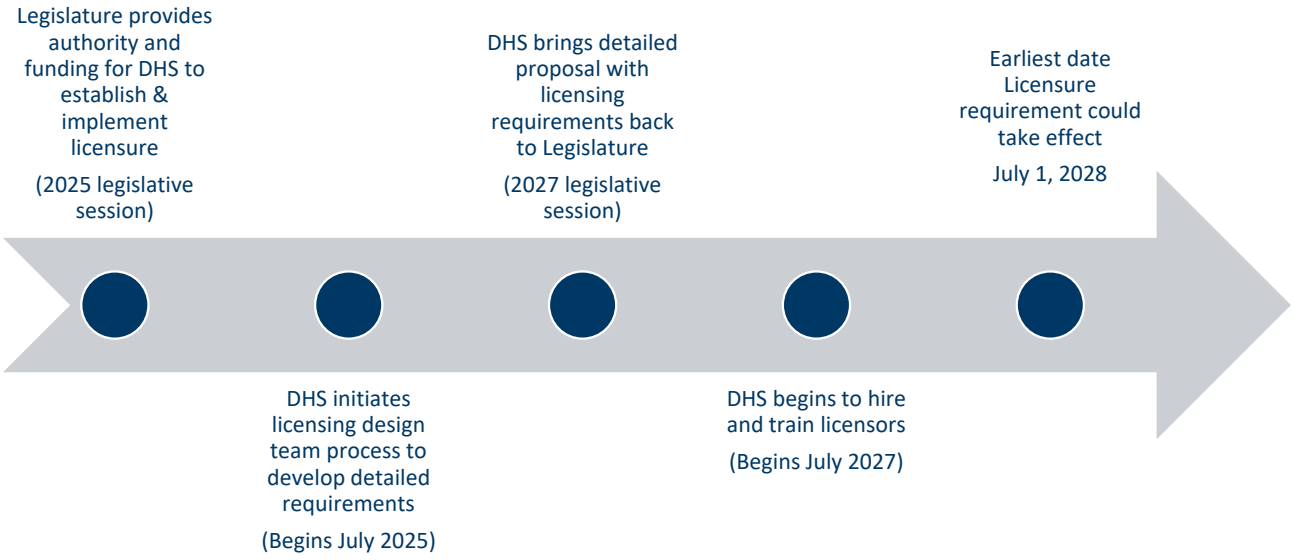
- DHS would continue its process of building detailed requirements with interested parties and develop a detailed legislative proposal for consideration in the 2027 legislative session.

2027:

- DHS would come back to the Legislature with a detailed set of proposed requirements for the 2027 session for the Legislature's consideration after the detailed public input process.
- If the Legislature approved the more detailed requirements and funding for additional FTEs to support licensure implementation, DHS could begin to hire and train new staff after the 2027 legislative session.
- In addition to hiring new staff, DHS and MNIT would need to work together to adapt the state's electronic licensing system to accommodate EIDBI provider agency licensing requirements.

2028:

- The earliest it would be feasible for the new licensure requirement to take effect would be July 1, 2028, and that timeline might be ambitious.



DHS resource needs to implement licensure

DHS would need significant resources to successfully implement a new licensing system for EIDBI provider agencies. A future system of licensure would involve several components:

- A web-based system by which a prospective provider locates necessary application materials and access to an electronic portal to submit completed forms and pay application fees. This portal exists and might need modification for EIDBI-specific protocols.
- DHS licensing staff reviewing applications and supporting materials to first determine if the application is complete and then to review the material.
- Prospective providers also will need to participate in a background study, ideally before they are able to enroll as MHCP providers.
- Licenses are typically issued after a licensing application has met requirements and no problematic issues surfaced during the background study process.
- An on-site licensing review typically occurs within the first year a program is open (but not before the program becomes operational).
- The on-site review would allow both licensing staff to perform most aspects of the review and program staff to monitor how clinical services are being provided through an examination of client files.

Policymakers would need to anticipate both one-time and on-going costs to implement and maintain licensing.

- One-time funding would be needed to pay for information technology systems development and infrastructure along with ongoing funding for maintenance; legal services; and support to engage external partners in designing licensing requirements. Additional FTEs would be required for background studies, program integrity, legal and data.
- Ongoing costs would include staffing to pay for new FTE positions. The Licensing Division would need an estimated 30+ full time equivalent (FTE) positions to implement licensure for EIDBI agencies. The Disability Services Division at DHS, which oversees the EIDBI benefit, would also need to hire additional program staff to conduct the clinical oversight components of site visits.
- Funding will be needed to support a design team process to put detailed licensing requirements together and to hire and train employees to carry out the licensing process. Given growth in the number of EIDBI provider agencies, a preliminary conservative estimate of the number of entities to go through a licensing process is 500.

It is important that any new system of licensure be based on electronic licensing systems rather than starting in a more manual, paper-based process and later migrating to electronic-based processes.

IX. Interim strategies to enhance oversight

Given it will take at least into mid-2028 to implement licensure, both the Legislature and DHS should also consider additional strategies for clarifying requirements for EIDBI provider agencies. Additionally the Legislature and DHS should consider creating a provisional license for EIDBI agencies as a way to enhance monitoring and compliance while a full license is developed. These strategies are in no way a substitute for licensure and should not be interpreted as such; however, to the extent that clarifications in the EIDBI statute could provide DHS a stronger basis for exercising its existing authorities, those measures would be useful steps. In addition, DHS should use its existing authorities more extensively to strengthen oversight of EIDBI provider agencies and staff.

Recommendations for DHS to consider include the following:

Provider enrollment

- Leverage existing authorities for MHCP provider enrollment processes to review EIDBI agencies as frequently as possible. Every MHCP provider type is assigned one of three risk levels (limited, moderate or high) that determines the frequency and methods by which the provider is monitored. EIDBI providers are currently assigned a "moderate" risk level, which means that after the provider enrolls and a site visit is completed, their reverification site visit will happen every five years. More monitoring will occur if there are concerns about fraud. DHS should revisit this risk designation and adjust the risk level for EIDBI providers from "moderate" to "high." The impact of this change in designation would increase the frequency of reverification site visits from a five-year cycle to a three-year cycle.
- Redesignation of risk level to "high" risk would also leverage other types of monitoring, including criminal background checks using fingerprinting.
- Consider resequencing some aspects of the MHCP provider enrollment process for EIDBI agencies so that prospective agency operators take more training before being designated as an MHCP provider. This would help prospective providers be much more aware of what they are required to do, which should help inform decisions about whether they are prepared to own and operate an EIDBI agency. And, while the MHCP provider enrollment process should not be made unduly burdensome to applicants, inserting a value-added step in the process may help incent only those who are ready to take on the challenging work of running an EIDBI provider agency to complete the MHCP enrollment process. Owners and managing employees of personal care assistant agencies, designated as high-risk providers, are required to take a three-day Steps for Success orientation training.
- Consider revisiting current practice for inactive EIDBI provider agencies included in the MHCP provider directory with the goal of removing inactive providers from the provider directory. Given the high rate of inactive EIDBI provider agencies included in the MHCP provider directory

and the difficulty this creates for families searching for an EIDBI provider, DHS should consider reaching out to inactive provider agencies; ask them to respond affirmatively if they would like to continue their enrollment as MHCP providers; and disenroll them if DHS does not receive a response to its inquiry.

- This would help families looking for provider agencies to have a more current provider directory and, if the numbers of MHCP EIDBI provider agencies is reduced, would also help DHS have more accurate estimates of the number of EIDBI agencies that might seek licensure down the road and therefore a more accurate projection of DHS staffing needs to support that work.

Table 5: A comparison of MHCP screening actions by designated risk levels[25]

Provider Enrollment screening action	Risk level: Limited	Risk level: Moderate	Risk level: High
Provider-specific requirements verification	Yes	Yes	Yes
Licensure verification. if applicable	Not applicable currently to EIDBI agencies	Not applicable currently to EIDBI agencies	Not applicable currently to EIDBI agencies
Database checks to screen for potential issues (verify NPI and check HHS OIG exclusion list, excluded parties list system, death of individual with ownership or control interest, termination by Medicare or another state's program).	Yes	Yes	Yes
Unscheduled or unannounced site visits	No	Yes	Yes
Criminal background check (based on fingerprints)	No	No	Yes
Fingerprinting	No	No	Yes

[25] Minnesota Department of Human Services' website.

Program Integrity Oversight Division

- Analyze administrative and billing data to help identify potential program integrity concerns, such as managed care organization encounter data and fee-for-service billing data to identify unusual patterns, such as higher than normal billing of units or outliers on proportion of services billed as telehealth. These data points could be cross-referenced in a comparison of EIDBI agencies with out-of-state QSPs/advanced certification providers or with QSPs/advanced certification providers affiliated with multiple EIDBI provider agencies.
    - In the event concerns about specific provider agencies materialize in such analyses, DHS could conduct targeted site visits to EIDBI provider agencies to investigate their concerns. DHS could leverage other MHCP provider requirements when conducting targeted site visits or revalidation site visits and assess whether medical records are being maintained as required and whether services being delivered are outlined in a client's ITP.
    - DHS could consider whether there are opportunities to conduct prepayment review where they have particular concerns about an EIDBI provider agency.
- Consider whether working with managed care organizations and encounter data would provide any additional capabilities for monitoring for potential program integrity concerns.

Further leveraging current authorities to monitor EIDBI provider agencies will help assess current program integrity concerns and increase public confidence and trust in DHS' commitment to ensuring the services being provided are high-quality, regulated and safe for those in the community. These steps would also require additional resources for new FTE positions in the Program Integrity Oversight Division and provider eligibility and compliance to implement these strategies.

Legislative considerations

- The Legislature could consider adding some requirements to the EIDBI statute this session to specify that QSPs and advanced certification providers must live or have an office in Minnesota or a bordering state. The Legislature could also limit the number of EIDBI provider agencies with whom a single QSP or advanced certification provider may be employed by at the same time.

X. Conclusion and recommendation summary

This report strongly recommends the Legislature provide DHS the authority and resources to establish and implement EIDBI provider agency licensure. Stronger program requirements and enforcement mechanisms are needed to protect EIDBI client safety and well-being.

This report provides licensing recommendations in nine areas:

1. Health and safety standards

- Licensing standards should emphasize safety and prevention of abuse of children.
    - All providers should participate in annual training and professional development focusing on abuse, mandated reporting, alternative restrictive methods and crisis intervention.
    - Standards should establish protocols for identifying, reporting and addressing instances of abuse.
- A system of licensure should require EIDBI provider agencies to meet facility physical plant safety guidelines commonly applicable to other DHS licensed programs. Examples of these standards include the following:
    - Maintain equipment, vehicles, furniture, supplies and materials in good condition.
    - Comply with all applicable state and local fire, health, building and zoning codes.
    - Ensure that areas used by participants are free from debris, loose plaster and peeling paint.
    - Facilities should be kept clean and free from accumulated dirt, grease, garbage, mold and infestations.
- Facility standards should also address the potential for children with ASD and related conditions to wander or run away and how to safeguard against this potential while maintaining compliance with fire codes.
- Standards should also be in place related to medication administration, toileting and sanitation, preparation for emergencies, food hygiene, cleaning protocols and storage of dangerous items.
- Standards should be tailored for home environments and account for safety of individual providers working in client homes. In this type of environment, for example, it might be important to have policies related to pets as well as storage of dangerous items.

2. Investigating, reporting and acting on alleged violations of program standards

- DHS should establish standards related to ethical conduct, data privacy, health and safety and other program standards and the tools to investigate, report and act – swiftly, if necessary – on violations of these standards. This can be accomplished through licensing.
- DHS currently has no authority to conduct investigations related to alleged child maltreatment incidents and a licensing system needs to provide DHS this authority.
- A licensing system should create professional obligations for individual EIDBI providers to report alleged violations of program standards directly to DHS.
- Licensing provides an easier process by which to work with providers on corrective action plans, levy fines or require them to stop offering services if necessary.

3. Administrative and clinical infrastructure

Health records

- EIDBI provider agencies are required to maintain a health record for every person receiving services from that agency and for every service that individual and their family receives. This is critical information for treatment planning, clinical supervision and monitoring client progress. As part of a system of licensure, DHS should have staff with clinical qualifications visit provider agencies; pull a random set of sample client files; assess whether the provider agency is maintaining these types of records; and the extent to which these records document provision of medically necessary services.
- Clear standards should be established for how and where individual providers who work in client homes – and especially for individual providers who work exclusively in client homes – maintain and store client health records and ensure clinical supervisors have access to those records.
- DHS could also strengthen use of nonelectronic health record systems by creating a template for case notes for providers to use if they are maintaining client case notes in manual health record systems.

Clinical capacity

- Under current program requirements, QSPs must be employed by the agency with whom they work. There are no limits on the number of provider agencies employing the same supervisory provider at the same time. DHS should establish limits related to the number of agencies and/or sites with which a single provider may be employed.
- DHS should require QSPs to live or have an office in either Minnesota or a bordering state.

- DHS should specify that clinical supervision must include direct supervisory activities (and not just documentation review) for every client receiving EIDBI services.
- DHS should limit the amount of supervision that can be conducted solely be telehealth, while keeping in mind provider shortages in rural areas and underserved communities. Requiring some amount of on-site supervision is needed to ensure a QSP can see daily clinic operations in action and is able to observe how care is provided, physical facilities, etc.

Administrative capacity and business operations

- Given the numerous responsibilities of EIDBI provider agencies, DHS should also consider requiring provider agencies to have some administrative capacity to support the provision of medically necessary services:
    - Mental health provider agencies are required to designate a coordinator, a manager and a compliance officer. DHS should consider requiring EIDBI agencies to have manager and coordinator roles like those of mental health provider agencies. EIDBI provider agencies should also dedicate at least a portion of a staff person's time (or, for larger centers, require a full- time position) to human resources functions.
    - DHS should require EIDBI provider agencies to have dedicated support for billing, authorizations and provider credentialing.
    - Provider agencies should be required to establish fundamental components necessary for client service, including a functional website, dedicated agency and employee phone numbers and a secure business email system for both sending and receiving communications.

4. EIDBI provider agency staff training requirements

- EIDBI provider staff currently have fewer initial training requirements as compared to providers working in licensed programs. EIDBI providers should have stronger initial training requirements, including all current training requirements and training on at least the following topics:
    - Health and safety standards
    - Emergency procedures/incident reporting
    - Child development
    - Mental health
    - Medication administration
    - CPR/First aid.

- EIDBI provider staff currently have no annual ongoing professional development or training requirements. We recommend that EIDBI providers participate in 18-24 hours of annual training or have the option to demonstrate knowledge on the required topics to bypass the training requirement.

5. Supervision standards

- DHS should establish specific supervision requirements and specify that one to two hours of supervision should be provided for every 10 hours of direct treatment using the ABA modality.

6. Caseload limits

- DHS should establish limits on the number of clients a single BCBA can serve.
    - In a more intensive program where clients receive 30 to 40 hours of therapy per week, a BCBA should manage six to 12 clients.
    - In a focused program, through which clients participate in therapy 10 to 25 hours per week, a BCBA should manage 10 to 15 clients.

7. Treatment modalities and provider qualifications

- The Legislature should consider narrowing the list of approved modalities for EIDBI service provision in Minnesota. Not all approved modalities are being offered in Minnesota; three of them (Play Project, Early Start Denver Model and ESI) never have been. The work needed to become certified in these approaches is substantially less than in ABA.
- The vast majority of Minnesota's EIDBI advanced providers are certified in ABA. It should be noted that providers with advanced certification in modalities other than ABA are required to have substantially less education and training as compared to those with ABA credentials. While this report is not making specific recommendations to adjust any provider qualifications, this might be an area where DHS might consider developing quality metrics across various treatment modalities or agencies offering different approaches to care.

8. Verifying required qualifications and scope of practice

- Agencies should be required to collect and maintain documentation verifying licensure, certification or other credentials of individual providers employed by the agency:
    - During a licensing review, DHS should examine the agency's employee roster to ensure all providers – and especially those working in a supervisory capacity – have obtained the credentials necessary for their level and have completed a required background study.

- Agencies should regularly update their employee rosters for MHCP provider enrollment records to ensure DHS has reasonably current information about individual providers and at which provider agencies they are employed.
- We also recommend some level of clinical auditing as part of a licensure process. This would help to ensure providers are working within their scope of practice and to ensure other aspects of care are being carried out as designed in the client's individual treatment plan.

9. Removing inactive providers from MHCP provider directory

- Licensing should provide DHS specific authority for how to keep its provider roster more current for EIDBI provider agencies. Mechanisms should be available for removing inactive provider agencies from the MHCP provider directory while assuring due process considerations for providers.

Interim measures

DHS and the Legislature should also consider other interim measures they can take to improve oversight of EIDBI provider agencies until licensure can be implemented.

Recommendations for DHS to consider include the following:

- Leverage existing authorities for MHCP provider enrollment processes to review EIDBI agencies as frequently as possible. EIDBI providers are currently assigned a "moderate" risk level, which means that after the provider enrolls and a screening site visit is completed, their reverification site visit will happen every five years. DHS should revisit this risk designation and adjust the risk level for EIDBI providers from "moderate" to "high." The impact of this change in designation would increase the frequency of reverification site visits from a five-year cycle to a three-year cycle.
- Redesignation of risk level to "high" risk would also leverage other types of monitoring, including criminal background checks using fingerprinting.
- Consider resequencing some aspects of the MHCP provider enrollment process for EIDBI agencies so that prospective agency operators take more training prior to being designated as an MHCP provider.
- DHS should screen more specifically for whether EIDBI provider staff have attained requisite hours of experience needed for each provider level qualification. It should be noted this may be challenging to implement but is important in terms of understanding whether provider staff have the experience needed to qualify for the role.
- Consider revisiting current practice for inactive EIDBI provider agencies included in the MHCP provider directory with the goal of removing inactive providers from the provider directory.

- DHS should proactively analyze administrative and billing data to help identify potential program integrity concerns, such as managed care organization encounter data and fee-for-service billing data to identify unusual patterns, such as higher than normal billing of units or outliers on proportion of services billed as telehealth. These data points could be cross-referenced in a comparison of EIDBI agencies with out-of-state QSPs or advanced certification providers or with QSPs or advanced certification providers affiliated with multiple EIDBI provider agencies.
    - In the event concerns about specific provider agencies materialize in such analyses, DHS could conduct targeted site visits to EIDBI provider agencies to investigate their concerns. DHS could leverage other MHCP provider requirements when conducting targeted site visits or re-enrollment site visits and assess whether medical records are being maintained as required and whether services being delivered are outlined in a client's ITP.
    - DHS could consider whether there are opportunities to conduct prepayment review where they have particular concerns about an EIDBI provider agency.
    - DHS should consider whether working with managed care organizations and encounter data would provide any additional capabilities for monitoring for potential program integrity concerns.
- The Legislature could consider adding some requirements to the EIDBI statute this session to specify that QSPs and advanced certification providers must live or have an office in Minnesota or a bordering state. The Legislature could also limit the number of EIDBI provider agencies with whom a single QSP or advanced certification provider may be employed by at the same time.

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Appendix 1: Number of QSPs registered with out-of-state addresses by state

State	Number of QSPs providing supervision with registration address in that state
Arizona	2
Florida	2
Georgia	1
Illinois	1
Iowa	2
Massachusetts	1
Missouri	2
North Dakota	1
Oregon	1
South Dakota	1
Texas	1
Utah	1
Virginia	1
Wisconsin	7

Appendix 2: Current EIDBI agency requirements

Although EIDBI provider agencies are not licensed, they are required to carry out certain responsibilities under Minnesota Statutes 256B.0949 in order to provide services to MHCP enrollees:

- Enroll as a medical assistance MHCP provider according to Minnesota Rules, part 9505.0195 and Minnesota Statutes, section 256B.04, subdivision 21 and meet all applicable provider standards and requirements.
- Demonstrate compliance with federal and state laws for EIDBI service.
- Verify and maintain records of a service provided to the person or the person's legal representative as required under Minnesota Rules, parts 9505.2175 and 9505.2197.
- Demonstrate that while enrolled or seeking enrollment as an MHCP provider the agency did not have a lead agency contract or provider agreement discontinued because of a conviction of fraud; or did not have an owner, board member or manager fail a state or federal criminal background check or appear on the list of excluded individuals or entities maintained by the federal Department of Human Services Office of Inspector General.
- Have established business practices including written policies and procedures, internal controls and a system that demonstrates the organization's ability to deliver quality EIDBI services.
- Have an office located in Minnesota or a border state.
- Conduct a criminal background check on an individual who has direct contact with the person or the person's legal representative.
- Report maltreatment according to section 626.557 and chapter 260E.
- Comply with any data requests consistent with the Minnesota Government Data Practices Act, sections 256B.064 and 256B.27.
- Provide training for all agency staff on the requirements and responsibilities listed in the Maltreatment of Minors Act, chapter 260E and the Vulnerable Adult Protection Act, section 626.557, including mandated and voluntary reporting, nonretaliation and the agency's policy for all staff on how to report suspected abuse and neglect.
- Have a written policy to resolve issues collaboratively with the person and the person's legal representative when possible. The policy must include a timeline for when the person and the person's legal representative will be notified about issues that arise in the provision of services.
- Provide the person's legal representative with prompt notification if the person is injured while being served by the agency. An incident report must be completed by the agency staff member in charge of the person. A copy of all incident and injury reports must remain on file at the agency for at least five years from the report of the incident.
- Before starting a service, provide the person or the person's legal representative a description of the treatment modality that the person shall receive, including the staffing certification levels and training of the staff who shall provide a treatment.
- When delivering the ITP and annually thereafter, an agency must provide the person or the person's legal representative with:
    - A written copy and a verbal explanation of the person's or person's legal representative's rights and the agency's responsibilities.
    - Documentation in the person's file the date that the person or the person's legal representative received a copy and explanation of the person's or person's legal representative's rights and the agency's responsibilities.

- Reasonable accommodations to provide the information in another format or language as needed to facilitate understanding of the person's or person's legal representative's rights and the agency's responsibilities.

Appendix 3. EIDBI provider levels and required qualifications

Provider level	Required qualifications
CMDE	To qualify as a comprehensive multidisciplinary evaluation (CMDE) provider, a professional must meet all of the following requirements: 1. Be either: • A licensed physician, advanced practice registered nurse (APRN) or mental health professional as defined in Minn. Stat. §245I.04, subd. 6. • A mental health practitioner who meets the requirements of a clinical trainee as defined in Minn. Stat. §245I.04. 2. Have either: • At least 2,000 hours of clinical experience in the evaluation and treatment of people with autism spectrum disorder (ASD) and/or related conditions. • Completed the equivalent in graduate-level coursework (refer to equivalent coursework section) at an accredited college or university. Note: Coursework must be documented in one or more of the following areas: ASD or a related condition diagnosis, ASD or a related condition treatment strategies or child development. 3. Be able to diagnose, evaluate and/or provide treatment within their scope of practice and license.
Qualified supervising professional	To qualify as a qualified supervising professional (QSP), a person must meet all the following requirements: 1. Be employed by an EIDBI provider agency. 2. Be a physician, advanced practice registered nurse (APRN), developmental or behavioral pediatrician or licensed mental health professional as defined in Minn. Stat. §245I.04, subd. 2. 3. Have either: • At least 2,000 hours of clinical experience and/or training in the examination and/or treatment of people with autism spectrum disorder (ASD) or a related condition. • Completed the equivalent in graduate-level coursework at an accredited university (refer to equivalent coursework section).

Provider level	Required qualifications
	Note: Coursework must be documented in one or more of the following areas: ASD or a related condition diagnostic, ASD or a related condition treatment strategies or child development. 4. Be able to provide treatment within their scope of practice and license.
Level I	To qualify as a Level I provider, a person must meet both of the following requirements: 1. Be employed by an EIDBI agency. 2. Complete either: • At least 2,000 hours of clinical experience and/or training in the examination and/or treatment of people with autism spectrum disorder (ASD) or a related condition. Note: The provider may include hours worked as a mental health behavioral aide, mental health practitioner, personal care assistance (PCA) worker, EIDBI level II or level III provider or another role in a clinic or education setting as required hours of experience. • The equivalent in graduate-level coursework at an accredited university (refer to the equivalent coursework section on this page). Note: Coursework must be documented in one or more of the following areas: ASD or related condition diagnostics, ASD or related condition treatment strategies or child development. In addition to the above requirements, a person must meet at least one of the following requirements: 1. Have a doctoral or master's degree from an accredited college or university in behavioral health, child development or a related field (e.g., mental health, special education, social work, psychology, speech pathology, occupational therapy, health science, education, sociology, nursing, human services, counseling, family studies). 2. Be a board certified behavior analyst-doctoral (BCBA-D) through the Behavior Analyst Certification Board Inc. (BACB). 3. Be a board certified behavior analyst (BCBA) through the BACB. 4. Be a qualified behavior analyst as defined by the Qualified Applied Behavior Analysis Credentialing Board. 5. Have a bachelor's degree from an accredited college or university in behavioral health, child development or a related field (e.g., mental health, special education, social work, psychology, speech pathology, occupational therapy, health science, education, sociology, nursing, human services, counseling, family studies) and advanced certification in one of the DHS-recognized treatment modalities.

Provider level	Required qualifications
	6. Be a board certified assistant behavior analyst (BCaBA) through the BACB and have 4,000 hours of supervised clinical experience that meets all registration, supervision and continuing education requirements of the certification.
Level II	To qualify as a level II provider, a person must be employed by an EIDBI provider agency and meet at least one of the following sets of requirements: 1. Have a bachelor's degree from an accredited college or university in behavioral health, child development or a related field (e.g., mental health, special education, social work, psychology, speech pathology, occupational therapy, health science, education, sociology, nursing, human services, counseling, family studies) and meet at least one of the following requirements: a. Have at least 1,000 hours of clinical experience and/or training in the evaluation and treatment of people with ASD or a related condition. b. Have completed the equivalent in graduate-level coursework at an accredited university. Note: Coursework must be documented in one of the following areas: ASD or related condition diagnostics, ASD or related condition treatment strategies or child development. c. Be a board certified assistant behavior analyst (BCaBA) through the Behavior Analyst Certification Board, Inc. (BACB) d. Be a registered behavior technician (RBT) through the BACB e. Be certified in one of the other treatment modalities recognized by DHS 2. Have both: a. An associate's degree from an accredited college or university in a behavioral health, child development or a related field. b. At least 2,000 hours of supervised clinical experience delivering treatment to people with ASD or a related condition. 3. Have at least 4,000 hours of supervised clinical experience delivering treatment to people with ASD or a related condition. 4. Be both: a. A graduate student in behavioral health, child development or a related field b. Formally assigned by an accredited college or university to an EIDBI provider agency for clinical training with people with ASD or related conditions and receiving clinical supervision from a QSP affiliated with the agency. 5. Meet all of the following requirements: a. Be age 18 or older. b. Be fluent in a non-English language or be certified by a tribal government. 6. Complete the ASD Strategies in Action and EIDBI 101: Overview of the Benefit required trainings. a. Receive observation and direction from a QSP or qualified level I provider at least once per week until they meet 1,000 hours of supervised clinical experience.

Provider level	Required qualifications
	More flexible standards are required to qualify as a Level II provider under current provider shortage variance standards.
Level III	1. Be employed by an EIDBI provider agency. 2. Complete the Level III provider training requirements during the first six months of employment. 3. Be age 18 or older. 4. Meet at least one of the following requirements: a. Have a high school diploma or general equivalency diploma (GED). b. Be fluent in a non-English language or have a tribal nation certification. Have one year of experience as a primary personal care assistance (PCA) worker, community health worker, waiver service provider or special education assistant to a person with ASD or a related condition within the past five years.

SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 971

(SENATE AUTHORS: MANN, Abeler and Boldon)

DATE	D-PG	OFFICIAL STATUS
02/03/2025	265	Introduction and first reading Referred to Health and Human Services
02/06/2025	316	Author added Boldon

A bill for an act

relating to health occupations; providing immunity from criminal liability for health care providers when providing health treatment and services; proposing coding for new law in Minnesota Statutes, chapter 145.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[145.686] IMMUNITY FROM CRIMINAL LIABILITY FOR HEALTH CARE PROVIDERS WHEN PROVIDING HEALTH TREATMENT AND SERVICES.**

Subdivision 1. **Definition.** For the purposes of this section, "health care provider" means a health professional who is licensed or registered by the state to provide health treatment and services within the professional's scope of practice and in accordance with state law.

Subd. 2. **Immunity from criminal liability.** (a) Notwithstanding any provision of law to the contrary, a health care provider providing health treatment and services shall be immune from criminal liability for any harm or damages alleged to arise from an act or omission relating to the provision of health treatment and services, except as provided in paragraph (b).

(b) Nothing in this section limits any liability for gross negligence or wanton, willful, malicious, or intentional misconduct.

(c) Nothing in this section shall be construed to amend, repeal, or alter any other immunity, defense, limitation of liability, or procedure available or required under any other law or contract.

MINNESOTA
BOARD OF PSYCHOLOGY

Minnesota Board of Psychology Executive Director Report
February 21, 2025

Introduction

The mission of the Board is to protect the public through licensure, regulation, and education to promote access to safe, competent, and ethical psychological services. The work of the Board is strategically aligned to accomplish this mission, including prioritization of Board action and the assignment of resources (both human and financial).

The work of the Board has focused on the following since the last Board meeting:

I. Administrative Updates

a. Assistant Executive Director Licensing Update
The Licensure Team has continued to support the Mission and Vision of the Board by processing Psychologist and Behavior Analyst license applications. Board staff have processed a number of Behavior Analyst applications and issued licenses under the delegated authority granted by the Board. A handful of new applications have been received since January 1, 2025. The licensure team continues to carryout efficient procedures to provide applicants an equitable process to licensure.

II. Executive Director's Report

a. Culturally Informed and Culturally Responsive Mental Health Taskforce
The Minnesota Department of Health published the Culturally Informed and Culturally Responsive Mental Health Taskforce report. The report makes recommendations related to the diversification of the mental health fields from supporting students looking to enter graduate programs to continued competence of licensed professionals and how they are supported by their employers.

b. Behavior Analyst Licensure: As of this week, a total of 573 Behavior Analyst licenses have been granted. There are approximately 45 applicants whose materials have been sent to the CBC and when the results are received the review of those applications will move forward in the final reviews. Board staff continue to work ahead to ensure that when the CBC results are received that this is the final item to certify. The turnaround time for an application to be approved once all materials have been received is one day. In all the Board has received 700 applications for behavior analyst licensure and have continued to receive a small number of applications from in state and out of state applicants since January 1, 2025.

c. Legislative Update:

a. Early Intensive Developmental and Behavioral Intervention benefit legislation – No published language as of today, and the proposal does include licensing facilities that provide autism treatment services by the Department of Human Services.
b. SF 971 – limits criminal liability for health care providers.

- MINNESOTA BOARD OF PSYCHOLOGY

DATE: 2/21/2025

SUBMITTED BY: State Program Administrator

TITLE: Board Administrative Terminations

INTRODUCTION TO THE TOPIC:

The Board shall terminate the license of a licensee whose license renewal is at least 60 days overdue and to whom notification has been sent as provided in the administrative rules. Failure of a licensee to receive notice is not grounds for later challenge of the termination.

Licensees are provided several opportunities to renew the license prior to Board termination. Licensees are sent a notice within 30 days after the renewal date when they have not renewed the license. This letter is sent via certified mail to the last known address of the licensee in the file of the board. This notifies the licensee that the license renewal is overdue and that failure to pay the current renewal fee and the current late fee ($250.00) within 60 days after the renewal date will result in termination of the license. A second notice is sent to the licensee at least seven days before a board meeting (which occurs 60 days or more after the renewal date). Minn. R. 7200.3510.

BOARD ACTION REQUESTED:

LP	Name	Expiration Dare
LP5319	Roberta Singerhouse	11/30/2024
LP1852	Neil Shirreff	11/30/2024