John J. Heldrich Center for Workforce Development

roundtable proceedings

Improving the Quality of Care: Proceedings from a Roundtable on the Behavioral Health Care Workforce in New Jersey

Background

According to the Annapolis Coalition, a nonprofit organization committed to improving workforce development in the nation's behavioral health field, employers face multiple challenges finding, developing, and retaining skilled workers. While challenges occur at all job levels, employers face particular challenges providing appropriate on-the-job training, mentoring, and career advancement assistance to the direct-care human services staff that spend large amounts of time with consumers. Evolution in knowledge about treating behavioral disorders is also increasing and changing the skills all workers need to provide quality care, making it difficult for employers and some educational institutions to keep pace with workers' training needs.

The result of these difficulties in properly training and supporting workers is often diminished quality of care for behavioral health care consumers. To ensure that consumers have access to quality services in New Jersey, employers and educators must work together to identify the key skill-related workforce challenges the state's behavioral health care employers face and to develop education and training solutions for addressing these challenges.

Developing a Response to Workforce Development Issues in New Jersey

In May 2008, over 30 stakeholders from New Jersey's behavioral health community gathered for a roundtable discussion on the key workforce development challenges facing the field. Participants included state government officials, including representatives from the state psychiatric hospitals and developmental centers, the state mental health system, and high-level state policymakers; national organizations; community-based organizations and agencies; the education community; as well as mental health advocates and others. The roundtable was convened by the John J. Heldrich Center for Workforce Development at Rutgers, The State University of New Jersey in partnership with the Mental Health Association in New Jersey. Support for the roundtable was provided through a grant from Johnson & Johnson. See Appendices A and B for the roundtable agenda and a full list of participants.

RUTGERS
Edward J. Bloustein School
of Planning and Public Policy

To frame the discussion, Carolyn Beauchamp, President of the Mental Health Association in New Jersey, highlighted several key issues facing New Jersey's behavioral health care system. These include dealing with diversity (educational, cultural) in the workforce, the need to develop a peer workforce that includes consumer-providers, integrating the wellness and recovery model of care with the medical model, and building the infrastructure needed to implement best practices systemically at both the institutional and cross-institutional levels.

Dr. Michael Hoge of the Annapolis Coalition then provided an overview of the key workforce development issues, and needed solutions, at the national level. Dr. Hoge is a Professor at Yale School of Medicine, Department of Psychiatry and Senior Research Director at the Annapolis Coalition. A copy of a presentation that includes the main findings from the Annapolis Coalition's study of the national workforce issues is included in Appendix C. For more information on the Annapolis Coalition, see: *www.annapoliscoalition.org*.

Following these presentations, Carolyn Beauchamp led a roundtable discussion with participants to identify key workforce issues and action priorities for New Jersey's behavioral health care systems. Dr. Michael Hoge answered questions regarding his presentation and provided insight into workforce solutions being carried out in other states.

Roundtable Discussion Highlights

Participants identified two priority workforce issues for New Jersey, as well as several key action items for state agencies and community-based behavioral health employers, as well as for educational institutions and training providers.

The priority workforce issues in New Jersey are as follows:

- Promote short- and long-term systems change that supports effective post-employment professional and continuing education for employees at all job levels of the behavioral health care workforce; and
- Improve the quality and effectiveness of pre-employment education and training, including creating stronger partnerships with New Jersey's postsecondary educational institutions.

Key Action Priorities for Community-Based Providers and State Agencies (public and private employers)

Participants identified several action priorities that behavioral health care providers and related state agencies must take to make progress on the priority workforce issues identified above. These action priorities, as well as promising models for strategy implementation, are:

Action Priority#1: Prioritize workforce issues and solutions (especially for state hospitals) and establish guiding principles for change

According to participants, workforce issues facing employers, especially state hospitals, are overwhelming. Training needs cross multiple staff education levels and involve a variety of issues that need to be addressed—from institutional barriers such as inflexible salary structures and civil-service regulations, to issues of staff culture and others. To be effective, participants recognize that providers and state agencies need to develop guiding principles for action and to prioritize their workforce development approaches based on their relative impact on improving the quality of care provided to consumers.

Promising models include:

New Jersey: The Department of Human Services is developing a statewide workforce development plan that will include a set of guiding principles to assist decision-makers in prioritizing key workforce issues and developing appropriate solutions.

National: The Annapolis Coalition developed a report on the key workforce development challenges facing the nation's behavioral health care system. The report includes priority action steps for addressing important issues. These action steps are included in Appendix C. A copy of the full report can be accessed at *www.annapoliscoalition.org*.

Action Priority #2: Develop a mechanism to promote sustained planning for the behavioral health workforce pipeline

To ensure that behavioral health care employers in New Jersey have access to skilled workers well into the future, participants agree that the provider community and state agencies must take steps to promote honest dialogue and to break down institutional silos both within the behavioral health community and between the provider community and educational institutions in the state.

Due to the decentralized nature of higher education in New Jersey, participants suggested that an inclusive employer/advocate coalition be formed to approach colleges and universities one by one to voice the concerns and priorities of employers. Suggestions for engaging the education community to respond to these needs include:

- Provide financial incentives for schools to develop and implement curricula that meet employer needs,
- Frame discussions with schools in terms of improving care, not in terms of a new "practice fad", and
- Lobby school accreditation bodies to establish more specific standards for research-based education in behavioral health care related fields.

Promising models include:

New Jersey: Governor Corzine's Economic Growth Strategy for New Jersey (2007) includes a program designed to provide seed money for higher education institutions to develop curricula that meet the needs of the state's key industries. Called the Innovation Partnership Institute, this program provides a model for incentivizing schools to develop curricula in partnership with employers.

National: The State of Connecticut provided financial incentives to schools to work with behavioral health employers to develop and implement curricula that meet industry skill needs.

The Accreditation Council for Graduate Medical Education may provide assessment strategies for assessing the quality of education.

Action Priority #3: Develop strong institutional leadership to develop and promote evidence-based training practices that improve the quality of care for consumers

State agencies and behavioral health care providers must develop and reward leaders that promote a culture of lifelong learning and professional improvement in their organizations. This can be achieved through the development, implementation, and sharing of training practices that have been shown to be effective at raising staff competencies and improving the quality of care provided to consumers, or that have a reasonable expectation of doing so (promising practices). Some promising and evidence practices in behavioral health staff training mentioned by participants include:

- Reinforce training in practice and through supervision,

- Mentoring, and
- Encourage new ways of thinking by promoting intergenerational idea exchange.

Promising models include:

New Jersey: Some state psychiatric hospitals are developing "training-focused wards". In these wards, trainers come to the workers and systems are put in place to reinforce learning through supervision and additional training support.

The Child Sexual Abuse and Juvenile Offender Training Institute provides intensive, supervision-based competency training for workers in the state's juvenile justice system.

Leadership New Jersey helps to develop better leaders and to change the culture of direct care workers to focus on lifelong learning and providing quality care to consumers.

National: A leadership development model in Denver is helping to transform direct care culture to improve the quality of care. The National Association of Social Workers is developing a similar model.

Action Priority #4: Introduce motivational practices and incentives to retain qualified staff and to encourage the development of new staff competencies

Strategies that motivate trained and qualified staff to stay in their jobs and that help them to avoid burnout and improve their competencies are important components of a workforce development approach for the state's behavioral health care system. Less-qualified personnel also need motivation to improve their skills and performance. Participants noted several possible motivation-based approaches to improve the retention and quality of direct care staff. These approaches include:

- Build a professional identity for the direct care workforce through professional certifications,
- Increase salary in step with education and certification,
- Articulate career ladders for staff,
- Provide needed supports for staff to advance their careers, and
- Allow for some imperfection among staff and take a positive, lifelong learning approach, as opposed to a punitive approach, to professional development training and education.

Promising models include:

New Jersey: The Aggressive Community Treatment (ACT) program provides grassroots consultation and training to direct care staff and provides certification for competencies developed to work with consumers who have a dual diagnosis (MH/DD).

Consumer Connections, a project of the Mental Health Association in New Jersey and funded by the Division of Mental Health Services since 1997, has created comprehensive training and support programs for peer providers, linking the training to the Community Mental Health Associate (CMHA) and the Peer Specialist Associate (PSA) certifications that combine classroom and work experience into a professionally recognized credential.

The Consumer Provider Association in New Jersey, established by the Mental Health Association in New Jersey through a Substance Abuse and Mental Health Services Administration consumer networking grant, is a consumer-run association focused on advocacy, training of mental health providers, and peer support to develop the consumer provider workforce in New Jersey.

National: The Certified Psychiatric Rehabilitation Program offers a nationally recognized credential for psychiatric rehabilitation direct care staff. No degree is required.

Some states and individual employers use the U.S. Department of Labor's Registered Apprenticeship program to build competencies

among direct care staff. As required by the program, employers provide raises based on training/certification.

Action Priority #5: Develop cost-effective training solutions

High staff turnover and the time it takes to hire new staff, especially for state-funded positions, increase the cost of post-employment staff training and education. At the same time, many providers have limited funds to pay for training and related support activities. To be effective, training solutions must be not only effective, but also cost-efficient.

Key Action Priorities for New Jersey Higher Education Institutions that Prepare Behavioral Health Care Workers

Action Priority #1: Prioritize research-based teaching practices tied to the workforce needs of employers (including work-based learning)

According to participants, educational institutions in New Jersey should focus degree-based and continuing education courses on practices that are both relevant to employer workforce needs and proven to be effective through research. In particular, participants suggested that colleges and universities should consider integrating more work-based learning opportunities into behavioral health programs. Work-based learning has been show to engage supervisors and support systemic change, as well as provide needed hands-on experience for students. Participants mentioned that federal funds may be available to support research-based practice training, but support for follow-up supervision would be needed.

Promising models include:

New Jersey: The state's community colleges are getting more involved in developing curricula employers need, especially in the areas of psychiatric rehabilitation and substance abuse counseling.

The Addictions Certification Board has partnered with several New Jersey colleges to develop curricula needed among employers.

Some colleges offer field-relevant electives that allow students to develop competencies in areas needed by particular types of behavioral health care employers.

Action Priority #2: Ensure workers and other non-traditional students have access to training and education

Participants agreed that colleges and universities in New Jersey need to develop more flexibility in their practices to improve accessibility of behavioral health care education. Both flexibility in course scheduling to accommodate many types of students, as well as providing credit for work experience, were discussed.

Appendix A. Roundtable Agenda

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John J. Heldrich Center for Workforce Development
Edward J. Bloustein School of Planning and Public Policy
Rutgers, The State University of New Jersey
www.heldrich.rutgers.edu

Mental Health Association in New Jersey, Inc.

A Roundtable Discussion on the Workforce Needs of the Behavioral Healthcare Industry in New Jersey

May 15, 2008
8:45am -12pm

AGENDA

8:45-9:15 am	Coffee & Networking	
9:15-9:20am	Welcome and Introductions	Kathy Krepcio Heldrich Center
9:20-9:30	Improving the Quality of Care: The Importance of Addressing Workforce Issues in Behavioral Health	Carolyn Beauchamp Mental Health Assn of NJ
9:30-10:15am	Workforce Challenges in Behavioral Healthcare: A National Perspective	Dr. Michael Hoge The Annapolis Coalition Yale University
10:15-10:30	Break	
10:30-11:50am	Facilitated Discussion to Understand the Workforce and Skill Needs of New Jersey's Behavioral Healthcare Employers	Carolyn Beauchamp Mental Health Assn of NJ Jennifer Cleary Heldrich Center

Discussion Topics:

a. Key industry trends impacting the skill and workforce needs of the Behavioral Healthcare Industry in New Jersey ; and
b. Occupations or groups of occupations experiencing rapid growth and/or critical skill shortages.
c. Special topics, including developing peer support specialists, special skills needed for the dually diagnosed, children, elderly, etc..

11:50-12:00pm	Summary of Key Discussion Points and Next Steps	Carolyn Beauchamp Mental Health Assn of NJ

Appendix B. Roundtable Participants

Addiction Professionals Certification Board, Inc.
Richard Bowe

Alternatives, Inc.
Nicole Zenner

Ancora Psychiatric Hospital
Greg Roberts

Ann Klein Forensic Center
John Main

The Annapolis Coalition, Yale University School of Medicine
Michael Hoge, Ph.D.

The ARC of New Jersey
Maddi Sink

Family Services Association of New Jersey
Cindy Herdman-Ivins

Greystone State Psychiatric Hospital
Janet Monroe

Hagedorn Center for Geriatrics
Debra Smith

John J. Heldrich Center for Workforce Development, Rutgers University
Jennifer Cleary
Kathy Krepcio

Mental Health Center of Morris County
Julia Wimmer

Mental Health Association in New Jersey
Carolyn Beauchamp
Ray Cortese
Bob Kley
Dennis Lafer

Monmouth University
Ellie Mazza

National Association of Social Workers
Walter Kalman

New Jersey Association of Mental Health Agencies
Megann Anderson

New Jersey Department of Children and Families, Office of Education
Brian Hancock

New Jersey Department of Human Services, Division of Mental Health Services
Lorna Hines-Cuningham
Patti Holland
Kevin Martone

SERV Centers of New Jersey
Linda Gochfeld

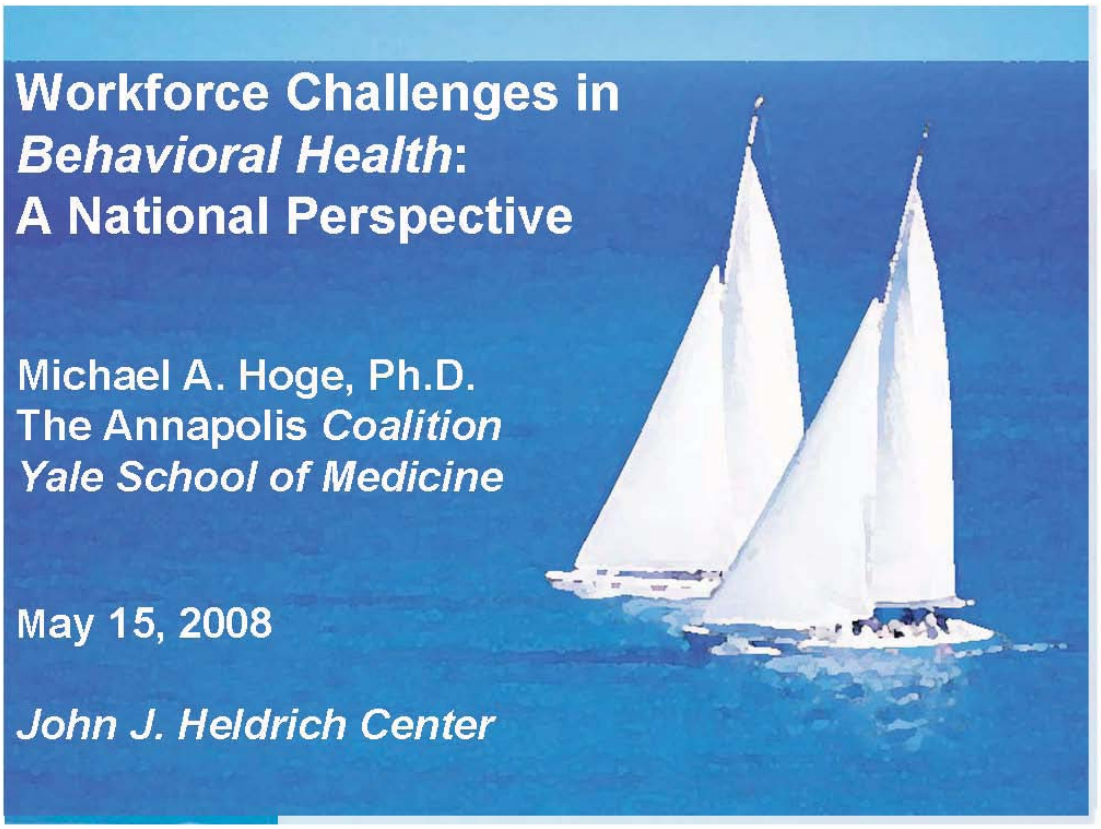
Trenton State Psychiatric Hospital
David Kensler

Trinitas Hospital, Behavioral Health and Psychiatry
Marylyse Benson

The University of Medicine and Dentistry of New Jersey
Nora Barrett
Peg Grandison

The University of Medicine and Dentistry of New Jersey, Elizabeth A. Boggs Center
Dan Baker

Appendix C. Presentation on Workforce Challenges in Behavioral Health: A National Perspective



Two Decades of Change in Behavioral Health Care

- Managed care and shifts in financing
- Recovery & resilience
- Patient safety
- Cultural competency
- Performance/outcomes measurement
- Consumerism
- Co-occurring illnesses & medical co-morbidity
- Evidence-based practice & the rapidly expanding body of evidence

Response of the Field

- Typically - delayed & minimal
- Frequently – significant erosion
- Notable exceptions stand as exceptions
- Universal problem irrespective of setting, discipline, or specialty

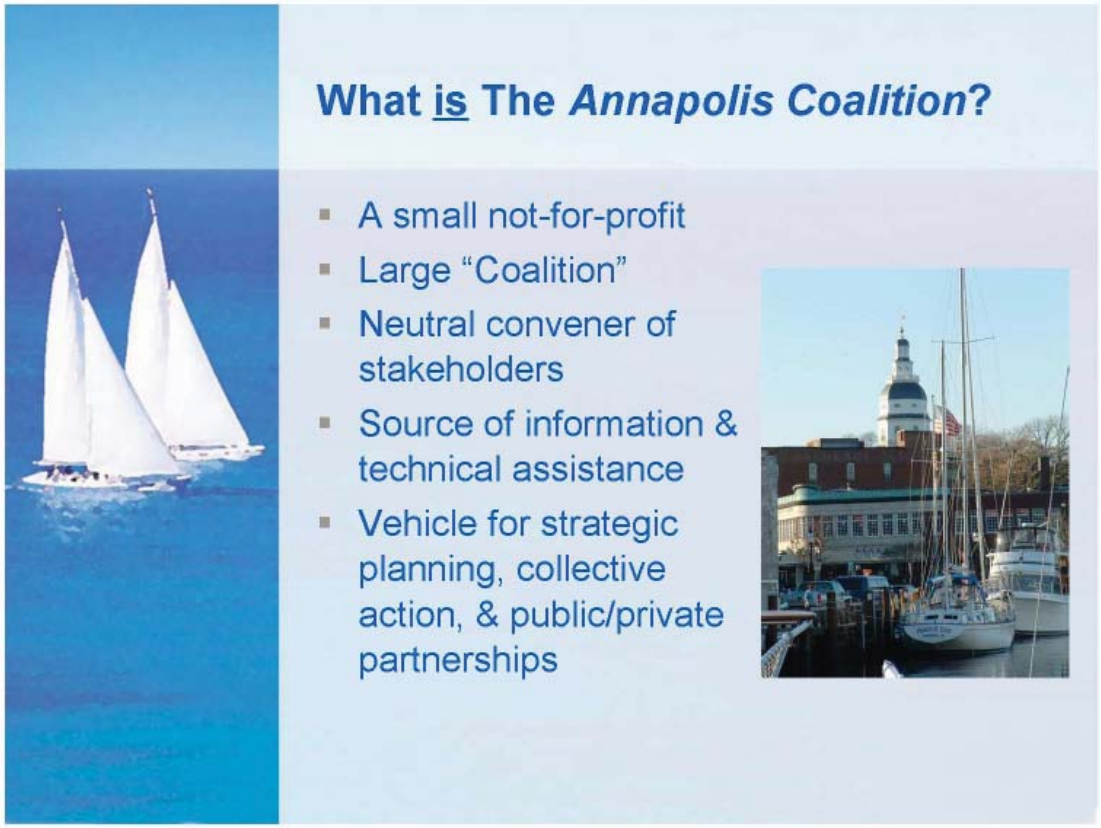
The Paradoxes of Behavioral Health Workforce Development

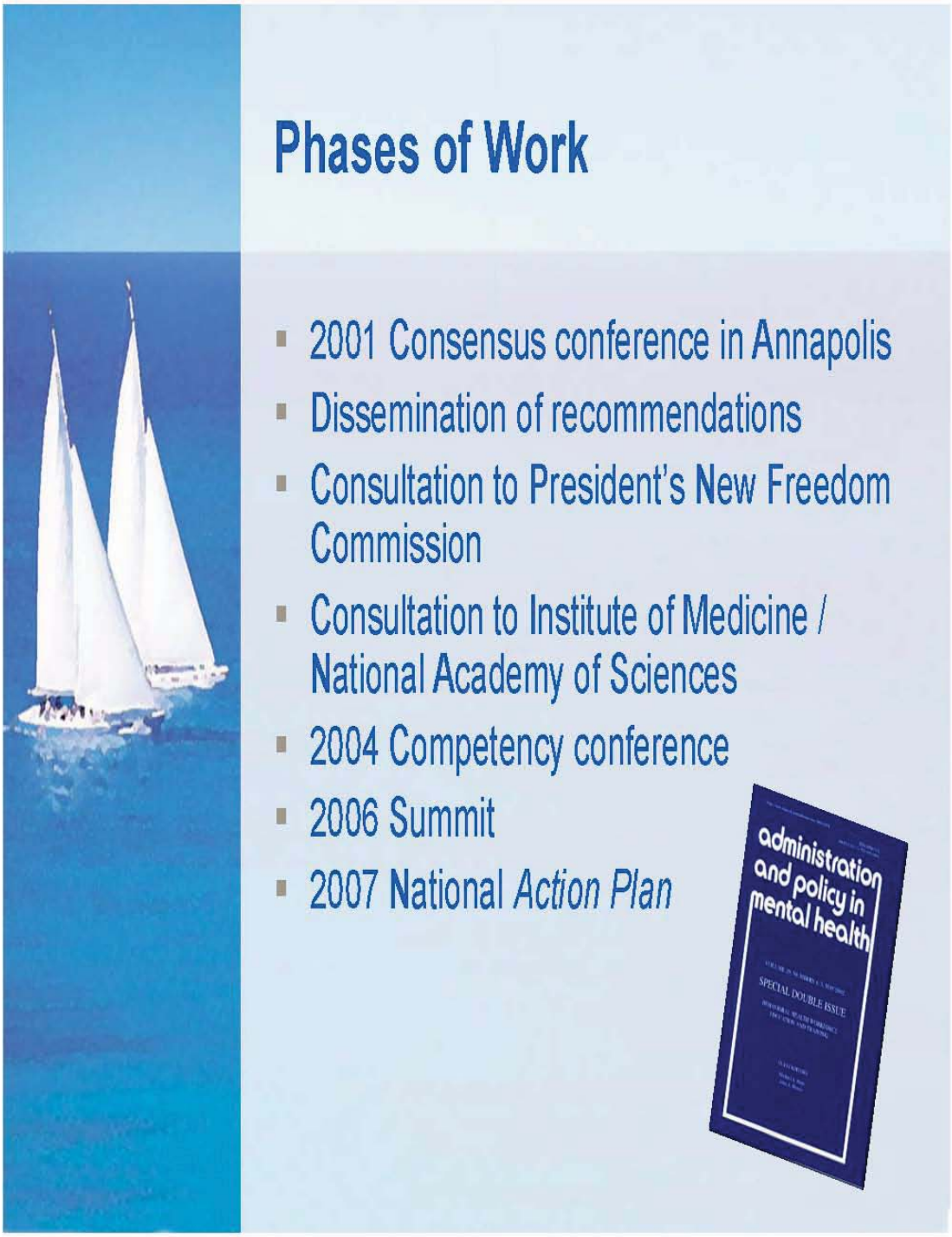
Paradoxes of Workforce Development

- We train graduate students & residents for a world that no longer exists
- Those who spend the most time caring for persons in recovery receive the least training
- Continuing education programs persist in utilizing ineffective teaching strategies
- We train only where willing crowds gather
- Persons in recovery and families receive little educational support
- The diversity of the current workforce doesn't match the diversity of those served.

Paradoxes of Workforce Development - continued

- Students are rewarded for "Doing Time" in our educational systems
- We do not plan systematically to recruit or retain staff
- Once hired, little supervision or mentoring is provided
- Career ladders and leadership development are haphazard
- Service systems thwart rather than support the competent performance of individuals


What is The Annapolis Coalition?
A small not-for-profit
Large "Coalition"
Neutral convener of stakeholders
Source of information & technical assistance
Vehicle for strategic planning, collective action, & public/private partnerships


Phases of Work
2001 Consensus conference in Annapolis
Dissemination of recommendations
Consultation to President's New Freedom Commission
Consultation to Institute of Medicine / National Academy of Sciences
2004 Competency conference
2006 Summit
2007 National *Action Plan*
administration and policy in mental health
SPECIAL DOUBLE ISSUE

National Action Plan

- Two years & 5,000 participants
- Federally funded
- Mental health & addictions
- Treatment & prevention
- Seeking to identify:
  - A core set of strategic goals & objectives
  - High priority ACTION items by stakeholder
- A planning resource
- Call to action

Planning Process

- Senior consultants
- Expert panels & Advisory Groups (12)
- Reviews of existing recommendations
- Planning sessions in existing meetings
- Specially convened planning sessions
- Targeted requests and open calls for recommendations
- Panel reports, including innovations
- Integrated core report
- National Steering Committee review
- SAMHSA Review

Expert Panels & Advisory Groups

Child, Adolescent, & Family Panel
Consumer & Family / Adult MH Panel
Cultural Competency & Disparity Panel
Older Adults Panel
School Based Mental Health Panel (MHEDIC)
Substance Use Disorders Treatment Panel
Substance Abuse Prevention Panel (NPN)
Rural Panel
Accreditation Advisory Group
Educators Advisory Group
IT/Distance Learning Advisory Group
Workforce Economics Advisory Group

Elements of the Plan

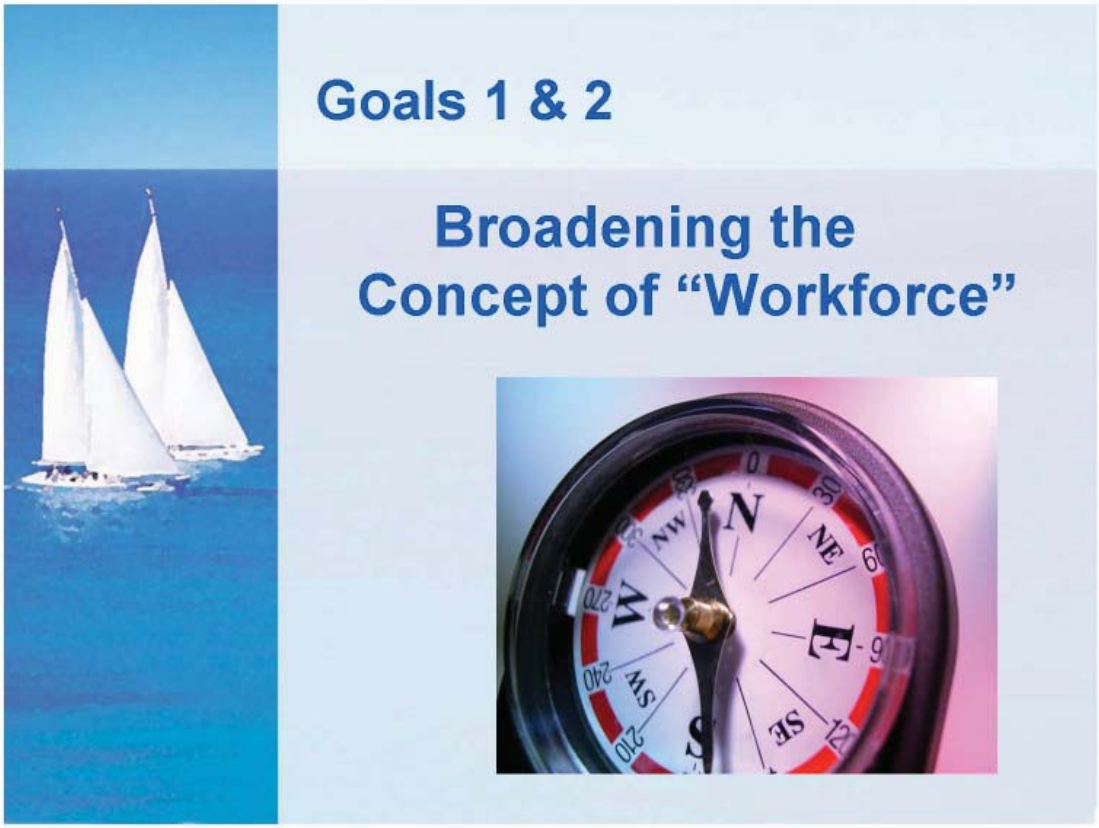
- General findings
- Seven strategic goals
- Objectives & Actions
- Preliminary implementation tables with recommended stakeholders
- Special topics
  - Relevance of core recommendations
  - Unique issues & recommendations

General Findings (1)
National *Action Plan*

- Widespread concern & attention
- High levels of dissatisfaction
  - Persons in Recovery & Families
  - Workforce employers
- Change occurs with the generations
- "We" are fragmented: disciplines, sectors, & effort
- Narrow focus on urban, white adults, missing:
  - Life span issues (children & elders)
  - Culturally diverse populations
  - Rural America

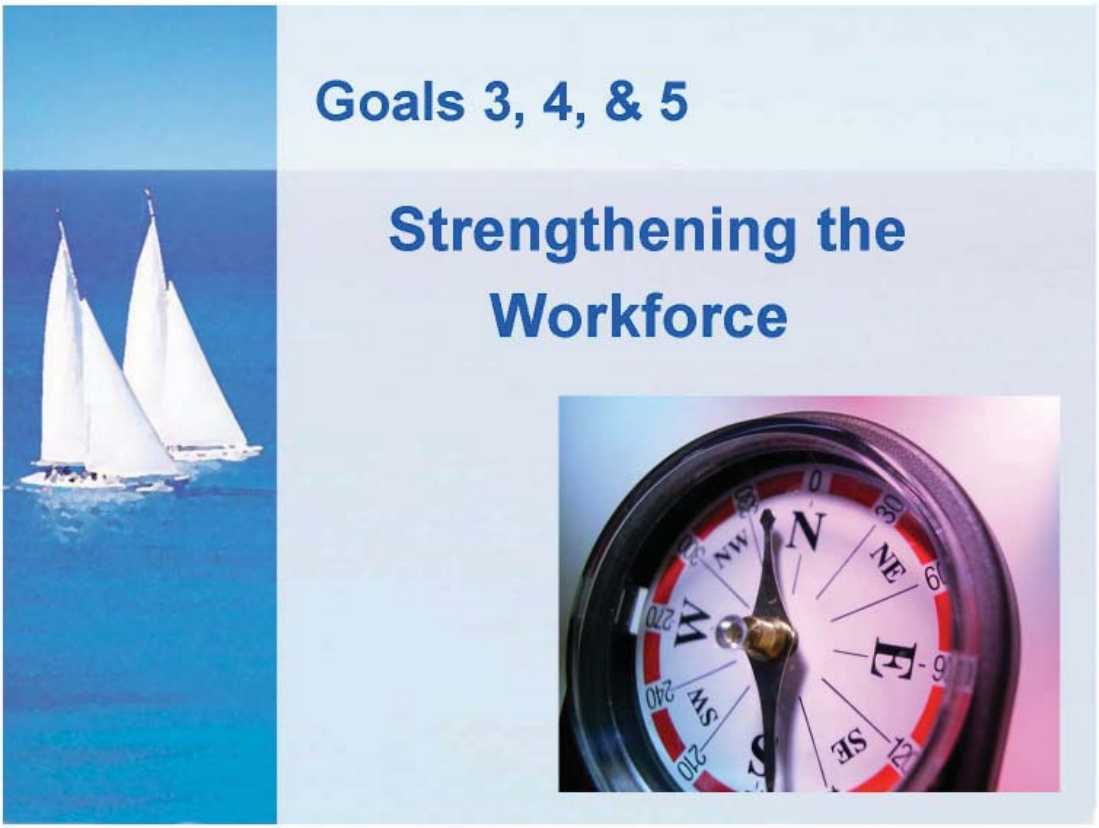
General Findings (2)
National *Action Plan*

- Scarcity of data
- Doing what is easy or affordable - not what is effective
- A hunger for "tools"
- Pockets of innovation
- Difficulties with sustainability and dissemination
- Workforce crisis extends throughout health & human services***


Goals 1 & 2
Broadening the Concept of "Workforce"


Goal 1: Persons in Recovery & Families
Objectives:
Increased educational supports
Shared-decision making
Expand peer & family support
Greater employment as paid staff
Formal engagement as educators of the workforce
"Transformational" in nature


Goal 2: Communities
(Source: Prevention & Rural Health)
Objectives:
Competency development with communities
Competency development of the behavioral health workforce in community collaboration
Strengthening connections between behavioral health organizations and their communities


Goals 3, 4, & 5
Strengthening the Workforce

Goal 3: Recruitment & Retention

Selected Objectives:

- Implement & evaluate interventions:
  - Salary, benefits, & financial incentives
  - Non-financial incentives & rewards
  - Job characteristics
  - Work environment
- Develop career ladders
- "Grow your own" workforce
- Cultural & linguistic competence
- Public relations campaign

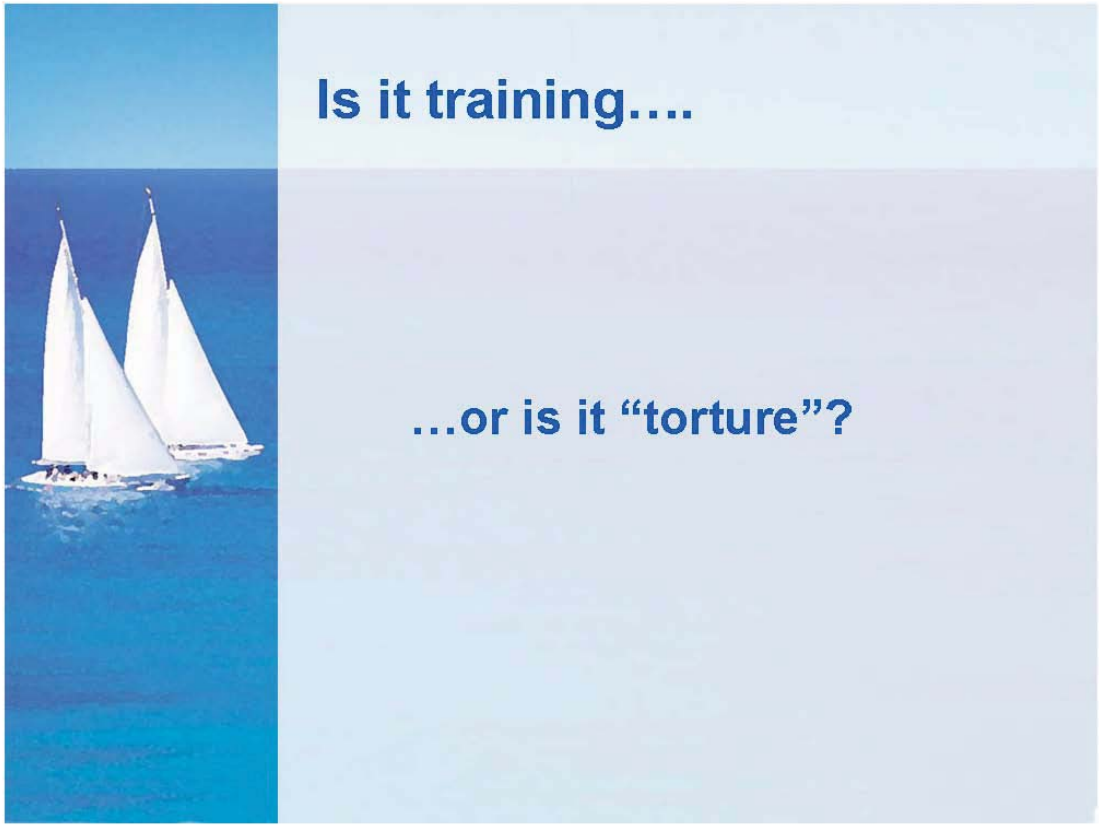
Goal 4: Training: Relevance, Effectiveness, & Accessibility

Objectives:

- Competency development
- Curriculum development
- Evidence-based training methods
- Substantive training of direct care workers
- Technology-assisted instruction
- Co-occurring competencies in every staff member
- Systematic support to sustain newly acquired skills

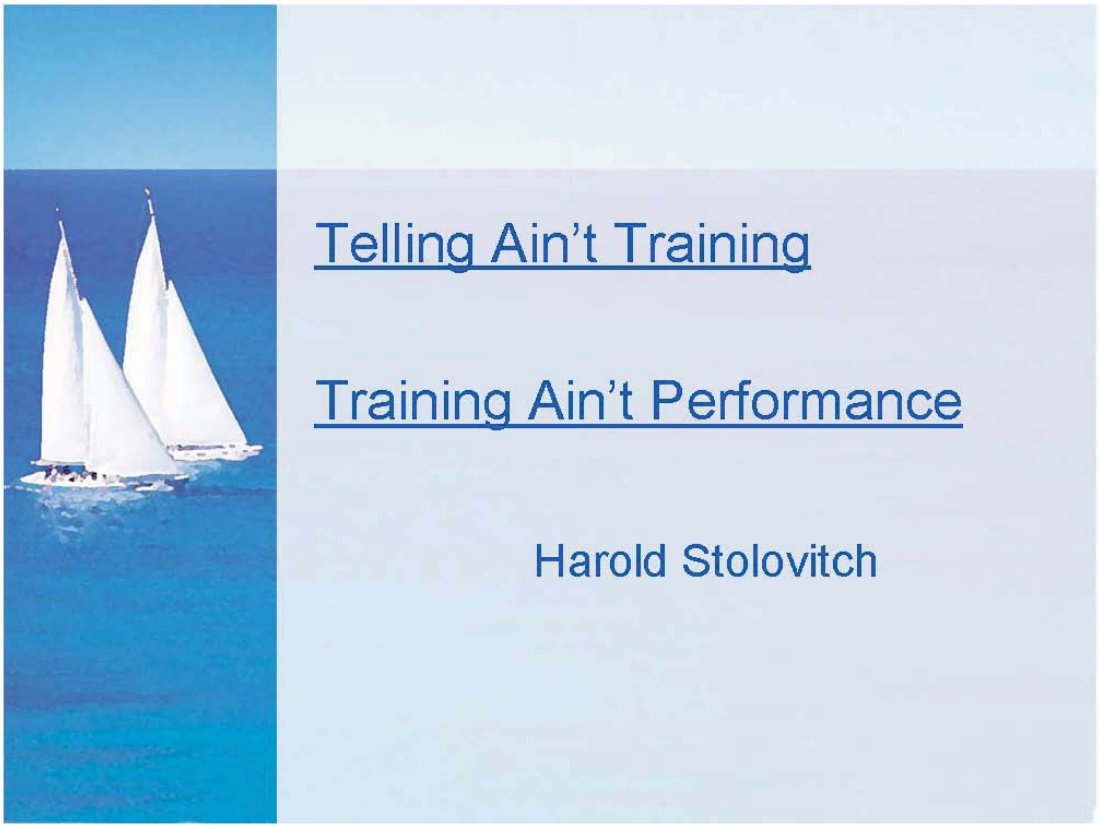

Assessing Competency
Standardized written and oral exams
Standardized patient exam
Record review
Behavioral checklists
Patient surveys
360 degree evaluations
Simulations & standardized patients
Portfolios


Is it training….
…or just “exposure”?


Is it training….
…or is it “torture”?


“Rhetoric informed care”
Person centered, Consumer directed, Family driven, Recovery & resiliency oriented, Strength-based, Trauma Informed, Gender specific, Time limited, Co-occurring, Culturally competent Evidence-based, Transformative, Preventative, Wrap-around, Community care


Effective Teaching Strategies
"No magic bullets"
Interactive sessions
Academic detailing / outreach visits
Reminders
Audit and feedback
Opinion leaders
Patient mediated interventions
Social marketing


Telling Ain't Training
Training Ain't Performance
Harold Stolovitch


Goal 5: Leadership Development
Objectives:
Identify leadership competencies tailored to behavioral health
Competency-based curricula
Formal, continuous leadership development in all sectors beginning with supervision
Succession planning


Goals 6 & 7
Structures to Support the Workforce

Goal 6: Infrastructure

Selected Objectives:

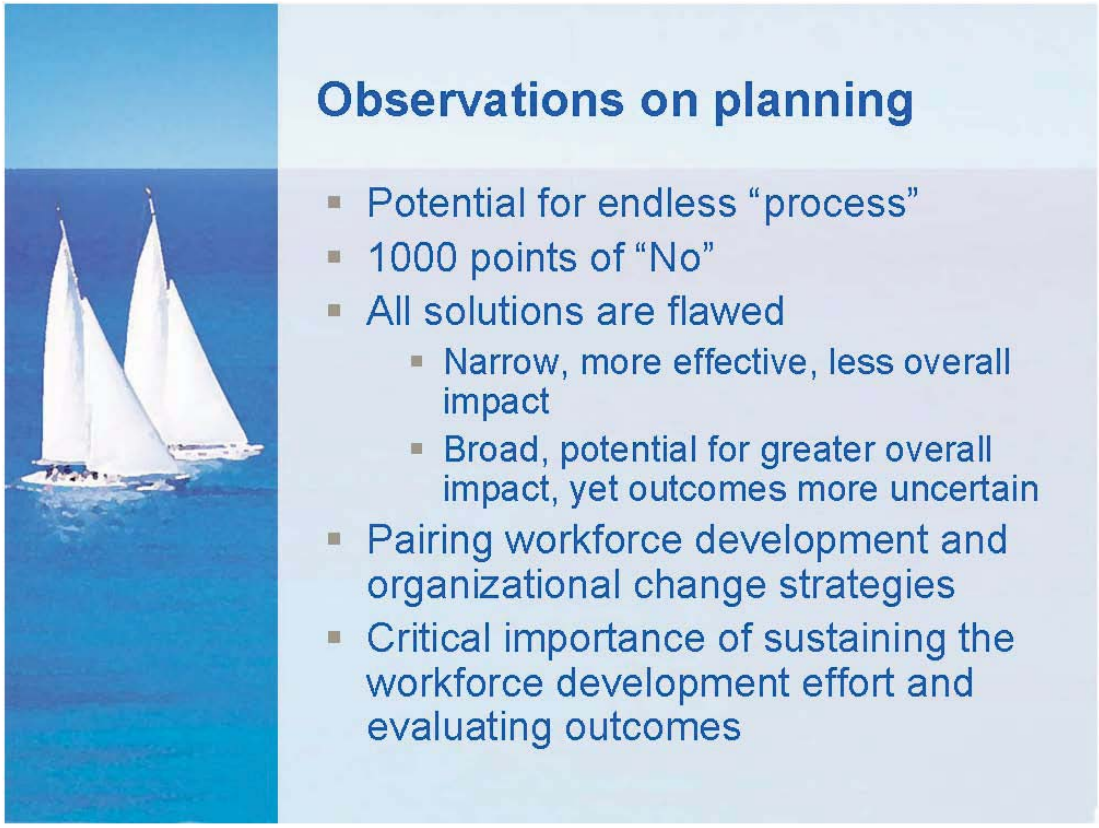
- A workforce plan for every agency
- Data-driven CQI on workforce issues
- Strengthen HR & training functions
- Improve the economic market for services
- Improve IT support for training, workforce support, & tracking
- Decreased paperwork burden: variable, redundant or purposeless reporting

Goal 7: Research & Evaluation

Objectives:

- Federal and state inter-agency research collaboratives
- Technical assistance to field on evaluation of workforce practices


Conclusions
Strategic goals & objectives are a guide for assessment & planning
State / organization plans must be unique and tailored
Levers of change
Leadership
Competency assessment
Financing
Accreditation, licensure & certification
Advocacy


Observations on planning
Potential for endless "process"
1000 points of "No"
All solutions are flawed
Narrow, more effective, less overall impact
Broad, potential for greater overall impact, yet outcomes more uncertain
Pairing workforce development and organizational change strategies
Critical importance of sustaining the workforce development effort and evaluating outcomes

What you can do:

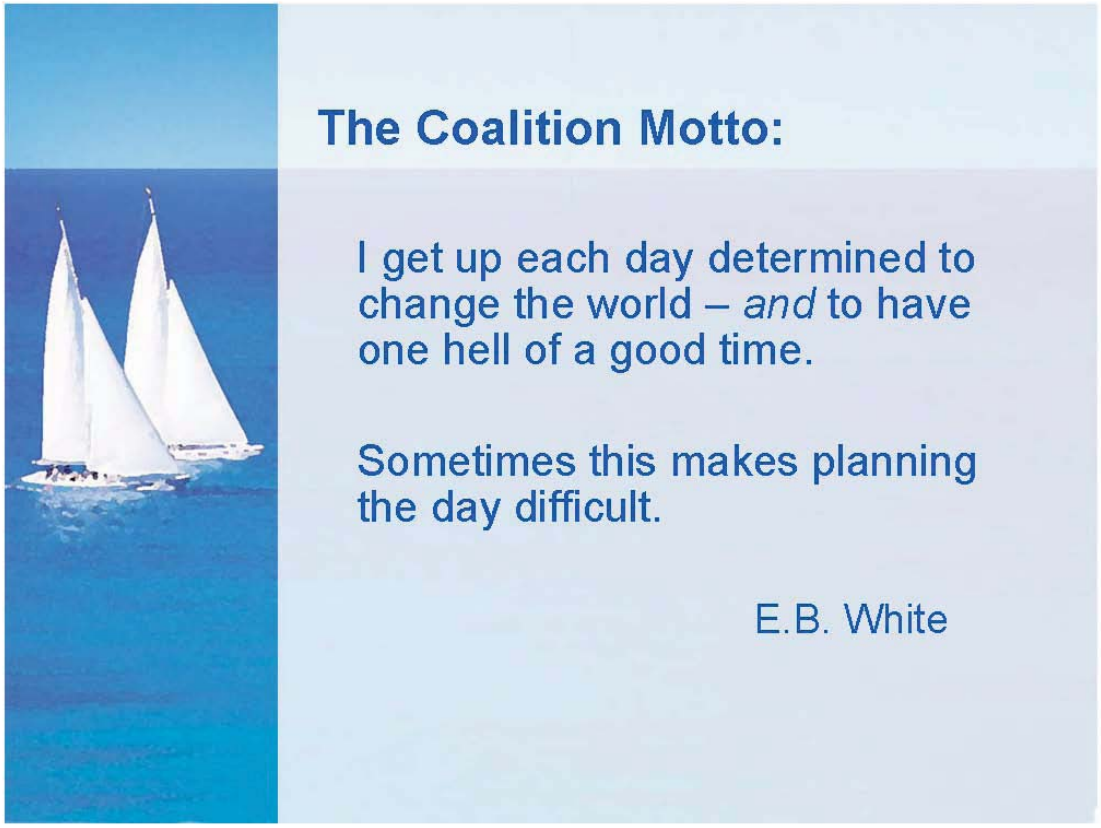
- Advocate and Act
- Individual and organizational plan
- Data-driven quality improvement
- Stop torturing your workforce
- Reinvest in Evidence-Based Training
- Work-based learning
- Develop your supervisors
- Don't go anywhere alone
- Brag about your field

An Emerging Direction

From the competencies of individuals

to

The competencies of teams


The Coalition Motto:
I get up each day determined to change the world – *and* to have one hell of a good time.
Sometimes this makes planning the day difficult.
E.B. White


Visit us on the web
www.annapoliscoalition.org