

Building a Competent Workforce in the Age of Healthcare Reform



**PERSPECTIVES FROM THE ANNAPOLIS
COALITION ON THE BEHAVIORAL HEALTH
WORKFORCE**

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About Presenters



- **John A. Morris, MSW – Executive Director of the Annapolis Coalition on the Behavioral Health Workforce; Independent Consultant with the Technical Assistance Collaborative, Inc.; Immediate past Chair of the Board of Directors of Mental Health America (formerly the National Mental Health Association).**
- **Michael T. Flaherty, Ph.D. – Executive Director of the Institute for Research, Education and Training in the Addictions in Pittsburgh, Pa. and the SAMHSA/CSAT Northeast Addiction Technology Transfer Center serving New York and Pennsylvania. He serves on the Board of the Annapolis Coalition and Co-Chaired the Substance Use Treatment section of the Annapolis Coalition Action Plan.**

Context for this presentation



BEHAVIORAL HEALTH: 1969 – 2010

- Trans- and de-institutionalization
- Major transition from state mental health authorities to Medicaid as the driver of services for people with mental illnesses (and increasingly for substance use conditions as well)
- Move from 12-step models of recovery to more ‘professionalized’ models
- The rise of the consumer movement
- *Better But Not Well...Frank & Glied*

Better But Not Well



- Mental Health “exceptionalism” vs. mainstream integration
- At one time this was a real policy question....
- Now mainstream integration is accelerating reality
- Substance use and prevention a greater priority while themselves changing paradigm to better address the often chronic nature of the illness and its need for more recovery focused care.

Better but not well



Historical Barriers to BH and SU integration to consider in developing unified workforce:

- * Etiology of nature of MH and SU and their treatment philosophies and techniques**
- * Practitioners from MH and SU have trained differently and often are unwilling or unprepared to treat MH, SU or COD**
- * Competition for scarce resources**

- White/Davidson, 2006

Better but not well



- **BUT – Individual, family and community recovery is the common denominator ...the unifying principle of our work ... we cannot lose it!**
- **Each person must be the agent in his or her own recovery**

Behavioral health/primary care integration



- **Do we really know what this will mean?**
- **Are providers in either sector really prepared?**
- **What are the dynamics likely to be?**

It kind of feels like this



Or maybe this...



Agreed.



- **There is a lot at stake**
- **The history of behavioral health integration has some scary precedents...**
 - ✦ **Reduced access and benefits**
 - ✦ **Inappropriate limits on visits and medications**
 - ✦ **Dramatically under-priced reimbursement rates**
 - ✦ **Narrow definitions of medical necessity that negatively impacted using natural supports and peers; resistance to inclusion of substance use treatment in basic coverage**
 - ✦ **Loss of recovery focus in care to medical management**

On the other hand.



- **Data on mortality and morbidity for people diagnosed with major mental illnesses, including comorbid substance use disorders = a scandal for our field**
- **Life expectancy reductions of 20+ years cannot be allowed to continue**

The way forward: Reasons for optimism



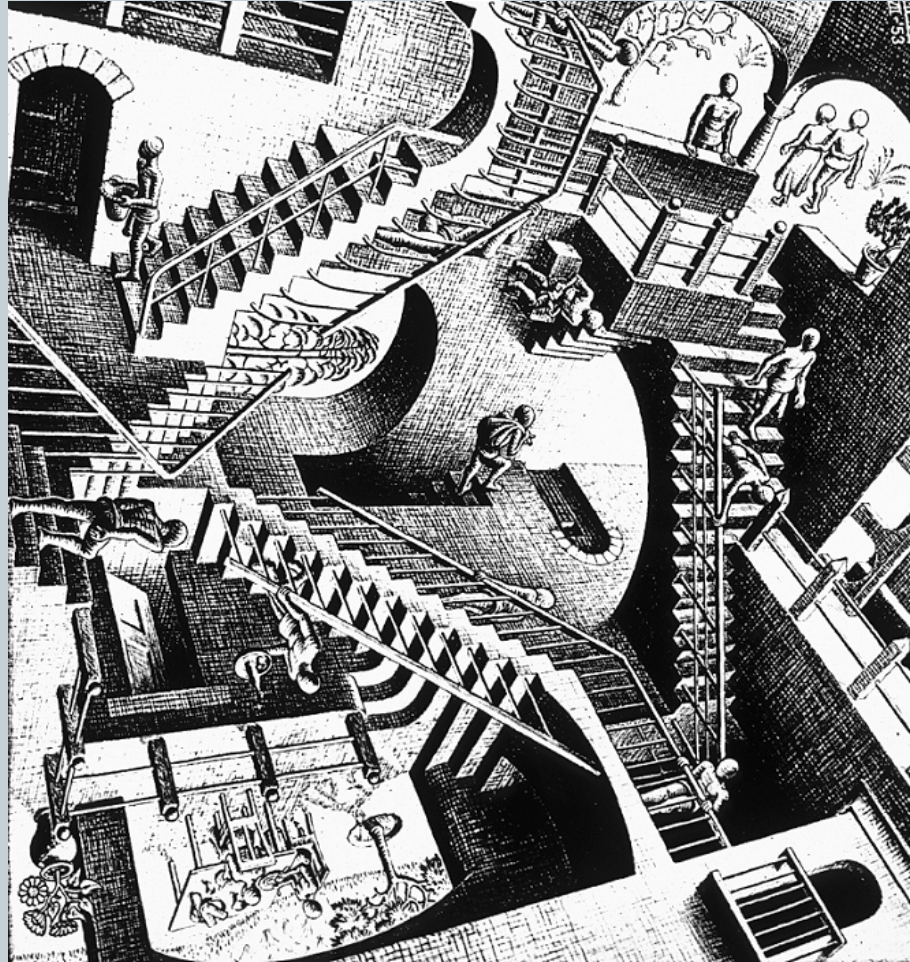
- Health care reform—improved potential for access for millions
- Behavioral health actually has something to bring to the table (more on this later)
- The new buzz words in federal integration circles is “bidirectional”: **not** a foregone conclusion that the mergers or integration will all be from behavioral health into primary care – and from primary care into behavioral specialty care.

Lessons from healthcare



- The history of how we arrived at the current healthcare “system” for general health is every bit as haphazard as ours.
- Atul Gawande, MD: Health care development was “path-dependent”, following the paths of least resistance
- M.C. Escher might have envisioned this history thus...

Can we all say “non-linear”?



Change in the real world.



- **What role can we play in shaping the change?**
 - We have learned a lot about engaging healthcare consumers in self-care, peer-supports, and non-medical supports and recovery services. We need to build on this and bring more “competent” workers into our ranks at ALL levels.
 - The Institute of Medicine has been pushing “person-centered care” for years—substantive convergence.
 - E-health and the Internet are arming healthcare consumers with vastly more knowledge...but it’s changing the **behavior** that improves health outcomes. New practitioners (e.g. interventionists) and practices (e.g. phone follow-up and outreach) are emerging.

The change process...



- Change always occurs in some real-world context
- ‘Managing’ change is not an illusion, but it is *also* non-linear
- One man’s theory of change...

Policy pinball.



The message for us:



Be prepared for the

- Political dimensions
- Economic dimensions
- Practice dimensions
- Need to keep building measurable resiliency, wellness and recovery in the impending change.

And there is even some helpful science: an emerging body of literature on integration, and successful models, too (Cherokee, InterMountain, etc.)

Wisdom from rural behavioral health



- **Behavioral health Exceptionalism... never an issue in rural America**
- **Practical realities have always encouraged if not required collaboration, co-location, integrated approaches**
- **But what about the PEOPLE needed to make it all work?**

Workforce development



- **For decades we have been using methods that don't work**
 - For continuing education
 - For graduate education
 - For bringing recovery specialists, wrong-degreed person and second career workers into the workforce

“Healthcare reform cannot happen on the backs of M.D.s and Ph.D.s alone. That will be too expensive.” – Mike Flaherty

Continuing Education



Graduate Education



And using approaches that make no sense



Some promising resources



- SAMHSA's *An Action Plan on Behavioral Health Workforce Development*
- CSAT's *Strengthening Professional Identity - Challenges of the Addictions Treatment Workforce*
- 2009 ATTC Workforce Survey and plan for 2011
- Annapolis Coalition and the Western Interstate Commission for Higher Education's *Alaskan Core Competencies for Direct Care Workers in Health and Human Services*
- *Emerging collaborations with Department of Labor and local Workforce Investment Boards*
- *Health Resources and Services Administration workforce development grants (see: HRSA web site)*
- *SAMHSA priority of workforce development (Dr. W. Clark, lead) and development of competencies*

More promising resources

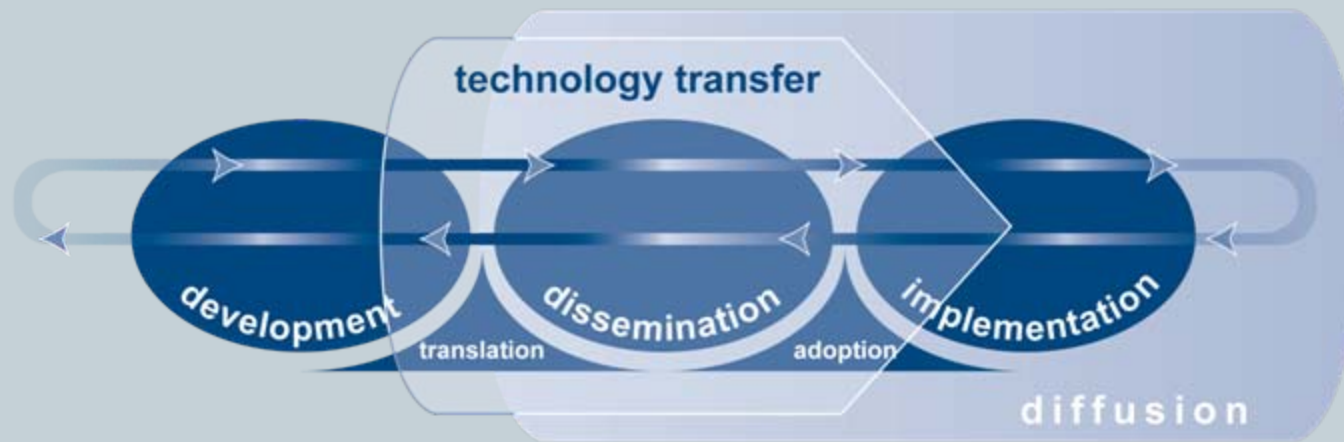


- **Tools: The ATTC Change Book (2002); Addiction Counseling Competencies (TAP 21);**
- **Guide to Substance Use in Primary Care (TIP24);**
- **Implementing Science Methodology, (2010)**
- **Building new collaborations, e.g. Department of Labor, HRSA, et al**

Building skills that can stick!

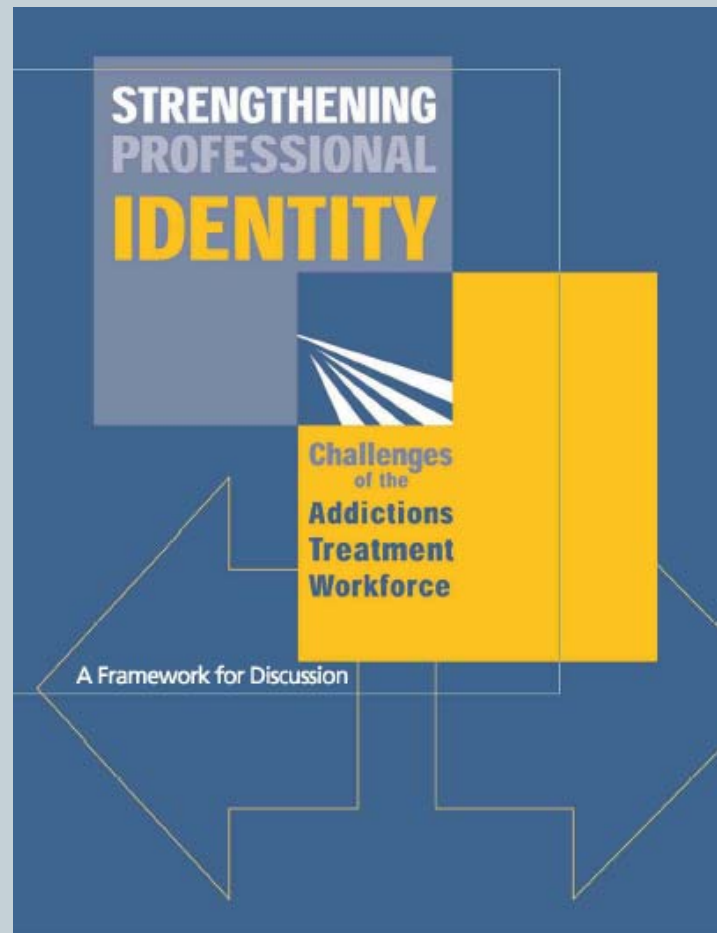


Technology Transfer in the Innovation Process



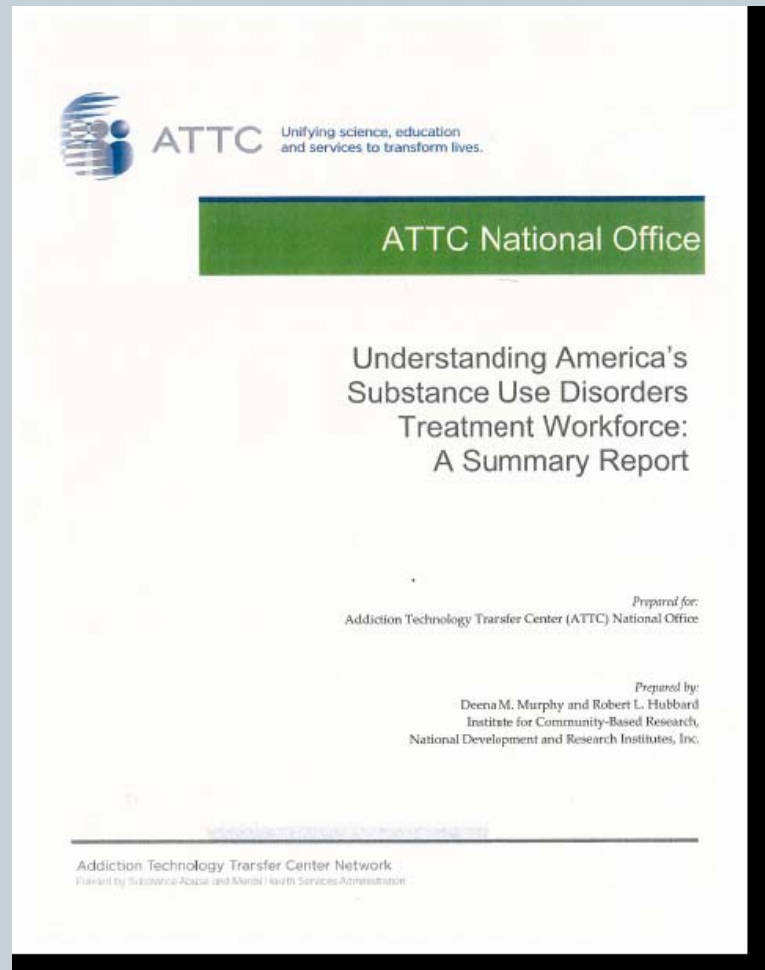
ATTC/Network.org

SAMHSA/CSAT's SU Focused Plan



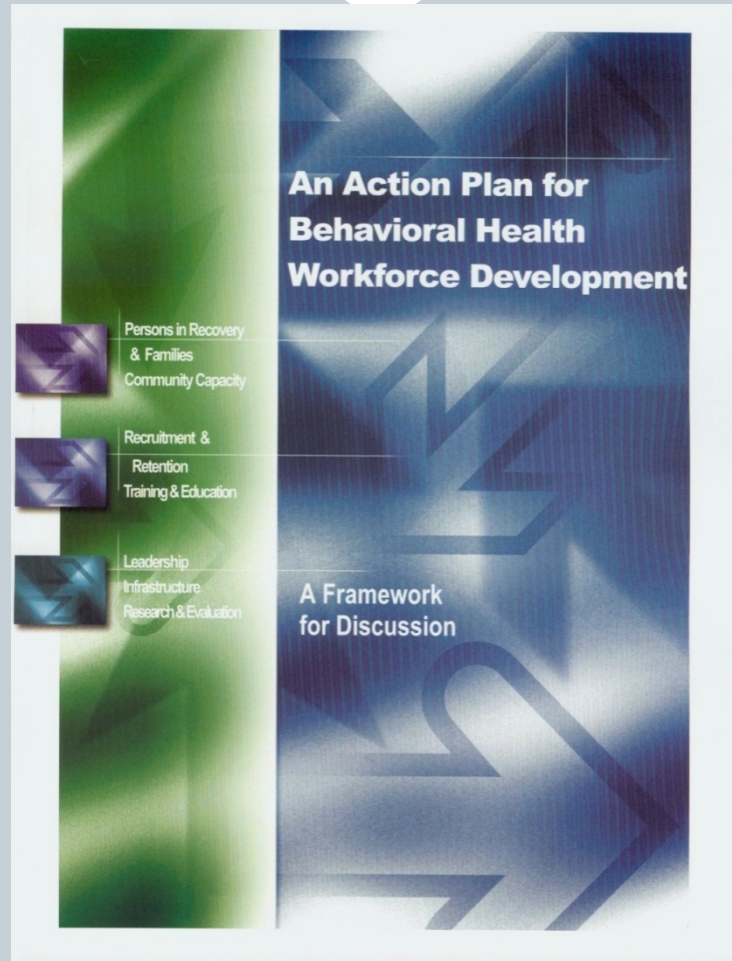
SAMHSA/CSAT (2007)

National ATTC Summary and Plan



ATTC/Network.org

National Action Plan



The seven major goals



- **GOAL 1: Significantly expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.**
- **GOAL 2: Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.**

The 7 major goals



- **GOAL 3: Implement systematic recruitment and retention strategies at the federal, state, and local levels.**
- **GOAL 4: Increase the relevance, effectiveness, and accessibility of training and education.**
- **GOAL 5: Actively foster leadership development among all segments of the workforce.**

The 7 major goals



- **GOAL 6: Enhance the infrastructure available to support and coordinate workforce development**
- **GOAL 7: Implement a national research and evaluation agenda on behavioral health workforce development**

CSAT's Strengthening Professional Identity



- Describes challenges today and fact we have an insufficient existing workforce to meet demands per se – not even considering 32% anticipated increase in demand for “Parity” and “Healthcare Reform”
- Describes the current high cost of NOT treating substance use (\$184 billion, Mark et al, 2005)
- Describes demographics of aging, short-stay workforce, low salaries, higher demands for technical competence and needs for special populations: e.g. elderly, adolescents, military, generalist practice, COD, criminal justice, medication misuse, interventionists-health educators, et al.
- Suggests implementation priorities for all including national core competencies standards and ATTC enhancement.

2009 ATTC National Office Report on Workforce



- **Updates demographics**
 - average age 50s; diversity and gender needs; high turnover-low retention
- **Anticipates needs 2010-2015 (prior to Reform)**
 - insufficient treatment capacity
- **Highlights common strategies and methodologies to prepare, retain and maintain the workforce**
 - retention: salary, tenure, education, workload
 - need for coordination and research of impact

WICHE and ANNAPOLIS



Alaskan Core Competencies for Direct Care Workers in Health and Human Services



Version 1.0
January 2010

Developed through a collaboration of
The Alaska Health Workforce Authority • The State of Alaska Department of Health and Social Services
The University of Alaska • The Western Interstate Commission for Higher Education
The Alaska Council on the Behavioral Health Workforce

This has it all



- **Cross-discipline**
- **Cross-disability**
- **Focused on those closest to the consumer**
- **Competency based**

In closing



- The True North of healthcare reform has got to be improved health outcomes for real people in the real world—which means people who have multiple health conditions.
- There can be no health without behavioral health.
- Therefore we are positioned to provide leadership and context as we navigate the various “paths” that Gawande alerts us lie ahead.

Thanks for listening, and...



Be in touch



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