Expanding the Behavioral Health Workforce

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Four of the six leading causes involve behavioral health:

1. Depression
2. Alcohol use disorders
3. Schizophrenia
4. Bipolar disorder

The other two:

Cancer
Cardiovascular Disease
The Behavioral Health Treatment Gap

- Mental Health Conditions
  - 45 million or one in five adults / year
  - 39% obtain treatment

- Substance Use Conditions
  - 22 million or one in ten adults / year
  - 10.8% obtain treatment
Causes of the Treatment Gap

- Stigma and discrimination
- Lack of health care coverage
- Insufficient services
- Inadequate linkages among services
- Inadequate behavioral health workforce: size and preparation
U.S. National Action Plan on Workforce Development

- Two years & 5,000 participants
- Funded by the federal government
- Developed by Annapolis Coalition
- Identified:
  - Set of Paradoxes
  - Strategic goals & objectives
  - Priority action items by stakeholder

www.annapoliscoaliton.org
Paradox 1: We train students for a world that no longer exists
Paradox 2: Those who spend the least time with patients receive the most training
Paradox 3: Training programs often use ineffective approaches to teaching
Paradox 4: We train behavioral health staff, though patients usually seek help from others.
Paradox 5: Patients & their families receive little educational support
Paradox 6: The diversity of the workforce doesn’t match the diversity of the patient population.
Paradox 7: Students are rewarded for “doing time” in our educational systems.
Paradox 8: We do not systematically recruit or retain staff
**Paradox 9:** Once hired, little supervision or mentoring is provided
Paradox 10: Career ladders and leadership development are haphazard
Strategic Goals & Policy Options

The Annapolis Framework
Three Broad Categories
1. Broaden the concept of “workforce”
2. Strengthen the workforce
3. Build structures to support the workforce

*Relevant at any “level” and any area of health and social services
Goal 1: Workforce Roles for Patients & Families

Objectives:

- Education about self-care
- Shared-decision making
- Expand peer & family support
- Greater employment as paid staff
- Roles in training the workforce

Example: Role of peers in decreasing hospital admissions & readmissions
Goal 2: Workforce Roles for Community Groups

Objectives:

- Develop community competencies
- Teach behavioral health providers to work with community groups
- Strengthen connections between behavioral health organizations and their communities

Common in Prevention, Rural Health, & Substance Use
Goal 3: Roles for Health & Social Service Professionals

Objective: Skill development with

- Primary Care Providers
  - Screening & brief intervention
  - Co-location
  - Consultation and referral
- Emergency department personnel
- School personnel
The Competency of Individuals and Teams
Goal 4: 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 strategies
Recruiting a Diverse Workforce
Goal 5: 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
Is it training....

...or just “exposure”?
“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 Care
Effective Teaching Strategies

“No magic bullets”

- Interactive sessions
- Academic detailing / outreach visits
- Reminders
- Audit and feedback
- Opinion leaders
- Patient mediated interventions
- Social marketing
Direct Care Workforce – Alaska Core Competencies

1. Cross-sector set of core competencies
2. Assessment tools
3. Comprehensive curriculum
4. Train-the-trainer learning communities
5. Coaching toolkit
6. Cost-model
7. Marketing initiative
Objectives:

- Improve organizations’ supervision policies, standards & support
- Identify leadership and supervisor competencies
- Competency-based curricula & programs
- Formal, continuous leadership development in all sectors beginning with supervision
- Succession planning
Why Focus on Supervisors?

- More stable workforce – less turnover
- Large sphere of influence (lever)
- Less of them (more cost-efficient)
- Bridge from administration to direct care staff
- Undermine new policies & practices if not thoroughly involved

“If you could only do one thing…..”
Increased Need for Supervision

1. Increased case-loads
2. Shift from facility to community care
3. Greater autonomy
4. Individual complexity (co-occurring)
5. Greater risk (risk assessment & mgmt)
6. Service complexity (EBPs)
7. Systems complexity
Supervision OR Surveillance?
Implementation science approach

1. Organizational change
   - Supervision Policy & Standards

2. Staff development at all levels
   - 3 classic functions (admin, education, support)
   - Consultations & conversations
   - Ongoing learning community

Tailored approach with various systems & organizations in multiple states
Another Paradox: Healthcare systems often undermine the competent performance of individuals.
Goal 7: Infrastructure

Objectives:

- Strengthen human resource & staff development functions
- A workforce plan
- Data-driven quality improvement on workforce issues (CWI)
- Information technology to support training, workforce activity, & activity tracking
- EMR to decrease the paperwork burden: variable, redundant or purposeless reporting
State Level Infrastructure

- Behavioral Health Education Center of Nebraska
  https://www.youtube.com/watch?v=kKbcCBpa_Tw&feature=youtu.be

- Alaska Mental Health Trust Authority
  http://mhtrust.org

- Connecticut Workforce Collaborative on Behavioral Health
  http://www.cwcbh.org

- Massachusetts Children’s Behavioral Health Knowledge Center
  http://www.cbhknowledge.center/workforce-in-ma/
Goal 8: Evaluation & Research

Objectives:

- Improved workforce data and trending
- Documentation & dissemination of effective workforce practices
- Evaluation & research on workforce development practices

The search for innovation…
Goal 9: Financing

Objectives: Adequate service funding and worker compensation
- Service agencies are underfunded
- Workforce size is constrained
- Wages and benefits are suppressed
- Worker caseloads, burden, burnout, and turnover increase
- The economic benefit of pursuing these careers declines
- Recruitment becomes more challenging
Healthcare Reform: Affordable Care Act

- Major increase in coverage
  - 32 million newly covered
  - 30 million with expanded benefits
- ACA Workforce provisions
  - Expanded education & training grants
  - Expanded loan repayment
  - Focus on social workers, psychologists, and child/adolescent
  - Some provisions lack appropriations
  - Overall workforce impact is small
Health Care Reform: Parity Act & Regulations

- MH/SA one of 10 essential benefits
- “Full” parity (co-pays, limits, UM)
- Includes outpatient & residential tx
- Does not apply to Medicare
- A earlier “Guidance” indicated that the 2008 law should apply to Medicaid
- Next issue: compliance & network access & adequacy
- State insurance commissioners responsible for compliance
Health Care Reform: H.R. 2646 & H.R. 2680

- Enforcement of Parity
- Minority Fellowship Programs
- Graduate Psychology Education
- Interprofessional Education Training
- Pediatric Mental Health Specialists eligibility for National Health Service Corps
- Underserved child populations as designated workforce shortage areas
- Campus mental health
Handouts / Articles

- 20 Strategies (One pager)
- Annapolis Framework (Health Affairs)
- State Workforce Transformation
- Integrated Care Competencies
- Higher Education Curriculum Reform
- Direct Care Workers (Alaska)
- Strengthening Supervision
THANK YOU

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Alaskan Core Competencies
The Annapolis Coalition played a central role in developing the Alaskan Core Competencies for direct care workers in the health and human services sectors.

The Annapolis Coalition on the Behavioral Health Workforce is a non-profit organization dedicated to improving the mental health and addictions workforce.

About Us
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Our Work
Since 2001, the Coalition has served as strategic planner, advisor and technical assistance provider on the behavioral health workforce.

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Resources
Currently in development, our Resources page is the portal to a repository of links, articles and other sources related to the behavioral health workforce.

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