WORKFORCE DEVELOPMENT WORKGROUP CHALLENGES 4/10/2013

Meeting Process:
Of the 122 registrants, 79 individuals attended.
To allow for processing in small groups, 15 tables were set "dining room" style, for 10 individuals each.
Random assignment to groups was assured by pre-numbering sequential packets that corresponded to numbers on each table.

WORKFORCE DEVELOPMENT was defined as encompassing:
- Crating a competent, co-occurring capable workforce
- Skills and knowledge throughout the system from hospital to community
- Cultural values and cultural competence of consumers and community providers
- Clear roles and expectations
- Credentialing and knowledge
- Delivery of EBPs
- Division staff modeling systems reform, skill sets, knowledge and direction
- Collective bargaining
- Involvement of education systems, Institutions of Higher Learning, other outside resources
- External workforce development – credentialing, staffing, training, competencies and skills throughout the system
- Training
- Cost and manpower for measurement
- Impact of community integration and move to managed care
- Special Populations

Based on feedback from the first workgroup participants, 4 challenge areas were presented for small group discussion and input. The challenge to define Division Strengths was removed, as it was viewed as repetitive with Opportunities by several respondents of the Community Integration work groups:
- What might stand in the way of the Division taking action? Discuss obstacles that can be changed and make suggestions!
- What opportunities does the Division have? Discuss things that can we can take advantage of toward growth!
- What action steps need to be taken? Discuss things that can we can accomplish toward growth!
- What are potential outcome measures? How can we measure our accomplishments?

The meeting began at 10:05 am.

After introduction to the day, a large group Challenge was issued:
In the area of Workforce Development, what would be important for the Division to focus on?
What should our goals be?

Input was recorded, and at 11:30 small groups began working on the 4 challenge areas.

Impact of process:
The groups developed lists of items that were important for the Division to focus on. At the end of the day, individuals prioritized those items by placing stickers onto items that each individual thought were most important to start with in systems change. Group(s) input is presented in running lists, using the language and order of their work sheets.

Challenge! Group 1: What might stand in the way of the Division taking action?

Discuss obstacles that can be changed and make suggestions!
Ability of leadership to model standards and principles of integration
Provide a directory of Division staff
Ability for funding of needed resources
Political/theoretical differences remain
Having to make policies and regulations agency friendly
Working collaboratively with licensing entities
Ability to increase trainings and accessibility
IT capability and capacity
Meeting the needs of co-occurring
Current service delivery system is not modernized enough for the system being created.
Funding mechanism does not support client centered care
Lack of agency accountability
Lack of integrated records systems between providers and Division
Decreased legislative dollars
How to address over-utilization of resources by consumers with addiction in mental health
Silos in agencies effect staffing practices, and delivery of services
A small segment of the population uses the majority of resources
Timeline for cultural change - ambitious
Becoming timely in response ability
Being realistic about our ability to acclimate to our new processes.
Being proactive rather than reactive.
The lack of funds to seed and sustain the system change at all levels
Requirements need to match resources.
The preconceived notions, perceptions and attitudes that remain in both the mental health and addictions communities
There are outdated views about full time and part time employment for peers, especially those working in mental health settings
There is a lack of knowledge of all services available within both systems.
Stakeholders have contrasting expectations, belief systems, visions

Communication, cultural, philosophy, orientation, training differences all create barriers
Due to retirement, staff change there is a loss of history
Unknown variables: ASO, fee for service, managed care, peer roles required credentials, funding from year to year.
Delays in moving the ASO process forward.
Funding streams remain separate
There is a fundamental belief that mental health and addiction are different
     'We don't say 'MH and Bi-polar, but we say MH and SA'
DMHAS doesn't know Daily Treatment Capacity

Challenge! Group 2: What opportunities does the Division have? Discuss things that can we can take advantage of toward growth!

Prevention grant – only for DAS licensed – open those kind of things up
Create/provide credentialed organizations that are empowered and required to hire licensed staff with diversity of core competencies and credentials, including peer.
DMHAS should recognize and work in conjunction with credentialing Boards.
Empower and fund agencies.
Allow agencies to include training cost in their budget lines.
Opportunity to provide core competencies in best practices
- Stages of change
- Meant health
- Trauma
- Motivational interviewing
- Co-occurring
- Cross training
Utilize opportunities with the ASO to develop needed training
Merge mental health and addictions
Use existing providers, counties, state employees for training
Expand internship programs
Standardize orientation across providers
Develop core standardized courses to maintain credentials
Outcome measures can be developed and related to training, competencies can be related to targeted funding (eg via federal funding)
Training priorities can be established
Assessment to identify what is available statewide and what is needed for development
Find the commonalities between DAS/DMHS to unify and create an umbrella through DMHAS that will eliminate silos.
True integration on state level
Integrate website
Improve communication
Improve knowledge of resources

Challenge! Group 3: What action steps need to be taken? Discuss things that can we can accomplish toward growth!

Merge belief systems
Cross train staff so that MH and addictions staff understand that addiction IS a MH issue and treatment shouldn't be denied or separated
Crate an integrated mental health assessment
EDUCATION:
Encourage masters level, LCADCs LSWs, LPCs, Dual credentials
Increase reimbursement
Join with UMDNJ to provide trainings to obtain different levels of credentials.
Advanced education for peers and offer reimbursement to match credentials.
REVIEWS
Develop a joint review and educate agencies on it
Combine reviewers and have common language
Improve licensing communication
Combine regulations
Detox on demand
Change criteria for screening for substance use vs mental health
      Reduce barriers to access
      Same guidelines
Career progression is in the system
Identification of existing resources, and those resources are made consumer/peer friendly (education, intervention, screening, treatment)
Increased use of IT for training
Incentives for career development, advertising what opportunities exist
Core competencies at all levels are defined, and peers were used in the development of those competencies
Sensitivity training
Train staff to provide person centered treatment. Eliminate paternalistic and coercive treatment
Cross training occurs for all staff and it includes uniform standards, e-Learning and webinars
There is accountability for supervision
Internal audits exist for clinical supervision
Adopt an existing, effective system for training ex. NAMI, program analysts-substance abuse & expedite the training
Commit to a reasonable budget (Based on the that we need a competent and well paid workforce to accomplish the mission)
Decide on core competencies *(including med. Monitoring, person entered care, trauma informed care, IMF/WMR, wrap, crisis intervention, working with peers)
Provide opportunities to train in core competencies and earn CEU's
Require Appropriate credentials for substance abuse MH & dual recovery services Accept: CPRP (with or without degree) approve peer certs: CRASP, CWC
Give priority to supervision time to assure quality services are provided.

Train staff to provide person center thanks and eliminate paternalistic and coercive thanks (sensitivity training)

Encourage more youth to enter MH and AS professions.

Identify existing programs and providers using effective practices

Looking at existing partnerships and building upon them.

Reviewing other disciplines efforts to overcome shortages in the workforce in different regions i.e. (utilizing schools, universities and professional associations. i.e. NJAMHM NIATZ, NAMI, SAMSHA

Utilizing licensed professionals (Dual) to draw upon their experience to streamline the process, reduce redundancy and provide mentoring.

Provide incentives for agencies who achieve Gold Standards

Create a Behavioral Health model of care that encompasses continuity across treatment programs

Define what it means to be a Co-occurring specialist

Define workforce development components for all levels

Support patient navigator throughout all levels

Cultural competency for the workforce

Explore compensation for direct care staff

Support academic incentives for students pursuing clinical certifications

Collaborate with academic institutions to offer scholarships and field placement opportunities

Challenge! Group 4: What are potential outcome measures? How can we measure our accomplishments?

The ASO and insurance companies will recognize all licenses for supervision and reimbursement.

Core Competencies are well defined for co-occurring disorders

The curriculums in graduate school match need in community

Credentials for all levels of care are clarified.

Staff can pass the ICRC qualifications for COD services before being employed for provision of services.

Addiction treatment adheres to the LCADC/CADC standards

There will be standardization of core competencies

A percentage of agency budgets will be dedicated to training

Life experience will be recognized as of value.

Consumer satisfaction will be reflected in outcomes

Recognized Centers of Excellence will be developed

Use of standardized staff and consumer satisfaction surveys

Group supervision at the provider level

Regional co-occurring service providers meeting on a consistent, regular basis.

Integration on state level via website- Div. of MH & A Services ex. Separate pages, MH pages only under Div. of MH. Improve knowledge of services, resources, improve communication- mimic DCF webpage.

Collaboration opportunities under the ACA (Affordable care act)

A survey of the NJ addiction and MH workforce ascertains the level of satisfaction/perception of role of peer specialists in agencies.

Measure and track staff turnover

Survey ability of agencies to conduct legitimate outcome measures

- Consider benchmarking

Survey the workforce to ascertain level of satisfaction/perception of role in agency and among peer specialists

Consistently measure turnover among staff

Benchmarking

Measure staff clinical competency

Develop standardized mechanism for benchmarking/outcome measures

Measure staff learning before and after bot observational learning and training

Measure clinical competence on:

- Staff and consumer outcomes

- Satisfaction

- Retention

- Abstinence

An expanded workforce can be measured by:

- Tiered system

- Reimbursed case management and peer support

- Increased funding to attract people into the workforce

- Standardized training that is open to all providers not just funded providers, across both disorders

- Training and supervision for EBPs can be measured by:
    - Collaborative training between agencies
    - Treatment becoming recovery oriented and person centered