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Members of the study team include (alphabetically): Seong-yi Baik, RN, PhD, Lon Herman, MA, Ronnie D. Horner, PhD, Danelle Hupp, PhD, and Phyllis C. Panzano, PhD.

We are especially indebted to the five Ohio behavioral healthcare organizations that participated in this research: The Centers for Families and Children in Cleveland, Community Support Services, Inc. in Akron, Greater Cincinnati Behavioral Health Services in Cincinnati, Shawnee Mental Health Center, Inc. in Portsmouth, and Southeast Recovery & Mental Health Care Services, Inc. in Columbus.
Executive Summary

Little is known about how the job duties and tasks of Direct Service Workers (DSWs) have changed and will further change under new models of healthcare integration in which primary care is brought into behavioral healthcare settings that serve adults with severe and persistent mental illness (SPMI), a rapidly emerging best practice.1,2 Hence, little is known about what knowledge, skills and other competencies may be required of DSWs who are involved with this particular niche of integrated healthcare (IHC) programs.

The purpose of this study is to begin to fill the gap in knowledge by exploring changes in current and emerging job requirements and worker qualifications of DSWs involved with the delivery of IHC to adults with SPMI. The study responds to two priority areas in Ohio’s Long-term Direct Care Workforce Project Request for Applications (RFA) (i.e., skill sets and competencies; organizational best practices) in that it considers job requirements that have emerged for DSWs across five Ohio sites that are currently engaged in implementing Substance Abuse and Mental Health Services Administration (SAMHSA)-funded primary and behavioral healthcare integration (PBHCI) demonstration programs for adults with SPMI.3 The study also explores DSW job requirements that are anticipated to emerge as Ohio implements its Centers for Medicaid and Medicare Services (CMS)-approved Health Home Benefit (HHB) for adults with SPMI.

The logic model that guides our research questions and study methods is shown below. Beginning at the top left, the logic model suggests that the formal IHC program requirements for SAMHSA-funded PBHCI grantees along with the federally-approved requirements for Ohio’s HHB define a set of criteria that must be satisfied. Some of these criteria are likely to affect DSW job design. The box to the immediate right recognizes that behavioral healthcare organizations (BHO) have substantial latitude to determine how these IHC programs will be operationalized or carried out in real-world settings while still meeting mandated requirements. In accomplishing this, BHOs are expected to take past experience, local resources and other constraints or conditions into account as the details of IHC program design (i.e., PBHCI program or HHB package) are fleshed-out. So, moving downward in the model, requirements and contextual variables are anticipated to converge and define a set of factors that will affect DSW job design for this IHC program niche. In turn, these common and unique factors are expected to dictate new, essential DSW job duties and worker qualifications. The logic model below forms the basis for the three research questions that guide this exploratory study:
• **Research Question 1**: Do the job duties and worker qualifications (i.e., competencies) of DSWs involved with delivering IHC services in SAMHSA-funded PBHCI programs and/or who will be involved with Health Home Benefit (HHB) Teams differ from those for comparable DSW positions carried out in traditional, non-integrated, behavioral healthcare settings?

• **Research Question 2**: Do existing PBHCI or anticipated HHB program requirements and contextual characteristics converge to define a set of factors that account for essential (anticipated) differences in DSW requirements?

• **Research Question 3**: Can DSW worker competencies associated with IHC or HHB Team service delivery be prioritized by importance for all DSWs so as to guide the training of the workforce to more effectively function within the context of the rapid healthcare integration that is occurring within this IHC program niche?

All five (5) SAMHSA-funded PBHCI programs for adults with SPMI in Ohio (out of 56 projects nationwide) that were underway when the study began agreed to participate. Although the five sites, located in Akron, Cincinnati, Cleveland, Columbus and Portsmouth, varied in terms of key contextual characteristics (e.g., IHC program structure, past history with primary care), each had to meet mandated program requirements set forth by SAMHSA that they did in a variety of ways. In addition, although the study intended to focus on direct service work in the context of PBHCI demonstration programs, the scope of the study was expanded to have relevance to the rapidly emerging healthcare context as Ohio moved forward with an HHB application to CMS. Accordingly, and with unanimous support from participating sites, the three research questions were expanded to include anticipated changes in DSW job requirements under Ohio's HHB application.

Our methods were primarily qualitative. Each site completed a background survey and was asked to provide additional written material describing the nature of their PBHCI program and DSW worker jobs. Subject matter experts (SME) were recruited at each site to participate in a sequence of two, on-site, structured, small-group interviews. Finally, ten SMEs representing the five sites participated in a cross-site focus group to review and react to major study findings and to discuss their policy implications. As detailed in the full report, the findings provide preliminary support for the logic model and suggest initial answers to research questions:

• **Research Question 1**: DSWs involved with the delivery of PBHCI and/or HHB programs were found to have new job duties and competency requirements that are substantially different from those required of DSWs working in traditional program settings (i.e., non-integrated, behavioral healthcare programs).

• **Research Question 2**: Program requirements and contextual factors were found to define a set of common and unique factors that are driving change in DSW job duties and competencies among behavioral healthcare organizations (BHOs) that are offering IHC programming within this niche.

• **Research Question 3**: There was indication that priority should be given to workforce development related to ‘common’ (rather than context-specific) changes in DSW job requirements for DSWs working within this IHC program niche.

These findings suggest some likely areas of policy impact, which are addressed in more detail in the full report:

• **Regulatory Requirements**: Regulatory requirements impact DSW job design in important ways but contextual characteristics matter too. Common and unique factors must be taken into account.

• **Recruitment**: New duties and qualifications are likely to affect compensation packages, worker eligibility/qualifications, and job structure (e.g., scheduling, job design, IHC team composition).

• **Retraining Existing Workforce**: This niche of IHC programs calls for both on- and off-the-job training and supplementary education for DSWs in several content domains. Of note, for
DSW managers, it demands new leadership skills and knowledge about change management, and effectively managing teams.

- Pre-service Training: New curricula will need to be developed for training DSWs. Roles and incentives for colleges/community colleges/universities, and work experience and job readiness programs must be clarified. This will require state-level leadership support, for example the Board of Regents’ expectations and alignment of resources, such as a MEDTAPP subsidy, to promote the growth and development of these programs for the emerging workforce.

**Project Overview**

Ohio is proceeding with great urgency to transform the direct care workforce system in response to healthcare forecasts which, if unchecked, have high potential to result in negative impacts on the Ohio economy and the financial and overall health of all Ohio residents. Unless a solution is found, there will be a dramatic shortage of appropriately trained, long-term DSWs in the health and human services sectors at a time of a rapid rise in the number of Ohio residents receiving Medicaid and the associated increase in demand for long-term care while general revenue funds are limited.

Ohio leaders envision the transformation of the direct care worker system into an efficient, high-quality system through professionalization; that is, by integrating basic and developmental education into a series of technical, credit-bearing, 'stackable' certificates. Beyond improved service quality and efficiency, professionalization yields new career paths, and expanded employment opportunities for the state's long-term direct care workforce.

Building on the work from Alaska and elsewhere, the Ohio work plan is to create a career lattice that articulates core (level 1) competencies that apply to all members of the long-term, direct care workforce. Additional skill and competency sets will be identified that are setting-, service sector-, and specialization–specific. This will result in the articulation of a compartmentalized and stackable system which will guide education, training, planning, and policy-making (e.g., compensation system design) activities.

The conceptual model of the career lattice and ladder underlies our research questions, particularly as the model addresses the structure and relationships among competencies across the various competency levels. The sum-total of competencies required of particular DSWs is conceptualized as a stackable array of competencies which include: core competencies + setting-specific competencies + sector-specific competencies + specialization-specific competencies.

This study applies this general framework and a related logic model to direct services workers (DSWs) involved with Integrated Health Care (IHC) Programs that serve adults with severe and persistent mental illnesses (SPMI). The original intent of the project was to focus on new job requirements (e.g., duties and competencies) of DSWs affiliated with several federally-funded Primary and Behavioral Healthcare Integration (PBHCI) demonstration programs underway in behavioral healthcare organizations (BHO) in Ohio. The scope of the study expanded to address emerging DSW job requirements linked to Ohio's implementation of Health Home Benefit (HHB) teams that serve adults with SPMI because Ohio's HHB application to the Centers for Medicaid and Medicare (CMS) was approved roughly at the same time data-collection for this study began. As a result and as described below, the specific aims of the study were broadened to be inclusive of the larger context affecting the niche of Integrated Health Care (IHC) programs which serve adults with SPMI.

**Background and Significance**

Effective and sustainable workforce education and planning systems must be future-oriented. They must be sensitive to the competency requirements of the existing workforce while also being responsive to emerging worker and industry needs. Ohio's current plan to transform its long-term direct care workforce is such a forward-looking system. This study focused on a rapidly emerging best practice -- integrated healthcare -- in terms of its potential implications for job requirements (e.g., duties and competencies) and new career opportunities for Ohio's long-term direct
IHC Programs

The integration of primary and behavioral healthcare is increasingly recognized as a best practice for which rapid implementation is being driven by the emergence of new health care demonstration and funding programs, and by new healthcare structures such as federally qualified health centers and accountable-care organizations. Consequently, it is important to begin to examine the potential implications of the IHC programs and structures for Ohio's long-term direct care workforce. This investigation does that with regard to IHC programs that serve adults with SPMI.

IHC programming affects all aspects of operations at the organization and system levels: clinical, operational, and financial. Issues arise as diverse and far-reaching as funding stream compatibility, electronic medical records and billing systems, integrated clinical models, differences in world-view among behavioral and physical healthcare practitioners, and a myriad of additional workforce challenges. Yet, the need for IHC is so well-documented that it cannot be ignored, especially for adults with SPMI. Extensive data demonstrate that individuals with SPMI are disproportionately affected by physical health conditions. For example, Jones and colleagues determined 74% of adults with SPMI had at least one chronic health problem and 50% had two or more chronic physical health problems. Adults with SPMI also are at high risk for premature morbidity with their average lifespan estimated to be 25 years less than for the general population. Physical health issue and lack of accessible, affordable physical healthcare are major factors accounting for this increased mortality. For example, an extensive review of the literature on bipolar disorder and medical mortality found the majority of premature mortality was due to general medical illness. Causes included: 1) modifiable risk factors (e.g., unhealthy diet, obesity, smoking); 2) access to care challenges (e.g., poor access to and less effective use of physical healthcare, biased attitudes among healthcare providers), and 3) biological factors (e.g., effects of stress on the immune system, side effects of pharmacologic treatment).

As a result of calls for integrated approaches to reduce excess morbidity and mortality for this population, different IHC models are being evaluated by the Substance Abuse and Mental Health Services Administration (SAMHSA) through a primary and behavioral healthcare integration (PBHCI) program which is just beginning its fifth year. Currently, roughly 90 such programs have been funded nationwide, seven of which are in Ohio. PBHCI programs are hosted by behavioral healthcare organizations (BHOs) and primary care services tend to be made available either by partnering with primary care providers or by hiring primary care professionals. Consequently, PBCHI programs stand in contrast to the most common IHC programming structures which bring behavioral health services into an existing medical home or primary practice. This more typical solution appears to hold high promise for individuals with mild to moderate mental illness. However, alternative views of integration such as SAMHSA's PBHCI demonstration program “run[s] the river the other way and integrate[s] the practice of medicine into psychiatry” by locating the medical home where a person receives behavioral health care services. This strategy is expected to increase access and be a more effective approach to providing integrated care for adults with SPMI. In fact, beginning in 2009 and every year since, SAMHSA issued a Request for Applications (RFA) that follows this alternative view. The main goals of this PBHCI program are to assess the impact of PBHCI on the health status of adults with SPMI, and to explore the relative effectiveness of different PBHCI approaches. The funding allowed grantees, including the five from Ohio that participated in this investigation, to coordinate and/or integrate primary care services into publicly-funded, community-based behavioral health settings.

Competency-based Approaches to Strengthening the Direct Care Workforce

Many initiatives are underway to strengthen the long-term direct care workforce through job and task analysis, and assessments of competency (e.g., skill, knowledge, and ability) requirements. An exemplar of this trend is an initiative spearheaded
The AMHA initiative is well into implementing its “ambitious, multi-year agenda” to: (1) build a set of core competencies tailored to Alaska’s direct care workforce; (2) create a set of assessment tools for use by educators and employers to evaluate worker competency, and (3) implement a credentialing system for this workforce to promote professionalism, career mobility and advancement, and greater access for employers to a qualified pool of job candidates. Building on this work, Ohio has launched a comprehensive initiative to develop a competency and skill-based health and human services lattice to support the transformation of the state’s long-term Direct Care Workforce (DCW) system. This project was designed and conducted to generate data to inform this initiative.

**Logic Model**

The logic model that guides the study design, methods and research questions is shown below. Beginning at the top left of the figure, the model suggests that formal IHC program requirements from entities such as funding agencies, and state and federal authorities are expected to significantly impact the design of jobs for service workers, at all IHC program levels. For example, SAMHSA requires all PBHCI demonstration sites to provide a core set of services to adults with SPMI which include: 1) behavioral healthcare services, 2) primary healthcare services, 3) wellness and prevention services, and 4) referral to (and follow-up on) specialty services from outside providers. These required PBHCI service components clearly have an affect on job duties and competency requirements of DSWs who work on or in conjunction with these federally-funded IHC programs. The same can be said of performance domain requirements and worker qualifications (e.g., licensing, experience) associated with the delivery of Ohio’s recently-approved Health Home Benefit (HHB) to adults with SPMI. Ohio’s HHB requires DSW’s to assist with overall care coordination, referral and linkage, follow up and consumer, family, guardian and/or significant others support and health promotion services. Thus, mandated IHC program requirements are expect to define a set of factors that shape the jobs of DSWs.

The box in the top right of the figure reflects the idea that BHOs have considerable latitude in determining exactly how IHC programs will be designed (e.g., local approaches and constraints). In other words, IHC programs can be operationalized by BHOs in a variety of ways and still meet required parameters. For example, PBHCI demonstration sites can choose among a wide array of prevention (e.g., smoking cessation, chronic disease self-management programming) and wellness (e.g., yoga, walking groups, dance) programs in order to suit their preferences, take advantage of available expertise, and/or to satisfy client interests. The same can be said about BHOs which offer HHB Team services to adults with SPMI. For example, some job duties associated with the role of Qualified Health Home Specialist (QHHS) can be divided up, shared, or performed in parallel among different HHB team members (e.g., peer specialists, community support psychiatric team staff) who meet QHHS qualifications. Local context
is expected to make a difference as well. BHOs are expected to take past experience, local resources and other constraints or conditions into account as the details of IHC program design (i.e., PBHCI program or HHB package) are 'localized' and fleshed-out. Continuing downward in the figure, requirements and contextual variables are expected to converge in a set of concrete, common and unique factors that directly drive or account for change in the jobs of DSWs who work on or with IHC Teams, serving this particular niche of clientele. The DSW job duties and worker qualifications that result are a product of these factors.

The logic model forms the basis for three exploratory research questions that guide the investigation:

- **Research Question 1**: Do the job duties and worker qualifications (i.e., competencies) of DSWs involved with delivering IHC services in SAMHSA-funded PBHCI programs and/or who will be involved with HHB Teams differ from those for comparable DSW positions carried out in traditional, non-integrated, behavioral healthcare settings?

- **Research Question 2**: Do existing PBHCI or anticipated HHB program requirements and contextual characteristics converge to define a set of factors that account for essential (anticipated) differences in DSW requirements?

- **Research Question 3**: Can DSW worker competencies associated with IHC or HHB Team service delivery be prioritized by importance for all direct care workers so as to guide the training of the workforce to more effectively function within the context of the rapid healthcare integration that is occurring within this IHC program niche?

## Design and Methods

### Study Design

The project was designed as an exploratory study that would generate preliminary information regarding new and emerging job requirements (e.g., duties, competencies) of DSWs who work on or with IHC programs tailored to adults with SPMI. The research methods were primarily qualitative.\(^{14,15}\) Due its short, 1-year time frame, the primary goals of the investigation were to provide initial data about the changing nature of DSW jobs, to identify an initial set of related policy issues, and to contribute to the development of a research agenda to guide future, more definitive investigations on this topic.

### Research Sites

The project was conducted using a convenience sample of all five SAMHSA-funded PBHCI demonstration project sites in Ohio that were active at the time of the study. These five sites include: The Centers for Families and Children in Cleveland, Community Support Services, Inc. in Akron, Greater Cincinnati Behavioral Health Services in Cincinnati, Shawnee Mental Health Center, Inc. in Portsmouth, and Southeast Recovery & Mental Health Care Services, Inc. in Columbus. In keeping with the full group of 56-grantees, across 26 states that were funded at that time, the five Ohio sites were considered by SAMHSA to be leaders in integrated healthcare for adults with SPMI. The project was reviewed and approved by the University of Cincinnati Institutional Review Board (IRB) and that of the Northeast Ohio Medical University with the former IRB serving as the IRB of record for the project.

### Initial Site Visits and Distribution of the Facility Survey

The research team made four visits to each site. The first visit was with agency leaders such as the Chief Executive Officer (CEO), the Chief Clinical Officer (CCO) and the PBHCI Program Director. The primary goal of the meeting was to provide a detailed project overview to give agency leaders a clear understanding of major research questions, what the project entailed, and the burden of participating. During each of these initial site visits, we obtained a verbal agreement of willingness to participate.

Agency leaders subsequently were asked to complete a Facility Survey which included a series of questions about the BHO's prior history delivering primary care to adults with SPMI and/or client populations, and about their PBHCI program and staffing model and implementation status. The facility survey was adapted from a survey developed by the RAND
Corporation and administered to a subset of PBHCI grantees in the spring of 2011. The research team sought and received permission from RAND (via email communication with Dr. Deborah Scharf) to adapt the survey. Modifications made were extensive. Agency leaders also were asked to provide any additional written information which described their PBHCI program and staffing model (e.g., SAMHSA proposal, job descriptions), and/or their HHB Team application to the Ohio Department of Mental Health (ODMH).

The second visit to each site was to recruit subject matter experts (SME) into the study at which research team members provided participants with a study overview, described the burden of participating, and reviewed the informed consent form in great detail. Participants were nominated by agency leaders based on their ability to serve as SMEs regarding IHC programming for adults with SPMI, and/or DSW job duties (traditional, PBHCI program-related, and HH Benefit – related). Each agency was asked to nominate 7-10 SMEs. SMEs were technically viewed as key informants rather than research subjects. This is because SMEs were asked to address issues and questions about classes of DSW jobs, and types and trends of IHC programs rather than to answer questions about their own jobs. These individuals were expected to be able to describe and contrast past and current DSW job requirements and to envision future DSW job requirements associated with evolving and emerging models of IHC, including Ohio’s HHB Team model. However, each provided signed informed consent to participate.

Small Group Interviews and Cross-site Focus Group

Two structured interviews were conducted at each site, about 1 month apart, at which information was obtained regarding barriers and facilitators to integrated health program implementation, factors driving change in DSW jobs, DSW job titles, roles and responsibilities within the integrated healthcare program as such compared with similar workers in traditional programs and anticipated under the Health Home delivery model that would begin within about a year. A subset of participants from each site then attended a final cross-site focus group. These individuals were asked to review and react to a synopsis of the findings and discuss the implications of findings for the development of the DSW workforce in Ohio, and/or the implementation of IHC programs that serve adults with SPMI.

Interview protocols for the two face-to-face small-group interviews at each site, and the script for the cross-site focus group were formulated, selected or adapted on the basis of existing measures, protocols, job and occupational data, the IHC Program literature, research team member experience, guidance from experts, and information provided by sites (e.g., written material regarding PBCHI program design) and our logic model (Figure, page 8). Following standard qualitative research techniques, these protocols evolved over the course of the study as new information was learned from participants.

Similarly, we drew from materials produced by the Alaska Mental Health Trust and the Annapolis Coalition and other sources to formulate questions pertaining to existing and future core competencies required of DSWs serving on or in conjunction with IHC Teams that provide services to adults with SPMI. The Annapolis Coalition was available to provide consultation and technical assistance at no cost.

All small-group interviews and the cross-site focus group discussion were audio-taped with comments recorded simultaneously on projected slides for participants to view; probes to clarify comments were made as deemed necessary by study team members. At least two investigators from our research team co-conducted all structured interviews and the focus group.

Data Analysis

Study team member independently reviewed the set of notes from each structured interview and abstracted themes or concepts of interest and important dimensions. These were then compared and discussed in a series of group meetings to arrive at a consensus.

Caveat
Final data analysis for the project is still in progress as the cross-site focus group was conducted during the first week of November. When the research team reaches consensus regarding focus group findings, participating SMEs will be given an opportunity to provide review and comment on the findings and interpretations. This is an important final step in the analyses as it helps ensure validity of the conclusions drawn. Consequently, the findings presented here may undergo revisions; however, any revisions are anticipated to be minor in nature, and an updated version of this report will be produced to reflect any changes.

Results: Summary of Key Findings

Research Participants: SMEs

A total of 42 individuals provided signed informed consent to serve as subject matter experts (SME) for the project. At four of the sites, 7 SMEs participated in the research; at one site, 14 SMEs participated. This group of SMEs was comprised of core members of each site's PBHCI implementation teams (from BHO-grantee and primary care partner organizations) and adjunct PBHCI team members. Senior managers (e.g., CEOs, CCOs) from grantee and partnering organizations also participated because they were important sources of expertise regarding envisioned DSW job requirements associated with the implementation of HHB Teams. SME job titles included: Chief Executive Officer (CEO), Chief Financial Officer (CFO), Chief Clinical Officer (CCO), Medical Director, Clinical Director, Human Resources Director, SAMSHA Project Director, Director of Standards and Certification, Corporate Compliance Officer, Primary Care Physicians, Nursing Director/Team Leaders, Nurse Care Manager/Adv. Practice Nurses/ACT Nurse; Case/Care Managers and Case/Care Manager Supervisors, Clinical Psychologists, and EHR Analyst.

Research Sites: Participating Organizations

As noted in Design and Methods, the project was conducted using a convenience sample of all 5 SAMHSA-funded PBHCI demonstration project sites in Ohio that were active at the time of the study (out of 56 nationwide). Since that time, an additional 34 PBHCI demonstration projects have been funded, two of which are in Ohio.

Contextual Variability

The overall logic model specifies that Contextual Variability (see figure below) will exist across IHC program sites and this variability will ultimately affect the emergence of DSW job requirements (e.g., job duties, competency requirements) associated with the implementation of IHC Programs.

- Local Model Developed and Approach(es) used to Meet IHC Requirements
- Past experience, resources, constraints, etc. affecting local implementation of IHC program

Confirming the logic model, the data obtained from the facility survey indicated there was, indeed, substantial variability across the five participating sites in terms of the local PBHCI program models underway being used to meet SAMHSA's programmatic requirements. For example, 3 sites are attempting to deliver IHC by utilizing a partnership arrangement (involving one or more primary care providers) whereas two are attempting to integrate by operating primary care clinics on-site (staffed by primary care personnel employed by the site). PBHCI programs also vary in terms of enrollment criteria (e.g., payor source requirement; chronic illness requirement), size of the target population to be served (i.e., 450 adults with SPMI to 900+); the perceived degree of integration achieved at the program level and the extent to which IHC team members are operating collaboratively, the primary care staffing mix (e.g., the array of primary care providers affiliated with the program), the form (paper, electronic, a combination) and the extent to which client health records are integrated, the particular prevention, wellness and evidence-based programming offered to PBHCI enrollees, and much more (e.g., the extent to which enrollees have access
to case management, care management and care coordination services).

Sites also varied in terms of prior experience in offering primary care as well as other local factors (e.g., presence of rural sites). For example, 4 of 5 sites had prior experience offering primary care but differed in populations to which primary care services were made available (e.g., SPMI adults only, SED children, Non-SPMI adults, and/or Homeless adults), in the amount of prior experience they had (a couple of years to more than a decade), and with regard to the extent to which union activity does or is likely to impact DSW job descriptions, wages etc. This contextual variability across site created a research context in which it was possible to discern whether variation in local IHC models or other contextual conditions accounted for variability in other components of the logic model, as discussed below.

**Job Titles of Direct Service Workers**

During the first small group interview at each site, several definitions of the term ‘direct service worker’ were provided to SMEs along with examples of DSW job titles that are common to other social service sectors (e.g., home health aide). SMEs then were asked to generate a list of DSW job titles that came to mind when they thought about the term “DSW” in conjunction with their existing PBHCI program. SMEs were asked to do the same with regard to DSWs likely to be involved with HHB Teams (and associated ODMH HHB model parameters). The initial set of DSW job titles identified by SMEs at each site during the first small group interview was reviewed again during the second small group interview in order to produce a final list of DSW job titles for each site. SMEs were asked to keep their site’s unique list of titles in mind, particularly those titles traditionally affiliated with behavioral health (e.g., case manager), when responding to subsequent questions about new and emerging DSW job duties and competencies.

Two composite, cross-site lists of DSW job titles that emerged from this process are shown below.

A. PBHCI Program-Related: DSW Job titles identified by SMEs as being associated with the implementation of their PBHCl program include:

1. CPST (Levels 1 – 2)
2. Case Manager
3. Community Rehabilitation Specialist
4. Peer Specialist or Recovery Specialist
5. Residential Specialist (or Residential Aid)
6. Community Living Specialist
7. Community Rehabilitation Specialist
8. Wellness Coach (or Peer Wellness Coach)
9. Primary Care Medical Assistant
10. Behavioral Healthcare Medical Assistant

B. HHB Team-Related: DSW Job Titles identified by SMEs as being associated with the implementation of a HHB Team include:

1. Qualified Health Home Specialist
2. Case Manager
3. Community Rehabilitation Specialist (non-licensed)
4. Care Navigator (Levels 1 – 2)
5. Peer Specialist
6. Wellness coach

It’s important to note that titles #2 - #6 above were seen as fitting within the broad category of “Qualified Health Home Specialist” (formerly, Care Manager Aid) as defined by the Ohio Department of Mental Health.

**Factors Affecting DSW Jobs within this IHC Program Niche**

As noted by the logic model (see page 8), program requirements and contextual variables or characteristics define the component labeled “Factors Affecting DSW Jobs within this IHC Program Niche”. This model element was articulated during two small group interviews conducted at each site. SMEs alluded to and then were asked to confirm a set of factors associated with IHC Program implementation that do (or will in the foreseeable future) account for new job requirements among traditional behavioral-health-oriented DSWs (e.g., case managers, peer specialists). The composite list of generated is sorted by category and shown in Table
1. Appendix A includes definitions of each factor.

**Table 1. Factors Associated with IHC Program Implementation**

*Expected to Account for New DSW Job Duties and Competency Requirements*

<table>
<thead>
<tr>
<th>A. Factors associated with program mission, identity and culture</th>
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<tbody>
<tr>
<td>1. Shift in mission from behavioral health to whole health focus.</td>
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<tr>
<td>2. Cultural and/or philosophical differences between PC and BH Organizations &amp; Practitioners.</td>
</tr>
<tr>
<td>3. Shift in professional identity of BH-DSWs from behavioral health to whole health.</td>
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<tr>
<td>4. Increased emphasis on team performance, functioning and effectiveness.</td>
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<tr>
<td>5. Effect of whole-health-related job expectations BH-DSW well-being.</td>
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<tr>
<th>B. Communication</th>
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<tbody>
<tr>
<td>1. Patient engagement in whole health.</td>
</tr>
<tr>
<td>2. Communication re: client physical health among IHC Team members &amp; with specialty providers.</td>
</tr>
<tr>
<td>3. Communication re: physical health with clients, their families and with significant others.</td>
</tr>
<tr>
<td>4. Communicating and interacting with colleagues and consumers who are not enrolled in the IHC Program.</td>
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<tr>
<td>5. Whole health promotion and marketing.</td>
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<td>5. Effective and concise documentation regarding physical health issues.</td>
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<tr>
<th>C. Decision Making</th>
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<tr>
<td>1. Elevated emphasis on data-based decision – making and collaborative decision-making processes.</td>
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<tr>
<th>D. Coordination</th>
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<tr>
<td>1. Coordination of client care and coordination of IHC team member activity are essential to effective &amp; efficient IHC.</td>
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<th>E. Outcomes Focus</th>
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<tr>
<td>1. The achievement of whole health outcomes depends on optimizing the engagement of family members and/or significant others.</td>
</tr>
<tr>
<td>2. Increased importance of a wider array of (whole) health outcomes.</td>
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<tr>
<td>3. An elevated emphasis on health outcome achievement requires that information used to track progress is easy for providers to understand and act upon.</td>
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<tr>
<th>F. Additional Factors</th>
</tr>
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<tbody>
<tr>
<td>1. New models of IHC continue to be developed, introduced, tested and refined.</td>
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</tbody>
</table>
During the second small group interview, SMES considered the factors expected to drive job change (Table 1) and for each, to identify either new job duties or competencies arising or anticipated to arise from those factors. As noted earlier, SMEs were asked to respond to this question in the context of DSW job titles they had previously identified, specifically DSW job titles that are traditional to the behavioral healthcare sector (i.e., BH-DSWs).

The composite set of new and emerging BH-DSW job duties and competencies that were the product of these site visits are listed below: duties are listed first, followed by competency requirements. It should be noted that these duties and competencies are written in a way that most directly applies to Behavioral Health – DSWs (BH-DSW) such as case managers who work on or with Integrated Health Care (IHC) Programs. Items on the list which are asterisked (*) are particularly relevant to HHB Teams.

1. Duties

   a. Educate and ‘sell’ clients on the IHC model and on core concepts of prevention and wellness. It is imperative that clients understand and embrace the need to take action to preserve health and/or to restore health and to be proactive in making lifestyle decisions that prevent or reduce the likelihood of health issues.

   1. Function as a ‘change agent’ to effect change in clients’ whole-health knowledge, attitudes and behaviors
   2. Utilize evidence-based approaches such as motivational interviewing to increase clients’ insight, acceptance and/or acknowledgement of existing behavioral and/or primary healthcare conditions and to reduce defenses and barriers to taking action on those issues

   b. Educate clients in disease self-management techniques and approaches.

   1. Equip clients with strategies which are geared to managing various chronic physical and/or behavioral health care conditions.
   2. Educate and engage clients in evidence-based programs for chronic disease self management, including programs geared to clients with co-morbid physical and mental health diagnostic conditions (e.g., depression and diabetes) such as Lorig’s Chronic Disease Self Management Program model which is promoted by SAMHSA.

   c. Serve as a role model for healthy living (e.g., nutrition, exercise, stress management) and, if relevant, for the self-management of chronic health care conditions.

   d. Ensure that clients keep primary care appointments (and follow-up appointments) and understand doctor recommendations and prescriptions made during those appointments.

   1. Facilitate clients’ efforts to maintain updated appointment schedules and to adhere to those schedules. Assist as needed.
   2. Transport clients to primary care, dental and specialty provider appointments or arrange for transportation [as needed].
   3. Attend and participate in primary care, dental and specialty care appointments with clients [as needed]; take notes, ask questions, consult with, and explain information to clients that is given by providers in the course of those appointments.
   4. Transport or assist clients with securing transportation to pharmacies to obtain prescriptions.
   5. Provide suggestions and devise strategies to increase client compliance with primary care and dental prescriptions.

   e. Serve as an advocate and educator to primary care, dental and specialty providers regarding the needs of the population of adults with SPMI and/or of individual adults with SPMI in order to improve: client access to care, the quality of the client-care experience, and the insight of primary care, dental and specialty providers about the unique health care needs and issues facing the population of adults with SPMI and/or individuals and subgroups within the...
accurate and comprehensive integrated client health care record and to make data-informed decisions on the basis of information included in the record.

2. Competencies

Personal Characteristics

a. Flexible
b. Ability to divide attention/multi-task
c. Tolerance for ambiguity in order to function effectively in an environment in which information may be incomplete and rapidly changing
d. Screener: Ability to work effectively and efficiently in settings which may be noisy and may even seem to be chaotic at times due to open scheduling, space limitations, shared workspace, etc.
e. Detailed-oriented
f. Feedback – seeking
g. A good memory and/or facility with tools and technologies to augment memory
h. Excellent verbal, non-verbal and written communication skills

1. Articulate – ability to communicate concisely
2. Able to adjust communication style to situation and background of involved party (ies) – clients, family members, primary care and specialty practitioners, etc.
3. Good listening skills
4. Good non-verbal communications – self presentation, warmth

i. Strong time management skills (and openness to applying new rules to time management practices)
j. Resourceful: ability to take effective action when circumstances and access to resources are less than ideal
k. Goal or outcome-oriented
l. Self-starter
m. Team player: collaborative style
n. Strong organizational skills and facility with planning and organizational techniques and technologies
o. Good judgment and critical decision-making skills [e.g., skilled at managing competing priorities], including crisis decision-making skills
p. Non-smoker
q. Healthy weight (not obese)
r. Physically active
s. Skilled at using healthy stress-management techniques in one’s personal life
t. Good driving record

Attitudes

a. Willing to work a non-traditional work schedule (e.g., on call, evening hours)
b. Willingness and ability to take and follow direction
c. Growth- and learning- oriented and willing to apply new knowledge
d. Belief/commitment in what’s being sold (e.g., prevention, whole health)
e. Willingness to be assertive (e.g., advocate for clients at risk in order to get medical attention when needed)
f. Tolerance and openness to different perspectives
g. Openness to change: healthy attitude toward change
h. Optimistic (e.g., strength rather than weakness-focused)
i. Respectful of adults with SPMI
j. Belief in the value/importance of data
k. Confident

Medical Knowledge, Skills, Abilities and Other Factors (KSAOs)

a. Health Literacy

1. Basic knowledge about the nature and treatment of common acute (e.g., insomnia) and chronic medical conditions (e.g., diabetes, hypertension, heart disease) and the role medications may play in symptom expression
2. Knowledge, skills and confidence to discuss medical issues/physical health problems with adult clients with SPMI (and family members or significant others) and to do so effectively while recognizing the boundaries of one’s expertise and barriers to client understanding that may be a result of the nature of their SPMI. Hence, education about physical health and knowledge about SPMI are critical to effective communication with clients and significant others
3. Knowledge of cutoffs for basic health and blood markers
4. Ability to understand doctors’ notes and standard abbreviations and terms
5. Knowledge of common medications for primary care conditions, their side-effects, drug interaction issues, proper use protocols, etc.
b. Ability to take vital signs
c. Knowledge of standard protocols for common medical conditions and awareness of how standard approaches may need to be adjusted for adults with SPMI (e.g., different diagnostic conditions)
d. Sensitivity/awareness of extent to which information about physical health care conditions may exacerbate psychological symptoms and/or be ‘understood’ differently by adults with particular psychiatric conditions (e.g., depression, anxiety, paranoia)

Whole Health & Prevention Knowledge, Skills, Abilities and Other Factors (KSAOs)

a. Ability to assess or understand the emotional, cognitive, and physical state of clients and the capacity to effectively present medical information to clients in light of clients’ states.
b. Skill at determining circumstances under which involvement of others (e.g., family members) is required in order to facilitate the achievement of client’s whole health goals.
c. Knowledge about how physical health affects mental health and vice versa. Knowledge about health conditions that may have both physical and mental health origins (e.g., depression, insomnia, asthma).
d. Ability to consult effectively with primary care, behavioral health and specialty providers.
e. Knowledge of prevention and wellness activities (yoga, exercise) and where they are offered/ available in the organization and local community.
f. Knowledge of recommended preventive services (e.g., recommended screening protocols) by age, condition and other key variables.
g. Knowledge of key behavioral health, physical health terminology, and data systems terminology.
h. Knowledge of theories of addiction and the impact of addiction on physical and/or psychological well-being. For example, should possess a sound understanding of how tobacco impacts the therapeutic qualities of psychiatric medications and physical and psychological conditions.

i. Understanding of nutrition, healthy diet (e.g., healthy eating on a budget) and exercise.

j. Knowledge of chronic disease self-management approaches geared to adults with chronic mental health and physical health care conditions (such as Lorig’s Chronic Disease Self Management Model).

k. Skilled at doing warm handoffs.

l. Appreciation of boundaries; skilled at not overstepping one’s area of professional expertise within the IHC or HH team context.

m. Adept at seeking out information regarding factors and issues that go beyond one’s area of professional expertise, job description and/or authority.

n. Ability to work effectively on or with an interdisciplinary team and to work in an intentional, confident, and collaborative way with primary care physicians and other team members – so multiple perspectives can be brought to complex problems.

Behavioral Health Knowledge, Skills, Abilities and Other Factors (KSAOs)

a. Skilled in motivational interviewing (MI). MI skills are needed in carrying out job duties pertaining to Medical and Whole Health issues noted above, as well.

b. Familiarity with stage-based interventions.

Data Systems and Data Interpretation Knowledge, Skills, Abilities and Other Factors (KSAOs)


b. Ability to interpret and understand information provided in the form of charts, graphs and other data displays.

c. Experience with databases (e.g., spreadsheets) and good data manipulation skills.

d. Ability to communicate and update charts/medical documents in ways that are easy to understand.

e. Ability to process significant amounts of information and use data to guide decision-making and planning.

f. Ability to use client assessment tools and interpret assessments in daily work.

g. Knowledgeable about information that is required in documentation to demonstrate medical necessity.

Other Issue-related Knowledge, Skills, Abilities and Other Factors (KSAOs)

a. Familiarity with community resources which support efforts to optimize whole health.

b. Basic understanding of the fundamentals of the PMPM concept*

Unintended Consequences and Concerns Linked to the Implementation Ohio’s Health Home Benefit

Discussions that occurred during small group interviews at each site regarding new and emerging DSW job requirements under Ohio’s Health Home Team model often turned to HHB Team implementation concerns. This subject matter was not envisioned when the decision was made to expand the scope of the investigation to encompass IHC programming delivered within the HHB Team context. However, because some of these concerns have potential implications for workforce development and for DSW job performance, they are listed here. They suggest potential future research questions to be considered that are pertinent to the DSW workforce.

Potential Concerns or Unintended Consequences Associated with HHB Team Implementation

1. Over-doing for the client to insure outcomes/goals are met. This may be driven by the need to demonstrate outcome achievement in the short-term. However, it is likely to run counter to longer-
term interests in building client independence, confidence and self-reliance.

2. Conflict, tension, feelings of inequity arising among HH Team members and other staff as a result of:

a. The restructuring of lines of authority based on credentials rather than experience (e.g., feelings of inequity among non-licensed case managers who have been doing an effective job for years and whose clinical acumen may greatly exceed newly licensed, inexperienced individuals).

b. Tension and perceived workload inequities among CPST workers operating according to a traditional fee for service/productivity model versus Qualified Mental Health Specialists (QMHS) operating on the basis of a HH, outcomes-driven model.

c. Negative reactions among QMHSs on HH Teams who may no longer be directly involved in developing and refining client care plans – but, instead, who will be expected to execute plans devised by others.

3. Reduced intrinsic work motivation among licensed clinicians due to a shift in job duties toward administrative and management responsibilities, and away from the clinical aspects of the job a) that may have attracted these individuals to the profession, in the first place, and b) for which they may have far more on-the-job experience.

4. Misplaced decision-making authority to individuals who meet licensing requirements but who may have limited experience with and/or commitment to serving the population of adults with SPMI.

5. Disruption to treatment and dissatisfaction among established SPMI clients as a result of being assigned to a new HH team and [potentially] to a new case manager (i.e., QMHS).

6. Varying levels of motivation among BH DSW staff with regard to persuading clients to opt-in to the Health Home Benefit. Motivation may vary based on how client opt-in decisions impact caseloads and long-term relationships between clients and case managers.

7. Role and boundary confusion among HH Team Members stemming from one or more of the following issues: increased job complexity, need to carefully coordinate roles and duties, shift from a productivity-driven to an outcome-oriented delivery model, and/or team and individual-on-the-job-learning curve issues.

8. Inadequate representation of the expertise of the embedded PC physician in treatment plans and decisions due to practical factors which may limit PCPs’ ability to attend all HH team meetings (e.g., availability, feasibility, affordability).

9. Lack of or limited involvement by psychiatrists in the functioning of HH Teams.

10. Lower quality of IHC services received by HH Opt-out (and uninsured) clients compared to HH Opt-in clients.

11. Increased staff turnover resulting from issues mentioned above (e.g., tension and conflict among staff, dissatisfaction with changes in job duties and/or lines of authority) and other issues (e.g., requirement to work non-traditional hours, especially for independently licensed staff).

12. Effects of union involvement and issues on HH Benefit implementation (e.g., affects of seniority policies on BH-DSW eligibility for HH team membership).

13. Competition for qualified staff among HH providers within a region.

14. Competition for eligible clients among HH providers within a region.

Potential Workforce-Related Policy Implications of Findings

The integration of primary health care into behavioral health programs, an emerging trend in IHC programming for adults with SPMI, holds great promise for improving health and quality of life outcomes for members of this population. New models of integrated healthcare (IHC) tailored to this population such as SAMHSA-funded, PBHCI program models and the new Medicaid Health Home
Benefit underway in Ohio, are and will continue to dramatically impact the nature of work for the largest segment of the behavioral healthcare workforce - namely, direct service workers (DSWs) such as case managers and peer specialists. Anticipated changes in job requirements for these DSWs have potentially important implications for policy development in four broad arenas: regulatory requirements, recruitment of DSWs, retraining of the existing DSW workforce, and pre-service training. Key recommendations and findings from this study that are seen as relevant to these policy arenas are summarized below.

**Regulatory Requirements**

There is strong support for the idea that regulations need to be developed to insure that DSWs and IHC program team members are qualified to deliver the array of services provided through IHC programs for adults with SPMI in a safe and effective manner. Regulation supports standardization which, undoubtedly, is an important aspect of quality control processes. However, standardization is possible without over – regulation. Over-regulation at this early stage of IHC program development is not recommended. This is because IHC programs for adults with SPMI are relatively new and important contextual differences may exist among programs (e.g., programs in rural settings may have reduced access to qualified staff, and/or staff-development opportunities). Regulations must allow for a level playing field to exist for providers working in settings that differ in important ways. Consequently, standardization without over – regulation is recommended when it comes to specifying job duties, competency requirements, and qualifications of DSWs working in IHC program contexts. Consideration may need to given to the extent to which prior experience may serve as a substitute for licensing requirements. Further, regulations should be end-state focused and allow providers some latitude to experiment with and develop the most effective and efficient means for achieving desired end-states, in light of local resources and constraints.

Retraining Existing Workforce

A fundamental concern identified in this research relates to the ability of integrated health care organizations, regardless of program model, to develop the capacity within their human resource functions to identify, select, train and retain qualified DSWs. Human resource departments are likely to need more information regarding which DSW characteristics need to be selected for (e.g., personal attributes, background or experience, credentials and licenses) and which competencies can be learned. Due to the anticipated increase in the complexity and sophistication of DSW jobs, significant compensation issues are likely to arise. This issue will need to be addressed at the state, local and organizational levels to insure organizations that seek to hire qualified DSWs can afford to do so. An increase in the involvement in unions is expected as a result of issues related to job complexity and compensation.

Once hired, organizations need to have the capacity to retain qualified workers. This is another domain for which increased involvement by unions is expected. Competition already exists for qualified and experienced staff among behavioral healthcare providers and with other types of healthcare organization such as hospitals and medical centers. Under the Health Home benefit, the competition for skilled staff is anticipated to be exacerbated. Strategies must be identified to minimize losses in training investments and intellectual capital incurred by organizations that result from inter-organizational and inter-system competition for skilled employees. Level of competition is expected to vary across locales.

Context is likely to be an important factor that affects the extent to which challenges exist with regard to recruitment and retention. For example, IHC providers that employ unionized staff anticipate greater difficulty in hiring, rewarding productivity, and retaining and promoting staff due to union rules. Consequently, it may be important to allow for some level of flexibility in regulatory requirements to insure that IHC providers operating in substantially different contexts or implementing substantially different approaches to IHC programming are provided with equitable opportunities to attract and retain qualified staff, thus having equal opportunity to succeed as IHC providers.
New on- and off-the-job education and training opportunities will need to be developed and/or identified that are affordable and feasible for employed DSWs who need to develop new competencies or update existing ones in order to perform effectively in IHC programs serving adults with SPMI. This will be challenging in light of the amount of new knowledge and skills that are expected to be required for DSWs to perform new, IHC-related duties effectively. The cost of retraining is also of concern. Costs are likely to be considerable so it will be critical to identify and/or develop mechanisms and/or incentives to make retraining of the existing DSWs feasible, from both time and cost perspectives.

Pre-service Training

Community colleges, 4-year colleges and universities, and other providers of education and training (e.g., work experience and job readiness programs) will need to develop new curricula to prepare future DSWs to successfully meet the challenges and take advantage of the opportunities associated with working in IHC programs serving adults with SPMI. In the late 1980s, Ohio was recognized as a leader in promoting state-of-the-art approaches to developing the case management workforce. Many of those efforts were supported by the Ohio Department of Mental Health through federal block grant dollars, the availability of which may be more limited at this time. An important opportunity now exists for Ohio to assume a leadership role with regard to developing the workforce of DSWs working on or with IHC programs serving adults with SPMI. Ohio can support additional opportunities to investigate new and emerging DSW roles and their impact on IHC program quality and outcomes. Ohio can prioritize MEDTAPP funding for colleges and universities to further develop pre-service curricula pertaining to DSWs working in IHC contexts. Ohio can strengthen this initiative by engaging the support of the Ohio Board of Regents to place a high priority on this work. It is essential for Ohio to assume a leadership role in this domain in light of the complex challenges, potential unintended consequences and the importance of developing a skilled and stable workforce of DSWs to serve the state’s population of adults with SPMI.

Limitations

As an exploratory study, the project has limitations. First, it includes only 5 of 56 grantees funded by SAMHSA as part of the national demonstration of PBHCI models. Yet, the models underway at these Ohio sites are diverse in their key components as required to achieve the major study aims. Second, the project budget dictated that we use a key informant approach and limited the number of study participants. Even so, our targeted participants were on the leading edge of PBHCI programming for adults with SPMI, and senior members of the Ohio teams have experience that extends well beyond the formal start of the demonstration project. In addition, our investigation of direct care worker occupational titles (as related to core and adjunct PCBHI job roles) and associated job duties, competencies and skills and the factors driving change in job requirements is preliminary and limited in depth. Even so, the study produced timely information about new and emerging job duties of DSWs in the wake of the rapid diffusion of healthcare integration on a broad scale and within the context of particularly important IHC program niche in which primary care is brought into behavioral health organizations to serve adults with severe and persistent mental illness.
References


16. SAMHSA Primary & Behavioral Health Care Integration Program: A Snapshot of Grantees, Presented at the SAMHSA Primary and Behavioral Health Care Integration 2011 Grantee Meeting, May 4-4, 2011, San Diego, CA.