



Behavioral Health

Pacesetter Award

in Support of Direct Care Workers

BETTER JOBS
BETTER SERVICES
BETTER BUSINESS

***Pacesetter Case Study:
Family Services of Western Pennsylvania
Pittsburgh, Pennsylvania
2011 Pacesetter Award Winner***

To learn more about the Behavioral Health Pacesetter Award, please see a description of the process on the last page of this report.



During the summer and fall of 2006, there were important changes brewing in the Pittsburgh area mental health system—some at Family Services of Western Pennsylvania, an agency with deep roots in the Alle-Kiski Valley, and others at the state and county levels. The convergence of these local micro-level and countywide macro-level events would have significant implications for the behavioral health workforce in Allegheny County.

Macro Changes (County Level)—In late 2006, Pennsylvania state officials began quietly planning the closure of Mayview State Hospital near Pittsburgh. They would not publicly announce the plan until they were ready to answer fundamental questions, including, “What would happen to hospital staff?” and, “What would be done to support former patients discharged to the community?” Official word of the hospital closure came on Aug. 15, 2007.

First opened in December 1893 and occupied by more than 4,200 patients in its heyday, the antiquated facility, like many similar psychiatric hospitals throughout the United States, had outlived its usefulness. Mayview was slated to close its doors in December 2008, with most of its nearly 300 patients placed in community residential settings, supportive housing or independent living.

In the years before Mayview closed, the facility provided long-term psychiatric care. Although the hospital did not directly admit acute-care psychiatric patients, it functioned as a “relief valve” by taking transfer patients with refractory mental illnesses, whose symptoms had not stabilized during short-term treatment in psychiatric units at local general hospitals. Now, the relief valve would be gone. Additionally, within a year prior to Mayview’s closure, a local general hospital in Pittsburgh with an inpatient psychiatric program went out of business, and a third hospital reduced the size of its inpatient unit. Thus, in a short time span, the availability of inpatient psychiatric beds in the county was significantly reduced.



Building South 2 at Mayview State Hospital in Bridgeville, Penn.

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Micro Changes (Case Management at Family Services)—Meanwhile, at Family Services of Western Pennsylvania, workforce and programmatic changes were occurring that would create unique opportunities for the agency and for the entire mental health system in Allegheny County. Family Services CEO, Don Goughler had given the go-ahead for his COO, Stephen (Steve) Christian-Michaels, to revamp the agency’s ailing case management program. The transformed program would be designed to enhance staff competencies, improve accountability and emphasize recovery-oriented care.

Christian-Michaels knew that changes were needed. He had been hearing from his senior managers that the agency’s case management program lacked quality, was crisis driven and was not focused on recovery. The program was seen as reactive and only became involved in the lives its clients when they were falling apart.

Because most interactions between staff and clients took place during crises, many staff believed clients were incapable of caring for themselves. As a result, case managers developed paternalistic relationships and held less regard for client opinions. Although staff took pride in their willingness to “do anything it takes” to help, their actions sometimes impeded client progress by removing learning opportunities. Instead of supporting the client in his/her attempts to get things done, the case manager would simply do it for the client.

This meant there was scant attention to interventions that might reduce the need for services over time. Because case managers held little hope that clients would get much better, it was believed that supports would be required indefinitely. Consequently, the flow of clients through the program was very limited—once the program reached its capacity, new people seeking services were denied care or waitlisted for admission. The program was full, the staff was overworked, and clients weren’t getting much better. It was a problem for everyone involved.

Empowerment and Recovery

From the start, case management program workers in Pennsylvania and in many other parts of the country had been trained to “do anything it takes” to help clients with serious mental illnesses adjust to community living. However, in recent years, as care delivery has become more recovery-oriented, this approach has lost its appeal. Today, teaching self-help skills and encouraging their use has gained broad acceptance because it empowers the individual and promotes recovery.



“The ‘do anything it takes’ approach disempowered our clients, and people were telling us our case managers were ‘acting like cowboys.’ ”

—Stephen Christian-Michaels, COO

In an attempt to fix its case management program, Family Services leadership contacted Drs. Shaun Eack, Catherine Greeno and Carol Anderson at the University of Pittsburgh. The agency already had an established relationship with the university focused on clinical practice issues (this had been achieved in part through Goughler’s involvement as a part-time faculty member).¹ The university faculty agreed to conduct a study at Family Services that would examine staff perspectives regarding ways to improve case management. The researchers found that case managers felt ill-prepared for the job of serving the people with complex behavioral health needs. Newly hired staff told the researchers they were “thrown into the job” and compelled to “learn on the go” with insufficient training. Some had no academic preparation in health or human services, and many knew little or nothing about community-based mental health and the type of system in which they were now employed. They also lacked basic information about psychiatric diagnoses, medications (and their side effects), treatment approaches and rudimentary clinical skills.²

In order to strengthen case management, Christian-Michaels obtained funding from Allegheny HealthChoices, Inc. (AHC),³ to hire a consultant for five months to advise, mentor and train staff regarding case management best practices. The consultant spent many hours observing staff at work with clients in field situations. She then provided immediate feedback about what was done well and how to improve interventions. Based on the consultant’s work, changes were planned in the deployment, supervision and mentoring of case managers.



Drs. Catherine Greeno, Associate Professor, School of Social Work and Shaun Eack, Assistant Professor, School of Social Work, University of Pittsburgh

¹ Goughler DH, and Anderson CM. (2009) Structural design for a university—agency research collaboration: bridging an historical distance. *Families in Society: The Journal of Contemporary Social Services*, 90: 419-24. doi: 10.1606/1044-3894.3918

² Eack SM, Greeno SG, Christian-Michaels S, Dennis A, & Anderson CM. (2009). Case managers’ perspectives on what they need to do their jobs. *Psychiatric Rehabilitation Journal*, 32, 309-12.

³ Allegheny HealthChoices, Inc., an agency under contract with the county’s Office of Behavioral Health monitors operations of the county’s Medicaid behavioral health managed care organization.

Changes in Case Management at Family Services		
	Before	After
Deployment	Solo case managers	Case management provided by teams
Supervision Format	Occasional individual supervision	Regular supervision carried out in small groups within teams
Supervision Location	Office-based only	Some supervision to occur in the field, based on direct observation of the case manager with the client
Mentoring	Informal or None	Mentor positions established to guide newly hired staff as they learned about case management and other core process of the agency
	Did not involve supervision	Expanded to include group supervision

Some supervisors opposed the proposed changes and especially disliked the idea of providing supervision in the community. They would ask, “What’s going to happen if I’m out of the office and there’s an emergency?” Resistance among these supervisors began to spread among line staff, some of whom disagreed with the proposed emphasis on client recovery. Others rejected the idea that a person with a disorder like schizophrenia could make decisions about his/her own care. The old program seemed barricaded against change. Despite training by the consultant and mollifying efforts by Family Services’ leadership, the program’s atmosphere became increasingly toxic. In the end, two supervisors left, as did many of the line staff who claimed that proposed program changes required them to do things they had not been hired to do. Departure of these staff members was not easy for the agency’s senior management—it was not what they set out to do, but it was the new reality they were now required to meet.

Gradually, Family Services began refilling vacated positions with people who were open to learning new skills, and who accepted the basic notion that recovery among individuals with severe mental illnesses might be achieved with the right combination of treatments and supports. Unlike workers in the old program, who held bachelor’s degrees in such diverse and unrelated fields as art, history, and English, new hires had degrees related to health and human services (social work, psychology, human services, family studies, rehabilitation and sociology). Additionally, two mentoring positions were established utilizing experienced and enthusiastic staff who trained all new case managers for their first six months in recovery-oriented care and use of naturally occurring community supports.

Demographics of Population and Those Served—2010						
	Age (in years)		Gender		Race	
Alle-Kiski Valley Area	<5	5%	Male	48%	White Caucasian	90%
	6–17	20%	Female	52%	African American	5%
	18–29	21%			Native American	1%
	30–64	35%			Hispanic	1%
	65+	19%			Other	3%
People Served by Family Services' Service Coordination Program	<5	0%	Male	57%	White Caucasian	85%
	6–17	22%	Female	43%	African American	8%
	18–29	20%			Native American	2%
	30–64	51%			Hispanic	1%
	65+	8%			Other	4%

Family Services – Staff Demographics								
Year	Age (in years)		Gender		Race		Degree	
2006	Mean: 32.7		Male	7%	White Caucasian	92%	High School/Associate	8%
	22–29	61%	Female	73%	African American	8%	Bachelor's (Psychology/Social Work)	58%
	30–39	19%					Bachelor's (Other)	34%
	40–49	8%					Master's	0%
	50+	12%						
	Mean: 33.4							
2010	22–29	27%	Male	54%	White Caucasian	87%	High School/Associate	0%
	30–39	33%	Female	46%	African American	13%	Bachelor's (Human Services)	77%
	40–49	13%					Bachelor's (Other)	15%
	50+	27%					Master's (Human Services)	8%*

*Excludes mentors.



“As the system moves toward a recovery-oriented model, our staff need to be prepared and confident in their abilities. This is why it’s so important that we focus on workforce issues; we’ve got to gird them for the challenging work we’re asking them to do.”

—Don Goughler, CEO

Economic and Social Change

Allegheny County is in the heart of southwestern Pennsylvania’s rust-belt region. For more than 100 years, the area’s economy was dominated by steel production and other heavy industries. However, during the mid-1980s these businesses rapidly declined, forcing massive changes in the region’s economy and workforce.

Today, Allegheny County is still the region’s economic hub, but its jobs have shifted to health care, financial services, technologies, light manufacturing and to the educational and social services sectors. Recently, natural gas deposits found in the area’s Marcellus shale field have added new jobs but also raised questions about environmental impact. These seesaw economic forces are still in motion, and the workforce of Allegheny County is continuing to adjust.

Positive Signs

- In December 2010, Allegheny County had lower unemployment (7.1%) than the Pennsylvania state average (9.1%). *Source: U.S. Department of Labor, Bureau of Labor Statistics*
- Employment data indicate that recession-related job losses reached their peak in Pittsburgh (Allegheny County’s largest city) in September 2009. Since then, conditions have gradually improved. In 2010, Pittsburgh added 9,100 non-farm jobs. *Source: Pittsburgh Today*

Worrisome Signs

- From 2000 to 2009, the population of Allegheny County declined by 4.9%, while Pennsylvania’s population increased by 2.6%. Population in the county has been declining for more than 20 years. *Source: U.S. Department of Agriculture, Economic Research Service*
- Standard & Poor’s recently downgraded Allegheny County’s credit rating outlook from stable to negative, citing pension funding and reassessment issues. *Source: Pittsburgh Tribune-Review, Feb. 4, 2011*
- Substance abuse prevalence in Allegheny County continues to exceed Pennsylvania averages on a large number of indicators. *Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, National Survey on Drug Use and Health*

Convergence of Micro and Macro Events—Shortcomings with case management were not just confined to Family Services; they existed in agencies throughout the county and in other parts of Pennsylvania. This meant that innovations at Family Services could potentially benefit the entire county. Here is how it happened.

In 2005, many months before the Mayview closure announcement, Allegheny County had initiated a broad-based strategic planning process. A stakeholders group concluded that people with serious mental illnesses should be served in the community whenever possible, not in hospital settings; but at that point in time, few people anticipated Mayview would actually close.

Pat Valentine, Deputy Director, Allegheny County Office of Behavioral Health, was an exception—she had quietly begun planning for the closure. She also recognized that case management across the county was ill-equipped for the new role it would need to assume. Although 95% of case managers had bachelor's degrees,⁴ many (40%) were in liberal arts or fields unrelated to health care. Because of this, some of the case managers lacked the competency and professionalism needed to properly fulfill their role. Valentine knew it was vitally important that the service be strengthened and made ready to help prevent the majority of future psychiatric hospitalizations from Allegheny County. She and her colleagues at AHCI and Community Care Behavioral Health (the Medicaid behavioral health managed care organization in Allegheny County) also knew that a revitalized case management service would need to become the single point of accountability (defined below) for county residents with serious mental illnesses.

Since AHCI was already funding consultation and research on case management at Family Services, and because Valentine trusted the vision and leadership skills of Christian-Michaels, she asked him to lead the countywide effort in November 2006. Valentine requested that he use lessons learned about case management in the Family Services “laboratory” and establish a process to strengthen the service throughout the county.

In January 2007, Christian-Michaels convened a large stakeholder group comprised in equal parts of:

- **Consumers**
- **Family members and advocates**
- **Private nonprofit agencies**—including Family Services and all 10 other agencies in Allegheny County that offered case management services
- **Payers and monitoring agencies**—including Allegheny County Office of Behavioral Health, AHCI and Community Care Behavioral Health

During the next 12 months, the group concluded “case management” would become “service coordination” and would function as the single point of accountability (SPA) for clients in the service system. Additionally, the SPA concept would drive the entire reform initiative. Thus, the term “SPA” would (1) describe the role of individual service coordinators and (2) become the name of the countywide reform initiative.

⁴ Five percent had a high school diploma or GED only.

Next, the stakeholder group outlined service coordinator responsibilities and made recommendations about structural, financial and workforce development objectives. In January 2008, under the leadership of Christian-Michaels, four subgroups started working on these recommendations. The four groups are listed below, with a partial list of accomplishments:

Recovery Orientation of Services/Planning

- Defined service coordination competencies
- Devised universal service plan format
- Initiated family involvement planning

Workforce Development (*focused on recruitment and training of new service coordinators*)

- Developed curriculum for adult service mentors
- Developed overall training plan

Workforce Stabilization (focused on retention of existing service coordinators)

- Gathered countywide data on service coordinator salaries and training
- Planned steps for base salary increases

Financial Analysis and Performance-Based Contracts (i.e., SPA Finance Subcommittee)

- Added SPA expectations to county contracts with agencies offering service coordination
- Developed and implemented contract monitoring process
- Developed/supported recommendations for service reimbursement rate increase, performed bi-annual salary survey and conducted cost analysis involving all 11 service coordination agencies
- Monitored adequacy of new rates

Single Point of Accountability – A Countywide Reform Initiative

The SPA Initiative was designed to transform the way in which mental health case management services were financed, supervised and delivered throughout Allegheny County. Compared with the old case management model, in which staff assumed direct responsibility for people in their care, the new model required staff to spend more time assessing client needs, planning with the client, coordinating and monitoring service delivery, and advocating for system improvements. The SPA Initiative emphasized a recovery-oriented approach based on significant input from consumers, families, advocates, payers and service-provider agencies, and marshaled academic, administrative and clinical resources to improve the quality of life for people with serious mental illnesses.

10 Affirmative Responsibilities of Service Coordinators Acting as SPAs

- Be the “go-to” resource for the client and their family.
- Ensure there are effective safety-net resources for the client.
- Clearly communicate to the client what they can expect from the system and what the system will expect of them.
- Ensure there is periodic assessment and cross-system planning to meet the client’s needs while utilizing their strengths.
- Prepare for and convene/facilitate service-planning meetings and provide follow up after meetings.
- Ensure there is a cross-system coordination of services and that services are being provided.
- Develop relationships that endure with persistent outreach, even when there is client reluctance to receive services.
- Assist the client in developing and using natural supports.
- Be a persistent advocate for those served and provide feedback on systemic problems.
- Provide a consistent positive outlook that encourages recovery and full inclusion in the community.

Better Jobs

Training Initiatives—The relationship between Family Services and the University of Pittsburgh would prove crucial to the countywide workforce development initiative. Drs. Eack and Greeno collaborated with Christian-Michaels in developing the service coordinator curriculum. In 2009, this training program was adopted within the university's School of Social Work.

Training for service coordinators and mentors was implemented in several distinct stages:

1. A mentoring program was established (based on lessons from the experience at Family Services), making it possible for all newly hired service coordinators in the county to be mentored for the first six months of employment. As part of the university's training program, mentors chosen from among the more skilled and experienced case management staff were taught to use guided discussion and brainstorming to solve problems encountered by team members. This enfranchised staff in the decision-making process and built *esprit de corps*—important factors associated with improved quality of care and better staff retention rates.
2. A specialized four-day training series conducted by the Allegheny County Office of Behavioral Health staff was implemented to familiarize new staff with their SPA responsibilities. This training began on a countywide basis in the spring of 2010 and takes place within the first 60 days of employment. All future new hires would also need to participate in the 16-week certificate course (to occur within six months of the employee's start date).
3. A 50-hour/16-week training program on recovery-oriented care (similar to the training for new hires) was implemented at the university for existing service coordinators.

Initially, there was considerable resistance to the training proposal by service coordination agencies. Opposition declined when ACHI agreed to pay half of the approximately \$6,000 cost per existing employee (each agency would need to pick up the other half, i.e., \$3,000). The cost per employee included lost productivity caused by the employee's absence while in training (approximately \$5,000), the purchase of a DSM-IV,⁵ travel reimbursement and tuition. In the fall 2010 semester, ACHI paid out nearly \$130,000 in training match funds. Approximately \$690,000 in match funds is expected for three years (including some funds from new sources). At that point, it is hoped that local agencies would be able to absorb lower anticipated training costs. Lower training costs would be the result of a reduction in turnover caused by better employee training and higher salaries.

⁵ Diagnostic and Statistical Manual of the American Psychiatric Association, Fourth Edition



“It feels great to be able to help clients meet their goals thanks to the skills you’ve helped them acquire, rather than just doing it for them.”

—Shayna Sokol, Children’s Service Coordination Supervisor

(Sokol has completed supervisor and mentor training at the University of Pittsburgh.)

In addition to training activities, Christian-Michaels and his colleagues developed detailed job descriptions for mentors, service coordinators and service coordination supervisors containing extensive information about the core competencies each position required. Finally, a guidebook was developed for mentors and service coordinators, and a manual was prepared with specific information about service documentation requirements.

Recruitment Initiatives—In addition, the SPA Workforce Development Team created and began implementing an extraordinarily detailed recruitment strategy, designed to attract new students to the service coordination career path. The results of their work can be seen at www.allegHENYcounty.us/dhs/spa. In order to reach tech-savvy students, marketing materials and Web links were developed that enable interested students to follow developments regarding service coordination, such as course offerings, internships and job openings, on Facebook and Twitter.

The SPA Workforce Development Team defined educational pathways students should follow to pursue careers in service coordination and mentoring. In general, students needed to obtain a bachelor’s degree in social work or psychology that included a service coordination specialty or concentration. At the University of Pittsburgh, a social work student would need to take a course in service coordination and complete two full semesters of field placement working as a service coordinator in one of the 11 Allegheny County agencies.



Members of SPA Workforce Development Team

(Left to right: Courtney Burns, Jody Bechtold, Mike Gruber, Bethany Smith)

People who had already graduated from college would, at minimum, need to have a bachelor’s degree in social work, psychology, criminal justice, pastoral counseling, counseling psychology, rehabilitation counseling, sociology, education (with a certificate in special education) or nursing (with a Registered Nurse license). They would also need to take the 16-week course in service coordination.

In total, approximately \$1.2 million was made available to support the university-based training initiatives (\$600,000 from the County via ACHI and \$600,000 from service agencies). And, although the University of Pittsburgh service coordination certification program was by far the largest, the program and related internship components were also established at Carlow University and Chatham University in Pittsburgh.

Service Coordination Career Ladder at Family Services

Although career ladders for service coordination vary across agencies in Allegheny County, the Family Services example shows how job opportunities are beginning to evolve in the region.

Position Title	Average Salary	Number of Staff Members
Supervisor (requires master’s degree)	\$36,000	2
Service Coordinator Coach (Envisioned for 2013; would require master’s degree or 10 or more years’ experience)	\$34,500	1
Service Coordinator Mentor	\$32,500	2
Service Coordinator	\$27,500	14
Service Coordination Field Placement (Stipend; starts in Fall 2011)	\$1,000	TBD

Salary Enhancement—In the very early days of the SPA Initiative, there was growing consensus that salaries at some agencies were too low. This was thought to be having an adverse impact on staff recruitment and retention. Then, research faculty from the University of Pittsburgh recommended that pay be increased for service coordination positions. The recommendation was supported by the SPA Finance Subcommittee and subsequently adopted by county officials who, in 2009, instituted an 18% rate increase for the service. Contract language between the county and local agencies ensured that staff salaries would be raised to a new minimum level.

As part of its monitoring activities, in 2008 and 2010, the SPA Finance Subcommittee conducted salary surveys, collecting data on the number and tenure of service coordination staff, and staff salaries and benefits. Comparison of data from these surveys regarding the nearly 280 staff members (shown in the next two tables) provided confirmation that SPA workforce development efforts were paying off. The subcommittee found that the length of employment among service coordinators and their supervisors increased from one survey to the next.

Employee Tenure

“Improving employee tenure is one of our foremost objectives. Employees who stay on the job are able to build strong therapeutic relationships with clients. This is directly linked to positive client outcomes. Increased staff tenure also has a huge business benefit. When we add the cost of advertising, training and lost productivity, we estimate that it costs the agency at least an entire year’s wages to replace each worker who leaves. Avoiding that cost is very important to us.”

—Stephen Christian-Michaels, COO

Service Coordinator: Staff Tenure 2008 and 2010 Comparison <i>(Includes all 11 Allegheny County agencies that provide service coordination)</i>			
Indicator	Year		Direction of Change
	2008	2010	
Average length of service (experience) at agency and in related fields	75.8 months	94.1 months	Positive
Service coordinators with fewer than 12 months of tenure	25%	20.3%	Positive
Service coordinators with fewer than 18 months of tenure	34.2%	28.1%	Positive
Average tenure of service coordination supervisors	79.8 months	83.4 months	Positive

Similar positive changes were found in wages. A comparison of wage data revealed that average minimum hourly wages for newly hired service coordinators had gone up. In addition, minimum, average and maximum salaries had all increased, as had benefits as a percent of average salaries.

In 2006, there were no mentor positions in the county. However, the 2010 salary survey revealed that three agencies had added mentoring positions as an opportunity for career advancement. By 2011, all 11 service coordination agencies had established these positions (totaling 36 staff members). The number of mentors is expected to grow to 40 by June 2011. As an aside, the first person to be hired as a mentor at Family Services has been promoted to a supervisory position, and an intern has become a service coordinator. These data indicate modest but steady improvement in career advancement options.

Service Coordinator: Salaries and Benefits			
2008 and 2010 Comparison			
<i>(Includes all 11 Allegheny County agencies that provide service coordination)</i>			
Indicator	Year		Direction of Change
	2008	2010	
Average minimum hourly rate for new hires	baseline	+8.4%	Positive
Average minimum annual salary	baseline	+8.5%	Positive
Average annual salary (excluding benefits, bonuses and other perks)	baseline	+4.9%	Positive
Average maximum annual salary	baseline	+6.6%	Positive
Benefit package as percentage of average salary	26.7%	28.9%	Positive

At the county level, salary, benefit and tenure data were also used in reimbursement rate calculations and strategic planning, while at individual agencies, it helped administrators to assess how their agency compared with other agencies in the county.

Better Services

Paul Freund, a representative from the National Alliance on Mental Illness, directs an annual consumer satisfaction survey in the county to assess opinions regarding service coordination for adults and children. During the December 2010 meeting of the SPA Finance Subcommittee, Freund reported results on service access, quality and outcomes. These data revealed high levels of satisfaction for adults, and for adolescents and parents of children who received care. Client satisfaction ratings among adults receiving care from Family Services (presented in the right-hand column below) compared favorably with average ratings for all 11 agencies (see highlighted items). The comparatively better performance of Family Services is thought to be due to the head start it had in developing and refining service coordination.

Client Satisfaction: Access, Quality and Outcomes				
		Children's Services All 11 agencies (N=165)	Adults All 11 agencies (N=404)	Adults Family Services of Western Pennsylvania (N=30)
Access	Satisfied with scheduled visits	93%	89%	97%
	Received all help needed	80%	83%	84%
	Had adequate transportation to services	92%	83%	94%
Quality	Was not forced or pressured to accept treatment	95%	93%	90%
	Had treatment or service questions answered	96%	92%	94%
	Was given a chance to make treatment decisions	93%	88%	94%
	Was given respect for their choices	98%	93%	97%
Outcomes	Was helped with recovery goals	88%	88%	93%
	Reported improved quality of life	83%	82%	93%
	Overall satisfaction	N/A	87%	90%

The survey also found areas that needed improvement. For example, among parent or adolescent respondents:

- 22% percent reported that their child or they did not have a hobby or regular activity that was important to them.

Adult respondents gave the following answers to survey questions:

- Does your service coordinator explain your goals and plans to all staff members you work with? Yes—74%; No—7%; Unsure—19%
- Does your service coordinator support you when staff members you work with do not cooperate to help you achieve your goals? Yes—79%; No—4%; Unsure—17%

Clearly, more needed to be done to involve children in hobbies or valued regular activities, and adults needed more support to help them achieve their goals.

Better Business

People working on the business aspects of the SPA Initiative began to recognize that optimal diffusion of lessons learned required a relatively high degree of transparency. And transparency, especially in difficult economic times, meant taking risks because it involved sharing proprietary information. It became obvious to SPA participants that the level of transparency and cooperation shown by the leadership at Family Services transcended fear about competition. Because Christian-Michaels had taken the lead in sharing his agency's data, he improved his personal credibility with sister agencies, thus making it easier for him to lead the effort. Additionally, to cure any remaining jitters, some data were cloaked by identifiers known only to an analyst at county government. Soon, all 11 agencies were willing to contribute their financial and operational information. This strengthened SPA planning and evaluative capabilities, enabled each agency to compare its standing on important operational variables with other agencies in the region and facilitated better management of the service system.

The SPA Finance Subcommittee also keeps close tabs on service coordination unit costs and reimbursement rates. While it is still too soon to know whether efforts to improve staff training, salaries and retention rates will have a lasting impact on the business viability of the 11 agencies, preliminary indications are positive. In 2010, the SPA Finance Subcommittee found there was a shift in the number of agencies that had costs near or less than the reimbursement rate for service coordination. Thus, more agencies were at the break-even point or beginning to make money.

Unit Cost and Reimbursement Rate Comparison

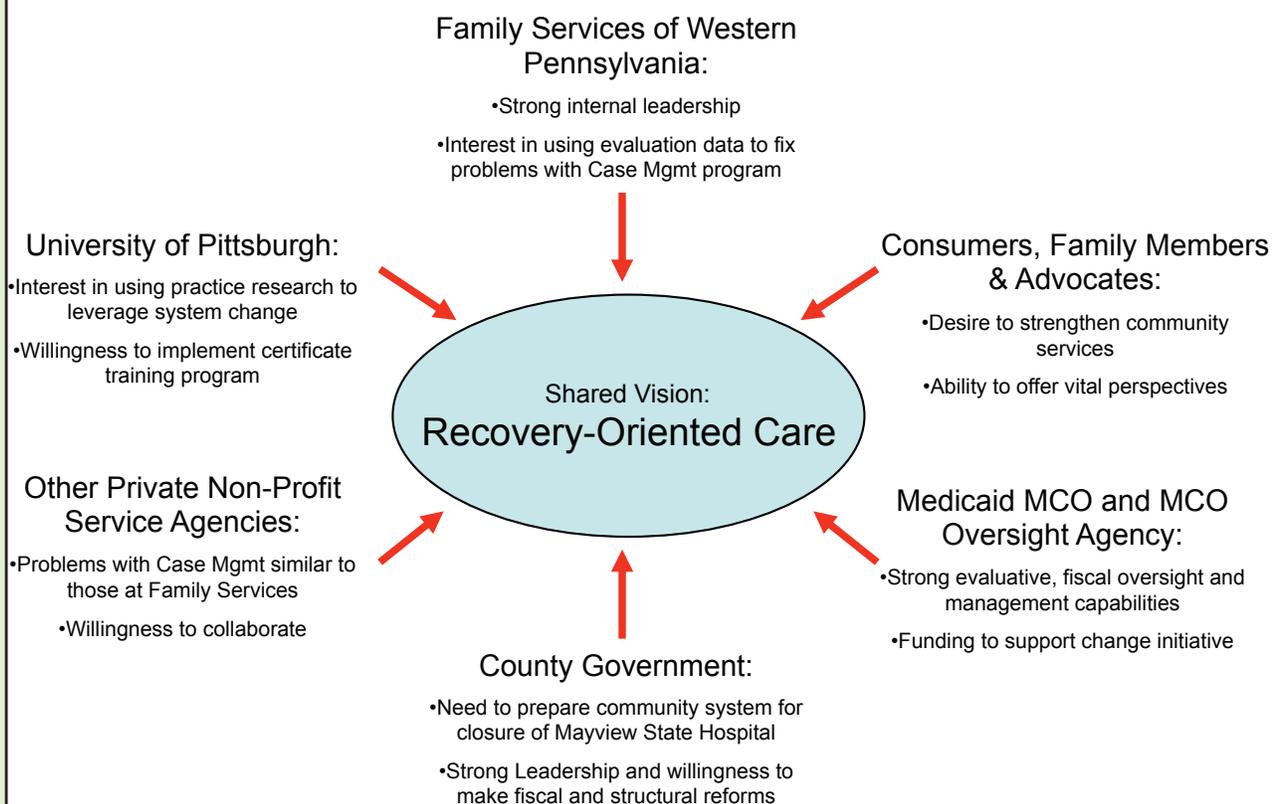
(Service coordination provider agencies that made or lost money based on current reimbursement rate; Includes all 11 Allegheny County Agencies that provide service coordination)

	FY09	FY10
Agencies with unit costs less than reimbursement rate	3	5
Agencies with unit costs near reimbursement rate (i.e., within \$0.50)	1	3
Agencies with unit costs significantly higher than reimbursement rate	7	3
Agencies with unit costs near or less than reimbursement rate	4	8

Conclusion

Establishing and maintaining a cadre of qualified staff needed to provide recovery-oriented care for people with serious mental illnesses is a challenge in western Pennsylvania and throughout the nation. Family Services of Western Pennsylvania started a process that has produced important insights about how to meet this challenge. Its collaboration with the University of Pittsburgh, Allegheny County, consumers, family members and other stakeholders opened a pathway that has greatly improved preparedness for an important segment of the region's mental health workforce. Prior to development of the SPA Initiative, many individuals had been hired as case managers in Allegheny County who knew little or nothing about serious mental illnesses or the work they would be asked to perform. This caused problems with the continuity and quality of care. Now, service coordinator certification training and related internships and field placements are beginning to serve as a selection mechanism that will help students decide whether they are well suited for a career in service coordination before they even apply for the job. This strategy shows promise for reducing turnover and improving vitally important services.

Workforce Change in Allegheny County



It is perhaps useful to consider that the scale of workforce investment in Allegheny County—which involved three universities, a significant infusion of new resources affecting hundreds of staff, the quality of care for thousands of people with severe mental illnesses and the business viability of 11 service agencies—would not have been justified if the change initiative had been confined to a single agency. What began at the micro level at Family Services of Western Pennsylvania as a modest scheme, when propelled at the macro level by necessity for change (i.e., the need to improve services and the state hospital closure) and aided by the vision and leadership of some truly committed and talented individuals, has become something much greater and worthy of note.

About The Annapolis Coalition:

The Annapolis Coalition is a non-profit organization dedicated to improving the recruitment, retention, training and performance of the prevention and treatment workforce in the mental health and addictions sectors of the behavioral health field. As part of this effort, it seeks to strengthen the workforce role of persons in recovery and family members in caring for themselves and each other, as well as improving the capacity of all health and human service personnel to respond to the behavioral health needs of the individuals they serve. The Coalition is celebrating its 10th year as the nation's leader in strategic planning regarding the behavioral health workforce; advisor to federal agencies and commissions on workforce issues; and provider of technical assistance to states and non-profit organizations on practical workforce development quality improvement initiatives.

About The Hitachi Foundation:

Hitachi Foundation is an independent nonprofit philanthropic organization established by Hitachi, Ltd. in 1985. Its mission is to forge an authentic integration of business actions and societal well being in North America. The Foundation's strategic focus through 2013 is on discovering and expanding business practices that create tangible, enduring economic opportunities for low-wealth Americans, their families, and the communities in which they reside—while also enhancing business value. At its core, the Foundation is on a path toward discovery, committed to investments that enhance what society can learn about socially sustainable business practice and corporate citizenship.

This report was prepared by the Annapolis Coalition on the Behavioral Health Workforce. The report was authored by Wayne F. Dailey, PhD, project coordinator for the Behavioral Health Pacesetter Award, an initiative sponsored by the Annapolis Coalition in partnership with The Hitachi Foundation.
“Better Jobs, Better Services, Better Business”